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How do People React to Someone Who Has Recently Tested for HIV? An Experimental Study of the Effects of Sexual Orientation and HIV Status

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**HOW DO PEOPLE REACT TO SOMEONE
WHO HAS RECENTLY TESTED FOR HIV?
AN EXPERIMENTAL STUDY OF THE EFFECTS OF
SEXUAL ORIENTATION AND HIV STATUS**

by

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ABSTRACT

HOW DO PEOPLE REACT TO SOMEONE WHO HAS RECENTLY TESTED FOR HIV? AN EXPERIMENTAL STUDY OF THE EFFECTS OF SEXUAL ORIENTATION AND HIV STATUS

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HIV/AIDS-related stigma remains prevalent in our society despite advances in medical treatment, and appears to be based on fear of the illness and negative attitudes toward gay individuals. Previous literature examining the phenomenon, enactment, and consequences of HIV/AIDS-related stigma has primarily been based on self-report measures examining participants' imagined reactions toward a person with HIV/AIDS (PWH). The present study attempted to expand on the self-report findings and contribute uniquely to the literature by examining participants' attitudes toward an individual believed to be gay and HIV-positive after a real-life interaction. This study, which involved the use of a confederate whose sexual orientation (straight, gay) and HIV serostatus (negative, positive) had been manipulated, examined participants' attitudes along dimensions of liking and trust, willingness to affiliate, and enactment of social support and self-disclosure. Results revealed several gender differences in reactions to the confederate, whereby men offered more solace and made fewer low descriptive/low evaluative statements toward an HIV-positive individual, but women were more willing to affiliate with the confederate regardless of his sexual orientation or HIV serostatus. Participants also used more low descriptive/low evaluative statements when interacting with a gay, versus straight, HIV-positive confederate, suggesting that negative attitudes toward gays

is a driving force in the perpetuation of HIV/AIDS-related stigma. The findings offer support to the previous literature demonstrating that HIV/AIDS continues to be strongly associated with homosexuality, and reveal that negative attitudes are apparent in real-life situations as well as on self-report measures. However, participants' willingness in many cases to provide social support and intimate self-disclosure is hopeful, and indicates that continued educational efforts aimed at reducing HIV/AIDS-related stigma may meet with success.

To my family, for their steadfast love and their support for all my endeavors.
And to my husband, whose encouragement and infinite patience are but
a small part of what makes him the light of my life.

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CHAPTER 1

INTRODUCTION

HIV/AIDS is a serious chronic illness that affects individuals worldwide. In the United States, it was estimated that approximately 1.1 million people were living with HIV/AIDS at the end of 2006 (CDC, 2008a), with thousands of new infections occurring each year. The CDC estimated an incidence of 56,300 infections in 2006 alone (CDC, 2008b). Advances in the treatment of HIV/AIDS have slowed its progression and greatly reduced the number of AIDS-related deaths (CDC, 2008b). However, individuals living with HIV/AIDS still face a multitude of challenges. In addition to the complicated and often difficult medical management of the disease, persons with HIV/AIDS (PWHAs) also experience a variety of mental health concerns, such as personality and mood disorders (Brown et al., 1992; Kalichman & Sikkema, 1994; Perkins, Davidson, Leserman, Liao, & Evans, 1993) and neuropsychological/neuropsychiatric decline (van Gorp & Buckingham, 1998)¹. Additionally, they face a variety of negative consequences in many other areas of life, including difficulty with employment, healthcare, insurance, education, and other social, vocational, and recreational activities (Herek, 1999).

These challenges, particularly within the social, interpersonal, and financial domains, are what make the experience of coping with HIV/AIDS unique when compared to other chronic illnesses such as cancer or diabetes. Herek (1999) noted that *stigma* and discrimination were the source of these challenges; the fear elicited in others and the ensuing rejection of those infected can lead PWHAs to lose their jobs, their access to healthcare, and their social support networks. Men who have sex with men

¹ The model used is the *Publication Manual of the American Psychological Association, 5th Ed.* (2001).

(MSM), the group comprising the largest proportion of HIV/AIDS diagnoses in the United States (CDC, 2008b), are particularly susceptible to the stigma surrounding HIV/AIDS, due to the merging of negative sociopolitical and cultural beliefs about both HIV/AIDS and homosexuality. These individuals, already marginalized by society because of their sexual orientation, receive especially powerful injury to their physical and psychological well-being when they are additionally subjected to rejection for their illness.

To date, the literature on HIV/AIDS-related stigma and homosexuality confirms that individuals typically hold more negative attitudes and are less willing to disclose personal information or provide social support to PWHAs who are also gay, versus those who are straight. What is remarkable, however, is that not only have these studies been based primarily on self-report rather than on examination of actual behavioral interactions between research participants and PWHAs, most also do not examine how these negative attitudes compare to attitudes toward gay and straight individuals of healthy status, in order to determine the relative contributions of both HIV serostatus and sexual orientation. These shortcomings are what the present study will attempt to address.

First, the phenomenon of *HIV/AIDS-related stigma* will be discussed. A definition and overview of this particularly virulent form of stigma will be provided, and will include discussion of how HIV/AIDS and homosexuality came to be intimately linked in the public mind. Next, attributional models explaining the connection between HIV/AIDS-related stigma and the degree to which others are willing to provide support to PWHAs will be explored, and gender differences in attitudes toward PWHAs and willingness to provide assistance will be reviewed. Finally, a discussion of the limited

existing literature on the contributions of HIV serostatus and sexual orientation in shaping others' reactions to PWHAs will highlight the previously mentioned gaps in the literature and provide the basis for this current exploratory study.

Stigma and its Association with HIV/AIDS and Homosexuality

Stigma is a social psychological term defined as “a pattern of social prejudice, discounting, and discrediting that an individual experiences as a result of others' judgments about her or his personal characteristics or group membership” (Herek & Glunt, 1993, p. 231). Individuals with privileged status (i.e., belonging to groups holding power and influence) determine which groups have violated social norms and thus do not share this status. As a result, these socially “deviant” groups become stigmatized (Parker & Aggleton, 2003; Whitley & Kite, 2006).

Based on the work of Jones et al. (1984), Schneider (2004) described seven dimensions along which stigmas vary: concealability, time course, aesthetic value, stigma origins, peril or danger, disruptiveness, and mental versus physical stigmas. HIV/AIDS is a stigmatizing condition within several of these dimensions. Though concealable until later stages of illness and usually non-disruptive (i.e., there is no obvious physical impairment or behavioral unpredictability that would render interactions with PWHAs awkward), HIV/AIDS is chronic and terminal, causes facial and bodily disfigurement in late stages, arouses fears of contagion, and is perceived by many to be a consequence of irresponsible behavior. This notion of “responsibility” is especially important when examining HIV/AIDS-related stigma, as individuals are much more likely to devalue or blame those who are perceived as being responsible for, or having had control over, their illness (Kelly et al., 1987; Schneider, 2004). Weiner (1993a) noted that HIV/AIDS

typically rates high on controllability when compared to other conditions such as Alzheimer's disease, blindness, and cancer. However, these attributions of control can be changed when the conditions under which a person contracted the illness change, such as whether the disease was acquired as the result of a blood transfusion (less controllability is assigned) or through sexual activity (more controllability is assigned). Weiner also noted that individuals tend to feel more anger toward someone believed to have control over his situation (e.g., HIV/AIDS contracted via sexual means), and more sympathy toward someone in a situation perceived as uncontrollable (e.g., HIV/AIDS contracted through a blood transfusion), thus illustrating the importance of perceived responsibility when evaluating HIV/AIDS-related stigma.

Though HIV/AIDS itself provokes anxiety and negative reactions, HIV/AIDS-related stigma cannot be examined without simultaneously considering the influence of negative attitudes toward homosexuality. The association of HIV/AIDS with homosexuality stems from the initial discovery of clusters of rare viruses found among gay men in the early 1980's. The syndrome was originally termed GRID (Gay-Related Immune Deficiency). Though the virus was renamed in 1982, HIV/AIDS and homosexuality had become intimately linked (Herek & Capitano, 1999; Pryor & Reeder, 1993; Pryor, Reeder, & Landau, 1999). This connection has been reinforced by the fact that throughout the history of the disease, men who have sex with men make up the largest group of infections.

There is evidence (Connors & Hely, 2007; Dijker, Kok, & Koomen, 1996; Herek & Glunt, 1993) that negative attitudes toward illness may stem from perceived characteristics of both the disease and the affected individuals. Thus, notions about the

serious consequences of HIV/AIDS and its contagiousness, as well as associations of the disease with homosexuality and sexual promiscuity, contribute to HIV/AIDS-related stigma, and in fact this stigma is unique when compared to the stigma attached to other serious illnesses because of this association with already marginalized members of society (Herek & Glunt, 1993). Attitudes toward PWHAs are thus more negative than attitudes toward individuals with other chronic illnesses (Dijker et al., 1996) because HIV/AIDS “seems to have provided many Americans with a vehicle for expressing antigay prejudice. It is a convenient hook upon which they can hang their pre-existing hostility toward gay men, lesbians, and anyone who engages in homosexual behavior” (Herek & Glunt, 1993, p. 231). Ultimately, this conflation of the stigmas toward both HIV/AIDS and homosexuality leads to social ostracism, employment difficulties, social isolation, public endorsement of stigmatizing and ineffective means of controlling HIV/AIDS (such as quarantining those infected), rejection of PWHAs, overestimation of the ability to contract the disease through casual contact, and even avoidance of PWHAs by members of the healthcare community (Herek & Glunt, 1993).

Herek and Glunt (1993) conducted focus groups in several U. S. cities, as well as a national telephone survey, to determine how attitudes toward gays influenced public opinion about HIV/AIDS and contributed to HIV/AIDS-related stigma. The authors found that, similar to other STDs and to cholera in the 19th century, individuals were divided in their attitudes toward HIV/AIDS along pragmatic (working to prevent the spread of illness) and moralistic (promoting moral standards concerning risky behavior) lines, as well as along compassionate (believing that PWHAs are deserving of care and respect) and coercive (believing that PWHAs are to blame, and should be handled

punitively) lines. HIV/AIDS-related stigma appeared similar to the stigma surrounding other potentially lethal illnesses in that it was derived both from fears for personal safety as well as negative attitudes toward the social groups at risk for contracting it. These varying attitudes served a psychological function in that they may have enhanced individual self-esteem or reduced anxiety surrounding the fear of infection.

Though many participants in the Herek and Glunt study were aware of accurate information concerning the modes by which HIV/AIDS is transmitted, individuals may still have overestimated the risks posed by casual contact, which resulted in the desire for coercive (punitive) measures to be taken to reduce its spread. Overestimation of the risks posed by casual contact may have stemmed from a general disbelief in public health officials, or from transference of beliefs about “pollution” from homosexuality onto HIV/AIDS. Interestingly, Herek and Glunt also noted that overestimation of casual contact risk stemmed from faulty reasoning and a willingness to believe information provided by less-than-credible healthcare sources, as well as selective willingness to accept risks (i.e., individuals who ignore risk in routine situations, such as riding in a car, are unwilling to accept even the remotest risk that they could become infected with HIV/AIDS through casual contact). All of these factors contributed to the perpetuation of HIV/AIDS-related stigma.

A comparable study conducted via two national telephone surveys in 1997 and 1999 (Herek, Capitano, & Widaman, 2002) revealed the hopeful findings that overt expressions of HIV/AIDS-related stigma (such as social distancing and support for punitive measures) had decreased; however, a substantial proportion of people still endorsed feelings of disgust toward PWAs, and discomfort with coming into direct or

symbolic contact with them. Others continued to believe that PWHAs were responsible for their infection. While knowledge of how HIV/AIDS is transmitted appeared to have increased, there was still ignorance surrounding knowledge of how it is *not* transmitted, possibly leading to findings of continued support for mandatory testing of groups believed to be at risk.

Similarly, in 2009, HIV/AIDS-related stigma continued to appear on the decline, although one-third of Americans reported at least one misconception about how HIV is transmitted, such as sharing a drinking glass with an HIV-positive person (Kaiser Family Foundation, 2009). This statistic is troubling when considered together with the Kaiser Family Foundation's findings that four in ten people know someone affected by HIV/AIDS, and that these misconceptions appear to contribute to discomfort around PWHAs.

Herek, Widaman, and Capitanio (2005) noted that symbolic and instrumental stigmas also shape beliefs about HIV/AIDS. In this case, *symbolic stigma* refers to the use of HIV/AIDS-related stigma as an indirect form of negative expression aimed at sexual minorities and injection drug users, the two groups representing the largest proportion of infections. Symbolic stigma embodies the prejudicial and moralistic attitudes that are often brought to discussions about HIV/AIDS. *Instrumental stigma*, on the other hand, refers to the concern over personal safety and the attempts made to reduce anxiety and avoid infection, regardless of epidemiological facts. The authors pointed out that "both types of stigma help to perpetuate the belief that sex equals AIDS, especially when that sex occurs between two men" (p. 34).

Other surveys have revealed similar associations between HIV/AIDS and homosexuality. A national telephone survey conducted from 1990 to 1991 involving both a general adult and an African-American sample revealed that a significant minority of the general sample was misinformed about how HIV/AIDS is transmitted, and instead appeared to associate male homosexuality and drug use with HIV/AIDS, even in situations where transmission is impossible. For example, 46.2% of the general sample reported that infection is “likely” between two HIV-negative men who have sexual intercourse without using condoms. Similar findings were noted among the African-American sample, though, in general, African-Americans appeared more concerned with transmission of HIV/AIDS, while Caucasians harbored more negative feelings toward PWHAAs (Herek & Capitano, 1993). In a follow-up 1996-1997 national telephone survey using similar general adult and African-American samples, Herek and Capitano (1999) found that HIV/AIDS continued to be strongly associated with homosexuality. Most individuals (52.9%) in the general sample reported that gay men, lesbians, or bisexuals were the first groups to come to mind when they heard the word “AIDS.” These individuals also tended to hold more negative attitudes and feelings toward gays.

Herek and Capitano (1999) also presented participants with a set of scenarios designed to determine whether *any* form of homosexual activity continued to be associated with HIV/AIDS. In these scenarios, participants were first asked to determine the likelihood of HIV/AIDS transmission through one episode of unprotected male-female sex and male-male sex, when the male partner was infected. Participants were next asked to determine the likelihood of transmission through one episode of male-male sex (either with or without a condom) when both partners were uninfected. While a

majority of participants responded accurately to the first two scenarios, nearly 25% of participants surprisingly responded that HIV/AIDS transmission was “very likely,” “somewhat likely,” or “somewhat unlikely” to occur in the scenario where both male partners were uninfected, and when a condom was used. That number jumped to more than 40% in the scenario where no condom was used.

Participants producing inaccurate responses also endorsed significantly more negative attitudes toward gay men. This evidence makes a strong case for the fact that homosexuality is linked to HIV/AIDS in the minds of Americans regardless of medical fact and overwhelming evidence to the contrary. Should members of the public lack adequate information about HIV/AIDS and its mode of transmission, negative attitudes toward gays most likely lead these individuals to overgeneralize and to assign high risk to sexual activity, particularly among gay men, thus perpetuating stigma. The authors noted repeated experimental findings that, when presented with scenarios describing men who contracted HIV through sexual activity, participants consistently report more negative reactions toward a gay man with AIDS versus a straight man with AIDS. These findings led the authors to conclude that gay men are perceived as “guilty” both for choosing to engage in same-sex activity, and simply for being gay.

Sadly, the association of HIV/AIDS infection with homosexuality is so strong that stigmatizing beliefs may be held by PWHAs themselves. Pryor and Reeder (1993) reported that HIV/AIDS-related stigma is evident even among non-gay PWHAs. This may be for several reasons, including the idea of “sympathetic magic,” in which a contiguous object (such as a sweater worn by a PWHA) becomes “contaminated;” the attribution of control (Weiner, 1993a), in which those assigned more control or

responsibility over their infection (such as a gay man who contracted the disease through sexual intercourse) are more highly stigmatized; and the idea of HIV/AIDS as a symbol which represents homosexual promiscuity and immorality (cf. Herek, 1999; Herek & Capitanio, 1999). The authors noted that this extensive application of stigma can have widespread, devastating effects, as stigma may affect not only the stigmatized, but also his or her family and the objects in the stigmatized person's possession. Stigma can also come at a great societal cost, as people who fear stigmatization and discrimination may fear being tested or seeking appropriate healthcare. Finally, the psychological consequences of stigma can leave stigmatized individuals bereft of hope. Fife and Wright (2000), in their study examining the impact of stigma (including stigmatizing mechanisms of social rejection, financial insecurity, internalized shame, and isolation/anomie) on the self-perceptions of individuals with HIV/AIDS and cancer, found that the effects of illness were experienced indirectly through the experience of stigma, leaving individuals with lowered self-esteem, poorer body image, and decreased perceptions of personal control.

