

January 2013

Social Contact Theory: A Framework for Understanding AIDS-Related Stigma

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Recommended Citation

Attell, Brandon K. (2013) "Social Contact Theory: A Framework for Understanding AIDS-Related Stigma," *The Journal of Public and Professional Sociology*. Vol. 5 : Iss. 1 , Article 1.

Available at: <https://digitalcommons.kennesaw.edu/jpps/vol5/iss1/1>

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Social Contact Theory: A Framework for Understanding AIDS-Related Stigma

Cover Page Footnote

The author would like to extend gratitude to the Georgia Sociological Association for providing funding that allowed an early form of this paper to be presented at the 2011 Annual Conference in Savannah, GA. The author would also like to thank Gail Markle for her continued support and encouragement on this publication.

Introduction

Sociology obliges one to understand the human immunodeficiency virus and the acquired immunodeficiency syndrome (HIV/AIDS) in a context beyond its biological basis. The relationship between the disease and its impact on individuals, households, communities, orphans, the elderly, agriculture, the private sector, economic growth, and government (to name a few) has been duly noted (Arp 2004, Barnett and Blaikie 1992: 99, Barnett and Whiteside 2006: 171-337, and Biesma et. al. 2009). Because of this complexity, it is without doubt that any scholar beginning to study the sociology of HIV/AIDS is likely to become overwhelmed by the social nature of the disease. However, critical analysis of this “social nature” can result in broad themes that tie the literature together.

One such theme is the way in which stigma shapes the disease and those living with it. In general terms, AIDS-related stigma refers to the “prejudice, discounting, discrediting, and discrimination directed at people perceived to have AIDS or HIV, and the communities with which they are associated” (Herek 2005: 122). This concept of stigma is so relevant to HIV/AIDS, that some consider it to be the last stage of the epidemic, following the introduction and spread of the virus within a society (Mann 1987).¹ Although this assertion was made in the late 1980s, stories of AIDS-related stigma and its accompanying discrimination are still surfacing within our global society: the Chinese government recently ruled against a man who was denied a teaching job after his HIV status become known (Jacobs 2010), gay men in the United States are still not allowed to donate blood (Mroz 2010), and about one third of countries in the world prohibit persons living with HIV to enter their borders (McNeil 2009).

These few examples serve as an illustration to the prolifically abundant presence of AIDS-related stigma contained in the literature. It is alarming to discover such an occurrence, but it nonetheless presents the reader with a deep-seated question: how does AIDS-related stigma come to be?

Beginning with Goffman’s (1963) conceptualization of stigma, the social psychological phenomenon has been widely studied, particularly with emphasis on how stigma impacts those living with HIV/AIDS. The purpose of this paper is to provide a detailed overview of Goffman’s original conceptualization of stigma, how this concept has been utilized in the discourse of AIDS-related stigma, and to offer into the literature an alternative explanation to the origin of AIDS-related stigma: Allport’s social contact theory.

¹ Although this notion was asserted at an informal assembly, it has been accepted into the literature and mentioned elsewhere, for example: Maluwa et al. 2002.

Goffman's Seminal Work on Stigma

Sociologist Erving Goffman has long been considered an expert on micro-level social phenomenon. His dramaturgical model established in *The Presentation of Self in Everyday Life* has proven itself as a practical way of examining human behavior in particular social situations. Likewise, his essays within *Asylums* have been championed by many as enduring pieces on the inner workings of total institutions. His work *Stigma* is no exception to his expertise within sociology.

Goffman explains stigma as attributes that are deeply discrediting to an individual (Goffman 1963: 3). He claims that a stigma “constitutes a special discrepancy between virtual and actual social identity” (Goffman 1963: 3). For Goffman, the process of stigmatization occurs in situations of mixed social contact, which force the stigmatized individual to confront the causes and effects of stigma (Goffman 1963: 12-13).

In fact, one can be stigmatized by many different means. Specifically, Goffman provides us with three preliminary types of stigmatization: abominations of the body, blemishes of individual character, and tribal stigma (Goffman 1963: 4-5). Abominations of the body are physical deformities that are readily seen by others (Goffman 1963: 4). Blemishes of individual character refer to the aspects of one's life that tend to discredit them. Goffman provides examples such as alcoholism, homosexuality, or radical political behavior (Goffman 1963: 4). Tribal stigma refers to stigma that is due to one's association with particular heritages; this stigma can be passed on by means of intergenerational transfer (Goffman 1963: 4).

But yet, what happens when one becomes stigmatized? Goffman claims that stigmatization results in the stigmatized individual having to learn to accept their perceived deviance; in fact, Goffman claims that this aspect of stigmatization is the central feature of the stigmatized individual's life (Goffman 1963: 8). This results in what Goffman refers to as a “moral career” (Goffman 1963: 32).

