They Do, but I Don’t: Relationships Among AIDS Stigma Gap, AIDS Knowledge, and Attitude Toward AIDS-Related Issues

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This study examines whether there is a significant AIDS stigma gap among Korean people, and reveals causes and consequences of this perceptual gap. An analysis of the survey data collected to evaluate the impact of 2011 AIDS campaign in Korea revealed a perceptual gap between personal stigma and attributed stigma. AIDS knowledge was a significant factor in reducing this perceptual disparity. AIDS stigma gap significantly predicted public support on regulating prostitution but not on restricting same-sex marriage.

Keywords: AIDS Stigma, AIDS Knowledge, Demographic Variables, AIDS Media Campaign
As the UN Secretary-General Ban Ki Moon said, AIDS stigma is “a critical barrier to public action” for preventing AIDS and “a chief reason why the AIDS epidemic continues to devastate societies around the world” (Ban, 2008). Since the history of HIV/AIDS (Human Immunodeficiency Virus / Acquired Immunodeficiency Syndrome) epidemic began, it has been portrayed as a disease of death, horror, punishment, guilt, or shame. These stark metaphors have contributed to creating a social atmosphere that fears, stigmatizes, and discriminates against people living with HIV/AIDS (hereafter PLWHA) (Parker & Aggleton, 2003). Such prejudice and discrimination against PLWHA (AIDS stigma) has led various negative consequences. AIDS stigma has been associated with avoidance of HIV/AIDS testing, disclosure of HIV-related health status, and seeking/receiving necessary treatment (Brown, Macintyre, & Trujillo, 2003; Gielen, O’Campo, Faden, & Eka, 1997). Moreover, AIDS stigma aggravates a social sentiment that avoids and blames PLWHA rather than assisting them (Adeyemo & Oyinloye, 2007; Chesney & Smith, 1999).

AIDS stigma is a multi-dimensional construct (Lee, Oh, Keum, & Lee, 2012; Sayles, Hays, Sarkisian, Mahajan, Spritzer, & Cunningham, 2008; Smith, Miller, Newsome, Sofolahan, & Airhihenbuwa, 2014; Visser, Kershaw, Makin, & Forsyth, 2008). At the public level, AIDS stigma can be distinguished into personal stigma and attributed stigma. Personal stigma refers to how people perceive their own stigmatic behavior toward PLWHA (Visser et al., 2008). On the other hand, attributed stigma refers to one’s perception on how other people in the society stigmatizes PLWHA. The current study focuses on the perceptual discrepancy
between these two types of stigma, which we name as "AIDS stigma gap" (Visser et al., 2008). The present study proposes that people would underestimate the extent of how they themselves stigmatize against PLWHA while they overestimate the extent of how others stigmatize PLWHA.

The main reason why such gap is pervasive among Koreans might be due to the unique nature of the HIV/AIDS epidemic in South Korea. Although the number of new inflections in South Korea has sharply increased, the estimated number of Korean PLWHA and the prevalence of HIV/AIDS among Korean adults are much lower than the global estimates (Korea Centers for Disease Control and Prevention [KCDC], 2015). Most Koreans, therefore, have very low chances of directly interacting with PLWHA or witnessing social discrimination against PLWHA. Their perception on attributed stigma mostly came from what they saw on the media, such as news stories, TV drama, movies, documentary shows, and public campaigns (Lee, Oh, Keum, & Lee, 2012). Excessive media attention on a rare problem can produce an unintended effect that people tend to overestimate the incidence of such problem (see Cho & Salmon, 2007). Such inaccurate perception would then influence public opinion on social issues and governmental regulations on HIV/AIDS.

The purpose of this study to explore the extent of AIDS stigma gap among Koreans and explore the antecedents and consequences of it. In particular, this study examine (1) whether there exists an actual AIDS stigma gap among Koreans, (2) what are the key factors associated with such perceptual gap, and (3) how the AIDS stigma gap influences
attitudes toward the policies related to HIV/AIDS. Understanding antecedents and consequences of AIDS stigma gap would provide implications for health communication practitioners for implementing effective public communication campaigns to reduce stigmatization against PLWHA in countries where the prevalence of the HIV/AIDS epidemic is low like South Korea.

**AIDS Stigma**

As Goffman (1963) defined, stigma is "an attribute which is deeply discrediting." Stigma can be distinguished into “abomination of the body,” (e.g., physical distortion), “blemishment of individual character,” (e.g., dishonesty, mental disorders) and "category identity."(e.g., race, religion) (p. 3) In the context of HIV/AIDS, AIDS stigma refers to a social construction that involves undesirable characteristics such as prejudice and discrimination against PLWHA, and an enduring attribute which leads to negative perspectives from society (Herek, 1990; 1999).

AIDS stigma has influenced many realms including the statutes of government, healthcare, place of work, and family interaction (Avert, 2010; Varas-Diaz, Serrano-Garcia, & Toro-Alfonso, 2005). Generally, it takes place at two levels. First, at an individual level, PLWHA often attempt to conceal their health status to avoid rejection or discrimination from others. For example, a study of African-Americans infected with HIV/AIDS demonstrated that the majority of PLWHA had fear of experiencing rejection, discrimination, and violation when they reveal the fact that they are HIV-positive (Gielen et al., 1997). Without disclosing
HIV status, PLWHA cannot seek out appropriate treatment in a timely manner. Since PLWHA cannot receive a prescription without a medical examination, many of them give up taking medicine on a regular basis (Chesney & Smith, 1999). Furthermore, AIDS stigma hinders regular HIV testing (Brown et al., 2003). In South Africa, for instance, discriminative attitude toward PLWHA was a significant inhibitor of voluntary counseling and HIV testing (Hutchinson & Mahlalela, 2006).

Second, on the societal level, PLWHA are more likely to experience rejection from healthcare services, dismissal from their jobs, isolation, and even exile from their homeland where AIDS stigma is prevalent (Adeyemo & Oyinloye, 2007; Chesney & Smith, 1999; Herek, 1999). It is surprising that AIDS stigma persists among healthcare professionals. For example, a survey study showed that 46% of skilled nursing facilities, 26% of plastic and cosmetic surgeons, and 55% of obstetricians in Los Angeles County would not take a HIV-positive patient for any type of service, even when patients were asymptomatic (Sears, 2006). In addition, a survey conducted in 2002 among 1000 physicians, nurses and midwives in four Nigerian states reported that about 20% of the respondents believed that getting HIV/AIDS is a result of immoral behavior and thus PLWHA deserve unfair treatment (cited in Johnson, 2012).