Attributional Models of HIV/AIDS-related Stigma

Others' fear of contracting HIV/AIDS, the association of HIV/AIDS with homosexuality, and beliefs about responsibility for, or controllability of, the illness all influence the social experiences of PWHAs. Individuals who are not infected may feel little empathy toward PWHAs, may blame PWHAs for their illness, and may fear infection through casual contact, making them less likely to interact with PWHAs and provide them with social support. A number of authors have examined the social impact

of HIV/AIDS-related stigma, and proposed attributional pathways by which this stigma translates to avoidance and neglect of PWHA's.

As part of their national telephone survey, Herek and Capitanio (1999) provided participants with vignettes describing 32 experimentally manipulated conditions involving a target PWHA's sexual orientation, race, sex, and route of infection, in order to determine whether negative attitudes toward gays still fueled HIV/AIDS-related stigma and resulting affective responses. Participants received one randomly selected scenario and were asked to report on the PWHA's responsibility for infection, the participant's levels of sympathy and anger toward the PWHA, and the participant's willingness to help the PWHA. The authors found that, as expected, attitudes toward men who had contracted HIV/AIDS through sexual intercourse with another man were significantly more negative. These men were assigned more responsibility for their condition, received more anger and less sympathy, and earned significantly less help. It is interesting to note that female participants assigned the lowest sympathy ratings to bisexual men who had had multiple sexual partners. This may be due to perceptions that bisexual males pose a greater threat to women's personal safety, both in terms of transmission of infection as well as infidelity within a relationship.

Similarly, Fish and Rye (1991) conducted a study in which undergraduates responded to vignettes about a target individual based on their attitudes. In these vignettes, the target's sexual orientation and disease status (HIV/AIDS, sexually transmitted disease, cancer, healthy) were manipulated. Results showed that students were significantly less likely to engage socially with PWHA's, and judged gay individuals most negatively regardless of health status. The authors concluded that stigma may have

impacted these students' willingness to interact with PWHAs, and noted that, similar to the discussion of symbolic stigma in Herek et al. (2005), HIV/AIDS phobia was present even when individuals had appropriate knowledge about the disease. Additionally, Pryor, Reeder, Vinacco, and Kott (1989) found that students holding prejudiced attitudes toward homosexuality were less likely to welcome interaction with a *non-gay* person with HIV/AIDS than students who were less prejudiced. Though this finding initially appears surprising, the authors suggested that this result was again due to the symbolic link between negative attitudes toward gays and feelings about HIV/AIDS, independent of instrumental concerns.

Dijker et al. (1996) sought to explore the emotions evoked in others by PWHAs, and how those emotions influenced decisions to interact with them. They hypothesized that attributions of the causes of a stigmatizing illness, such as HIV/AIDS, give rise to emotions such as anger and pity, which occur based on the degree to which an observer holds the ill person responsible for his illness. When an observer attaches blame to the ill individual—such as blaming an injection drug user for acquiring HIV/AIDS—anger is likely to be the predominant emotion. This in turn influences the observer's willingness to help the ill individual. The authors found that pity, fear, and irritation each predicted an individual's willingness to interact with a PWHA; those reporting pity were more willing to engage with a PWHA, while those reporting fear and irritation were less likely. However, attitudes toward gays were unrelated to fear of PWHAs, and seemed instead to induce aggressive emotional responses, which in turn reduced individuals' feelings of pity toward PWHAs and thus their willingness to interact with them. Dijker et al. noted that those with negative attitudes toward gays who are uncomfortable with casual contact

with PWHAs may in fact be expressing their anti-gay prejudice rather than concern about infection. Additionally, risk perception was correlated with fear and aggression (and thus less willingness to engage), while attributing blame to an individual was correlated with decreased pity and less willingness to engage.

Weiner (1993a) also incorporated attitudes toward gays into this framework, and hypothesized that those with negative attitudes toward gays (“sexual hostility”) and a tendency to blame them for infection view them as “morally repugnant” and are unwilling to interact with or to assist them. Weiner reported that gays who were assigned responsibility for infection elicited more anger and less pity than each of three other conditions—gays without responsibility, heterosexuals with responsibility, and heterosexuals without responsibility (Mallery, 1990, as cited in Weiner, 1993a). Thus, when a situation is perceived as “controllable,” individuals are likely to be judged as “responsible” for their condition(s), and anger results. When this anger outweighs sympathy (for uncontrollable, non-responsible situations), support is withdrawn or punishment meted out (Weiner, 1993b). For example, neglect may result from feelings of anger, and helping behaviors may arise from feelings of sympathy/pity. These types of behavioral responses to affective reactions also affect the likelihood of willingness to provide charity to those in need (Weiner, 1993a).

Dijker, Koomen, and Kok (1997) proposed that fear is an important determinant of willingness to interact with a PWhA. Drawing on previously cited research showing that individuals are motivated to avoid PWHAs through fear of contagion (Dijker et al., 1996; Herek & Capitanio, 1993), the authors explained that fear likely causes attentional and cognitive consequences, including exaggerated beliefs about infection through casual

contact, even when participants hold adequate knowledge about how HIV/AIDS is transmitted. Dijker et al. also argued that, in addition to the fear aroused by an individual's determination of how threatening a stimulus is to his or her safety, fear is also triggered by the stimulus' degree of behavioral predictability. Greater predictability, in this case, increases an individual's ability to determine, and thus avoid or escape, a perceived threat. In their study examining reactions to target PWHAs whose sexual orientation and degree of predictability were experimentally manipulated, Dijker et al. found that a PWA who is described as "uncontrolled" and "unpredictable" aroused greater anxiety among participants and less willingness to engage in indirect physical contact (such as sharing a coffee machine) than a PWA who is described as "self-controlled" and "serious." These findings lend credence to the authors' theory, and may also suggest that PWHAs who are "impulsive" may be viewed as reckless and thus responsible for having made poor decisions that led to their infection.

Of note, Pryor et al. (1999) developed a social-psychological model which states that initial reactions to a stigmatizing condition such as HIV/AIDS are affectively fueled, automatic, and usually negative; however, given adequate time, motivation, and reasoning ability, an individual may positively alter his/her perception of the stigmatized person based on other contributing factors, such as perceptions of controllability. This is a hopeful idea, and in fact was confirmed in a study by Smith, Pryor, and Reeder (1998, as cited in Pryor et al., 1999) in which participants in a time-delay condition reported greater willingness to interact with a young girl with HIV/AIDS than participants in an immediate-response condition, presumably because those in the time-delay condition had ample opportunity to reconsider and revise their initial reactions. However, controllability

continues to be a critical factor in assessing others. Though participants had initially rated the young girl as having little control over her condition, they rated a drug addict as high on control; as a result, willingness to interact with the drug addict did not increase in the time-delay condition. Thus, to the extent that individuals believe others are responsible for contracting HIV/AIDS—such as by engaging in same-sex sexual activity—they will continue to regard these others with disfavor or contempt, and will be less likely to interact with them.

Finally, *defensive distancing* may play a role in influencing others' willingness to interact with PWHAs. Research has shown that individuals tend to be uncomfortable interacting with those who suffer from a serious illness, and will often avoid them (Kleck, 1968; Schulz, 1978; Stahly, 1988; Wortman & Dunkel-Schetter, 1979). This behavior may stem from the conflict many individuals experience over acting compassionately toward those who are seriously ill, while simultaneously coping with their own negative feelings about the illness. Pyszczynski et al. (1995) noted that defensive distancing may serve to shield healthy individuals from facing awareness of their own vulnerability to illness. In their study examining the mechanisms underlying defensive distancing toward cancer patients, the authors found that participants tended to perceive their personality characteristics as dissimilar to those of individuals with cancer in an effort to distance themselves psychologically and thus deny their own vulnerability. Kurzban and Leary (2001) also discussed the tendency for individuals to put physical distance between themselves and PWHAs in an effort to avoid contagion and sickness. Though the majority of literature on defensive distancing is centered on cancer patients, it is conceivable that defensive distancing plays a role in interactions with PWHAs as well,

particularly in later stages of illness when physical and mental deterioration become apparent.

Gender Differences in Reactions to Persons with HIV/AIDS

Men tend to hold more unfavorable attitudes toward those with HIV/AIDS overall than do women. These attitudes include greater fear of contracting the disease and more negative attitudes toward homosexuality (Bouton et al., 1987; Connors & Hely, 2007; Heaven, Connors, & Kellehear, 1990; Kunkel & Temple, 1992; Young, Gallaher, Marriott, & Kelly, 1993). Herek (2000) conducted a study assessing men's and women's attitudes toward lesbians and gay men as part of the 1996-1997 national telephone survey examining beliefs about HIV/AIDS. Responses to items on the Attitudes Toward Gay Men (ATG) and Attitudes Toward Lesbians (ATL) scales indicated that heterosexual men reported significantly greater sexual prejudice toward gay men than toward lesbians. Heterosexual women also reported significantly greater sexual prejudice toward gay men than toward lesbians, though the gap was smaller. Male and female participants also rated gay men and lesbians according to a "feeling thermometer," in which they were asked to use a 101-point scale to indicate the degree to which they felt emotional warmth or coldness toward the target groups. Again, men reported significantly greater emotional coldness toward gay men than toward lesbians, while women's scores for both target groups were nearly identical. A final examination of participants' comfort level with gay men and lesbians revealed that men were significantly less comfortable with gays of either sex than women, and particularly less comfortable with gay men. Where scores were inconsistent (i.e., either men or women rated one target group lower than another), greater discomfort was usually assigned to the target group of the same sex. Herek noted

that, generally, the data suggested that both heterosexual men's and women's attitudes toward gay men and lesbians are negative and highly correlated; differences occur primarily among heterosexual men, who exhibit greater sexual prejudice toward gay men.

Men are also less willing to interact socially with those affected by HIV/AIDS, whereas women tend to be more sympathetic toward these individuals (Connors & Hely, 2007). However, Connors and Hely (2007) found that fear of contracting HIV/AIDS was a significant predictor of both men's and women's willingness to have social contact with HIV-positive individuals. In their study of fear aroused by unpredictability, Dijker et al. (1997) found that men evidenced greater anxiety when expecting to work with a behaviorally unpredictable (i.e., disorganized, uncontrolled, impulsive) heterosexual man with HIV/AIDS, whereas women reported greater anxiety when expecting to work with an unpredictable gay man with HIV/AIDS. These gender differences may be due to the fact that men and women find it easier to develop close, sexually-neutral relationships in the workplace with heterosexual and gay men, respectively. When these colleagues are described as having HIV/AIDS, however, the emotional and physical threat within a close relationship becomes more imminent, leading to anxiety and avoidance.

Whitehead and Smith (2002) reported that men were more likely to engage in defensive distancing than women. Though their results were obtained using cancer patients and accident victims as target stimuli, the above studies suggest that future research may show these findings to be applicable to PWHAs as well.

HIV Serostatus, Sexual Orientation, and Reactions to Persons with HIV/AIDS

The above discussion demonstrates clearly the association between homosexuality and HIV/AIDS, and the ability of this association to cause pervasive stigmatization

toward PWHAs. However, in addition to being based primarily on self-report, the literature contains few studies in which researchers have attempted to examine the mechanisms of HIV/AIDS-related stigma, and to parse whether negative attitudes toward PWHAs are predominantly influenced by HIV serostatus or sexual orientation alone, or whether the influence stems from a unique combination of these two factors. Only two studies to date have provided the foundation for this important work.

Fish and Rye (1991) manipulated the target individual's sexual orientation and disease status (HIV/AIDS, sexually transmitted disease, cancer, healthy) in their self-report study, potentiating an examination of interactional effects of HIV/AIDS-related stigma. However, no significant interactions between these variables were found, suggesting that a gay PWHA was not significantly more likely to be judged negatively when compared to an individual of any other sexual orientation by disease status combination. In their discussion, the authors noted that while character evaluations of the target PWHA were not overly harsh when compared with evaluations of a target of any other disease status, participants reported being quite unwilling to interact with him, regardless of his sexual orientation. Within the HIV/AIDS condition, however, evaluations of a gay PWHA were significantly more negative than evaluations of a heterosexual PWHA. In a preliminary attempt to understand the mechanisms influencing these findings, the authors reported that both "homophobia" [authors' term] and HIV/AIDS phobia were the likely contributing factors. If participants were motivated by symbolic concerns stemming from the association of homosexuality with HIV/AIDS, they may have wished to distance themselves from a PWHA of any sexual orientation; in other words, HIV/AIDS-related stigma in this case would have resulted primarily from

negative attitudes toward homosexuality (“homophobia”). Conversely, if participants were motivated by instrumental concerns about their own safety, they may have distanced themselves to reduce the personal risk of infection (HIV/AIDS phobia), meaning the stigma was influenced primarily by HIV serostatus.

In the second study, Derlega, Sherburne, and Lewis (1998) examined participants’ reactions to a man they believed to be HIV-positive. The experiment was conducted in a laboratory setting using a confederate portraying himself as HIV-positive, making it the only study of its type to examine the actual behavioral reactions that might occur toward a PWHA. The authors were interested in exploring the impact of sexual orientation and perceived controllability of infection on reactions to a man believed to be HIV-positive, and hypothesized that individuals would respond significantly less favorably when interacting with a gay PWHA versus a heterosexual PWHA on measures of affect, liking and trust, social support, and self-disclosure. They also hypothesized that these same reactions would occur toward a PWHA perceived as having had control over the infection, compared to someone whose mode of infection was perceived as uncontrollable. Finally, the authors set out to explore the research question of whether participant gender would have an impact on the findings, based on the literature demonstrating that men typically respond less favorably to gay men than do women.

Results supported the hypothesis that participants would respond less favorably when interacting with a gay PWHA on all measures, suggesting that sexual orientation was a primary influence in shaping reactions. Additionally, an interaction effect was found between sexual orientation and participant gender on a measure of negative affect, demonstrating that, as predicted, men reported more negative feelings toward a gay

PWHA, whereas the women did not. Interestingly, perception of control by itself did not influence reactions toward the PWHA; however, perception of control interacted with gender such that men were more likely to question the accuracy of the HIV diagnosis and to reveal more intimate feelings when the PWHA's situation was seen as "uncontrollable." The authors noted that this may have been due to the men's ability to envision themselves in a similar situation to the PWHA.

The study by Derlega et al. (1998) was an initial examination of the mechanisms influencing stigmatization of PWHA's; in this case, beliefs about homosexuality appeared to drive participants' attitudes, particularly among men. Though this study did not examine how much of the negative reactions, social support, and self-disclosure were due to sexual orientation per se, HIV serostatus per se, or their unique combination, it formed the basis for continued research aimed at answering this question.

Purpose of the Present Investigation

Based on the questions raised by the literature regarding the contributions of sexual orientation and HIV serostatus to HIV/AIDS-related stigma, this study is designed to extend the findings reported by Derlega et al. (1998). This exploratory study will examine reactions to a person who has recently been tested for HIV. Based on the experimental manipulation, participants will be presented with one of four types of information: that the stimulus person is either HIV-positive and gay, HIV-positive and straight, HIV-negative and gay, or HIV-negative and straight. Data will be collected on personal reactions to the stimulus person, including enactment of social support and self-disclosure, interpersonal feelings of liking and trust, and defensive distancing. In an effort to collect data reflecting participants' true reactions to someone with a potentially

stigmatizing disease (such as HIV/AIDS), this study will use deception in its procedures in order to examine what are believed to be authentic behaviors toward an individual suspected to be HIV-positive and/or gay.

This study will allow us to examine the ways in which both sexual orientation and HIV serostatus influence reactions to an HIV-positive individual. While a number of findings have proposed that HIV/AIDS-related stigma is due primarily to the association of HIV/AIDS with homosexuality, other studies, including those demonstrating that negativity toward and avoidance of PWHAs is motivated by a fear of contagion (e.g., Herek & Capitano, 1993; Dijker et al., 1996; Kurzban & Leary, 2001), show evidence that HIV serostatus is the primary influence, and that the resulting negative attitudes are only weakly correlated with homosexuality. We expect that the present study will allow us to discern the contributions of sexual orientation, HIV serostatus, and their interaction effect on participants' reactions.

Hypothesis One: Based on the literature examining gender differences in reactions to PWHAs, we predicted that participant gender would interact with HIV serostatus, whereby male, compared to female, participants would provide significantly less self-disclosure and social support, lower ratings of liking and trust, and greater defensive distancing (which we also termed *affiliation* throughout) toward an HIV-positive individual. We also predicted that there would be an absence of gender differences in reactions to an HIV-negative individual.

Hypothesis Two: We predicted that participant gender would interact with sexual orientation, whereby male, compared to female, participants would provide significantly less self-disclosure and social support, lower ratings of liking and trust, and greater

defensive distancing toward a gay individual. An absence of gender differences in reactions to a straight individual was also predicted.

Hypothesis Three: We predicted that participant gender would interact with both sexual orientation and HIV serostatus, whereby male, compared to female, participants would provide significantly less self-disclosure and social support, lower ratings of liking and trust, and greater defensive distancing toward a gay, HIV-positive individual. We also predicted an absence of gender differences in reactions to an individual of any other sexual orientation by HIV serostatus combination.