A moral career is a patterned way of socialization for those who are stigmatized. He claims that there are primarily four types of moral careers. Foremost, one can be socialized if they have been born with a stigma and are brought up in contexts that make them aware of their differences (Goffman 1963: 32). Similarly, one can be socialized by families or neighborhoods that are considered “protective capsules” against the stigmatized (Goffman 1963: 32). A third pattern of socialization occurs when an individual acquires stigma late in life, at which point they must learn to accept their difference (Goffman 1963: 34). Lastly, a fourth pattern of socialization occurs when an individual comes of age in a protective environment of which they ultimately leave, at which point they must adapt to the conformities placed on that person by the new environment (Goffman 1963: 35).

However, the moral career of a stigmatized individual is not the only thing that happens once stigmatization occurs. Goffman concludes that once stigmatization occurs, two groups are likely to develop. Logically, we have the group of stigmatized individuals. These people are referred to as “the own”, and are likely to form enclaves of understanding and compassion amongst others who have been stigmatized as well (Goffman 1963: 19-25). Apart from the own, a second group is formed known as “the wise”. The wise are those people who are not stigmatized, but for one reason or another are sympathetic and understanding towards those who are stigmatized (Goffman 1963: 28-30).

Examining the results of stigmatization obliges the reader to question how stigmatization occurs to begin with. Goffman’s response is that stigmatization is perceivable because of the types of information that humans carry with them in day-to-day life. These signs include prestige symbols, stigma symbols, or disidentifiers (Goffman 1963: 43). For example, if a person who is walking down the street with a friend who is dressed in all black, they may be stigmatized as a “Goth”. This scenario would be considered a disidentifier. But yet, a person may not be stigmatized if they are walking down the street in a very expensive, well-kept outfit (a prestige symbol).

These symbols, with which we are constantly identified with, carry along with them social information that is used to make judgments with (Goffman 1963: 43-48). These judgments can be either positive or negative. As such, a negative judgment would result in the origination of a stigma. However, Goffman claims that we can be in control of the social information that we present to the world. One such way is to disassociate ourselves from the “biographical others” of whom may be the cause of our stigmatization (Goffman 1963: 65). By removing oneself from the context of the biographical other, we can formulate a new social identity (Goffman 1963: 67), the goal of which would be to escape the stigmatization.

Another form of information control is known as “passing”. In passing, a stigmatized individual makes an effort to hide the discrediting information that is known about them (Goffman 1963: 73-80). For example, an “open” male homosexual who may be negatively judged for his sexuality may choose to make an effort towards controlling those perceptions by concealing his sexual orientation at particular social outings, such as a major league baseball game, by presenting himself as heterosexual. In this given social situation, he would be controlling the social information that is known about him in an effort to not be discredited and stigmatized as a homosexual (essentially, what Goffman would refer to as controlling personal versus social identity).

A third form of information control is known as “covering”. While passing refers to an effort to hide the discrediting information that is known about a person, covering pertains to physically hiding the aspect about oneself that causes the stigmatization (Goffman 1963: 102). For example, consider an army

veteran who was wounded during battle. He returns home with half of a leg missing. In order to remain from being stigmatized, he may choose to acquire a prosthetic device that will attach to a pair of shoes. Once the prosthetic device is attached, he can then wear pants that cover the device, and thus make his physical deformity unnoticeable. In this circumstance, he is “covering” to prevent stigmatization.

In all three circumstances (disassociating from biographical others, passing, and covering), individuals are presented with opportunities for preventing the acquisition of a stigma. But yet, given the means to achieve this end, it becomes apparently clear that individuals who are attempting to control their social information are likely to have differing identities given the particular social situation in which they find themselves. Goffman refers to these two identities as a personal and social identity.

A personal identity is the notion of the self to which we truly belong, while a social identity is more aligned with the self who is portrayed in the situations in which social information must be controlled (Goffman 1963: 105-106). Having these two identities is likely to be troublesome. Goffman claims that these two contrasting identities will ultimately result in ambivalence in the life of the stigmatized (Goffman 1963: 106-108). A central issue here is how the stigmatized individual is expected to carry on in the day-to-day working of life.

Goffman addresses this issue by re-examining the groups that are in play in the realm of stigma. Referred to earlier in the text as “the own”, Goffman now claims that in-group alignments occur amongst those who are sufferers of stigma (Goffman 1963: 112-114). In other words, we see that those who lead stigmatized lives often suffer together and find social support amongst themselves.

On the other hand, we have the rest of the members of society who do not leave stigmatized lives. Goffman states that stigmatized individuals must learn to not only make alignments with in-group members, but to also make alignments with these “ordinary” members of society (Goffman 1963: 114-115). Those who are stigmatized must learn how to incorporate both their personal and social identities in order to function with society; or, as Goffman states: “the individual is advised to see himself as a fully human being like anyone else, one who at worst happens to be excluded from what is, in the last analysis, merely one area of social life” (Goffman 1963: 115).