According to national surveys conducted in South Korea (Lee, Choi, Shin, & Seo, 2012; Lee, Shin, & Ryu, 2013), people typically viewed HIV/AIDS as a result of unethical sexual behavior. The surveys also showed that Koreans tended to associate HIV/AIDS with fear, disease, immorality, sin, and dirt. In this survey study, many respondents agreed
that PLWHA should be punished for their immoral behavior and feel ashamed of their behavior (Lee, Choi, Shin, & Seo, 2012; Lee, Shin, & Ryu, 2013).

Acknowledging the importance of understanding AIDS stigma in Korea, studies have tried to explore antecedents and mechanisms of AIDS stigma (e.g., Lee et al., 2012; Sohn, Moon, Park, Chun, & Ko, 2007; Sohn, Moon, Shin, Chun, & Kim, 2008). Sohn and her colleagues (2008) discovered that attitude toward homosexuals are a significant factor predicting AIDS stigma and discriminative attitude towards PLWHA, but the sample of this study was limited to adolescents. Lee et al. (2012) found the importance of AIDS knowledge in explaining AIDS stigma. This study further suggests that fear of contagion mediates the relationship between AIDS knowledge and AIDS stigma. Given the prevalence of AIDS stigma among Koreans and the complex mechanism of AIDS stigma, an effort to understand the causes and consequences of AIDS stigma should continue.

**AIDS Stigma Gap: The Discrepancy between Personal and Attributed Stigma**

AIDS stigma is a complex social process that the different perspectives of the infected (a subjective experience) and the non-infected (an outsider perspective) are interwoven (Visser et al., 2008).

Acknowledging the complexity of AIDS stigma, researchers have started to examine it as a multi-dimensional concept, and some of them have classified it into “external stigma” (an explicit acts of
stigmatization: an outsider perspective) and “internal stigma” (a stigmatized individual’s sense of self-hatred: a subjective experience) (Herek, 2002; Lee, Kochman, & Sikkema, 2002; Visser et al., 2008). While internal stigma refers to the stigma felt by PLWHA as a response to stigma in a community or general population, external stigma refers to the stigma ascribed to PLWHA by some people who are not affected by HIV (Visser et al., 2008; Wolitski, Pals, Kidder, Courtenay-Quirk, & Holtgrave, 2009). These two types of stigma are closely interrelated. For example, as PLWHA blame themselves (internal stigma) when they feel discrimination (external stigma) and internalize the external stigma, resulting in negative self-image, feelings of shame or guilt, and other manifestations of internal (or felt) stigma (Lee, Kochman, & Sikkema, 2002; Wolitski et al., 2009).

Again, external AIDS stigma can be comprised of an individual-level perception/attitude and a societal-level perception/attitude toward PLWHA. Visser and her colleagues (2008) initially named these two levels of external AIDS stigma as “personal stigma” and “attributed stigma.” The needs for distinguishing these two levels of stigma arises from the existence of the discrepancy between how people perceive their own attitude/behavior toward PLWHA and how they think others treat PLWHA in the society. A national annually survey conducted by Korea Centers for Disease Control and Prevention (Lee, Joo, & Keum, 2011; Lee et al., 2012; Lee, Shin, & Ryu, 2013) has constantly found a gap between personal stigma and attributed stigma. In other words, there has been a tendency that people evaluate their own stigmatic behavior (personal stigma) toward PLWHA as significantly lower than that of
others in the society (attributed stigma). This phenomenon, AIDS stigma gap, was also found in Green’s study (1995). A street survey in Scotland (Green, 1995) showed that general people tended to think that other people possess far more illiberal attitudes than they reported themselves to hold.

By simple inference, the gap will occur either when people evaluate their own stigmatic attitude/behavior toward PLWHA as low or when people evaluate the prevalence of AIDS stigma in the society as high. The gap will also increase when people exaggerate the difference between their own attitude/behavior and others’ attitude/behavior toward PLWHA. There are several possible explanations for the mechanism of this phenomenon, namely, AIDS stigma gap.

First, AIDS stigma gap may exist if people view their own stigmatic behavior toward PLWHA as significantly lower than others in society. It happens when people internally assess themselves to have more tolerant attitude toward PLWHA than the general population. This prediction is grounded on a psychological mechanism or motive called as self-enhancement (Sharuger, 1975). People desire to be viewed by others in a positive way. Among a variety of the self-concepts, self-enhancement might well-explain such desire. This concept has received a wide scholarly attention since Allport (1943) addressed ego-protection as “nature’s law.” Shrauger (1975) also argued that humans are naturally inclined to maintaining a positive self-image, and they feel satisfied when they perform a self-enhancing behavior (Shrauger, 1975). This claim has been supported by later studies demonstrating that people obtain psychological health by evaluating themselves as more positive than
others (Taylor & Brown, 1988; Taylor & Gollwitzer, 1995). In Gunther and Mundy’s (1993) study, maintaining a positive self-image was reported as an underlying mechanism explaining the difference between how people view themselves and others.

Some scholars have argued that the self-enhancement motive is more prevalent in Western culture than in Eastern culture (Heine & Lehman, 1997; Heine, 2005). However, many have challenged this view and empirically confirmed that this self-enhancing tendency is the universal human motive (Brown, & Kobayashi, 2002; Gaertner, Sedikides, & Chang, 2008; Sedikides, Gaertner, & Vevea, 2005).

Secondly, AIDS stigma gap may arise when people have a biased perception about the reality on how PLWHA experience AIDS stigma in the society. This is more likely to occur when people learn the reality from the media environment. As Bandura (1967) originally argued, people learn new information or behaviors not only through direct experiences but also through vicarious experiences of watching others’ behaviors and outcomes of those behaviors. In the context of HIV/AIDS, Korean people might aware the social atmosphere toward PLWHA by observing news stories on HIV/AIDS, TV shows/drama episodes depicting the life of PLWHA, or even public campaigns intended to decrease AIDS stigma. Because the chances of directly interacting with PLWHA are very rare for Korean people, it is likely that the mass media (including Internet and social media) are the main source through which Korean people learn about how the society stigmatizes PLWHA. Although, there are no published studies that empirically observe such phenomenon, one can infer anecdotally that the media have portrayed
the Korean society as highly discriminative against PLWHA. For this reason, it is reasonable to predict that Korean people would overestimate how others stigmatize PLWHA, namely attributed stigma.