Hypothesis Four: We predicted that sexual orientation would interact with HIV serostatus, whereby all participants, regardless of gender, would provide lower ratings on all measures toward a gay, HIV-positive individual than toward an individual of any other sexual orientation by HIV serostatus combination.

CHAPTER II

METHOD

Participants

A convenience sample of 161 undergraduate men and women was recruited from the Psychology Department subject pool at Old Dominion University (ODU) for this study. Participants were enrolled through the use of the SONA Research Participation System. Only participants 18 years of age and older who were currently enrolled at ODU were eligible to take part; the mean age of the sample was 20.22 years ($SD = 4.04$). Additional demographic characteristics of the sample are provided in the following section. In exchange for their involvement, participants received extra course credit.

Approval for this research was obtained from the ODU Institutional Review Board on August 30, 2007, for a period of one year. This study was subsequently re-approved in June, 2008, and June, 2009. Upon receiving initial approval, information regarding participant eligibility, consent, and the location of the study were posted on the SONA System website for ODU recruitment (Appendix A). Through SONA, eligible participants registered to participate in the research by viewing available timeslots created by the researcher. Credit for participation was also granted by the researcher through SONA. In accordance with APA ethical guidelines (2002), participants had the option to withdraw from the study at any time without penalty.

As SONA was being used only as a vehicle for enrollment, registered participants' names and identifying information could not be linked to paper-and-pencil measures that were completed during the course of the study.

Materials

Demographic Questionnaire. Information concerning participants' age, sex, year in college, student status (full- or part-time), race/ethnicity, religious affiliation, employment status, and marital status was collected via a questionnaire (Appendix D) administered while participants were plausibly waiting to receive a written message from a target individual (portrayed by the confederate) described as their "partner."

Participant Self-Disclosure Form. Participants replied to their "partner's" message by providing a direct response to the message as well as sharing information about themselves with their "partner" (Appendix F). Responses to the "partner's" message were coded for enactment of social support using the Barbee Interactive Coping Behavior Coding System (Barbee, 1990; Barbee & Cunningham, 1995). Information participants shared about themselves was coded for self-disclosure using the Morton Two-Dimensional Intimacy Scoring System (Morton, 1978). See below for descriptions of these systems.

Stress Appraisal Measure (SAM). The SAM (Appendix G; Peacock & Wong, 1990) is a 28-item measure used to assess appraisal of threat, available coping resources, and perceived stressfulness. Items were rated on a 5-point Likert-type scale ranging from 1 (*not at all*) to 5 (*extremely*). For the present study, the SAM was used as a distraction task in an effort to prevent participants from discerning the true nature of the research prior to its conclusion. Ten items from the SAM were chosen for administration, and the wording modified to reflect participants' current college experiences (e.g., "Is the college experience going to have a positive impact on me?"). The data obtained from this measure will not be scored nor analyzed.

Counselor Rating Form (CRF). The degree to which participants liked and trusted the target individual was measured using a modified version of the CRF (Appendix H; Barak & LaCrosse, 1975). The CRF contains 36 bipolar adjective pairs (e.g., “likeable – unlikeable”) rated on a 7-point bipolar scale, and is used to assess perceived counselor behaviors along the dimensions of expertness, attractiveness, and trustworthiness. Internal consistency ranges from .75 to .93, and results of a mixed analysis of variance offer evidence that the CRF can successfully distinguish between and within counselors on each dimension, though there is a relatively high degree of intercorrelation among the dimensions that may be attributable to what the authors term “charisma” (LaCrosse & Barak, 1976). For the present study, the 24 items comprising attractiveness and trustworthiness were included, with several minor wording changes made for ease of understanding. Item 1 was changed from “agreeable – disagreeable” to “easy to get along with – hard to get along with.” Item 2 was changed from “compatible – incompatible” to “I feel we are compatible – I feel we are incompatible.” Item 4 was changed from “confidential – revealing” to “likely to keep a secret – unlikely to keep a secret.” Per a revision by LaCrosse and Barak (1976), “unbiased – biased” was changed to “genuine – phony” for Item 3. For this study, a Cronbach’s alphas of .83 and .84 were calculated for the liking and trust subscales, respectively.

Defensive Distancing Measure. One item was developed to assess participants’ willingness to interact with the target individual a second time (Appendix I). This item was rated on a 5-point Likert-type scale ranging from 1 (*not at all willing*) to 5 (*very willing*).

Situational Reality Check. To assess for suspicion among participants about the study procedures, a two-item questionnaire was developed (Appendix J). This questionnaire was administered as the final measure in participants' survey packets, and completed after all other data had been collected.

Barbee Interactive Coping Behavior Coding System (ICBCS). The ICBCS (Appendix K; Barbee, 1990; Barbee & Cunningham, 1995) was used to code participants' written responses to their "partner's" message. Coder reliability was determined by comparing the codes of Katy Henry, M.Ed., the primary coder, with a subsample of 15% of the responses coded by Anita P. Barbee, MSSW, Ph.D., the creator of the coding system. The inter-rater reliability was Cohen's kappa = .92. Responses were broken down into one-sentence components. Based on characteristics of the sentence, each component was considered to fall into one of four categories: *Solve*, *Solace*, *Dismiss*, or *Escape*. To fit into the *Solve* category, the response would include asking questions about the problem, attempting to figure out the cause of the problem, giving perspective to the individual, offering a solution, or doing something tangible in an attempt to help the individual. To be judged a *Solace* response, the sentence would include showing affection, displaying empathy/sympathy, giving a compliment to the individual, reassuring the individual, attempting to lift the mood of the individual, confirming confidentiality, or asking the individual about his/her feelings. A response that demonstrates *Dismiss* would include avoiding the problem/self-focus, showing disinterest, criticizing, minimizing the problem, using sarcasm, or faking sympathy. Finally, a response that would fall into the *Escape* category would include verbal avoidance of the individual or his/her problem, ignoring the individual's emotional

displays, withdrawing physically in the room, encouraging the individual to escape the situation through the use of alcohol, drugs, or sex, making fun of the individual through an aggressive joke, becoming irritated by the individual, being mean to the individual, or encouraging suppression of emotions. After coding was complete, an SPSS 17.0 data set was created including a participant number and the number of each of the aforementioned variables.

Morton Two-Dimensional Intimacy Scoring System. Participants' written information about themselves was coded for self-disclosure according to this system (Appendix L; Morton, 1978), which provides information about intimacy based on two dimensions of self-disclosure: descriptive (disclosure of factual information) and evaluative (disclosure of personal feelings or judgments). Each dimension can also be classified as either "high" or "low" based on degree of intimacy. Combining both dimensions yields four categories describing level of self-disclosure and intimacy: *high description/high evaluation; high description/low evaluation; low description/high evaluation; low description/low evaluation.* *High description/high evaluation* statements contain highly personal factual information combined with intense feeling. A sample statement includes, "If my husband ever asked for a divorce, I think I would really fall apart." *High description/low evaluation* statements contain highly personal factual information combined with little expression of feeling. A sample statement includes, "My father would drink late into the night." *Low description/high evaluation* statements contain nonpersonal factual information combined with intense feeling. A sample statement includes, "I really hate spinach!" *Low description/low evaluation* statements

contain nonpersonal factual information combined with little expression of feeling. A sample statement includes, "I have four brothers and sisters."

Two independent judges, Priscilla Khuanghlawn, B.A., and Kalika Kelkar, B.A., were trained using an abridged version of this system (Morton, 1976). Written material was divided into thought units by the researcher, and judges coded each unit according to its fit into one of the four self-disclosure/intimacy categories. Inter-rater reliability was Cohen's kappa = .99. For the few ratings that were disputed by the judges, a final determination was made by Stacie Wilson, M.S., the researcher.

Procedure

Participants were recruited through the SONA Systems website at ODU, and were scheduled to meet in groups of five at the designated research room. Prior to beginning the research session, participants were instructed to sign the preliminary informed consent document (Appendix B) in separate cubicles, allowing them privacy to read the document and decide whether to participate. Those choosing to participate in the research were given a name tag listing his/her first name only. Participants were told that they were involved in a study examining the impressions we form of other people based on their personal attributes and background characteristics, and were given an explanation of how the study would proceed (Appendix C).

The experiment took place in three phases. In the first phase, participants were involved in a group discussion with each other, including the male confederate posing as a participant, and they were asked to introduce themselves and share some information regarding their experiences as college students at ODU. Participants typically chose to discuss their hometown, what led them to enroll at ODU, their current courses of study,

and any hobbies they enjoyed. Participants then retired to separate cubicles, where they were each assigned a partner. They were told they would engage in a writing task designed to share information about themselves with this partner, and to respond to information the partner shared with them. Participants were notified that this writing task was voluntary, and that they were not obligated to complete it. Participants were also informed that after the message exchange, they would be asked to complete a series of questionnaires regarding their impressions of the partner. Participants were told that their responses to these questionnaires were private, and would not be shared with the partner.

In the second phase, which took place in the individual cubicles, each participant was then paired with the confederate, and was asked to complete a demographic sheet and a neutral questionnaire which served as a distraction task, while ostensibly waiting for the confederate to write his message. The researcher then delivered a pre-written message from the confederate to each participant (Appendix E), in which information about the confederate's HIV serostatus (either HIV-positive or HIV-negative) and sexual orientation (either gay or straight) had been manipulated. The four message conditions were randomly assigned among male and female participants separately before being distributed. Once the participants responded, or declined to respond, to the confederate's message, they were given a series of questionnaires, including measures of liking, trust, and defensive distancing. Participants also completed a "situational reality check" form assessing their reactions to the study and asking them to describe what they thought the study was about. Data for participants who recognized the deception was not analyzed.

In the third phase, participants were debriefed individually at the end of the study as to the true nature of the experiment and the reason deception was required, following

guidelines provided by Mills (1976) (Appendix M). Debriefing included reassurance that participation was voluntary. The debriefing also included additional information about the confederate, the nature of HIV/AIDS and the importance of research in this area, and contact information for the ODU Counseling Center and the Tidewater Area HIV/AIDS Community Taskforce. Researchers' contact information was also provided to and discussed with all participants (Appendix N). Participants were asked to complete a secondary consent document, acknowledging their consent for the researchers to use their data in the research analyses (Appendix O). Participants were also informed that they could leave a self-addressed envelope that the investigators would use to send them a description of the results of the study if they so desired.

CHAPTER III

RESULTS

Of the total sample of 161 participants, three were removed due to verbal expression of suspicion during the research session, while an additional six were removed because they expressed written suspicion on the Situational Reality Check form. Thus, a final sample of 152 participants was included in the final analysis.

Demographic Characteristics of the Sample

Participants in the final sample ranged in age from 18 to 50 ($M = 20.22$, $SD = 4.04$), and included 116 (76.3%) women and 36 (23.7%) men. Eighty participants identified as Caucasian (52.6%), 43 identified as African-American (28.3%), 12 identified as Asian-American (7.9%), six identified as Hispanic (3.9%), and 11 identified as “Other” (7.2%).

Of the 152 participants, 68 were freshmen (44.7%), 39 were sophomores (25.7%), 24 were juniors (15.8%), and 19 were seniors (12.5%). Two participants were Post-Bachelor’s/Graduate students (1.3%). One hundred forty-four participants reported that they currently attend school full-time (95.6%), while 7 reported that they do not (4.6%). Eleven participants also reported that they work full-time while in school (7.2%), while 68 participants work part-time (44.7%). Seventy-three participants reported that they are not currently employed (48.0%).

With regard to marital status, 82 participants reported that they were single with an intimate partner (53.9%), while 59 reported that they were single with no intimate partner (38.8%). Seven participants reported being married (4.6%), while two reported being divorced (1.3%). Two participants also identified their marital status as “Other”

(1.3%). Regarding religious affiliation, 73 participants identified as Protestant (48.3%), 33 identified as Catholic (21.9%), three identified as Jewish (2.0%), and 42 identified as “Other” (27.8%). All the demographic information is summarized in Table 1.

Table 1

Frequency Table of Demographics

Variable	<i>N</i>	<i>Valid %</i>
Sex of Participant		
<i>Female</i>	116	76.3
<i>Male</i>	36	23.7
Age of Participant		
<i>18 – 22</i>	135	88.8
<i>23 – 29</i>	12	8.1
<i>30 – 34</i>	3	2.0
<i>42 – 50</i>	2	1.4
Ethnicity		
<i>White/Caucasian</i>	80	52.6
<i>Black/African-American</i>	43	28.3
<i>Asian-American</i>	12	7.9
<i>Hispanic</i>	6	3.9
<i>Other</i>	11	7.2

Table 1 continued

Frequency Table of Demographics

Variable	<i>N</i>	<i>Valid %</i>
College Year		
<i>Freshman</i>	68	44.7
<i>Sophomore</i>	39	25.7
<i>Junior</i>	24	15.8
<i>Senior</i>	19	12.5
<i>Post-B.S./Graduate</i>	2	1.3
Student Status		
<i>Full-Time</i>	144	95.4
<i>Not Full-Time</i>	7	4.6
Employment Status		
<i>Full-Time</i>	11	7.2
<i>Part-Time</i>	68	44.7
<i>Not Employed</i>	73	48.0

Table 1 continued

Frequency Table of Demographics

Variable	<i>N</i>	<i>Valid %</i>
Marital Status		
<i>Single with intimate partner</i>	82	53.9
<i>Single, no intimate partner</i>	59	38.8
<i>Married</i>	7	4.6
<i>Divorced</i>	2	1.3
<i>Other</i>	2	1.3
Religious Affiliation		
<i>Protestant</i>	73	48.3
<i>Catholic</i>	33	21.9
<i>Jewish</i>	3	2.0
<i>Other</i>	42	27.8

Note. *N* = 152.

Preparation of Data for Analysis

Less than 5% missing data was found in the final sample, so estimated means were not inserted, nor were cases removed. Composite scores for the *liking* and *trust* dependent variables were created from the two “liking” and “trust” subscales of the Counselor Rating Form. In an effort to control for variations in the length of written material among participants, proportional scores were calculated for each of the four

categories of self-disclosure and four categories of social support. These scores were obtained by dividing the number of thought units in each self-disclosure and social support category by the total number of self-disclosure or social support thought units provided by each participant. Arcsine transformations of these proportions were applied to improve variance in the sampling distributions of the proportions and to better approximate normality (Keppel & Wickens, 2004) and were used in statistical analysis. However, in an effort to aid with interpretation, means and standard deviations reported in text and tables for social support and self-disclosure reflect those variables prior to transformation. Frequency and descriptive statistics were performed to assess for violations of normality and to screen for both univariate and multivariate outliers (see Table 2). Normality of distribution was established through acceptable levels of skewness and kurtosis among variables, with the exception of the social support category *escape*. Because only two people enacted this form of social support there was little variability within the measure, and the decision was made to eliminate it from analysis. No univariate outliers were found for any variables as indicated by boxplots (Cohen et al., 2003). To address assumptions of MANOVA, no multivariate outliers were found as indicated by Cook's D for any MANOVAs (Cohen et al., 2003). Additionally, dependent variables were moderately correlated for all MANOVAs, $|r| < .70$ (Tabachnick & Fidell, 2007).

Table 2

Descriptive Statistics for Dependent Variables

Variable	<i>M</i>	<i>SD</i>	<i>Skewness</i>	<i>Kurtosis</i>	<i>Min.</i>	<i>Max.</i>
Affiliation	4.43	.83	-1.39	1.11	2.00	5.00
Liking	5.58	.74	-.34	-.42	3.42	7.00
Trust	6.07	.69	-.87	.67	3.67	7.00
Social Support						
<i>Solve</i>	.84	.64	.03	-1.05	.00	2.42
<i>Solace</i>	1.65	.68	.28	.70	.00	3.14
<i>Dismiss</i>	.86	.74	.46	.04	.00	3.14
Self-Disclosure						
<i>HighDesc./HighEval.</i>	.59	.62	.79	.67	.00	3.14
<i>HighDesc./LowEval.</i>	1.20	.69	-.13	-.05	.00	3.14
<i>LowDesc./HighEval.</i>	.61	.56	.25	-1.07	.00	1.91
<i>LowDesc./LowEval.</i>	1.10	.73	.14	.06	.00	3.14

Note. $N = 152$.

Affiliation

One factorial ANOVA was performed to examine the potential interaction of participant gender and the target individual's sexual orientation and HIV serostatus for their effect on participants' ratings of affiliation. Prior to performing the analysis, a test

for homogeneity of variance revealed that this assumption was violated for equal variance across treatment groups, so a more stringent criterion of $p < .025$ was used to examine the results in order to reduce the probability of Type I error (Keppel & Wickens, 2004; Maxwell & Delaney, 2004). Results of the ANOVA revealed no significant interaction effects. However, a significant main effect was found for gender, $F(1, 142) = 14.98, p < .001$, partial $\eta^2 = .10$, power = .97. Women reported significantly greater willingness to interact with their partner a second time than did men. Mean differences among groups are presented in Table 3.