Goffman gives several suggestions to the stigmatized individual with how to interact with the normal members of society. These include, but are not limited to: trying to fulfill the normal obligations of day-to-day life, informing and educating the normal person about how to act nicely towards the stigmatized, using the language of the stigmatized around normal people, allowing normal people time to respond to the confrontations that occur in mixed social contact,

and acting as if the efforts of normal people in mixed social contact are appreciated (Goffman 1963: 116-123).

Goffman concludes *Stigma* with an examination of the broader context of deviance within society. He concludes that individuals who are stigmatized are ultimately still members of the broader society at large, thus he refers to them as “the normal deviant” (Goffman 1963: 130). He considers them as normal deviants because deviance is a matter of social definition. In other words, no single deviant act can be solely recognized as its own occurrence. Of course, as time changes, what a society considers as deviant changes. Likewise, the life of a normal deviant is often one of trying to move along the lines of deviant to non-deviant. Therefore, in both cases, the social construction of what it means to be stigmatized and discredited is largely a part of the given social context in which a person lives (Goffman 1963: 135-139).

Arriving at the conclusion of this discussion of Goffman’s seminal text, we see that his 1963 theoretical piece offers sociologists a foundational understanding of the topic. But what would Goffman have said had he written the piece some time later? Had he been able to see our society during the plague years of HIV/AIDS, would his analysis be any different? How would Goffman conceptualize the origin of AIDS-related stigma? While these questions are rhetorical in nature, they are, in fact, a reality that we face within our discipline. Theories are written in specific contexts of social environments that incorporate time and history into them. Often times, popular theories are carried on continuously in the literature- so much so, in fact, that the original meaning of the theory is lost along the way (for example, see Connell and Messerschmidt 2005 and West and Zimmerman 2009). This is particularly true regarding the literature of AIDS-related stigma.

Next, I further discuss how the concept of AIDS-related stigma has been utilized in the literature, and establish the need for an alternative explanation as to the origins of AIDS-related stigma in the United States. I place particular emphasis on how research regarding the concept of AIDS-related stigma tends to inadequately grasp the original concept of stigma.

The Literature of AIDS-Related Stigma

While there is a profuse amount of research presented on AIDS-related stigma, I assert that a search into this literature reveals four troublesome themes: one: scholars have only sampled the prevalence of AIDS-related stigma within populations, two: if scholars go beyond this sampling, they only examine the *implications* of AIDS-related stigma while ignoring the *origination* of the stigma, three: very few, if any, define stigma in their research, and four: very few, if any, have questioned the little research that has been published. Collectively, these

assertions represent a gap within the literature: little has been said, or researched, as to the origination of AIDS-related stigma. Each of these four themes will now be examined.

Research on the Prevalence of AIDS-Related Stigma

A substantial portion of the literature aims to sample the prevalence of AIDS-related stigma within a society or particular group. These surveys of stigma towards those living with HIV/AIDS have been conducted within educators (Chao et. al. 2010), female sex workers (Raingruber et. al. 2010), families (Brown et. al. 2010) (Hamra et. al. 2006), health-care providers (Chan and Reidpath 2007) (Rutledge et. al. 2009), faith-based organizations (Ansari and Gaestel 2010), rural communities (Brems et. al. 2010) (Visser et. al. 2009), and children (Bhana 2008) (Campbell et. al. 2010) (Lin et. al. 2010), to name a few.

This research is useful as it highlights the multifaceted social nature of HIV/AIDS. Foremost, it exposes AIDS-related stigma as occurring at several various levels of society: we learn that AIDS-related stigma occurs not only in small contexts, but large social contexts as well (i.e., from families to governmental response). Furthermore, this type of research highlights the fact that, although after thirty years of HIV/AIDS in our global society, AIDS-related stigma still persists to varying degrees. Also, because this portion of the research targets specific populations to measure their stigmatization towards those living with HIV/AIDS, we have the advantage of knowing how specifically AIDS-related stigma “works” at varying levels. With this in mind, solutions tailored to specific circumstances could be developed to reduce AIDS-related stigma.

Apart from these studies that utilize targeted populations is a subset within the AIDS-related stigma body of literature that examines stigma from the perspective of persons living with AIDS (PLWAs) (Fosters and Gaskins 2009) (Gilbert and Walker 2010) (Kalichman et. al. 2009) (Wyrod 2011). From this portion of the literature, we are offered an alternative explanation of AIDS-related stigma, one that shifts the point of focus from those who stigmatize against PLWAs to those who are, in fact, living with HIV/AIDS. This focal shift gives intellectual depth to our understanding of AIDS-related stigma, as we essentially move from understanding the “stigmatizers” to the “stigmatized”.

While this portion of the literature is beneficial by the means outlined above, I contend that examining AIDS-related stigma in this context creates a dichotomous relationship. In other words, the studies present AIDS-related stigma in the context of those who either have AIDS or do not. Such a presentation lends itself to a situation of “us versus them” (see Devine et. al. 1999), which is likely to only further perpetuate stigma.