Following this argument, we believe there would be a perceptual gap such that individuals view themselves as more generous and tolerant to PLWHA than general others in society. People might also exaggerate how others in society discriminate against PLWHA because they hear about PLWHA from the media that tend to report extreme cases to drive public attention. Because Koreans have a very low chances of witnessing social discrimination against PLWHA, their perception on how others treat PLWHA is more likely to be formed through the media. Media attention on extreme cases of social discrimination against PLWHA can make people perceive a greater prevalence of AIDS stigma in society (Cho & Salmon, 2007). Thus, we propose hypothesis 1 as such:

**Hypothesis 1**: There will be a significant perceptual gap among Korean people between personal stigma and attributed stigma.

**Antecedents of AIDS Stigma Gap**

Socio-demographic variables. Scholars have revealed the associations between socio-demographic variables including gender, age, and education level and AIDS stigma. The influence of gender on AIDS stigma, however, was inconsistent across studies. A majority of studies have shown that males tend to possess and express a greater level of AIDS
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Stigma than females do (e.g., Herek, 2002; Lin, Zhao, Li, Stanton, Zhang, Hong, Zhao, & Fang, 2010). For example, a survey study conducted among adolescents aged 13-16 in Finland showed that boys hold a more hostile attitude toward PLWHA compared to girls do (Muinonen, Suominen, Valirnaki, Lohrmann, & Peare, 2002). In a study conducted by Lin and her colleagues (2010), boys reported a higher level of personal stigma than did girls, but the level of attributed stigma was not different between boys and girls. A study conducted in Korea also showed a similar result such that male respondents felt a greater social distance from PLWHA and showed a higher level of AIDS stigma than did female respondents (Sohn et al., 2008).

However, the opposite pattern was found in other studies. Females in those studies were more likely to possess stigmatic attitudes toward PLWHA than males (e.g., Chen, Choe, Chen, & Zhang, 2007; Yoo, Lee, Kwon, Chung, & Kim, 2005). In an attempt to reconcile the inconsistent findings, the current study explores the role of gender in predicting AIDS stigma and AIDS stigma gap.

Age has shown a consistent effect on AIDS stigma. Studies have shown that AIDS stigma increases as people age (Chen et al., 2007; Turhan, Inandi, & Inandi, 2006). For example, in Chen and her colleagues’ (2007) study, respondents aged 40-49 expressed a stronger unwillingness to interact with PLWHA than did younger people.

Education level is also a significant factor affecting AIDS stigma (Chen et al., 2007; Herek, 2002; Turhan et al., 2006). In Herek’s (2002) empirical research, less educated people showed a higher level of AIDS stigma. These less educated people were less knowledgeable about
HIV/AIDS compared to better-educated people. Chen and colleagues (2007) also found a positive relationship between educational level and willingness to interact with PLWHA. However, in a recent study conducted in Korea found a positive relationship between education and AIDS stigma such that highly educated individuals are more likely to possess personal stigma against PLWHA (Lee et al., 2012). This study further found that such relationship disappeared when it is mediated by AIDS knowledge.

Although existing studies have provided evidence that socio-demographic variables (i.e., gender, age, and education) are significant predictors of AIDS stigma, whether and how they influence AIDS stigma gap has not yet been determined. The present study, therefore, explores the influence of these variables on AIDS stigma gap by proposing research question 1 as such:

**Research Question 1:** Are individuals’ socio-demographic variables (gender, age, and level of education) significant predictors of AIDS stigma gap?

**AIDS Knowledge**

One major factor contributing to AIDS stigma is inaccurate knowledge people possess about HIV/AIDS (Chen et al., 2007; Sohn et al., 2008; Tavoosi, Zaferani, Enzevaei, Tajik, & Ahmadinezhad, 2004). Among various misconceptions about HIV/AIDS, misunderstanding on how HIV/AIDS is transmitted, in particular, is strongly associated with AIDS stigma (Adeyemo & Oyinloye, 2007; Kalichman & Simbayi, 2004).
Because people do not have accurate knowledge about causes of HIV transmission, they might fear of being infected by a casual contact with PLWHA. These ignorant people are more likely to believe that PLWHA should not use public facilities. For example, in Tavoosi and his colleagues’ (2004) study, people identified mosquitoes, swimming pool, and toilets as valid paths of HIV transmission, and this false conception was significantly associated with AIDS stigma.

A majority of Korean people possess inaccurate knowledge and belief about HIV/AIDS. According to the result of a national survey on HIV/AIDS knowledge, most Koreans believe that HIV/AIDS can be transmitted by kissing or sharing toilets with PLWHA, and that PLWHA cannot live more than 20 years (Lee et al., 2011). Possessing an inaccurate AIDS knowledge, in another study, was a significant predictor of personal AIDS stigma (Lee et al., 2012). In this study, Korean people who had accurate knowledge about HIV/AIDS had less fear of HIV-contagion, and therefore showed a lower level of AIDS stigma than less knowledgeable people. However, attributed stigma might increase among knowledgeable individuals because these people would perceive others as less knowledgeable about HIV/AIDS than themselves, and therefore have unnecessary fear about HIV/AIDS and higher AIDS stigma. A study by Visser and her colleagues (2008) found that people who are knowledgeable about HIV/AIDS attributed a greater level of stigma to others than to themselves. Based on the results of previous studies, the present study predicts a positive association between AIDS knowledge and AIDS stigma gap as such:
Hypothesis 2: AIDS knowledge is a significant predictor of AIDS stigma gap. Thus, people who have higher level of AIDS Knowledge will show a higher AIDS stigma gap, but those are less knowledgeable about HIV/AIDS will show a smaller AIDS stigma gap.

AIDS Stigma Gap and Support for Policies on HIV/AIDS

Another interesting issue that has been overlooked in the previous studies is how AIDS stigma gap influences people’s attitudes and/or behaviors related to HIV/AIDS. The possible effect of AIDS stigma gap on attitude/behavior can be explained by third-person effect, which originates from people’s perceptual distinction between self and others (Gunther, 1995; McLeod, Eveland, & Nathanson, 1997; Rucinski & Salmon, 1990). Third-person effect occurs when people overestimate the probability that others are more strongly influenced by mass communication than themselves (Davison, 1983). In many studies, such perception led to support for policy chances or censorship in various issues including gambling (Youn, Faber, & Shah, 2000), pornography (Gunther, 1995), internet pornography (Lee & Tamborini, 2005), and violent television show (Rojas, Shah, & Faber, 1996). For example, Mcleod and his colleagues’s (1997) study on rap music censorship showed that people who have a greater third-person perception were more likely to have a favorable attitude toward censoring rap music. Similarly, in Lee and Tamborini’s (1995) study of pornography, people with a higher third-person perception showed a greater support for censoring internet pornography. These studies indicate the powerful
impact of perceived self-other discrepancy on developing a strong censorship attitude.