Table 3

Impact of Gender, Sexual Orientation, and HIV Status on Affiliation

Source	Univariate		
	<i>Affiliation/Willingness to Interact</i>		
	<i>M</i>	<i>SD</i>	<i>F(1, 142)</i>
Gender			14.98***
<i>Female</i>	4.57	.70	
<i>Male</i>	3.97	1.04	
Sexual Orientation			.06
<i>Straight</i>	4.36	.90	
<i>Gay</i>	4.50	.76	
HIV Status			2.35
<i>HIV-Negative</i>	4.34	.84	
<i>HIV-Positive</i>	4.53	.82	

Table 3 continued

Impact of Gender, Sexual Orientation, and HIV Status on Affiliation

Source	Univariate		
	<i>Affiliation/Willingness to Interact</i>		
	<i>M</i>	<i>SD</i>	<i>F</i> (1, 142)
Gender*Sexual Orientation			3.67
<i>Female/Straight</i>	4.45	.83	
<i>Female/Gay</i>	4.69	.53	
<i>Male/Straight</i>	4.11	1.08	
<i>Male/Gay</i>	3.82	1.01	
Gender*HIV Status			.22
<i>Female/HIV-Negative</i>	4.49	.70	
<i>Female/HIV-Positive</i>	4.66	.69	
<i>Male/HIV-Negative</i>	3.83	1.04	
<i>Male/HIV-Positive</i>	4.12	1.05	
Sexual Orientation *HIV Status			.29
<i>Straight/HIV-Negative</i>	4.31	.95	
<i>Straight/HIV-Positive</i>	4.43	.85	
<i>Gay/HIV-Negative</i>	4.37	.71	
<i>Gay/HIV-Positive</i>	4.63	.79	

Table 3 continued

Impact of Gender, Sexual Orientation, and HIV Status on Affiliation

Source	Univariate		
	<i>Affiliation/Willingness to Interact</i>		
	<i>M</i>	<i>SD</i>	<i>F(1, 142)</i>
Gender*Sexual Orientation*HIV Status			4.43
<i>Female/Straight/HIV-Negative</i>	4.48	.78	
<i>Female/Straight/HIV-Positive</i>	4.41	.89	
<i>Female/Gay/HIV-Negative</i>	4.50	.63	
<i>Female/Gay/HIV-Positive</i>	4.90	.31	
<i>Male/Straight/HIV-Negative</i>	3.80	1.23	
<i>Male/Straight/HIV-Positive</i>	4.50	.76	
<i>Male/Gay/HIV-Negative</i>	3.88	.83	
<i>Male/Gay/HIV-Positive</i>	3.78	1.20	

Note. $N = 150$.

*** $p < .001$.

Preparation for Multivariate Analyses of Variance

Three factorial MANOVAs were performed to examine the potential interaction of participant gender with the target individual's sexual orientation and HIV serostatus for their effect on participants' ratings of liking and trust, and enactment of self-disclosure and social support. Prior to performing the MANOVAs, Box's M tests for

homogeneity of variance were performed. Because this assumption was violated for the social support MANOVA, Pillai's trace was chosen as the acceptable criterion as it is robust to this violation (Tabachnick & Fidell, 2007). Additionally, because homogeneity of variance was also violated for *liking*, the *low descriptive/low evaluative* category of self-disclosure, and the *dismiss* category of social support, an alpha of .025 was again used as the criterion for univariate significance.

Liking and Trust

Results from the MANOVA examining participants' degree of liking and trust of the target individual revealed a significant main effect for gender, multivariate $F(2, 142) = 4.60, p < .05$, partial $\eta^2 = .06$, power = .77. Follow-up univariate ANOVAs revealed significant gender main effects for both liking, $F(1, 143) = 9.23, p < .025$, partial $\eta^2 = .06$, power = .86, and trust, $F(1, 143) = 4.52, p < .05$, partial $\eta^2 = .03$, power = .56. Women reported liking the target individual significantly more than did men. Women also reported trusting the target individual significantly more than did men. Mean differences among groups are presented in Table 4.

Table 4

Impact of Gender, Sexual Orientation, and HIV Status on Ratings of Liking and Trust

Source	Univariate					
	<i>Liking</i>			<i>Trust</i>		
	<i>M</i>	<i>SD</i>	<i>F</i> (1, 143)	<i>M</i>	<i>SD</i>	<i>F</i> (1, 143)
Gender ⁺			9.23**			4.52*
<i>Female</i>	5.68	.68		6.13	.65	
<i>Male</i>	5.24	.84		5.85	.80	
Sexual Orientation			1.38			1.20
<i>Straight</i>	5.46	.80		5.99	.70	
<i>Gay</i>	5.69	.67		6.14	.68	
HIV Status			.04			.09
<i>HIV-Negative</i>	5.54	.76		6.05	.69	
<i>HIV-Positive</i>	5.61	.72		6.09	.70	
Gender*Sexual Orientation			.42			.00
<i>Female/Straight</i>	5.55	.77		6.05	.67	
<i>Female/Gay</i>	5.80	.57		6.21	.63	
<i>Male/Straight</i>	5.20	.88		5.79	.79	
<i>Male/Gay</i>	5.28	.82		5.91	.83	

Table 4 continued

Impact of Gender, Sexual Orientation, and HIV Status on Ratings of Liking and Trust

Source	Univariate					
	<i>Liking</i>			<i>Trust</i>		
	<i>M</i>	<i>SD</i>	<i>F</i> (1, 143)	<i>M</i>	<i>SD</i>	<i>F</i> (1, 143)
Gender*HIV Status			.26			1.17
<i>Female/HIV-Negative</i>	5.63	.68		6.09	.69	
<i>Female/HIV-Positive</i>	5.73	.68		6.18	.60	
<i>Male/HIV-Negative</i>	5.25	.94		5.93	.70	
<i>Male/HIV-Positive</i>	5.23	.74		5.76	.91	
Sexual Orientation*HIV Status			1.32			.42
<i>Straight/HIV-Negative</i>	5.38	.79		5.92	.66	
<i>Straight/HIV-Positive</i>	5.56	.82		6.07	.75	
<i>Gay/HIV-Negative</i>	5.71	.71		6.18	.70	
<i>Gay/HIV-Positive</i>	5.66	.63		6.10	.66	

Table 4 continued

Impact of Gender, Sexual Orientation, and HIV Status on Ratings of Liking and Trust

Source	Univariate					
	<i>Liking</i>			<i>Trust</i>		
	<i>M</i>	<i>SD</i>	<i>F</i> (1, 143)	<i>M</i>	<i>SD</i>	<i>F</i> (1, 143)
Gender*Sexual Orientation*HIV Status			.66			.12
<i>Female/Straight/HIV-Negative</i>	5.48	.75		5.94	.66	
<i>Female/Straight/HIV-Positive</i>	5.62	.79		6.17	.67	
<i>Female/Gay/HIV-Negative</i>	5.78	.59		6.22	.70	
<i>Female/Gay/HIV-Positive</i>	5.83	.57		6.19	.54	
<i>Male/Straight/HIV-Negative</i>	5.10	.85		5.85	.69	
<i>Male/Straight/HIV-Positive</i>	5.33	.95		5.71	.94	
<i>Male/Gay/HIV-Negative</i>	5.45	1.07		6.03	.73	
<i>Male/Gay/HIV-Positive</i>	5.13	.55		5.81	.94	

Note. $N = 151$.

⁺Multivariate F is significant at $p < .05$.

* $p < .05$. ** $p < .025$.

Social Support

A second MANOVA examining participants' enactment of social support toward the target individual (see Table 5) revealed a significant two-way interaction for HIV serostatus by gender, multivariate $F(3, 141) = 6.54, p < .001$, partial $\eta^2 = .12$, power = .97. A significant main effect for HIV serostatus was also found, multivariate $F(3, 141) = 8.80, p < .001$, partial $\eta^2 = .16$, power = .99; however, follow-up univariate ANOVAs revealed no significant HIV serostatus main effects on any of the social support categories. Follow-up univariate ANOVAs for the HIV serostatus by gender interaction were conducted, and revealed significant mean differences in the number of solace statements, $F(1, 143) = 7.64, p < .01$, partial $\eta^2 = .05$, power = .78, and dismissive statements, $F(1, 143) = 8.30, p < .01$, partial $\eta^2 = .06$, power = .82, enacted toward the target individual. Simple effects analyses of these variables (see Table 5 for group mean differences) revealed that women enacted significantly more solace toward the HIV-negative individual than did men. Women did not differ from men in the enactment of solace statements toward the HIV-positive individual. However, men enacted significantly more solace toward the HIV-positive individual than toward the HIV-negative individual. Women did not differ in their enactment of solace statements toward an individual of either serostatus. Typical solace statements made by participants included efforts to lift the partner's spirit, such as, "I'm glad you were not HIV-positive... That is very courageous for you to do"; "Although I have never been tested for HIV, I understand how scary that is"; and "I am very sorry to hear about your situation" [addressed to an HIV-positive partner]. Figure 1 illustrates the results of the HIV serostatus by gender interaction for solace statements.

Table 5

Impact of Gender, Sexual Orientation, and HIV Status on Enactment of Social Support

Source	Univariate								
	<i>Solve</i>			<i>Solace</i>			<i>Dismiss</i>		
	<i>M</i>	<i>SD</i>	<i>F</i> (1, 143)	<i>M</i>	<i>SD</i>	<i>F</i> (1, 143)	<i>M</i>	<i>SD</i>	<i>F</i> (1, 143)
HIV Status ⁺⁺⁺			2.13			3.01			3.44
<i>HIV-Negative</i>	.21	.21		.52	.27		.26	.28	
<i>HIV-Positive</i>	.25	.22		.53	.24		.22	.19	
Gender*HIV Status ⁺⁺⁺			.65			7.64**			8.30**
<i>Female/HIV-Negative</i>	.21	.20		.57	.25		.22	.24	
<i>Female/HIV-Positive</i>	.24	.23		.52	.24		.25	.20	
<i>Male/HIV-Negative</i>	.22	.25		.37	.29		.41	.35	
<i>Male/HIV-Positive</i>	.28	.18		.57	.26		.14	.13	

Note. $N = 151$.

⁺⁺⁺Multivariate F is significant at $p < .001$.

* $p < .05$. ** $p < .01$.

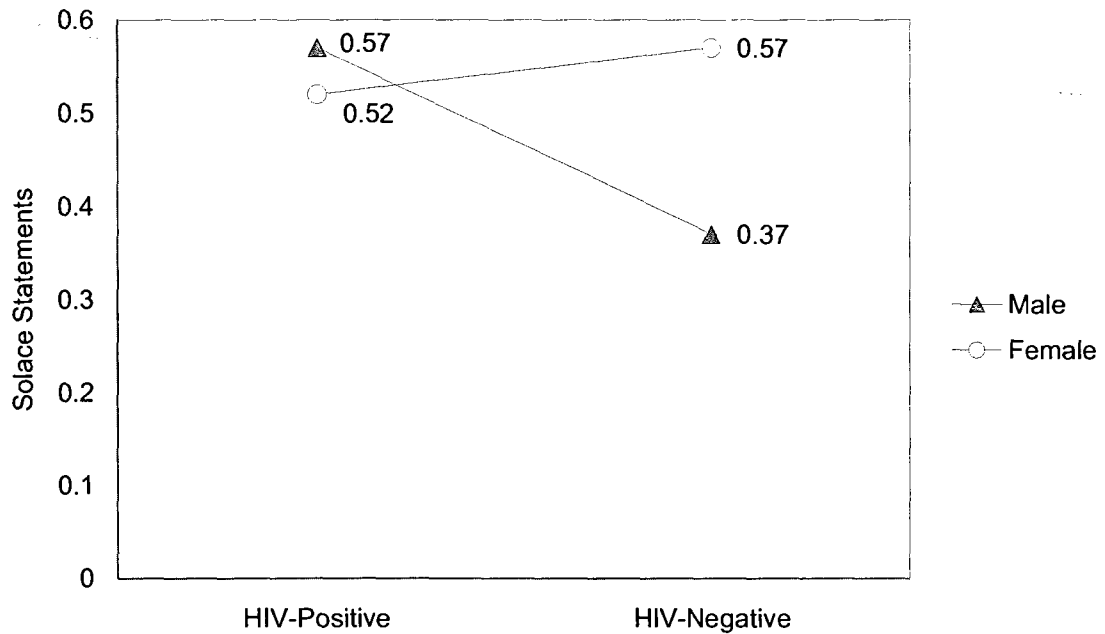


Figure 1. Mean group differences in male and female participants' enactment of solace statements toward an HIV-positive and an HIV-negative individual.

Men also enacted significantly more dismissive statements toward the HIV-negative individual than did women. Men and women did not differ in the enactment of dismissive statements toward the HIV-positive individual. Men also enacted significantly more dismissive statements toward the HIV-negative individual than toward the HIV-positive one. Women did not differ in their enactment of dismissive statements toward an individual of either serostatus. Dismissive statements included offerings such as, "That is a lot for one person to share with a complete stranger, probably more than I would share," and, "Take heart. Things happen" [addressed to an HIV-positive partner]. Figure 2 illustrates the results of the HIV serostatus by gender interaction on dismiss statements.

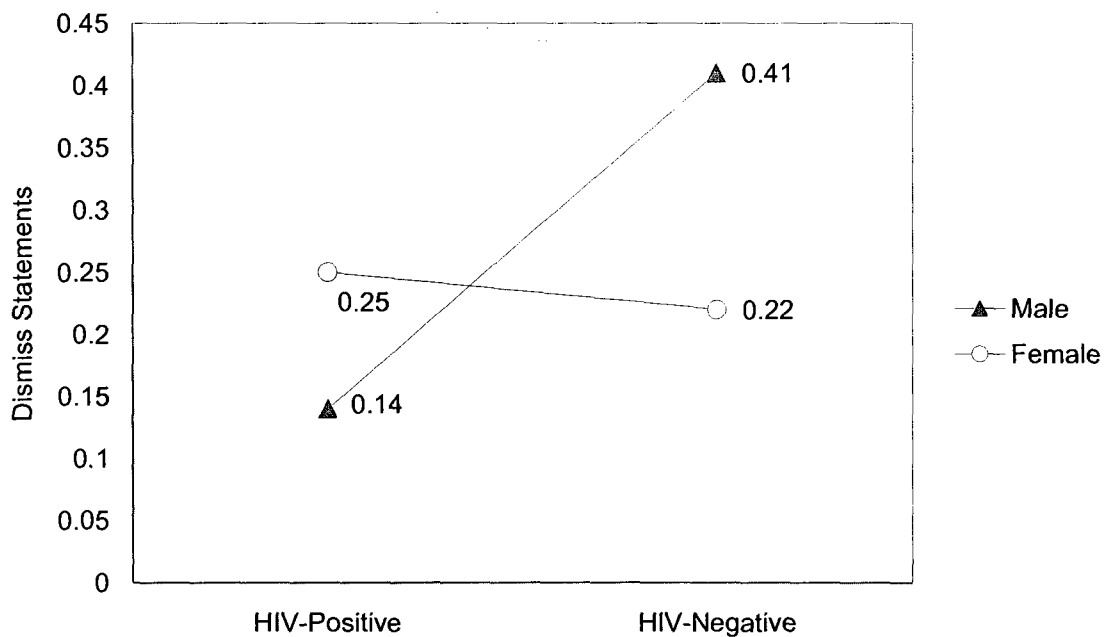


Figure 2. Mean group differences in male and female participants' enactment of dismiss statements toward an HIV-positive and an HIV-negative individual.

Additional Social Support Analyses

Exploratory chi-square analyses were conducted to further examine differences in the enactment of social support. Analysis revealed that there was a significant gender difference in the enactment of solace statements, $\chi^2(1, N = 151) = 6.64, p = .01$. Ninety-eight percent of female participants made one or more solace statements toward their partner, compared to 89% of male participants. Among men, a significant difference in the use of solace statements was found for HIV serostatus, $\chi^2(1, N = 35) = 4.27, p < .05$. Seventy-eight percent of men made one or more solace statements when interacting with a partner who was HIV-negative, while a full 100% made solace statements when interacting with an HIV-positive partner. On the other hand, when examining the

enactment of solace statements among women, there was no significant difference for HIV serostatus, $\chi^2(1, N = 116) = .00, ns$. Ninety-eight percent of women made one or more solace statements when interacting with both an HIV-negative and an HIV-positive partner.

A second chi-square analysis revealed a significant difference by HIV serostatus among women in their enactment of dismissive statements, $\chi^2(1, N = 116) = 4.31, p < .05$. Fifty-seven female participants made one or more dismissive statements when interacting with an HIV-negative partner, while 75% did so when interacting with an HIV-positive partner. No significant difference by HIV serostatus was found among men in their enactment of dismissive statements, $\chi^2(1, N = 35) = .23, ns$. Seventy-two percent of men made one or more dismissive statements toward an HIV-negative partner, and 65% did so toward an HIV-positive partner. Results from the enactment of both solace and dismissive statements suggest a trend toward sex differences in the enactment of social support. Though women, compared to men, seem to offer more solace to their partner overall, men appear to react more supportively toward an HIV-positive individual than do women.