Furthermore, examining AIDS-related stigma in such targeted populations can lead to overgeneralizations of results. One wanting to draw broad

conclusions about AIDS-related stigma cannot turn to these studies, as they are only representative of their target populations. Similarly, if one were to make an attempt at analyzing these studies aggregately, they would founder; the studies cannot be examined in a comparative perspective because almost every study operationalizes stigma differently. In other words, what would be considered “high stigma” in one study could translate to “moderate” or “low stigma” in a different study.

To remedy this problem, one has the option of turning to studies that utilize a broader, more representative sample. However, issues again surface. One, studies that utilize such a sample are a minority within the literature; more attention is given to targeted populations. Second, these studies tend to be *geographically broad*, but not *historically deep* (for an expansion of this idea see Farmer 2005: 42-43).² In other words, the samples are representative enough to draw conclusions, but ignore changes that have taken place over time that may affect AIDS-related stigma.

For example, consider a 1993 nationwide telephone survey that measured AIDS-related stigma within the United States. The survey utilized random digit dialing to sample 768 households, with a total of 538 successful responses, yielding a response rate of 70.1%. The successful responses were then “poststratified by race and gender with 1990 census data” (Herek and Capitanio 1993: 574). Indeed, it is without doubt *geographically broad*. At the time of this particular study, random digit dialing would have been considered adequate in obtaining a nationally representative sample.

However, this study is not *historically deep*. Not once do the authors make reference to AIDS-related stigma in the past, nor do they analyze the stigma in its (then current) social context. A historically deep study would add to the literature by providing us with a substantial discussion about the development of AIDS-related stigma. Such a discussion could highlight a number of important topics regarding HIV/AIDS, such as the changing social norms within our society (i.e., how HIV/AIDS may or may not be becoming more socially accepted), or how biological treatments over time may lend itself to changing levels of stigma (i.e., as more become harder to identify as HIV-positive due to better preventative treatment).

Nonetheless, while the study was geographically broad, only group

² Farmer’s notion is to create an analytic model that is capable of examining human suffering resultant from structural violence. Here, I have cautiously extended the scope of his argument into the realm of AIDS-related stigma, utilizing his own assertion for the importance of understanding phenomenon in appropriate contexts. Such a context would include an analysis of the historical timing of social phenomena. This particular assertion can also be found, although not as clearly articulated, in Farmer 1999: 59-93. Similarly, Tesh examines the importance of taking a multi-causal viewpoint in Tesh 1988: 58-82.

differences between race/ethnicity were analyzed, with a poor discussion that concludes the article:

“The results indicate that AIDS-related stigma remains a serious problem as the United States enters the second decade of the epidemic. Reducing stigma and fostering compassion toward persons with AIDS should be integral components of AIDS education and prevention programs” (Herek and Capitanio 1993: 576).

In short, each type of study (non-representative samples versus representative samples) has what the other is lacking. The smaller, non-representative samples with specifically targeted populations tend to analyze stigma in a manner that utilizes a social context. Hence, they are more likely to be historically deep, but not geographically broad. The larger, representative samples are geographically broad in their nature, but tend to only sample the prevalence of stigma, and do not analyze the stigma in a manner that is historically deep.

Research That Examines the Implications of AIDS-Related Stigma

A second subset of the AIDS-related stigma literature consists of research that not only samples the prevalence of AIDS-related stigma, but further analyzes the implications of AIDS-related stigma. For example the relationship between AIDS-related stigma and its implications for things such as HIV testing (Parker and Aggleton 2003) (Sambisa et. al. 2010), access to treatment (Akpa et. al. 2011), depression (Simbayi et. al. 2007), effective health interventions (Scambler and Paoli 2008) (Carr and Gramling 2004), family identity (Li et. al. 2008), life satisfaction (Greeff et. al. 2010) and overall quality of life (Holzemer et. al. 2009), have been noted.

Similar to the research that examines the prevalence of AIDS-related stigma, this portion of the literature adds substantial knowledge to the AIDS-related stigma discourse. This body of the literature adds that not only does AIDS-related stigma occur at various levels of society, but that it impacts various levels of society as well. Here again, with this type of research being conducted, better responses to reducing AIDS-related stigma (in this case its impact) can be derived.

This particular aspect of the literature is promising, due to the fact that in studying social problems, a central dilemma is the extent to which sociologists should provide solutions to identified problems (Crone 2007: 5). The scholars who study implications of AIDS-related stigma are valiant in their efforts of not simply sampling the prevalence of AIDS-related stigma, but also examining the implications that this stigma has, and more often than not confidently propose

solutions in the specific areas that were identified (such as access to treatment or life satisfaction).

The concern, however, is that these solutions are tertiary at best. In the prologue of Randy Shilts' epic tome documenting the history of AIDS in America, a bold statement is made: "The bitter truth was that AIDS did not just happen to America- it was allowed to happen by an array of institutions, all of which failed to perform their appropriate tasks to safeguard the public health" (Shilts 1987: xxii). Are we not doing the same by proposing solutions only to the *implications* of AIDS-related stigma?