The behaviors and/or attitudes of the people who have a self-other perceptual gap can be understood as paternalistic actions, practices of treating or governing people in a fatherly manner. People who hold paternalistic perceptions are often described as censors who "believe that they are immune to influence but that others lack the self-control, knowledge, intelligence, goodness, and so on to protect themselves." (McLeod et al., 1997, p. 156) According to Gert and Culver (1976), the paternalistic behavior can occur when at least one of the following conditions is satisfied: people believes that a) their action is for the good of another, b) they are qualified to act on someone’s behalf, c) their manners include violating a moral rule with regard to someone, d) they are justified in performing on someone’s behalf separately of someone’s past, present, or forthcoming assent, and e) someone considers that he knows what is for his own good. When people perceive a great AIDS stigma gap, they would believe that they are qualified to protect the public’s welfare by preventing the spread of HIV/AIDS. In other words, these people might become motivated to have a conservative position on the issues related to HIV/AIDS such as prohibiting prostitution or same-sex marriage, because sex workers and homosexuals are generally at a greater risk of getting HIV/AIDS.

This study expects that AIDS stigma gap would contribute to developing a supportive attitude for strong regulations on various risky behaviors. Those who perceive a significantly low level of personal stigma compare to the societal-level stigma (attributed stigma) would hold an
attitudinal position that supports governmental regulations for restricting various risky behaviors such as same-sex marriage or prostitution. Therefore, the present study hypothesizes that AIDS stigma gap is positively associated with supportive attitudes on governmental regulations prohibiting risky behaviors (same-sex marriage and prostitution).

**Hypothesis 3:** AIDS stigma gap is a significant predictor of forming supportive attitudes toward governmental regulations for preventing the spread of HIV/AIDS. Thus, people who have a higher AIDS stigma gap will show a greater support for policies or laws on prohibiting (a) prostitution and (b) same-sex marriage.

Figure 1 depicts all the relationships hypothesized in this study.
Method

Sample

This study analyzed the evaluation survey data of the 2011 AIDS nationwide media campaign in Korea. The survey was conducted to evaluate the effectiveness of a media campaign titled “Understand AIDS Accurately.” The campaign was implemented from July to August in 2011 by KCDC to increase AIDS knowledge among Korean people. The campaign used various forms of media such as advertisement, radio, and outdoor advertising. The advertisement contained an informative message that “HIV/AIDS is not transmitted by hugging, kissing, sharing food, or shaking hands with PLWHA.”

The survey was conducted among adults living in the metropolitan areas of Korea including Seoul, Incheon, and Gyeonggi-do aged 15 to 59 years old. A purposive quota sampling technique was used to select the sample, and a telephone survey was conducted from September 29th to November 8th, 2011. The survey had a series of questions measuring personal stigma, attributed stigma, AIDS knowledge, socio-demographic information, and attitudes on governmental regulations for preventing the spread of HIV/AIDS.

The final sample size was 300. About a half of the respondents were male (50.3%). The respondents were well distributed across age such that 9.7% (N = 29) of the respondents were “less than 20 years old,” 20.3% (N = 61) were “between 20 and 29,” 25.7% (N = 77) were “between 30 and 39,” 24.7% (N = 74) were “between 40 and 49,” and
19.7% (N = 59) were “50 and older.” More than half of the respondents (58.0%, N = 174) were either a 2-year or 4-year college graduates.

**Measures**

**AIDS Stigma Gap**

AIDS stigma gap was measured by subtracting personal stigma from attributed stigma. The measures of personal and attributed stigma were adapted from “HIV Stigma and Discrimination Scale” developed by World Health Organization in 2009 and Visser and her colleagues (2008). **Personal stigma** is operationalized as a personal belief and feeling individuals hold toward PLWHA. This construct was measured with seven items such as “I cannot have a meal with PLWHA” and “If anyone in my family and company is infected with HIV/AIDS, I am not confident of taking care of him or her.” These items were measured with a 5-point Likert-type scale ranging from “1” (very unlikely) to “5” (very likely). Higher scores indicate greater levels of personal stigma (M = 2.75, SD = 0.86, alpha = .74).

**Attributed stigma** is operationally defined as people’s perception on how others in a society feel and react toward PLWHA. This construct was measured with six items (5-point scale ranging from 1 = strongly disagree to 5 = strongly agree) such as “Most people desire to fire PLWHA if they work with them in the same building” and “Most people do not have a meal with PLWHA.” Higher scores indicate greater levels of attributed stigma (M = 3.38, SD = 0.62, alpha =
Although there have been some efforts to develop a reliable measure of AIDS stigma (e.g., Nyblade & MacQuarrie, 2006; Tanzania Stigma-Indicators Field Test Group, 2005), they did not provide parallel instruments for personal stigma and attributed stigma. Acknowledging the needs of distinguishing these two levels of AIDS stigma, Visser and her colleagues (2008) developed equivalent measures for personal and attributed AIDS stigma. However, their items were restricted to African culture, as they were developed after a series of focus group interviews with African people to make them culturally appropriate.

To enhance the external validity of the existing measure in the context of Korean society, this study modified measures drawn from World Health Organization (2009) and Visser and her colleagues (2008). Five parallel items of personal stigma and attributed stigma were used and their mean scores were computed to create an index score for AIDS stigma gap.

To assess the validity of the factor structure of each construct before testing the hypotheses and a research question, a confirmatory factor analysis (CFA) was performed with AMOS (Analysis of Moment Structures) 18.0. Model parameters were estimated using the maximum likelihood method. One item from the attributed stigma factor was dropped due to its low factor loading score. Its parallel item in the personal stigma factor was also dropped to match the items from each construct. After dropping these two items, CFA yielded good fit indices, \( \chi^2 (19) = 56.632, \text{SRMR} = .045, \text{CFI} = .962, \text{TLI} = .944, \text{GFI} = .957, \) and \( \text{RMSEA} = .081 \). The Cronbach’s alpha for each construct
### Personal Stigma