Self-Disclosure

A third MANOVA examining participants' enactment of self-disclosure toward the target individual (see Table 6) revealed significant two-way interactions for HIV serostatus by gender, multivariate $F(4, 137) = 2.74, p < .05$, partial $\eta^2 = .07$, power = .74, and sexual orientation by HIV serostatus, multivariate $F(4, 137) = 3.60, p < .01$, partial $\eta^2 = .10$, power = .86. A significant main effect was also found for HIV serostatus,

multivariate $F(4, 137) = 3.59, p < .01$, partial $\eta^2 = .10$, power = .86. Follow-up univariate ANOVAs were conducted for all effects.

Table 6

Impact of Gender, Sexual Orientation, and HIV Status on Enactment of Self-Disclosure

Source	Univariate											
	<i>HighDesc/</i>			<i>HighDesc/</i>			<i>LowDesc/</i>			<i>LowDesc/</i>		
	<i>HighEval</i>			<i>LowEval</i>			<i>HighEval</i>			<i>LowEval</i>		
	<i>M</i>	<i>SD</i>	<i>F</i>	<i>M</i>	<i>SD</i>	<i>F</i>	<i>M</i>	<i>SD</i>	<i>F</i>	<i>M</i>	<i>SD</i>	<i>F</i>
HIV Status ⁺⁺			7.42**			2.67			.02			8.21**
<i>HIV-Negative</i>	.12	.15		.35	.27		.16	.18		.36	.29	
<i>HIV-Positive</i>	.18	.21		.37	.24		.14	.15		.29	.22	
Gender*HIV Status ⁺			3.61			2.73			.08			7.56**
<i>Female/HIV-Negative</i>	.14	.16		.36	.25		.17	.18		.30	.25	
<i>Female/HIV-Positive</i>	.18	.22		.35	.23		.15	.15		.30	.22	
<i>Male/HIV-Negative</i>	.05	.10		.31	.33		.11	.16		.53	.33	
<i>Male/HIV-Positive</i>	.20	.20		.43	.26		.12	.15		.25	.19	

Table 6 continued

Impact of Gender, Sexual Orientation, and HIV Status on Enactment of Self-Disclosure

Source	Univariate											
	<i>HighDesc/</i>			<i>HighDesc/</i>			<i>LowDesc/</i>			<i>LowDesc/</i>		
	<i>HighEval</i>			<i>LowEval</i>			<i>HighEval</i>			<i>LowEval</i>		
	<i>M</i>	<i>SD</i>	<i>F</i>	<i>M</i>	<i>SD</i>	<i>F</i>	<i>M</i>	<i>SD</i>	<i>F</i>	<i>M</i>	<i>SD</i>	<i>F</i>
Sexual Orientation*HIV Status ⁺⁺			1.23			5.01*			2.36			6.79†
<i>Straight/HIV-Negative</i>	.14	.17		.30	.25		.12	.14		.41	.31	
<i>Straight/HIV-Positive</i>	.17	.25		.42	.24		.16	.15		.23	.20	
<i>Gay/HIV-Negative</i>	.09	.13		.39	.29		.20	.21		.31	.24	
<i>Gay/HIV-Positive</i>	.19	.18		.32	.23		.12	.15		.33	.22	

Note. $N = 148$. $Df = 1, 140$.

⁺Multivariate F is significant at $p < .05$,

⁺⁺Multivariate F is significant at $p < .01$.

* $p < .05$, ** $p < .01$, † = .01.

Results of follow-up univariate ANOVAs to the HIV serostatus main effect revealed significant differences in the number of high descriptive/high evaluative statements, $F(1, 140) = 7.42, p < .01$, partial $\eta^2 = .05$, and low descriptive/low evaluative statements, $F(1, 140) = 8.21, p < .01$, partial $\eta^2 = .06$, offered to the target individual. Participants enacted significantly more high descriptive/high evaluative statements toward an HIV-positive individual than toward an HIV-negative individual. Perhaps not

surprisingly, participants also enacted significantly fewer low descriptive/low evaluative statements toward the HIV-positive individual than toward the HIV-negative individual.

Results of follow-up univariate ANOVAs for the HIV serostatus by gender interaction revealed significant differences in the number of low descriptive/low evaluative statements made toward the target individual, $F(1, 140) = 7.56, p < .01$, partial $\eta^2 = .05$, power = .78. A simple effects analysis of this variable revealed that men enacted significantly more low descriptive/low evaluative statements toward the HIV-negative individual than did women. Men and women did not differ in the enactment of low descriptive/low evaluative statements toward the HIV-positive individual. Men also enacted significantly more low descriptive/low evaluative statements toward the HIV-negative individual than toward the HIV-positive one. Women did not differ in their enactment of low descriptive/low evaluative statements toward an individual of either serostatus. These “distancing” statements, which have the effect of keeping the partner at arm’s length, included offerings such as, “I certainly don’t have huge news like you do, but I’m from [another state]”; “I’m currently working at a practicum site for my internship and I plan to study abroad...next semester”; and, “I want to be a doctor.” Figure 3 illustrates the results of the HIV serostatus by gender interaction for low descriptive/low evaluative statements.

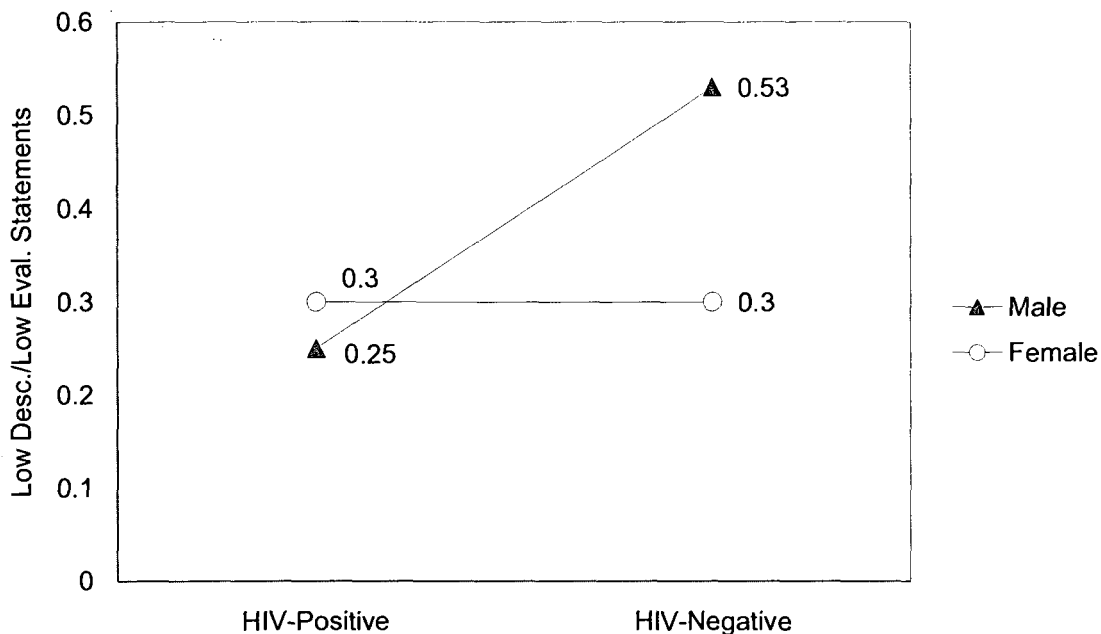


Figure 3. Mean group differences in male and female participants' enactment of low descriptive/low evaluative statements toward an HIV-positive and an HIV-negative individual.

Results of follow-up univariate ANOVAs for the sexual orientation by HIV serostatus interaction on the self-disclosure measures revealed significant differences in the number of high descriptive/low evaluative statements, $F(1, 140) = 5.01, p < .05$, partial $\eta^2 = .04$, power = .60, and low descriptive/low evaluative statements, $F(1, 140) = 6.79, p = .01$, partial $\eta^2 = .05$, power = .74 offered to the target individual. Simple effects analyses were performed on both of these variables. Participants offered significantly more high descriptive/low evaluative information about themselves toward a straight individual who was HIV-positive versus HIV-negative. On the other hand, no significant difference in the number of high descriptive/low evaluative statements offered to a gay individual of either serostatus was found. Examples of high descriptive/low evaluative

statements offered to the partner included, “I’m over halfway done with undergrad but still feel like I’m not ready to join the real world”; “I don’t want to let my family down or have people think of me as a failure”; and, “Recently I’ve been having problems with my parents about my boyfriend because he [isn’t] the same religion as I am.” Figure 4 illustrates results of the sexual orientation by HIV serostatus interaction for high descriptive/low evaluative statements.

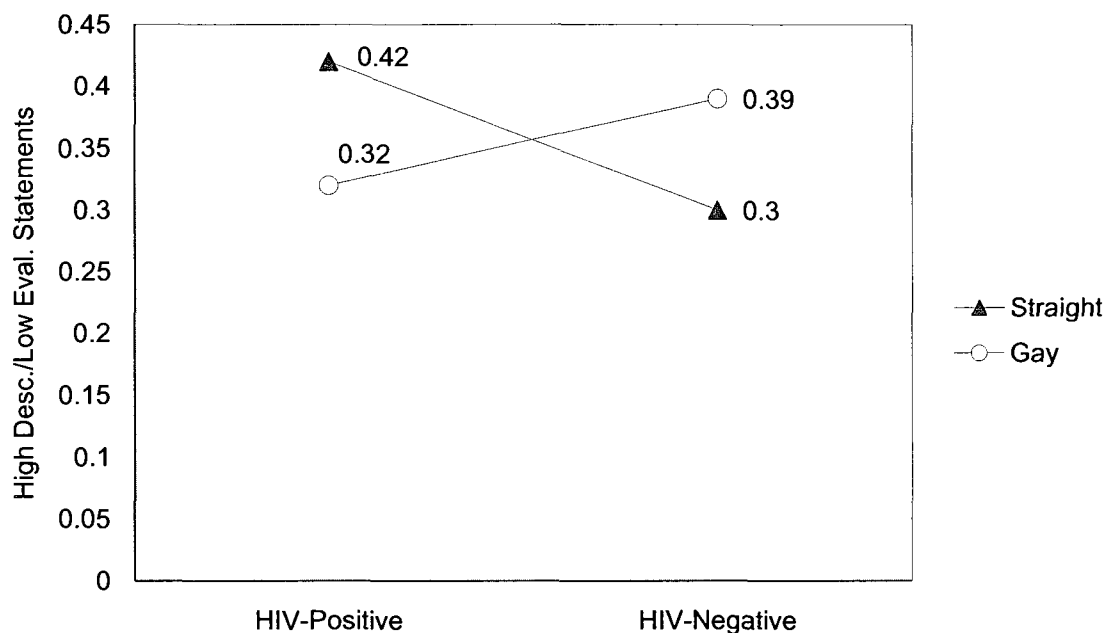


Figure 4. Mean group differences in participants' enactment of high descriptive/low evaluative statements toward a straight or gay, HIV-positive or HIV-negative individual.

Participants also enacted significantly more low descriptive/low evaluative statements toward a straight individual who was HIV-negative than toward one who was HIV-positive. Participants did not differ in their enactment of low descriptive/low

evaluative statements toward an HIV-negative versus HIV-positive gay individual.

Perhaps most important, participants also made significantly more low descriptive/low evaluative statements toward an HIV-positive individual who was gay versus one who was straight; no difference was found for participants' enactment of low descriptive/low evaluative statements toward a gay, compared to straight, HIV-negative individual.

Figure 5 illustrates the results of the sexual orientation by HIV serostatus interaction for low descriptive/low evaluative statements.

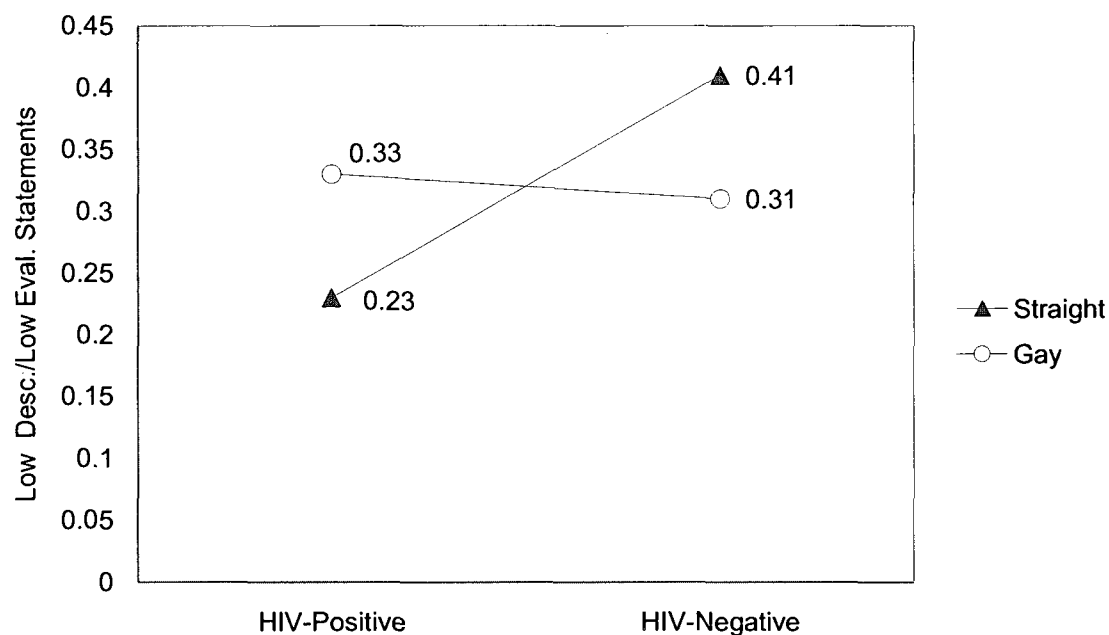


Figure 5. Mean group differences in participants' enactment of low descriptive/low evaluative statements toward a straight or gay, HIV-positive or HIV-negative individual.

Additional Self-Disclosure Analyses

Exploratory chi-square analyses were performed to further examine differences in the enactment of self-disclosure. A significant difference was found for gender in the use of low descriptive/high evaluative statements, $\chi^2(1, N = 148) = 4.45, p < .05$, where 64% of female participants enacted one or more low descriptive/high evaluative statements toward their partner, compared to 44% of male participants. A significant difference by sexual orientation was also found for participants in their enactment of low descriptive/low evaluative statements, $\chi^2(1, N = 148) = 4.94, p < .05$. Seventy-two percent of participants made one or more low descriptive/low evaluative statements when interacting with a straight partner, while 87% did so when interacting with a gay partner.

Further examination of self-disclosure by gender revealed similar findings based on sexual orientation among women enacting one or more low descriptive/low evaluative statements, $\chi^2(1, N = 112) = 5.77, p < .05$. Sixty-nine percent of women interacting with a straight partner made one or more low descriptive/low evaluative statements, while 88% of women interacting with a gay partner did so. In comparison, no differences related to sexual orientation were found among men in their use of low descriptive/low evaluative statements, $\chi^2(1, N = 36) = .07, ns$. When interacting with a straight partner, 79% of men enacted one or more low descriptive/low evaluative statements, while 82% did so when interacting with a gay partner.

However, surprising results were again found for men in their enactment of high descriptive/high evaluative statements, $\chi^2(1, N = 36) = 7.03, p < .01$, and high descriptive/low evaluative statements, $\chi^2(1, N = 36) = 7.78, p < .01$, as a function of the serostatus of their partner. Twenty-one percent offered one or more high descriptive/high

evaluative statements, and 63% offered one or more high descriptive/low evaluative statements, when their partner was HIV-negative partner. In contrast, 65% offered one or more high descriptive/high evaluative statements, and 100% offered high descriptive/low evaluative statements, when their partner was HIV-positive. No significant differences by serostatus were found among women in their use of high descriptive/high evaluative statements, $\chi^2(1, N = 112) = .04, ns$, and high descriptive/low evaluative statements, $\chi^2(1, N = 112) = .07, ns$. Fifty-nine percent enacted one or more high descriptive/high evaluative statements, and 84% enacted one or more high descriptive/low evaluative statements, when their partner was HIV-negative. Sixty-one percent enacted one or more high descriptive/high evaluative statements, and 86% enacted one or more high descriptive/low evaluative statements, when their partner was HIV-positive. Taken together, results from the enactment of self-disclosure again reveal that men tend to interact more intimately with an HIV-positive individual than do women; however, all participants, particularly women, appeared to be less intimate with a gay individual.