The point of contention is that providing solutions to the implications of AIDS-related stigma is a *prescriptive* process that ignores the *description* of the origination of such stigma.³ Stated another way: the results sections of these research articles usually discuss intervention mechanisms to solve the variety of problems that arise from AIDS-related stigma (a "prescription" for what a society "should do"). Yet, if attention was shifted on first being descriptive in understanding the origination of stigma, the implications of AIDS-related stigma may be quite different in our society. Stated simply, we could "safeguard" the public by describing and understanding how AIDS-related stigma is formed originally, and offer primary solutions to reducing the prevalence of the stigma within society. At this point, I must diverge for a brief moment and ask: why has this not been done?

It has been argued that the perplexity in solving AIDS-related problems lies in its nature of being a "long-wave" event (Barnett and Whiteside 2006: 19). People are infected with HIV at one point, and typically transition into AIDS at a much later date, when the critical problems associated with the disease begin to surface. Likewise, solutions (be they biological, social, political, etc.) to problems resulting from AIDS involve long-term thinking. Barnett and Whiteside assert that this aspect of time puts the problem out of our mindset; since the solutions are far out of sight, they become invisible (Barnett and Whiteside 2006: 22).

I propose that because of this concept of AIDS as a "long-wave" event, so much attention is geared towards providing solutions to the implications of AIDS-related stigma. These solutions are tangible, and they provide answers that are needed in present time. The predicament is that we cannot look either short-term or long-term in solving the problems resulting from AIDS-related stigma- we must do both. Admittedly, as McKinlay (2005) has noted, we need solutions that

³ Here, I use the term "origination" to refer to a social psychological process, rather than a socio-historical process. In other words, I am concerned with what causes AIDS-related stigma in social settings, rather than when AIDS-related stigma developed within our society. Also, see Fein 1999 for a practical discussion on prescriptive versus descriptive accounts of socially related phenomenon.

are immediate. It appears ironic, but if we were to focus our attention on the future by studying the origination of AIDS-related stigma, we can provide solutions that are long lasting. Clearly this is where we have lacked as sociologists.

The origin of stigma is of crucial importance, as it is likely that where or how the stigma originates influences how severely one will be stigmatized (Link 1987, Timmermans 1998). For example, those who acquire HIV/AIDS through the use of unclean syringes may be stigmatized more than one who received HIV/AIDS via blood transfusion (Carr and Gramling 2004). Also, there is a significant amount of attention regarding AIDS as a “gay disease” within the literature (see Mizuno et. al. 2012, Naughton and Vanable 2012, Rotello 1997, Sontag 1989, von Collani et. al. 2010, and Walch et. al. 2010). This literature suggests that homophobia ameliorates the fear of transmission of HIV/AIDS between heterosexuals and homosexuals (Connors and Hely 2007), and that homosexuals living with the disease are receiving punishment for their homosexuality (Fee and Manon 2008, Kopelman 2002, Wilkerson 1994).

Defining AIDS-Related Stigma in the Literature

The first two themes of the literature concerned sampling the prevalence of AIDS-related stigma and examining how this stigma impacts various aspects of society. We saw that both of these areas of research significantly contributed to our understanding of AIDS-related stigma, particularly by demonstrating the multi-faceted nature of the disease. Now I wish to turn my attention towards a third theme of the literature on AIDS-related stigma: very few, if any, provide a strong conceptual definition of AIDS-related stigma in their research.

For example, consider a recent publication regarding AIDS-related stigma and youth living with HIV (Tanney et. al. 2012). The authors utilize multiple regression analysis to examine the relationship between stigma, depression, and risk behaviors amongst youth living with HIV. Their conceptualization of AIDS-related stigma is as follows: “HIV and acquired immunodeficiency disorder can be described as a process of devaluation of people living with or associated with HIV and AIDS” (Tanney et. al. 2012: 300). Not once is Goffman’s original conception of stigma cited. Given the complex nature of his conceptualization (outlined in a previous section of this paper), we see that some of the original ideas of stigma are lost (as demonstrated by this conceptualization) and they become oversimplified.

Link and Phelan (2001) state that this oversimplification of AIDS-related stigma occurs throughout the literature for two reasons. One, studies regarding AIDS-related stigma apply to so many circumstances (for examples, see the above sections regarding the prevalence and implications of AIDS-related stigma).

Two, research on AIDS-related stigma is multidisciplinary. Various disciplines, such as psychology, sociology, and nursing, all approach the concept from their own theoretical viewpoints, which place varying emphasis on the conceptualization of stigma.

A substantial literature review conducted by Manzo further supports my position that AIDS-related stigma is conceptually over-utilized: “Perhaps unsurprising is the finding that the sociological summary of a ‘stigma’ is an overused and underdefined concept that does not grasp sociality” (Manzo 2004: 413).⁴ Why is providing a conceptual definition important? Neuman states:

“Part of the conceptualization process is to distinguish your concept from closely related ones. Often ideas overlap with others and blur into one another. Good measurement requires that you separate the concept you want to study from others” (Neuman 2009: 117).