<table>
<thead>
<tr>
<th>Item</th>
<th>M</th>
<th>SD</th>
<th>Factor Loading</th>
<th>Alpha</th>
</tr>
</thead>
<tbody>
<tr>
<td>If I work with PLWHA in the same building, I want them to be fired.</td>
<td>2.58</td>
<td>1.04</td>
<td>.85</td>
<td></td>
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<tr>
<td>I cannot have a meal with PLWHA.</td>
<td>2.84</td>
<td>1.06</td>
<td>.77</td>
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<tr>
<td>If anyone in my family and company is infected with HIV/AIDS, I am not</td>
<td>2.92</td>
<td>0.99</td>
<td>.74</td>
<td>.82</td>
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<tr>
<td>confident of taking care of him or her.</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>I am not confident of not verbally abusing or teasing PLWHA.</td>
<td>2.35</td>
<td>1.04</td>
<td>.59</td>
<td></td>
</tr>
<tr>
<td>I am not confident of getting along with someone with PLWHA who live</td>
<td>2.87</td>
<td>1.06</td>
<td>.77</td>
<td></td>
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<td>in neighborhood.</td>
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<tr>
<td>I would not allow my child to attend the same school with PLWHA.</td>
<td>2.87</td>
<td>1.09</td>
<td>.74</td>
<td></td>
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<tr>
<td>I am not confident of not verbally abusing or teasing PLWHA.</td>
<td>2.35</td>
<td>1.04</td>
<td>.59</td>
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<tr>
<td>I am not confident of getting along with someone with PLWHA who live</td>
<td>2.87</td>
<td>1.06</td>
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<td>in neighborhood.</td>
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### Attributed Stigma

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<tr>
<th>Item</th>
<th>M</th>
<th>SD</th>
<th>Factor Loading</th>
<th>Alpha</th>
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<tbody>
<tr>
<td>Most people desire to fire PLWHA if they work with them in the same</td>
<td>3.37</td>
<td>0.92</td>
<td>.82</td>
<td></td>
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<td>building.</td>
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<tr>
<td>Most people do not have a meal with PLWHA.</td>
<td>3.41</td>
<td>0.93</td>
<td>.74</td>
<td></td>
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<tr>
<td>Most people do not look after if anyone in their family and company</td>
<td>3.37</td>
<td>0.94</td>
<td>.68</td>
<td>.83</td>
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<tr>
<td>is infected by HIV/AIDS.</td>
<td></td>
<td></td>
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<tr>
<td>Most people insult PLWHA verbally.</td>
<td>3.42</td>
<td>0.92</td>
<td>.75</td>
<td></td>
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<tr>
<td>Most people believe that PLWHA are socially stigmatized.</td>
<td>3.65</td>
<td>0.92</td>
<td>.74</td>
<td></td>
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<tr>
<td>Most people feel uncomfortable being hospitalized in the same ward</td>
<td>3.09</td>
<td>0.98</td>
<td>.98</td>
<td></td>
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<td>with PLWHA.</td>
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### Support for Prohibition on Prostitution

<table>
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<tr>
<th>Item</th>
<th>M</th>
<th>SD</th>
<th>Factor Loading</th>
<th>Alpha</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prohibition on prostitution must be repealed because it violates</td>
<td>3.35</td>
<td>1.17</td>
<td>.58</td>
<td></td>
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<tr>
<td>parts of pleasure (reversed).</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prohibition on prostitution must be repealed because it threatens</td>
<td>3.32</td>
<td>1.08</td>
<td>.67</td>
<td>.67</td>
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<tr>
<td>the livings of women who work for prostitution (reversed).</td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td>Prohibition on prostitution must be lasted to eradicate the spread</td>
<td>3.34</td>
<td>1.11</td>
<td>.95</td>
<td></td>
</tr>
<tr>
<td>of AIDS (reversed).</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prohibition on prostitution must be lasted to prevent a moral crime.</td>
<td>3.55</td>
<td>1.08</td>
<td>.95</td>
<td></td>
</tr>
<tr>
<td>(reversed).</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Support for Prohibition on Same-sex Marriage

<table>
<thead>
<tr>
<th>Item</th>
<th>M</th>
<th>SD</th>
<th>Factor Loading</th>
<th>Alpha</th>
</tr>
</thead>
<tbody>
<tr>
<td>Same-sex marriage should not be legalized because it makes children</td>
<td>3.11</td>
<td>1.13</td>
<td>.74</td>
<td></td>
</tr>
<tr>
<td>grown by them have problems in character building.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Same-sex marriage should be legalized because it is the right to</td>
<td>3.08</td>
<td>1.16</td>
<td>.91</td>
<td>.89</td>
</tr>
<tr>
<td>pursue one’s happiness (reversed).</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Same-sex marriage should not be legalized because it threatens dignity</td>
<td>3.13</td>
<td>1.10</td>
<td>.67</td>
<td></td>
</tr>
<tr>
<td>of family and marriage.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Same-sex marriage should be legalized because the concept of</td>
<td>3.13</td>
<td>1.10</td>
<td>.67</td>
<td></td>
</tr>
<tr>
<td>marriage can be considered as love between family members (reversed).</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

* a. All factor loadings are significant at p < .01.
  b. Items excluded from the CFA model.
ranged from .82 to .83. The CFA factor loadings ranged from .59 to .85 for personal stigma and .68 to .82 for attributed stigma. The mean score of personal stigma was 2.67 (SD = 0.83, Min = 1.00, Max = 5.00), and the mean score of attributed stigma was 3.39 (SD = 0.76, Min = 1.00, Max = 5.00). Table 1 shows the actual items used in the study and their descriptive information.

Socio-demographic Variables

The following socio-demographic variables were measured for analysis: gender (1 = male, 0 = female), age, and education level. Existing research has found these variables to be significantly related to AIDS stigma (e.g., Adeyemo & Oyinloye, 2007; Goswami & Melkote, 1997; Salmon, Wooten, Gentry, Cole, & Kroger, 1996), but their associations with AIDS stigma were not being consistent and their effects on AIDS stigma gap have not been observed yet.

AIDS Knowledge

AIDS knowledge has been a significant predictor of personal stigma in the literature (Chen et al., 2007; Sohn et al., 2008; Tavoosi et al., 2004). This construct was measured by asking respondents if they think 11 statements are true or false (Dichotomous scale with 0 = incorrect, 1 = correct): (a) HIV/AIDS is not an incurable disease; (b) HIV could be infected through kissing someone who has HIV; (c) HIV could be transmitted by shaking hands with PLWHA; (d) PLWHA can get along with general public; (e) PLWHA can get along with the general public; (f) PLWHA can live longer than 20 years with a right treatment; (g)
People could be infected with HIV/AIDS by hugging PLWHA; (h) HIV/AIDS could be prevented by using a condom during sexual intercourse; (i) HIV could be transmitted through mosquito bites; (j) People could be infected with HIV/AIDS by working with PLWHA.