CHAPTER IV

DISCUSSION

In an effort to extend our understanding of the degree to which an individual's HIV/AIDS serostatus and negative attitudes toward homosexuality contribute to HIV/AIDS-related stigma, this study attempted to assess participants' evaluations of a gay male with HIV in a systematic way. Additionally, this study provided actual behavioral data, as participants believed they were having an authentic interaction with an individual with HIV. This is a unique and important contribution to the literature, which until now has relied primarily on paper-and-pencil responses to surveys or vignettes. Results of this study potentially reflect participants' true reactions were they really to meet someone with HIV. Expanding on the results found by Derlega et al. (1998) in their study of reactions to an HIV-positive man, the present study hypothesized that gender differences would be apparent in reactions to a confederate based on his HIV serostatus, his sexual orientation, or some combination of both factors. Specifically, males were expected to provide less self-disclosure and enactment of social support, less willingness to interact, and lower ratings of liking and trust to an HIV-positive and/or gay individual than females.

Aspects of the results were surprising. Analysis of 152 male and female research participants revealed that men, compared to women, offered more solace to an HIV-positive versus an HIV-negative person, and were more dismissive of the HIV-negative person. Men also enacted more low descriptive/low evaluative statements when interacting with an HIV-negative person versus an HIV-positive one, in effect holding the HIV-negative individual at arm's length.

Other results, however, supported the hypotheses that gender differences would be found in participants' reactions to their partner, though the findings were not always related to the partner's sexual orientation and/or HIV serostatus. Women reported greater willingness to interact with their partner than did men, and they also reported liking and trusting their partner more than men did. There were few significant differences among women in how much self-disclosure and social support they offered to a partner of any sexual orientation/HIV serostatus combination, which parallels the findings in the literature that women are typically more affectionate, supportive, and affiliative than men (Morton, 1978). All participants were more intimate in their self-disclosure (i.e., used more high descriptive/low evaluative statements) toward a straight, HIV-positive person versus a straight, HIV-negative person, whereas there was no difference toward a gay person as a function of his HIV serostatus. The most poignant finding was that all participants were the least intimate in their self-disclosure (i.e., used more low descriptive/low evaluative statements) toward a gay, HIV-positive individual, versus a straight, HIV-positive individual, suggesting that something about the characteristic of being gay, in addition to being HIV-positive, has a unique effect on how willing others are to get close to such an individual. Indeed, even the lack of significant findings regarding the amount of intimate information offered to a gay individual of either serostatus may be suggestive of the overall lower level of support and intimacy offered to gay individuals generally, when compared to that offered straight individuals.

There appeared to be some incongruity in the findings for men, in that they offered more solace to an HIV-positive person compared to an HIV-negative person, but were less likely to affiliate with, like, or trust their partner (regardless of sexual

orientation and/or HIV serostatus) than women. This may be due to a difference in the “public” versus the “private” face that men display when interacting with a partner. Male participants may have felt a sense that it was appropriate to offer comfort to a male partner who revealed a serious illness when it was believed that the partner would read the message; however, when told to make private ratings of their partner, men may have acknowledged more authentic feelings of dislike and rejection of their partner. These findings to some degree replicate the results found by Derlega et al. (1998) that men reported more negative feelings toward a gay versus a straight HIV-positive man than women, though in the case of this study, sexual orientation was not a factor in the male participants’ dislike of their partner. Fish and Rye (1991) also found that women were more positive than men in their ratings toward a stimulus person, regardless of that person’s sexual orientation or health status, which suggests that they may have more empathy and less homonegativity. Additionally, Fish and Rye reported that though people with AIDS knowledge tended to rate the stimulus person more favorably, they still wanted to keep social distance between themselves and PWHAs, suggesting that AIDS education alone, without education on homosexuality, is not enough to prevent stigmatization.

On the other hand, Mooney, Cohn, and Swift (1992) found that women put the greatest distance between themselves and a PWHA, versus a gay individual, cancer patient, or fellow college student. Thus, the women in the present study may be acting “polite” by reporting greater willingness to interact with their partner again, but during the actual interaction they are not quite as comforting or consoling toward their partner. Mooney et al. noted that college students tend to have mixed feelings about PWHAs, and

appear more willing to accept them “on paper” versus actually having to interact with them.

Male, compared to female, participants were also found to be more dismissive and distant toward an HIV-negative person, which may be suggestive of the way in which men typically interact with one another. Derlega et al. (1998) found that men were more dismissive of their partner when the cause of HIV infection was perceived as uncontrollable. It is possible that men prefer to enact social support when they believe an effective solution can be found; in fact, research suggests that men do provide better social support when faced with a task-oriented problem versus an emotional one (Barbee et al., 1993; Derlega, Barbee, & Winstead, 1994). However, if the cause of infection is uncontrollable or if the individual tests negative for HIV (as in this condition), men may feel that the “problem is solved,” thus making it easier to dismiss both the situation and the person.

In contrast, though, in addition to offering more solace, men, compared to women, made fewer “distancing” (i.e., low descriptive/low evaluative) statements toward an HIV-positive person. It is possible that the men may have been able to identify with a sexually-active, HIV-positive man, and thus may have been more willing to express solace and intimacy because they can picture themselves in the same situation (Derlega et al., 1998). It is still curious, however, that male participants chose to make fewer of these “distancing” statements toward a partner who is generally less well-liked, as discussed above. An early study by Cozby (1972) on the reciprocity of self-disclosure revealed a curvilinear relationship between level of self-disclosure and reciprocal feelings of intimacy. A low self-disclosing person may be viewed as “distant” and will not receive

much reciprocal self-disclosure from a partner. A high self-disclosing person may be viewed as “too close” or threatening to the partner, and similarly will not receive much reciprocity. Low reciprocity may also occur early in a relationship when people do not know each other well. However, results reported by Cozby were puzzling in that high self-disclosing individuals were also seen as maladjusted, possibly due to their being “indiscreet” in choosing what to share; nevertheless, they earned a fairly high level of self-disclosure in return. Though the Cozby study involved female participants only, results were similar to what was found in the present study. Perhaps, as Morton (1978) suggested, the male participants in this study chose to navigate the exchange of intimacy with a stranger by engaging in “a cautious ‘tit-for-tat’ reciprocity” (p. 79) before ultimately deciding that he was maladjusted, indiscreet, or otherwise less desirable.

The fact that participants overall made more high descriptive/low evaluative statements toward a straight, HIV-positive person than toward a straight, HIV-negative person may also reflect the idea that “there before the grace of God go they.” In other words, participants (who were primarily assumed to be heterosexual) may have easily been able to imagine themselves in the situation of the HIV-positive individual, and thus were more likely to share intimate information with them in an effort to connect and to provide comfort. It may also be a sympathetic response elicited by someone who is living under high stress associated with the diagnosis of a life-threatening disease. Powell, Christensen, Abbott, and Katz (1998) found that participants blamed a gay couple in a written scenario, regardless of whether the couple contracted HIV or not, as a function of the participants’ own degree of HIV/AIDS-related stigma. The more participants felt they were “similar” in behavior or character to the couple in the scenario, the lower their

degree of HIV/AIDS-related stigma. This finding suggests that people are less likely to blame those they consider similar to themselves, and is applicable to the present results as many college students are sexually active and may have found their partner's situation easily relatable.

Participants may not have found a sexually-active gay man's situation to be as relatable, however. Overall, participants enacted more low descriptive/low evaluative statements toward a gay HIV-positive partner than toward a straight HIV-positive partner, whereas no differences in this variable were found among participants interacting with a gay or straight, HIV-negative individual. It appears that sexual orientation, when combined with HIV-positive serostatus, is a critical variable, in that it somehow may make a partner less deserving of reciprocal intimacy and comfort. Similar findings were reported by Derlega et al. (1998), whereby participants were less willing to provide intimate disclosures to a gay versus a heterosexual HIV-positive man. Why is this? One explanation is that participants, being primarily heterosexual, found it difficult to empathize with a gay individual. The fact that his HIV infection occurred through sexual activity may have triggered underlying feelings of homonegativity in the participants, as well as the desire to psychologically "distance" themselves (and their own similar behaviors) from their partner as much as possible (Pyszczynski et al., 1995). This may be especially true for men, who tend to avoid intimacy in same-sex friendships possibly due to concerns of being perceived as gay (Winstead, Derlega, & Rose, 1997). A second explanation may be based on participants' feelings that their partner was responsible or was to blame for his infection, due to his engagement in sexual activity. Although the partner's message suggested a responsible course of action—a sexually-active person

deciding to be tested for HIV—it intimated that sexual intercourse was the route of infection, which may inspire feelings that the infection was “controllable” and that the partner was “irresponsible” for engaging in activity that led to his illness. In the study by Powell et al. (1998) examining ratings of blame in two scenarios, one involving a gay couple and one involving a heterosexual couple, results suggested that gays may be blamed for their behaviors regardless of whether they became infected with HIV. Conversely, heterosexual couples were blamed only if the behaviors led to HIV infection. Mean ratings in the two experiments shows that participants blamed gay individuals more for their behavior and character than they blamed heterosexual individuals. McBride (1998) also found that, in the absence of a behavioral explanation for infection with HIV (e.g., unprotected sex or IV drug use), homosexuality was considered both as a character flaw and “behavioral responsibility” contributing to someone’s misfortune. Both Powell et al. and McBride lend strong support to the idea that HIV/AIDS-related stigma is associated with both characterological and behavioral blame, and both factors may be influencing participants’ reluctance in the present study to be intimate with a gay HIV-positive individual. Herek et al. (2002) address the notion of blame and responsibility directly:

This pattern is worrisome because individuals with an undesirable condition are generally subjected to greater stigma when they are perceived to be personally responsible for their situation. In the case of AIDS, such perceptions may be an unintended consequence of public education campaigns that stress the importance of personal decision making in HIV prevention. If so, health educators face the challenge of communicating the importance of protecting oneself from AIDS

without promoting increased blame for individuals who become infected

(p. 376).

Certainly, the unwillingness of participants to disclose intimately to a gay HIV-positive individual is consistent with previous findings (Connors & Hely, 2007; Dijker et al., 1996; Herek & Capitanio, 1999; Herek & Glunt, 1993; Herek et al., 2005; Pryor & Reeder, 1993; Pryor et al., 1999; Weiner, 1993a) that homosexuality continues to be associated with HIV/AIDS, and that the resulting stigma expresses a public fear and moralistic rejection of both the illness and the individuals typically associated with it.

As we enter the third decade of HIV and AIDS, it is clear that, though medical treatment has advanced tremendously, social prejudices about this disease still exist. Now that HIV/AIDS is changing from a fatal illness to a chronic one, individuals living with the disease are faced with new challenges. It is becoming especially important to improve the quality of life for those individuals affected, particularly in terms of personal and social relationships. Greene, Frey, and Derlega (2002) noted the unfortunate finding that HIV/AIDS-related stigma has been slow to dissipate despite rapid advancements in medical technology and the fact that HIV/AIDS is no longer viewed as imminently fatal. Because HIV/AIDS-related stigma persists, public education about AIDS should continue to address this critical issue, with an emphasis on raising awareness of the factors that contribute to it. As Herek and Glunt (1993) noted, HIV/AIDS-related stigma is a product of fear of the illness and moralistic beliefs about blame and personal responsibility. These issues clearly highlight the need for education which addresses factual information about the disease, and symbolic and value-laden issues such as religious and public policy, anxiety about illness, and negative attitudes toward homosexuality.

Educational programs and efforts made toward reducing HIV/AIDS-related stigma are critical in helping to remove the shroud of secrecy and shame cloaking individuals affected by the illness, and allowing them to seek necessary support. In their meta-analysis of 21 studies examining HIV/AIDS-related stigma, Smith, Rossetto, and Peterson (2008) found that PWHAs who experienced greater levels of stigma also reported less social support and fewer disclosures of their serostatus to others. The authors noted that the stigma experienced by these individuals was both actual and perceived, illustrating that, in fact, PWHAs need only an awareness of the *possibility* of being stigmatized to prevent them from seeking help. At the time of their study in 1987, Kelly et al. found that even physicians were reluctant to interact with PWHAs, a sad irony that makes perfectly clear the destructive nature of stigma. It is difficult to ignore a social process that would lead those in the helping professions to withhold treatment from those who need it most.

It is clear that HIV/AIDS-related stigma, whether overt or subtle, may continue to marginalize PWHAs and prevent them from seeking social support for fear of continued rejection (Swedeman et al., 2006). This may be especially true for men with HIV/AIDS, who are typically socialized to be hesitant in asking for support, believing instead that they must minimize emotion, behave rationally, and be effective problem-solvers on their own (Barbee et al., 1993; Derlega et al., 1993). Choosing to share private information, such as one's sexual orientation or HIV serostatus, carries a degree of risk within relationships; however, individuals who choose not to disclose based on fear of rejection or stigmatization are subject to the negative physical and emotional consequences that stem from the effort expended to conceal the "secret." This failure to disclose also

prevents an individual from seeking and receiving appropriate support, guidance, and resources (Derlega et al., 1993).

Limitations and Directions for Future Research

Several limitations to the present study should be noted. Statistically, though sample size and power were adequate to examine interactional effects, the sample contained few men, which may have decreased the ability to find more significant, gender-based results. Additionally, the convenience sample of college students may have influenced several of the findings, as younger, better-educated people are less likely to stigmatize PWHA's (Herek, 1999).

According to the social-psychological model proposed by Pryor, Reeder, and Landau (1999), participants may also have had adequate time to alter their initial reactions to the PWHA. Since the participants were college students, they may have held more liberal attitudes and been at least somewhat invested in treating others equitably and without prejudice (Henry, 2008). Thus they may have experienced *internal* (fairness is important to participants' self-concept) or *external* (fairness arises from external pressure by others) pressures that helped to alter any automatic negative reactions they might have had. Even in light of this potential effect, it remains interesting that men revealed more negative, "private" reactions despite their "public" positive response to their partner.

There are also differences in beliefs about the transmission of AIDS and attitudes toward those with AIDS between Caucasians and African-Americans. For example, African-Americans are more likely to believe that the government is withholding information about how AIDS is transmitted (Herek & Glunt, 1993), and there appear to be racial differences in beliefs about transmission through casual contact and advocacy of

coercive policies (Herek, 1999; Herek & Capitano, 1993). Among African-Americans, HIV/AIDS-related stigma appears to be associated with negative attitudes toward injection drug users, whereas anti-gay attitudes more strongly predict HIV/AIDS-related stigma among Caucasians (Herek & Capitano, 1999). There is also some evidence that African-American PWHA's elicit more anger, are attributed greater responsibility for their illness, and receive less help from others, even among African-Americans (Herek & Capitano, 1999). These racial and ethnic differences in beliefs were not explored in the present study, either through examining reactions based on participant ethnicity or through varying the ethnicity of the stimulus person. Future research may wish to examine these racial and ethnic differences to determine whether the beliefs reported via survey are replicated in actual behavioral interactions with a PWHA.

Similarly, the gender of the stimulus person was not varied; thus, participant reactions to a male versus a female PWHA could not be explored. Examining reactions to a female PWHA will be important for researchers to consider, however, as the number of HIV infections among women in the U.S. increases (Greene et al., 2002).

Though the results provide some basis for speculating that participants may have blamed their partner or held him responsible for his illness, the issue of blame and personal responsibility was not explicitly addressed nor explored. However, because the confederate's message was limited to a scenario based on sexual activity, it is reasonable to suggest that these ideas may have influenced some participants' attitudes, and it may be beneficial to include this variable in future studies, perhaps by including scenarios in which "controllable" versus "uncontrollable" conditions are manipulated in addition to sexual orientation and HIV serostatus.

Weiner (1993a) noted that efforts by a PWHAs to cope with the illness in a positive, health-promoting manner versus a negative, self-destructive manner can also affect the affective and behavioral responses of others. Those individuals who are seen as actively working to preserve their health elicit more favorable and supportive responses from others. The confederate's message in this study did not contain information about how he was working to cope with his illness; thus, this effect was not examined. Though it appeared that participants nevertheless offered much positive social support, it would be interesting to examine whether the enactment of social support would vary based on whether or not the confederate was taking an active role in protecting his health.

Finally, future replications of this study may wish to examine potential differences between *explicit* and *implicit* attitudes held by participants. The present results suggest that what individuals report about their attitudes toward others on explicit rating tasks (such as Likert-type scale ratings of liking and trust) may differ from what is expressed through more indirect, implicit means, such as the writing task used in this study. This open-ended task afforded participants the means to express their thoughts and feelings in any manner they chose, and may have provided more subtle and nuanced information about their privately-held attitudes (or their desire to be "fair" and "nonjudgmental" toward others) than could be summarized by a Likert-type scale measure alone. Careful selection of both explicit and implicit measures of attitudes is warranted, and correlations among measures should be calculated. Measures that are correlated would lend support to the notion of "public" versus "private" expression of attitudes toward others, such as was suggested in this study.