It is alarming that so few provide conceptual definitions in their work, and while I feel confident that my colleagues writing on AIDS-related stigma would argue that their methodological discussions on the operationalization of AIDS-related stigma are sufficient in providing a conceptual definition, I contend the following: Foremost, there is a distinct difference between a conceptualization and an operationalization. A conceptual definition refers to “defining a variable or concept in theoretical terms with assumptions and references to other concepts” (Neuman 2009: 117), while an operational definition refers to “defining a concept as specific operations or actions that you carry out to measure it” (Neuman 2009: 117). As the operationalized definitions of AIDS-related stigma become increasingly abundant and diverse within the literature, the conceptual definition becomes lost along the way.

Few Question the Existing Research

So far, I have presented several disconcerting issues with the literature on AIDS-related stigma. Next, I wish to discuss a small problem that will lead into a more substantial discussion which will return us to Goffman’s original work on stigma. This problem is that little, if any, question the research that has been published on AIDS-related stigma (Link and Phelan 2001). This concept has been alluded to in my discussion thus far, but here it is reiterated for clarity.

⁴ Although Manzo supports my assertion that AIDS-related stigma is underdefined in research, I must note that he is much more critical than need be. His conviction that “*any* condition, conduct, or membership *can* be stigmatizing” (Manzo 2004:405) is shortsighted as well as culturally and sociologically ignorant to the social context in which AIDS developed. Such a lack of understanding is alarming, as the changing sociological context in which sexually transmitted diseases (see Brandt 1996), and more specifically AIDS (see Fee and Krieger 1993) has developed obliges us to re-conceptualize our research.

Because of the varying operationalizations of AIDS-related stigma, we cannot compare one study to another. To do so would represent a logical fallacy, and even if this fallacy was committed, such references and comparisons to and between other studies can only be used as starting points for newly conducted research.

In order to answer the question posed at the beginning of this paper (how does AIDS-related stigma come to be?), we must return to the original expert on stigma: Erving Goffman. In this section, I return to Goffman's original explanation of stigma and discuss how we can extend his theoretical concepts to AIDS-related stigma. What does Goffman say about the origination of stigma? Goffman's conceptual definition of stigma states that:

“While the stranger is present before us, evidence can arise of his possessing an attribute that makes him different from others in the category of persons available for him to be, and of a less desirable kind- in the extreme, a person who is quite thoroughly bad, or dangerous, or weak. He is thus reduced in our minds from a whole and usual person to a tainted, discounted one. Such an attribute is a stigma, especially when its discrediting effect is very extensive; sometimes it is also called a failing, a shortcoming, a handicap” (Goffman 1963: 2-3).

How does this relate to AIDS? Specifically, there are three characteristics of AIDS that are likely to cause stigma, each of which can be linked to Goffman's early conceptualization. One: “stigma is more often attached to a disease whose cause is perceived to be the bearer's responsibility” (Herek 2005: 123). This is easy to understand: many acquire HIV through risky sexual behavior or through the use of unclean syringes (CDC 2010). Through these individual behaviors, it becomes easier for society to attach stigma to the HIV-positive individual; it is almost as if they deserve the treatment because they “should have known better”. Additionally, this links back to the idea of AIDS as a “gay disease” and that homosexuals are being punished for their homosexuality. In Goffman's conceptualization, this would be considered a blemish of individual character.

Second, “greater stigma is associated with conditions that are perceived to be contagious or to place others in harm's way” (Herek 2005: 124). This explains the discrimination that HIV-positive individuals face within the realm of healthcare. Healthcare providers are at risk of acquiring HIV from the patients due to their medical exposure (in the form of needles, surgery, etc.) (Zenner et. al. 2009). This also explains the general fear of HIV/AIDS transmission in society: as a mechanism of biological protection, nobody wants to be on the receiving end of a disease that completely alters the life course trajectory. Here the link cannot be explicitly made between AIDS and what Goffman has given us. What Goffman speaks of is tribal stigma: “stigma that can be transmitted through

lineages and equally contaminate all members of a family” (Goffman 1963: 4). This comparison is metaphorical; Goffman asserts that stigma can be passed on from one individual from another. In other words, we stigmatize the person because of their association with the past. However, here I assert is that as AIDS biologically transfers from individual to individual, the stigma accompanies the transfer.

Third, “a condition tends to be more stigmatized when it is readily apparent to others” (Herek 2005: 124). This characteristic can be most understood during the latter stages of AIDS, during which the clinical manifestations of AIDS become most apparent. The disease becomes physically visible in the forms of oral candidiasis, shingles, and Kaposi’s sarcoma- to name a few (Fan, Conner, and Villarreal 2007: 75-83). Now the individual suffering from AIDS can be physically identified, and stigma is attached more easily. Goffman would refer to this as an abomination of the body.