This AIDS knowledge scale with the 11 items was employed from previous studies on AIDS transmission knowledge (Herek & Capitanio, 1993; Kalichman & Simbayi, 2004) (Cronbach’s α = .73). After computing the summed scores to the global score on a scale of 0 – 100, the average knowledge score was 69.03 out of 100 (SD = 22.55, Max = 100, Min = 0).

Support for policies related to HIV/AIDS

In the present study, supportive attitude was operationally defined as people’s degrees of supporting for policies preventing the spread of HIV/AIDS. The two constructs are measured to reflect two controversial issues related to HIV/AIDS in Korea, prohibiting prostitution and same-sex marriage.

Attitude toward prohibiting prostitution was measured with four items (5-point scale ranging from 1 = strongly disagree to 5 = strongly agree) such as “Prohibition of prostitution must be repealed because it violates parts of pleasure (reversed item)” and “Prohibition of prostitution must be lasted to prevent a moral crime.” (Cronbach’s α = .66)

Attitude toward prohibiting same-sex marriage was also measured with the four items (5-point scale ranging from 1 = strongly disagree to 5 = strongly agree) such as “Same-sex marriage should not be legalized because it makes children grown by them have problems in character
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building” and “Same-sex marriage should be legalized because it is the right to pursue one’s happiness (reversed item).” (Cronbach’s α = .89)

To assess the validity of the two-factor model for attitude toward policies restricting risky behaviors, another CFA was performed. Three items were deleted as they showed either low loading scores or highly correlated errors. The total five items showed a two-factor structure with acceptable fit indices, χ²(4) = 28.061, SRMR = .065, CFI = .964, TLI = .910, GFI = .962, and RMSEA = .142. The Cronbach’s alpha for each construct ranged from .67 to .89. The CFA factor loadings ranged from .58 to .86 for prohibiting prostitution and .67 to .94 for prohibiting same-sex marriage. Items for each construct were averaged to create a single index. The mean score of supporting prohibition of prostitution was 3.33 (SD = 0.97, Min = 1.00, Max = 5.00), whereas the mean score of supporting prohibition of same-sex marriage was 3.08 (SD = 1.00, Min = 1.00, Max = 5.00). Table 1 shows the actual items used in the study and their descriptive information.

Results

Zero-Order Correlations among Key Variables

Before testing the hypotheses and the research question, zero-order correlations among the main variables were observed. As shown in Table 2, partially significant associations among the variables were found. First, gender was significantly associated with education level (r = .18, p <
Variables 1  2  3  4  5  6  7  8
1. Gender† 
2. Age .02 
3. Education Level .18** .32** 
4. AIDS Knowledge .10 .07 .11 
5. Personal Stigma -.04 .05 .02 -.36** 
6. Attributed Stigma -.08 -.01 .02 -.11 .47** 
7. AIDS stigma Gap -.04 -.07 -.01 .27** -.58** .44** 
8. Support for Prohibition of Prostitution -.16** -.06 .10 .04 -.15** .02 .17** 
9. Support for Prohibition of Same-sex Marriage .12† .17** .05 -.03 .20** .11† -.10 .08

* p < .05; **p < .01; ***p < .001, two-tailed.
a Dummy coded as male = 1, female = 0.

Next, personal stigma was negatively associated with AIDS stigma gap (r = -.58, p < .01) and supporting prohibition of prostitution (r = -.15, p < .01). However, it was positively related to attributed stigma (r = .47, p < .01) and supporting prohibition of same-sex marriage (r...
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Attributed stigma was positively associated with AIDS stigma gap \((r = .44, p < .01)\) and supporting prohibition of same-sex marriage \((r = .11, p < .05)\). Finally, AIDS stigma gap was positively associated with supporting prohibition of prostitution \((r = .17, p < .01)\).

**Testing Hypotheses and Research Question**

Hypothesis 1 predicted a significant discrepancy between personal stigma and attributed stigma. The result of a paired sample t-test showed that attributed stigma \((M = 3.39, SD = 0.76)\) was significantly higher than personal stigma \((M = 2.67, SD = 0.83)\) with \(t(299) = 15.264, p < .001\). This result implies the existence of a significant AIDS stigma gap among people such that people attributed a greater level of AIDS stigma to others than they perceived it for themselves. Thus, Hypothesis 1 was supported.

Research question 1 explored the effect of socio-demographic variables (gender, age, education level) on AIDS stigma gap and hypothesis 2 proposed a positive relationship between AIDS knowledge and AIDS stigma gap. To address research question 1 and hypothesis 2, a hierarchical multiple regression was performed. Socio-demographic variables were entered in the first block, followed by AIDS knowledge in the second block.

Overall, the four variables explained 8% of the total variance in AIDS stigma gap as shown in Table 3. Socio-demographic variables explained 0.6% of the variance in AIDS stigma gap \((p = n.s.)\), but no variable
significantly predicted AIDS stigma gap. The second block containing AIDS knowledge explained 7.6% of the total variance (p < .01). AIDS knowledge positively predicted AIDS stigma gap (β = .279, p < .001) such that knowledgeable people were more likely to show a greater gap between personal stigma and attributed stigma. Thus, hypothesis 2 was supported.

Table 3. Hierarchical Regressions Analysis Results: Socio-demographic Variables and AIDS Knowledge as Predictors of AIDS Stigma Gap (N=300)

<table>
<thead>
<tr>
<th>Dependent Variable</th>
<th>AIDS Stigma Gap</th>
<th>β</th>
<th>t</th>
</tr>
</thead>
<tbody>
<tr>
<td>Predictor</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gender b</td>
<td>-.065</td>
<td>-1.141</td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>-.087</td>
<td>-1.478</td>
<td></td>
</tr>
<tr>
<td>Education Level</td>
<td>-.001</td>
<td>-.024</td>
<td></td>
</tr>
<tr>
<td>R² Δ</td>
<td>.006</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Block 2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AIDS Knowledge</td>
<td>.279</td>
<td>4.94$^*$</td>
<td></td>
</tr>
<tr>
<td>R² Δ</td>
<td>.076$^*$</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total R²</td>
<td>.082</td>
<td></td>
<td></td>
</tr>
<tr>
<td>F-value</td>
<td>6.614</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* p < .05; **p < .01; ***p < .001, two-tailed.

a Standardized coefficient.
b Dummy coded as male = 1, female = 0.