Conclusion

Recognition of HIV/AIDS as a major societal problem significantly predicted both men's and women's feelings that more research needed to be done (Connors & Hely, 1997). Half of Americans believe that too little is currently being spent on HIV/AIDS, and six in ten believe that continued prevention efforts will be successful (Kaiser Family Foundation, 2009). Though significant medical advances have been made since HIV/AIDS first emerged nearly 30 years ago, it appears that social attitudes are more entrenched. We may have been naïve to think that stigma surrounding an illness strongly associated with homosexuality, a practice that has been condemned repeatedly since Biblical times, would dissipate in one generation. Indeed, results of the present study demonstrate that negative attitudes persist, and that individuals—regardless of the “public” face they may choose to show—are still reluctant to become intimate with someone who is gay and HIV-positive. However, the results are also hopeful, as some unexpected findings emerged regarding male participants' willingness to offer solace to and share intimate information with an HIV-positive person, and female participants' willingness to like, trust, and respond to a partner similarly, regardless of his sexual orientation or HIV serostatus. It is also interesting to note that despite participants' unwillingness to disclose intimately in some circumstances, they did not rely on “escape” tactics according to Barbee's (1990) typology to distance themselves from their partner, perhaps feeling that this behavior would be harsh and unsympathetic. These trends suggest that continued efforts aimed at reducing HIV/AIDS-related stigma and negative attitudes toward homosexuality hold promise of success.

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APPENDIX A

IRB Approval Code: 07-060

ON-Project Impression

Abstract: The purpose of this study is to add to our understanding of how we form impressions and reactions to someone based on information about their personal attributes and background characteristics.

Description: The study is divided into three parts. In part 1, participants will be involved in a group discussion about personal experiences in attending a large university such as Old Dominion University. This will give participants the opportunity to become more acquainted. In part 2, participants will be placed in individual rooms where each participant will be given the name of a person who will be assigned as his/her partner for the rest of the study. Part 2 will ask each participant to share information about him/herself (divulging as much or as little as desired) with the assigned partner. In part 3, participants will each complete questionnaires describing their impressions and feelings about their partners.

Participants: Participants must be at least 18 years old and currently enrolled as a student at ODU.

Duration: 90 minutes

Credits: 1.5 credits

Researcher: Stacie Fine
Email: sfine001@odu.edu

Principal Investigator: Val Derlega

Deadlines: Sign-Up: 24 hour(s) before the appointment
Cancellation: 24 hour(s) before the appointment

APPENDIX B

PRELIMINARY INFORMED CONSENT DOCUMENT

PROJECT TITLE: Project Impression

INTRODUCTION

The purposes of this form are to give you information that may affect your decision whether to say YES or NO to participation in this research, and to record the consent of those who say YES. Project Impression will be conducted in Room 219/221 of the Mills Godwin Building (MGB) at Old Dominion University.

RESEARCHERS

Responsible Primary Investigator: Valerian J. Derlega, Ph.D., Old Dominion University, Department of Psychology

Investigator: Stacie Fine, M.S., Old Dominion University, Department of Psychology

DESCRIPTION OF RESEARCH STUDY

The purpose of this study is to add to our understanding of how we form impressions and reactions to someone based on information about their personal attributes and background characteristics. The study is divided into three parts. In part 1, everyone participates in a group discussion about personal experiences in attending a large university such as Old Dominion University. This will give everyone the opportunity to become more acquainted. In part 2, you will be placed in an individual room where you will be given the name of a person who will be assigned as your partner for the rest of the study. Part 2 will ask each person to share information about themselves (divulging as much or as little as you want) with the assigned partner. In part 3, we will ask each of you to fill out questionnaires describing your impressions and feelings about your partner. The information that you provide during parts 2 and 3 will not be shared with other participants in today's session, except that you should expect that what you write in part 2 for your assigned partner would be shared with that assigned person. The information that you provide today (based on your responses in Parts 1, 2, and 3 of the study) will only be used by the investigators for data collection purposes and it will be anonymous (meaning that we don't ask for or want your name on any forms or questionnaires that we ask you to fill out). We won't even look at the data or anyone's responses until the entire research is completed.

There are also important aspects of the study that we can't go over until the end of the session during the debriefing without influencing the results of the study. At the end of the study we will conduct a "one on one" debriefing, reviewing your individual reactions to participating in the study, answering any questions you may have at that point, and explaining in more detail the rationale, procedures, and implications of the study.

To review: If you decide to participate, then you will join a study involving research into impression formation. Participation will involve a brief group discussion, interaction with a partner and individual completion of questionnaires assessing your impressions of your

partner. We will review at the end of the session, during an individual debriefing, further information about the rationale and justification for the study. If you say YES, then your participation will last for approximately 90 minutes in MGB Room 219/221. If you say NO, then we thank you for considering participating in the study. Approximately 165 undergraduate men and women will be participating in this study.

EXCLUSIONARY CRITERIA

You should be at least 18 years old and currently enrolled as a student at Old Dominion University in order to participate in this study.

RISKS AND BENEFITS

RISKS: If you decide to participate in this study, then you may face a risk of some psychological discomfort based on the information you choose to share or that you hear and/or read about from other participants. The researchers will attempt to reduce these risks by removing any potential identifiers that might link you with your responses and by conducting a “one-on-one” debriefing for each participant at the end of the study. . And, as with any research, there is some possibility that you may be subject to risks that have not yet been identified.

BENEFITS: There are no tangible benefits to be gained from participating in this experiment. However, individuals may gain a greater understanding of themselves by participating in the study.

COSTS AND PAYMENTS

The researchers are unable to give you any payment for participating in this study. However, you will earn one and one-half (1.5) extra credit points for your participation, which can be applied to Psychology classes at Old Dominion University.

NEW INFORMATION

If the researchers find new information during this study that would reasonably change your decision about participating, then they will give it to you.

CONFIDENTIALITY

All information obtained about you in this study is strictly confidential. The results of this study may be used in reports, presentations and publications, but the researcher will not be able to identify your individual data.

WITHDRAWAL PRIVILEGE

It is OK for you to say NO. Even if you say YES now, you are free to say NO later, and walk away or withdraw from the study, without penalty, at any time. We will also ask you again during the debriefing if it is still okay to use your data in the study.

COMPENSATION FOR ILLNESS AND INJURY

If you say YES, then your consent in this document does not waive any of your legal rights. However, in the event of distress arising from this study, neither Old Dominion University nor the researchers are able to give you any money, insurance coverage, free

medical care, or any other compensation for such injury. In the event that you suffer injury as a result of participation in this research project, you may contact Dr. Valerian Derlega at 757-683-3118, Dr. Louis Janda at 757-683-4211, or Dr. George Maihafer, the current IRB chair, at 757-683-4519 at Old Dominion University, who will be glad to review the matter with you.

VOLUNTARY CONSENT

By agreeing to participate, you are saying several things. You are saying that you have read this form or have had it read to you, that you are satisfied that you understand this form, the research study, and its risks and benefits. The researchers should have answered any questions you may have had about the research. If you have any questions later on, then the researchers should be able to answer them:

Valerian Derlega, Ph.D.: 757-683-3118
Stacie Fine, M.S.: 757-646-9702

If at any time you feel pressured to participate, or if you have any questions about your rights or this form, then you should call Dr. George Maihafer, the current IRB chair, at 757-683-4519, or the Old Dominion University Office of Research, at 757-683-3460.

And importantly, by signing below, you are telling the researcher YES, that you agree to participate in this study. The researcher should give you a copy of this form for your records.

Subject's Printed Name & Signature

Date

INVESTIGATOR'S STATEMENT

I certify that I have explained to this subject the nature and purpose of this research, including benefits, risks, costs, and any experimental procedures. I have described the rights and protections afforded to human subjects and have done nothing to pressure, coerce, or falsely entice this subject into participating. I am aware of my obligations under state and federal laws, and promise compliance. I have answered the subject's questions and have encouraged him/her to ask additional questions at any time during the course of this study. I have witnessed the above signature(s) on this consent form.

Investigator's Printed Name & Signature

Date

APPENDIX C

RESEARCHER'S INSTRUCTIONS TO PARTICIPANTS

Commencing the experiment. [Researcher gives everyone a name tag and asks everyone to be seated in chairs situated in a circle.] Thank you, everyone, for your participation. Before I begin let me emphasize that everything we discuss here is confidential and that I will not disclose conversation contents and names of people anywhere beyond this room. I also expect you all to respect each other in this manner. Today we will be conducting some research on how we form impressions of each other when we meet for the first time. Today's experiment will consist of three different parts. In the first part, all of you will participate in a group conversation about your experiences in attending a large university such as this one. This will allow us all to become more acquainted and comfortable with each other. After ten minutes, I'm going to ask each of you to retire to an individual cubicle where I will give you the name of the person I have randomly assigned as your partner for the rest of the experiment. The second part will involve a "getting to know you" task, just between the partners. I will either have you commence, or have your partner commence, by writing a message to the other whereby you may divulge as little or as much information to your partner as you like—for instance, about something important that may have happened to you recently, or how you have been feeling about certain things going on in your life. I will then deliver this message and ask your partner to respond to what you have said, and then tell you something about him or herself in the same manner. Keep in mind that you do not have to write anything if you don't want to. Also keep in mind that only your partner, myself, and the researchers supervising this project and analyzing the data collected in the study will see this

information. It will not be available to anyone else in the study, the contents will not be associated with your name or identity in any way, and no data will be analyzed until all participants have completed the study. After this message exchange, we will begin the third part of the study, in which I will have you fill out some questionnaires regarding your feelings and the impressions you have about your partner. These are for my information only. Your partner will not see this information. After the questionnaires are finished, I will come by to talk to you about this study and to answer any questions you may have.

APPENDIX D
DEMOGRAPHIC QUESTIONNAIRE

Age: _____

Sex: Male Female

What year of college are you in?: Freshman Sophomore Junior Senior

Are you a full-time student?: Yes No

Race/ethnicity: Caucasian African-American Asian-American

Hispanic Other (Describe)_____

What is your religious affiliation?: Christian-Protestant Catholic Jewish Muslim

Other

Are you employed?: Yes, full-time Yes, part-time No

Marital Status: Single with intimate partner Single without intimate partner Married

Divorced Other

APPENDIX E

SAMPLE MESSAGE FROM CONFEDERATE

This is hard for me to share, especially since I don't know you very well, but I want to be open about myself. I was recently tested for HIV, which was really scary for me. I found out that I'm HIV-positive [HIV-negative]. I still can't really believe it [I am so relieved]. I'm gay [not gay], but I had never been tested before even though I've had sex, so I thought it would be a good thing to do. I still can't believe I'm telling you this, but it makes me feel better to share it with you.

APPENDIX F

PARTICIPANT SELF-DISCLOSURE FORM

Response to partner's message:

Information about yourself:

APPENDIX G

STRESS APPRAISAL MEASURE (SAM)

Think about your current experiences as a college/university student and the goals you are hoping to accomplish during your time here. After taking a moment to reflect, please answer all of the following questions. Answer each question by writing the appropriate number on the line, according to the following scale:

1 = not at all

2 = slightly

3 = moderately

4 = considerably

5 = extremely

___ 1. How much am I currently enjoying my college experience?

___ 2. Does this situation create tension in me?

___ 3. Is there someone or some agency I can turn to for help if I need it?

___ 4. Does this situation have important consequences for me?

___ 7. Is the college experience going to have a positive impact on me?

___ 8. How eager am I to tackle this challenge?

___ 9. How much will I be affected by the outcome of this situation?

___ 10. To what extent can I become a stronger person because of this problem?

APPENDIX H

COUNSELOR RATING FORM (CRF)

Please rate your partner on the following dimensions using this 7-point scale. Use the descriptions under “1” and “7” as anchor points in making your ratings on each dimension. Please make ratings relative to these extremes, according to your opinion of the person.

1	2	3	4	5	6	7
1. easy to get along with						hard to get along with
1	2	3	4	5	6	7
2. I feel we are compatible						I feel we are incompatible
1	2	3	4	5	6	7
3. genuine						phony
1	2	3	4	5	6	7
4. likely to keep a secret						unlikely to keep a secret
1	2	3	4	5	6	7
5. trustworthy						untrustworthy
1	2	3	4	5	6	7
6. appreciative						unappreciative
1	2	3	4	5	6	7
7. attractive						unattractive

1	2	3	4	5	6	7
8. respectful						disrespectful
1	2	3	4	5	6	7
9. dependable						undependable
1	2	3	4	5	6	7
10. straightforward						deceitful
1	2	3	4	5	6	7
11. responsible						irresponsible
1	2	3	4	5	6	7
12. enthusiastic						indifferent
1	2	3	4	5	6	7
13. warm						cold
1	2	3	4	5	6	7
14. casual						formal
1	2	3	4	5	6	7
15. close						distant
1	2	3	4	5	6	7
16. open						closed
1	2	3	4	5	6	7
17. cheerful						depressed
1	2	3	4	5	6	7
18. likeable						unlikeable

1	2	3	4	5	6	7
19. sincere				...		insincere
1	2	3	4	5	6	7
20. honest						dishonest
1	2	3	4	5	6	7
21. reliable						unreliable
1	2	3	4	5	6	7
22. sociable						unsociable
1	2	3	4	5	6	7
23. selfless						selfish
1	2	3	4	5	6	7
24. friendly						unfriendly

APPENDIX I

DEFENSIVE DISTANCING MEASURE

Please indicate how willing you would be to meet with your partner at a future time if I need to call people for a follow-up to the study.

1

2

3

4

5

not at all willing

very willing

APPENDIX J

SITUATIONAL REALITY CHECK

1) Do you have any reactions to the study that you would like me to know?

2) Describe in your own words what you think the study is about.

APPENDIX K

BARBEE INTERACTIVE COPING BEHAVIOR CODING SYSTEM (ICBCS)

Barbee's model of interactive coping is based on the notion that there are two major methods of personal coping, including those that are problem-focused and those that are emotion-focused. The second dimension involved in the coding scheme is approaching or avoiding the problem. The two combine to form four major categories of coping behavior, including dismiss and escape, which are both avoidant behaviors, and solve and solace, which are both approach behaviors. Both dismiss and solve involve dealing with the problem itself, whereas escape and solace focus more on the emotions involved with the problem. The data collected in this study will be coded according to a specific scheme developed by Barbee et al. using the following set of subcategories and examples as guidelines.

Solve Behaviors: Problem-Focused Approach

1. QUES: asks questions about the details of the problem; asks questions about how the seeker will continue to handle the problem; asks what's on the seeker's mind, "What's bothering you?" in positive tone; asks, "Are you okay?"
2. CAUSE: figures out the cause of the problem; gathers extra information about the problem.
3. PERSP: gives the seeker perspective; reframes the situation for the seeker; takes the perspective of the third party; provides insight into the event; clarifies the event.
4. SUGGEST/SOL: gives suggestions on how to solve the problem; suggests resources to help; recommends professional or non-professional help; suggests that the seeker

confront the problem; suggests that the seeker take some time to relax; suggests that the seeker stand up for him- or herself; suggests that the seeker compromise; suggests that the seeker do what makes him or her happy; suggests how to handle the problem; gives information to help solve the seeker's problem; tells seeker how the situation can be changed; comes to a conclusion about what he/she could do to solve the problem; tells about a book that could help; looks for solutions with the seeker; lists options of how to solve the problem; describes how he/she would handle it if it were him/her.

5. TANGIBLE: does something active or physical to help the seeker; gives money or a loan; offers to help now; offers to follow up in the future.

Solace Behaviors: Emotion-Focused Approach

1. AFFECTION: gives seeker a hug; touches seeker on the shoulder; puts an arm around seeker's shoulder; gives a kiss; verbal affection; conveys attachment to seeker.
2. EMPATHY: shows understanding; makes empathetic remarks such as "uh-huh," "ooh," etc.; cries with seeker; gets angry along with seeker about the problem's cause.
3. COMPLIMENT: compliments the looks of the seeker; compliments the ability of the seeker.
4. AVAILABLE: assures seeker of future availability to help with the problem; leans forward and displays quiet attentiveness; stifles impulse to interrupt seeker.
5. REASSURE: tells the seeker that he or she is a good person; tries to boost the seeker's self-esteem; shows shock/sorrow at hearing the problem; gives reassurance that

everything will be okay; agrees with the seeker; assures the seeker that it was not his/her fault; criticizes the behavior of the third party.

6. LIFT MOOD: offers to buy the seeker a gift or take them out to lunch in order to cheer up; exercises with the seeker to lift spirits; encourages seeker to engage in a creative task to lift spirits.
7. CONFIDENTIALITY: assures confidentiality; promises to mislead others about the problem.
8. FEELINGS: asks how seeker feels about the problem; asks why the seeker feels a certain way; encourages disclosure of feelings and emotional displays.

Dismiss Behaviors: Problem-Focused Avoidance

1. AVOIDPROB: tells the seeker about his/her own problem rather than dealing with seeker's problem; avoids dealing with the problem; changes the topic of conversation; talks, but doesn't address the real problem; talks about own interests.
2. SHOWDIS: shows disinterest in problem; says, "I don't care about the problem"; says, "There's nothing I can do."
3. CRITICIZE: criticism about how the seeker handled the problem; blames seeker for problem; says not to get upset until it's really a problem; suggests problem could have been handled with easily available information.
4. MINIMIZE: says that the seeker's problem is not serious; says, "That's life"; says, "It's not a problem"; says, "Forget about it"; suggests that others have similar problems and that the seeker is not unique.