These three aspects of HIV/AIDS make it easy to link our conceptual understanding AIDS-related stigma back to Goffman’s original concept of stigma. And while Goffman’s theory guides us in the right direction, his theoretical viewpoints are merely one way of understanding AIDS-related stigma. This is made evident by one often overlooked component of Goffman’s theory: the fact that his theory of stigma is based off of situations where individuals are physically in contact with one another. Stated in his own words: “This book, however, is specifically concerned with the issue of ‘mixed contacts’- the moments when stigmatized and normal are in the same ‘social situation.’...” (Goffman 1963: 12) [sic].

Thus, Goffman’s theory is based on physical social interactions that are taking place. However, one can argue that stigmatization of those living with HIV/AIDS can occur long before a physical interaction takes place. Indeed, we can have preconceived, stigmatizing thoughts towards an individual or group of individuals before encountering them in the social realm. Such a statement fundamentally shifts the conceptualization of AIDS-related stigma from Goffman’s viewpoint, one that would require a new theoretical understanding of the origin of AIDS-related stigma. Stated another way: Goffman’s theory leads us to believe in the notion that stigmatization is a static process. In order to understand how stigma is formed, I argue that we must picture stigmatization as a process that is not static, but rather in flux depending on social contact with the stigmatized individual or group. Next, I discuss a theoretical viewpoint that would lend itself to such a process.

Social Contact Theory: A Framework for Examining AIDS-Related Stigma

How can we examine AIDS-related stigma in a manner that is not static, but in flux? Without doubt, an appropriate answer to this question is difficult to obtain. Yet, in search of such a response, I turn to Allport's social contact hypothesis. Allport claims that various types of social contact have influential clout in either reducing or increasing prejudice held towards out-group members (Allport 1958: 250-251). The various levels of contact are: casual contacts, acquaintances, residential contacts, occupational contacts, and goodwill contacts (Allport 1958: 251-266). Although Allport's theory was developed in terms of prejudiced attitudes towards ethnic groups, specifically Blacks, here his argument is extended into the purview of AIDS-related stigma. What follows is a discussion of this extension.

Casual contacts are ones that are "wholly superficial" (Allport 1958: 251) in nature. As they are wholly superficial, these types of contact are the most socially distant. In other words, our contact with the out-group is limited and has no meaning, because there is no substantial contact occurring; there is no significant relationship with the member of the out-group. Allport warns that casual contacts are likely to not decrease, but instead *increase* prejudice (Allport 1958: 251). Casual contacts with persons living with AIDS (PLWAs) would occur when an individual is socially distant from a PLWA; that is, the individual does not have a significant relationship with a PLWA (as in friendship, family member, coworker, colleague, etc.).

If a significant relationship was had with a PLWA, such a relationship would be categorized as an acquaintance. Allport claims that contacts with acquaintances are likely to reduce prejudice (Allport 1958: 252).

Residential contact refers to segregated communities between the in-group and out-group (Allport 1958: 256). At the time of Allport's writing, this was a prevalent issue facing racial tension in America. For the purposes of AIDS-related stigma (at least, within the United States), residential contact is of no importance. Thankfully, we do not see residential segregation of PLWAs.

Occupational contact refers to two different types of contact. Foremost, Allport claims that in America, Blacks frequently hold jobs of lesser status than whites, which results in more prejudice (Allport 1958: 261-262). Also, occupational contact refers to situations in which both the in-group and out-group members are working collectively in an occupational context (Allport 1958: 263-264). In terms of AIDS-related stigma, I wish to examine occupational contact in a different context, one that refers to contact with PLWAs while on the job. Conceptually, I assert that different jobs expose individuals to divergent levels of contact with PLWAs.

Allport lastly speaks of goodwill contacts, which are contacts resulting from the "goodwill" intention of people to reduce prejudice of the out-group

(Allport 1958: 266). In terms of AIDS-related stigma, these would be people who willingly work with PLWAs. By “willingly work”, I mean not simply in an occupational sense, but those who are also willing to act as social advocates of PLWAs. Allport asserts that goodwill contacts are likely to reduce prejudice, but only if the relationship is considered to be of equal status between the in-group and out-group members (Allport 1958: 256).

Collectively, Allport’s concepts of casual contacts, acquaintances, occupational contacts, and goodwill contacts form a useful conceptual context for examining the formation of AIDS-related stigma; one that surprisingly, has not been put forth by sociologists.

Although I have described the basic notions of social contact theory and how it could be applied to HIV/AIDS, I now must answer two questions; foremost: why is social contact theory useful in examining AIDS-related stigma? and how can sociologists employ this theory as a research methodology?

In assessing social contact theory’s usefulness in examining AIDS-related stigma, I return to my own criticisms presented in this article’s literature review. At its most basic level, any research that involved utilizing social contact theory to examine AIDS-related stigma would have to sample the prevalence of the stigma within the population. This aspect of the research would allow the sociologist to understand AIDS-related stigma at its most basic level, most likely in the form of an AIDS-related stigma scale.