To test hypothesis 3, two separate hierarchical regression models were tested with two dependent variables: supporting prohibition of prostitution
and supporting prohibition of same-sex marriage. Socio-demographic variables and AIDS knowledge were entered in the first block for the control purpose. AIDS stigma gap and the total effect of personal stigma and attributed stigma were entered in the second block.

This method is called “the diamond model” which has been used in several studies to measure the effect of a gap between two constructs after controlling for the effect of each construct (Hope, 1975; Sun, Shen, & Pan, 2008). In the present study, the diamond method allowed us to predict the effect of AIDS stigma gap on policy support variables after accounting for the effect of personal stigma and attributed stigma.

Overall, six variables explained 9% of the total variance in supporting prohibition of prostitution as shown in Table 4. More specifically, Block 1 explained 5.7% of the variance ($R^2 = .057, p < .01$): females were more likely support prohibiting prostitution than males ($\beta = -.193, p < .01$), and having a higher education positively predicted being supportive on prohibiting prostitution ($\beta = .173, p < .01$). Block 2 with the total effect of personal/attributed stigma and AIDS stigma additionally explained additional 3.1% of the variance in supportive attitude toward prohibiting prostitution ($R^2 \Delta = .031, p < .01$). AIDS stigma gap was positively associated with supporting prohibition of prostitution ($\beta = .159, p < .01$).

To test the effect of AIDS stigma gap on supporting prohibition of same-sex marriage, an identical model was used with the second dependent variable, prohibition of same-sex marriage. Block 1, in this model, explained 4.1% of the variance in supportive attitude toward prohibiting same-sex marriage ($R^2 = .041, p < .01$). Males were more
likely to support prohibiting same-sex marriage than females (β = .127, p < .05), and age was a positive predictor of supporting prohibition of same-sex marriage (β = .156, p < .05). Block 2, then, additionally explained 1.6% of the variance in supportive attitude toward prohibiting same-sex marriage (R²Δ=.016, p < .01). The total effect of personal stigma and attributed stigma positively predicted supportive attitude.

Table 4. Hierarchical Regressions Analysis Results: AIDS Stigma Gap as Predictors on Supportive Behavior (N=300)

<table>
<thead>
<tr>
<th>Dependent Variable</th>
<th>Support for Prohibition of Prostitution</th>
<th>Support for Prohibition of Same-Sex Marriage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Predictor</td>
<td>β</td>
<td>t</td>
</tr>
<tr>
<td>Genderb</td>
<td>-0.193</td>
<td>-3.372**</td>
</tr>
<tr>
<td>Age</td>
<td>-0.099</td>
<td>-1.663</td>
</tr>
<tr>
<td>Education Level</td>
<td>0.173</td>
<td>2.875**</td>
</tr>
<tr>
<td>AIDS Knowledge</td>
<td>-0.024</td>
<td>-0.403</td>
</tr>
<tr>
<td>R²Δ</td>
<td>.057**</td>
<td>.041**</td>
</tr>
</tbody>
</table>

Block 2

<table>
<thead>
<tr>
<th>Total Effects of Personal Stigma and Attributed Stigma</th>
<th>β</th>
<th>t</th>
<th>β</th>
<th>t</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIDS Stigma Gap</td>
<td>0.159</td>
<td>2.747**</td>
<td>-0.055</td>
<td>-0.923</td>
</tr>
<tr>
<td>R²Δ</td>
<td>.031**</td>
<td>.016**</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Total R²  .088  .057
F-value  4.740**  2.970**

* p < .05; **p < .01; ***p < .001, two-tailed.

a Standardized coefficient.
b Dummy coded as male = 1, female = 0.
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toward prohibiting same-sex marriage ($\beta = .119$, $p < .05$) whereas AIDS stigma gap was not a significant predictor of being supportive toward prohibiting same-sex marriage. Taking the results from the two hierarchical regressions, Hypothesis 3 was partially supported.

Discussion and Conclusions

The present study examined (1) if there is a significant AIDS stigma gap, (2) which factors influence the perceptual gap, and (3) how the gap predicts people’s support for policies related HIV/AIDS. Here are some important findings that deserve scholarly attention.

Using four parallel scales for measuring a discrepancy between personal stigma and attributed stigma, the present study found a significant AIDS stigma gap among Koreans. Consistent with the prior research finding (Green, 1995), this result confirms that most people tend to perceive themselves as better and more positive. This natural tendency may decrease stigmatizing attitudes held by individuals, but the level of stigma individuals attribute to others could be influenced by different sources, such as media reports on PLWHA or HIV/AIDS.

As mentioned above, because the chances of interacting with PLWHA are very rare in Korea, most people form their attitudes towards PLWHA through indirect sources such as news stories, TV drama, movies, documentary shows, or even public communication campaigns for reducing stigmatization against PLWHA. If the media content continuously describes PLWHA as being severely discriminated, the level
of attributed stigma would unintentionally increase. As Cho and Salmon (2007) indicated, this phenomenon can be a case of the unintended effects of public health communication. AIDS campaign that directly focuses on delineating the incidence of social discrimination against PLWHA might have the effect of reducing individual’s personal stigma. However, it is also likely to increase individual’s attributed stigma to the same extent as it does. In terms of stereotypes and discriminations, the relationship between social attitude and behavior is not always consistent (see, e.g., the classic study by LaPiere’s classic study, 1934). If an individual faces a situation that he or she should take action related to PLWHA or HIV/AIDS (e.g., “having dinner with PLWHA”), his or her action might be determined based on the attributed stigma rather than personal stigma he/she posses. This phenomenon could make it harder for practitioners to make efforts to control HIV/AIDS because personal stigma is modified by the attributed stigma. Visser and her colleagues (2008) insisted that if stigmatizing attitudes are considered pervasive within a society, then theoretically this allows the individual more latitude to condone his or her stigmatizing behaviour. Green (1995) also indicated that a shared hostile perception of the attitudes towards PLWHA, namely, attributed stigma, may have a different impact on PLWHA and people who are not infected:

"It could be that most people hold both stigmatizing and non-stigmatizing attitudes towards people with HIV and that which comes to the fore varies according to time and place. For example, a person may support the rights of people with HIV theoretically but
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avoid actual contact with them. It could be that the punitive minority voice is a broad representation of what most people think, at least some of the time or in certain circumstances... (p. 564).