5. SARCASM: uses sarcastic tone of voice; ridicules the seeker; says, "Good luck" in patronizing tone.
6. POLLYANNA: feigns sympathy; says, "Don't worry"; says, "Look on the bright side."

Escape Behaviors: Emotion-Focused Avoidance

1. AVOID VERBALLY: tells the seeker to leave; uses excuses not to talk to seeker; reminds seeker of things the helper has to do; passes off the seeker to another.
2. DISTRACT: turns on the TV or radio; begins to read a book or magazine while the seeker is talking or instead of answering the seeker; acts distracted; ignores the seeker's emotional displays or mood state.
3. ENCOURAGE ESCAPE: encourages seeker to get drunk or take drugs; encourages seeker to have sex or to engage in fantasy; changes activity.
4. NONVERBAL ESCAPE: withdraws physically in the room; moves chair away from seeker; turns away from seeker; pulls back; leaves room; avoids eye contact.
5. AGGRESSIVE JOKE: makes fun of the seeker or the seeker's feelings, not with the intention to cheer up the seeker; laughs at the seeker and the situation; tells a joke that is out of context for the seeker's problem.
6. SHOW IRRITATION: shows irritation at the seeker or the seeker's problem; reports annoyance that the seeker is depressing.
7. MEAN: says, "I don't care about you"; "shut up"; "be quiet"; "quit talking about it"; "grow up."

8. SUPPRESSEM: encourages the seeker to suppress his/her emotions; encourages seeker not to cry; takes seeker to public places to discourage open display of emotions.

APPENDIX L

MORTON TWO-DIMENSIONAL INTIMACY SCORING SYSTEM

There are many different ways to be intimate. One way is to share some very private information about oneself: disclosing the make of car you drive is not as intimate as discussing a job failure. Another way to be intimate is to share your feelings: simply mentioning that you are getting a divorce is not as intimate a disclosure as describing your feelings about that prospect. In most kinds of conversation, these different forms of intimacy co-exist in rather complex ways.

This scoring system is designed to code two important dimensions of intimate self-disclosure, fact and feeling. Disclosing factual information about oneself is descriptive self-disclosure. Disclosing personal feelings or judgments is affective or evaluative self-disclosure. Scoring communication along these two dimensions will allow a closer scrutiny of how intimacy occurs in the self-disclosure process. One can be intimate solely by presenting very private facts or solely by presenting very private feelings. In addition, one can talk about a “heavy” or “deep” topic without expressing an opinion or emotion. And one can pick the most trivial topic but personalize it with intimate information or expressions of strong feelings or judgments.

Two levels of intimacy have been designated for each of the self-disclosure dimensions. Raters will use a four-category system combining both levels of each dimension:

1. *High Description/High Evaluation*: Highly private or personal factual information with intense or strongly personal feelings or opinion.

2. *High Description/Low Evaluation*: Highly private or personal factual information with little or no expression of feelings or judgments.
3. *Low Description/High Evaluation*: Generally public or nonpersonal factual information with intense or highly personal feelings or opinions.
4. *Low Description/Low Evaluation*: Generally public or nonpersonal factual information with little or no expression of feelings or judgments.

1. *Description: Self-Disclosure through Factual Information*

Some facts about oneself are less personal, more accessible, and more public than others. These facts are rated a low intimacy value. Biographical characteristics, and interests and hobbies generally represent a low level of descriptive facts. Other kinds of information about oneself are guarded more carefully, and shared with those we know more, like more, trust more. These facts are given a high intimacy value. Issues pertaining to marriage and family, sex, and self-concept generally represent a high level of description.

Samples of Factual Content and Intimacy Ratings

Interests, Hobbies, Habits

Low description:

how fast I eat

favorite sports

travel plans

smoking habits

things that interest me

ways I spend spare time

High description:

my drinking habits

whether or not I enjoy reading sexy or dirty stories

Physical Condition and Appearance

Low description:

foods I think are healthy

general health as a child

times I've been in the hospital

sleeping patterns

last physical exam

how well I hear

High description:

times when I wanted to change something about the way I look

long-range worries or concerns about my health

how I feel about getting old

Parental Family

Low description:

number of brothers and sisters I have

where my relatives live

how often I get together with my relatives

High description:

how I would feel seeing my mother drunk

things I dislike about my mother
mistakes my parents made when raising me
things I like about my mother
how much money my parents have/make
the way my family treats me
diseases that run in my family
things I fight with my family about
my father's personality
relatives I dislike and what I dislike about them

Own Marriage and Family

Low Description:

allowance I give my children
the age I was married

High description:

my ideas concerning marriage
how much sex education I would give my kids
how I would feel living with my in-laws
if I would lie to my spouse
what I would do if my spouse lied to me

Emotions and Feelings

Low description:

times I have been dissatisfied
times I have been enthusiastic

my fear of water or certain animals

how I feel seeing blood

High description:

times I have felt lonely

embarrassing situations I've been in

how much I care what others think of me

things I am most afraid of

feelings I have trouble controlling or expressing

times I felt life wasn't worth living

times I have cried as an adult when I was sad

2. Evaluation: Self-Disclosure through Judgment and Affect

Picking an intimate item and discussing it with continued intimacy are not synonymous. A very significant way to reveal a great deal of oneself is through judgment or affective (feeling) statements. Giving a strong opinion or emotional response on even a trivial topic represents high self-disclosure on the evaluative dimension.

The guidelines for rating evaluative communication are not as firm as those for factual material. Raters are urged to assimilate the following points, recognizing that the topic of conversation (what is being talked about) influences its evaluative score (how it is being talked about).

Intensity of feeling/judgment

Raters must be attuned to key words reflecting the intensity of the feeling component in any given statement. Obvious examples are the words "love," "hate,"

“loathing,” “depressed.” Be on guard also for evaluative adjectives which represent strong judgments. Examples are “awful,” “fantastic,” “stupid.” Qualifying words such as “really,” “very,” and “extremely” are also powerful cues which may increase the intensity of the affective or evaluative component.

Vulnerabilities and negative feeling/judgment

Revealing one’s vulnerabilities represents a fact or descriptive disclosure. Very often, however, such statements are affectively loaded and are rated as high evaluation as well. In addition to the intensity cues mentioned above, be attuned for the valence of the evaluation. Generally speaking, expressing negative feelings or opinions is riskier, less socially desirable, and more intimate than expressing positive feelings.

Self-references and present tense

Often self-references are more intimate than references to others. “I like my Spanish class” is, however, much less intimate than “He was brutally selfish.” The latter statement has no self-reference, yet the judgment about another demonstrates a high evaluative tenor. References to “you,” “we,” or to “you and me” may also be very high in evaluation, since they concern an immediate relationship. The archetypal example is “I love you.”

Communicating with immediacy also tends to raise the evaluative level, all things being equal. Thus, the present tense and the first person mode are more personal than the past tense or the third person. On the other hand, all things are usually not equal, and wishes for the future as well as long-buried emotions from past traumas may be more highly evaluative than statements such as “I feel kind of hot.”

3. *The Four Rating Categories*

1. High descriptive/high evaluative

- a) If my husband ever asked for a divorce, I think I would really fall apart.
- b) My sister went to jail for that, and as far as I'm concerned, she should have stayed there.
- c) I was shocked when Mom told me that I would have had a brother or sister, except that she miscarried.
- d) I didn't know you had such ugly feelings about my mother—I wish you could have told me before.

2. High descriptive/low evaluative

- a) My father would drink late into the night.
- b) I am seeing a shrink regularly because of that.
- c) Sexual matters were not discussed in my family when I was growing up.
- d) Then my first wife died and I took the kids and went back to Indiana.

3. Low descriptive/high evaluative

- a) Don't you think this psychology experiment is incredibly artificial?
- b) I really hate spinach!
- c) That movie was the most beautiful one I've ever seen!
- d) The corruption of the Clinton administration has got to be the worst scandal ever.

4. Low descriptive/low evaluative

- a) I have four brothers and sisters.
- b) I don't like getting less than 8 hours of sleep—I can't concentrate well then.

- c) So then I switched from engineering to psychology.
- d) I like to spend my summers traveling.

Miscellaneous Rules of Thumb

People versus Objects

Providing facts, feelings, or attitudes about people is generally more intimate than about objects. And specific people represent a more intimate focus than people in general, or in the abstract. Thus, a good deal of evaluation is necessary regarding objects, and a moderate degree of evaluation regarding people in the abstract to merit a (3) score. Only a small degree of evaluation is necessary regarding “significant others” to merit a (1) score. Examples:

- a) I don't like small dogs. (4)
- b) I hate small dogs. (3)
- c) I tend to get emotionally involved with pets. (3)
- d) I'm uncomfortable at parties where I don't know anyone. (3)
- e) I don't like my father. (1)
- f) I hate my father. (1)

Social and Political Opinions or Cliches

One not uncommon way of deviating from a “heavy” self-disclosure topic such as suicide, alcoholism, or self-criticism is to veer into clichés or generalizations. These kinds of statements are often made in social gatherings or to relative strangers because they are general statements without much idiosyncratic personal material, and because

they are often socially accepted or even approved of. Social or political opinions or other clichés are rated (4) or (3) unless rather personal matter is introduced. Examples:

- a) I'm not sure exactly what makes someone an alcoholic instead of a drinker. (4)
- b) I don't approve of the cheap, sensational way the press is handling the O. J. Simpson trial. (3)
- c) (In talking about the Planned Parenthood program:) Abortion is a terrible solution to an unwanted pregnancy. (3)
- d) (In discussing the possible but undesired pregnancy of oneself or spouse:) Abortion is a terrible solution to an unwanted pregnancy. (1)

Judgments or Feelings of Significant Others

When the speaker describes the feelings or judgments of significant others, raters should consider the material as fact and score as a (2) or (4) unless the speaker clearly adds his own evaluation to that of his subject.

An exception to this rule is made in the case where the speaker describes a significant other's evaluation of him or herself. In such cases, the interval is considered to be high in evaluative content, so would be scored (1):

- a) My ex thought women were vain, foolish, and ignorant. (2)
- b) My ex thought I was vain, foolish, and ignorant. (1)

Generalized People: Focus on People versus Focus on Speaker

When people in general, or people in the abstract are treated, raters must determine whether the focus of the statement is on the people or on the speaker. If it is on the people, the information level is considered public, and the interval will be rated a (4) or a (2). When people are treated clinically or in terms of a psychological relationship,

however, the speaker may be revealing quite clearly a good deal of private as well as evaluative material about him- or herself. Then the interval is rated (1). Examples:

- a) Most people like American food. (4)
- b) They say that the national employment rate is increasing. (4)
- c) Most people are pretty honest once you get to know them. (3)
- d) That sorority was full of sticky sweet types. (3)
- e) When people stare at me I wonder what's wrong with myself. (1)
- f) Everyone else seems to be so comfortable at parties and to be so smooth and everything. I just get awkward and embarrassed. (1)
- g) Sticky sweet people make me feel kind of trapped, and all I want to do is get away. (1)

“You” Questions

Raters should distinguish “you” questions from “you” statements. “You” questions are usually non-intrusive (public, non-intimate) prompts to encourage discussion “politely.” Such prompting questions are usually rated (3) or (4). Examples:

- a) What kinds of books do you like to read? (4)
- b) What did you do then? (4)
- c) Did you like it? (4)
- d) Did it upset you? (3)

On other occasions, however, speakers will ask “you” questions which are more intrusive or risky, for they divulge or ask for private facts or highly evaluative statements:

- e) Are you divorced? (2)
- f) Are you as freaked out by this room as I am? (1)

“You” Statements

“You” statements are riskier than “you” questions. They may be observations one person makes about another, or bids for solidarity. Examples:

- a) You are worth your weight in gold. (1)
- b) You seem to be very sure of yourself. (1)

APPENDIX M

DEBRIEFING SCRIPT

Closing the experiment. First, I would like to thank you again for your participation in this study. Do you have any questions or thoughts about the experiment, or anything that has happened so far? [*Experimenter allows time for answering questions.*] The major purpose of the study was to look at emotional and behavioral reactions to someone who was HIV-positive. I would like to emphasize here that the person you thought was your partner was what we would call a “confederate” or an “assistant” working with me. He is not really HIV-positive. It was necessary to give you the impression that the study was looking at something else in order to get what we hope might be true reactions if someone were to actually meet an individual with HIV. I want to emphasize the necessity for doing research of this nature. HIV is something that our whole society must deal with. As much as most of us would probably like to think it doesn’t affect us, or we don’t have to worry about it, it’s imperative that we address certain issues, like perhaps trying to reduce the stress of those who are coping with the disease. Unfortunately, there is some stigma associated with HIV, and as a result, quite often individuals who are HIV-positive suffer the consequences of that stigma. I believe in order to change people’s attitudes toward the disease, however, we must pinpoint causes of negative reactions, especially when those causes involve a person’s sexual orientation. I realize that I did not disclose certain information to you at the beginning of the experiment, so you might have some apprehensions about some of your responses. I would like to reiterate that anything you have said or written during the course of this study is strictly confidential. Your response messages were not really read by the confederate in the role of your partner. Your

personal information is not associated with your name. I realize you might have some concerns about or emotional reactions to this experience. If you feel very uncomfortable about anything you wrote, you do have the option to withdraw your data from the study without penalty. At this point, I'd like to ask if I still have your permission to include your responses in this study? *[Researcher waits for verbal assent/dissent.]* If you have further questions or concerns regarding this topic, I have the phone number for the Tidewater Area HIV/AIDS Community Taskforce, as well as for the ODU Counseling Center. Additionally, you are free to contact Dr. Val Derlega, who is the responsible primary investigator for this study. If he is not available, you are also free to contact Dr. Louis Janda, a clinical psychologist here at ODU, or myself. I can provide you with these phone numbers as well. I must also remind you again of the importance of not disclosing to other students or anyone until the end of the 2007-2008 academic year the nature of this study, due to the sensitive nature of the method. Please leave me a self-addressed envelope that I have available for you so I can mail the results of the study to you when it is finished. I will be glad to share them with you upon completion, but until then please do not share any information about this experiment with anyone. Thank you.

APPENDIX N
REFERRAL SHEET

ODU Office of Counseling Services
Phone: (757) 683-4401
Address: 1526 Webb Center, ODU

Tidewater AIDS Community Taskforce
Phone: (757) 583-1317
Address: 9229 Granby Street, Norfolk, VA, 23503
Website: <http://www.tact-online.com/Home.asp>

Dr. Valerian Derlega
Phone: (757) 683-3118
Email: vderlega@odu.edu

Dr. Louis Janda
Phone: (757) 683-4211
Email: ljanda@odu.edu

Stacie Fine, M.S.
Phone: (757) 646-9702
Email: sfine001@odu.edu

APPENDIX O

SECONDARY CONSENT DOCUMENT

Project Impression**Researchers:**

Responsible Primary Investigator: Valerian J. Derlega, Ph.D., Old Dominion University, Department of Psychology

Investigator: Stacie Fine, M.S., Old Dominion University, Department of Psychology

Secondary Consent

The purpose of this study is to understand the role of initial impressions influencing how people react to someone. In particular the study focuses on what factors influence reactions to someone who has been tested for a chronic disease--HIV. As part of your participation in the study, you were asked to provide written feedback and impressions about someone who was assigned as your partner for the second and third parts of the study. We have reviewed during the debriefing the full details of the procedures and now we are asking for your secondary consent to include your data in the study.

Voluntary Consent

By signing this secondary consent document, you are giving the researchers permission to use your responses in the data analyses. If you do not sign this secondary document, the researchers will discard your data and it will not be used in the data analyses. Whether or not you give voluntary consent, we ask that you not discuss the details of the study with anyone in order to maintain the integrity of the research. The study is expected to continue for at least one more year.

Subject's Printed Name and Signature:

Date:

Stacie A. Wilson

Virginia Consortium Program in Clinical Psychology
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 Virginia Beach, VA 23453

EDUCATION

- 2005-present **Virginia Consortium Program in Clinical Psychology**
 University-based, APA-accredited program, jointly
 sponsored by: The College of William & Mary, Eastern
 Virginia Medical School, Norfolk State University, and Old
 Dominion University
 Psy.D., 12/2009
- 2007 **Old Dominion University**
 M.S., Experimental Psychology
*Master's thesis: "HIV Risk Behaviors among Male
 Survivors of Childhood Sexual Abuse"*
- 2004 B.S., Psychology
- 1999 **The College of William & Mary**
 B.A., English

POST-DOCTORAL FELLOWSHIP

- 9/09-present **Virginia Beach City Public Schools**
 Virginia Beach, Virginia

CLINICAL INTERNSHIP

- 7/08-6/09 **Virginia Beach City Public Schools**
 Virginia Beach, Virginia

ADVANCED PRACTICUM

- 8/07-5/08 **The College of William & Mary Counseling Center**
 Williamsburg, Virginia

PUBLICATIONS

- Braitman, A. L., Lewis, R. J., Derlega, V. J., & Wilson, S. A. (2008). Minority stressors and dual identities: An analysis of lesbians' expressive writing journals. *Journal of Lesbian Studies, 12*, 501-517.