Yet, social contact theory has the potential to surpass this basic level. In terms of finding the origination of AIDS-related stigma, social contact theory presents the sociologist with a path of exploration. Earlier, I asserted that Goffman leads us to believe that the formation of stigma is a static process (an individual fails to meet our expectations while present before us in a physical state). Social contact theory has the ability to support an alternative explanation. As mentioned earlier, I assert that the formation of AIDS-related stigma is not a static process as Goffman suggests, but rather a process that is in flux depending on the type of contact that one has with PLWHAs. In this sense, social contact theory could potentially show that individuals who have no significant relationship with a PLWHAs (a “casual” contact) could very well have extremely high amounts of stigma towards PLWHAs. Furthermore, this type of contact may, in fact, be the starting point for the origination of stigma.

In my literature review, I also stated the necessity for performing research that is geographically broad and historically deep. Again, social contact theory has the potential to meet such a criteria. In terms of being geographically broad, the burden is placed on the sociologist to sample widely enough that populations are deemed a representative sample. In terms of being historically deep, social contact theory allows the sociologist to examine AIDS-related stigma from several differing types of viewpoints (casual contact, acquaintance, occupational

contact, or goodwill contact). If applied appropriately over time, examining such contrasting viewpoints has the potential for uncovering socio-historical changes that occur over the span of many years.

Additionally, social contact theory has the potential to move beyond homophobia as a foundational component of AIDS-related stigma. This is due to the fact that the theory examines the types of relationships that individuals have with one another, rather than Goffman's conceptualization that essentially focuses on the social information that we carry with us in day-to-day life (prestige symbols, stigma symbols, and disidentifiers).

How can sociologists utilize social contact theory as a research methodology? In terms of quantitative research, the answer is simple. Social contact theory simply becomes a coded entry that identifies each respondent. For example, an individual who has a sibling with HIV/AIDS would be coded as an "acquaintance"; a nurse or doctor would be coded as an "occupational contact" as these are people who are likely to have knowledge about HIV/AIDS and work with people who have HIV/AIDS on a frequent basis; an individual working for an AIDS activist organization such as ACT UP would be coded as a "goodwill contact". Once all of the respondents have been coded appropriately, statistical tests could be utilized to examine differences between the groups.

Employing contact theory in qualitative research is likely to be more difficult. The process of using qualitative techniques (such as grounded theory research) would be very time consuming to complete with such large amounts of data from so many different types of contacts. Nonetheless, the process would still be similar to that of coding in quantitative research; the sociologist would code each respondent as a different type of contact and then examine the data in light of each group of people that is created through the coding process.

Nonetheless, social contact theory has extreme potential in AIDS-related stigma research. But with such potential also comes difficulties. Foremost, to state it simply: social life is messy. In other words, how would a sociologist code for a health professional that is also a member of an AIDS activist organization? By presenting this question we come to see that often times, our social roles are overlapping and not easy to distinguish from one another. Social contact theory relies on the aspect that individuals can be easily identified and placed into an appropriate group depending on the type of contact held with the out-group member (in this case, the out-group being the PLWAs).

Also, social contact theory originated as a way to examine racial prejudice in 1950s America. In the process of adopting a "prejudice" framework to a "stigma" framework, there is a necessity in distinguishing between the basic notions of prejudice and stigma. How are the two alike? How are the two not alike? This will prove difficult to answer (I have already discussed the

controversy surrounding understanding AIDS-related stigma; these same controversies may be likely to occur when examining prejudice as well).

Lastly, social contact theory leads us to believe that varying types of contact affect the amount of stigma that we have towards other individuals. If this framework holds true, does that mean that in order to reduce the prevalence of AIDS-related stigma in a society, some way of generating meaningful relationships with PLWAs and “casual contacts” would have to be generated? If so, how would this be done?

Conclusion

Erving Goffman’s 1963 conceptualization established a foundational understanding of stigma, one that has forever impacted sociological literature. Had Goffman been alive to write about AIDS-related stigma, perhaps our understanding of the social phenomenon would be different. While we cannot turn to such a rhetorical statement to understand AIDS-related stigma, we can utilize the literature on the topic to critically analyze the phenomenon.

My over-arching point in this article is that while the literature we do have on AIDS-related stigma has been important for several reasons (particularly at highlighting the multi-faceted nature of HIV/AIDS), improvements can be made in understanding the origination of AIDS-related stigma. Such an improvement comes at the cost of shifting our theoretical understanding away from Goffman’s conception into one that accounts for stigmatization that occurs before physical social contact takes place. To accommodate for such a shift, I offer Allport’s social contact theory into the discourse.

While this shift is necessary, it does not dismiss the importance of Goffman’s work. Rather, it merely offers an additional explanation to AIDS-related stigma, one that will add to the existing body of literature and promote future research that is both quantitative and qualitative in nature. As this research takes place, the theory will be further evaluated and analyzed for its strengths and weaknesses in terms of understanding AIDS-related stigma, hopefully showing that this stigma can be influenced not only by the social information that we carry, but by the relationships that individuals have with one another as well.

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