In this context, during the past four years, KCDC has changed the strategy of national public campaign from directly delineating the incidence of social discrimination against PLWHA to increasing AIDS knowledge. In reality, the results of Hypothesis 2 confirmed that AIDS knowledge was positively related to AIDS stigma gap. Specifically, the zero-order correlations showed that AIDS knowledge was positively related to the lower level of personal stigma but not to attributed stigma. This result might imply that public campaigns for increasing the knowledge level were fairly successful in reducing personal stigma. Therefore, future public campaigns on HIV/AIDS should continue to focus on enhancing AIDS knowledge rather than highlighting the incidence of social discrimination against PLWHA.

From a different standpoint, people who hold stigmatizing attitudes are likely to justify themselves to discriminate against PLWHA by overestimating the level of attributed stigma. This tendency might aggravate the social climate surrounding HIV/AIDS and PLWHA. Consequently, as Visser and her colleagues (2008) argued, PLWHA’s direct or indirect experiences or even anticipation of this climate can contribute to their sense of being stigmatized, and the way that they respond to stigma can affect the negative influence of stigma in a society regardless of the actual level of enacted stigma or discrimination.

It is noted, in addition, that the perceptual gap might also affect
governmental decisions of enacting laws related to HIV/AIDS. The present study observed that people who have AIDS stigma gap were more supportive about prohibiting prostitution. In other words, people had the perceptual disparity, which may lead them to become anxious about the spread of HIV/AIDS through sex workers. Policy makers, then, would view this public anxiety as the majority opinion and begin to act on it, as Sun and her colleagues (2008) discussed, "political elites and advocacy groups may also take actions based upon their presumptions of influences on some ostensible audience (p. 258)." The complex relationship between the self-other disparity and policy support has been discussed in the third-person effect literature (e.g., Gunther, 1995; Lee & Tamborini, 2005).

Even though the present study did not examine the effect of mass media as did in the third-person effect studies (Davison, 1983), our result draws a similar conclusion that the perceptual discrepancy among the public could play a critical role in making the governmental decisions related to prohibiting prostitution in Korea.

Contrary to the prediction, however, AIDS stigma gap was not significantly related to supporting prohibition of same-sex marriage. The result of zero-order correlations indicates that supporting prohibition of same-sex marriage was positively associated with both personal stigma and attributed stigma. This result suggests that the matter of same-sex marriage should be explained by other reasons such as the cultural climate, but not self-other disparity. Interestingly, it was found that there was a gender difference in predicting support for prohibiting prostitution. Females tended to support prohibiting prostitution than
males did. This finding is consistent with prior research on sexual behaviors, which suggests that men tend to have false consensus that undesirable sexual behaviors are common (van den Eijnden, Buunk, & Bosveld, 2000). In Korean society, women who engage in unsafe or risky sex are more likely to be condemned by a society than men, so women might strongly perceive such behaviors as socially undesirable. On the contrary, men could perceive such behaviors as less undesirable because they could interpret engaging in a risky behavior as being more attractive (Kopetz et al., 2014). This false consensus might make men feel safer when they engage in a risky behavior than women do.

The present study provides useful implication for future AIDS campaign practitioners. AIDS campaigners should understand the nature of AIDS stigma and carefully design a message for reducing AIDS stigma because depicting a socially disapproved conduct as “regrettably frequent” may install a counterproductive norm in the minds of the audience (Cialdini et al., 2006, p. 4). Instead of showing how PLWHA are suffering from public discrimination, AIDS campaigners might focus on reducing attributed stigma by telling the audience that AIDS stigma does not exist in their positive reference groups such as highly educated or socially respected people.

A few limitations of the present study are worthy of note. First, although two contexts, support for prohibiting prostitution and same-sex marriage, were employed as the measures of consequences predicted by AIDS stigma gap, more policy issues related to HIV/AIDS and PLWHA would be needed to secure external validity. Future research should develop various policy issues related to HIV/AIDS and PLWHA in
different situations and contexts. By doing so, we may better understand the process of public opinion formation on the issues related to HIV/AIDS and PLWHA.

Second, since we only included the respondents who were exposed to the media campaign, it was not possible to examine the relationship between exposure to the media campaign and AIDS stigma gap. As such, we could not confirm whether the campaign affected AIDS stigma gap as we inferred. In addition, because the respondents of this study could have relatively higher level of AIDS knowledge compared to general population, their higher degrees of self-enhancement might affect them to determine their supportive attitudes on prohibiting prostitution. Future research on the relationship between exposure to the media campaign and AIDS stigma gap should be conducted.

Third, this study tested the direct association between self-other perceptual discrepancy and behavioral component as its consequences, but moderators such as paternalism or altruistic motives that could affect this association were not examined. Even though the total effects of personal stigma and attributed stigma were controlled, there might be other motivations that influence people’s supportive attitudes towards policies prohibiting risk behaviors. Further study should examine the possible moderators that affect the relationship between AIDS stigma gap and behavioral component.

Lastly, it should be noted that the data used in this study could be somewhat out-of-date since it was collected in 2011. Another study should be needed to verify whether the findings of this study remains valid, even though four years has passed since that time.
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에이즈 낙인 격차, 에이즈 지식, 에이즈 관련 뜻점에 대한 태도 간의 관계에 대한 탐색적 연구

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본 연구는 과연 우리 사회에서 에이즈와 관련된 낙인의 격차가 존재하는지에 대해 살펴보고, 존재한다면 그 원인과 결과가 무엇이 있는지에 대해 탐색하기 위해 수행되었다. 2011년에 이즈 예방 미디어 캠페인 효과 조사를 위해 수집한 자료를 분석한 결과, 한국인들에게는 에이즈와 관련된 낙인 격차가 존재하였다. 즉, 한국인들은 스스로 에이즈 감염인을 얼마나 차별할 것인가(개인적 낙인)에 대해서는 대부분 그렇지 않을 것이라고 여기는 반면, 우리 사회가 얼마나 나 에이즈 감염인을 차별하는가(사회적 낙인)에 대해서는 어느 정도 높은 수준으로 차별하고 있다고 지각하고 있었다. 에이즈 감염 및 치료와 관련된 지식은 에이즈에 대한 사회적 낙인과 개인적 낙인의 격차에 유의미한 영향을 미쳤으며, 에이즈 낙인 격차는 에이즈와 관련된 정책에 대한 태도에 영향을 미쳤다. 본 연구는 향후 에이즈 관련 캠페인에 대한 방향성을 제공하고 에이즈 낙인 격차라는 원상 및 그 원인과 결과에 대해 보다 다각적으로 연구할 필요성을 제안한다.

주제어: 에이즈 낙인, 에이즈 지식, 인구통계학적 변인, 에이즈 미디어 캠페인