

## AN INVESTIGATION INTO SUPPORT FOR RESTRICTIONS ON HIV CARRIERS IN THE CHICAGO METROPOLITAN AREA\*

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**ABSTRACT:** An investigation into support for restrictions on people testing seropositive for HIV is reported on. Data were collected during telephone interviews with two-hundred adults aged eighteen to sixty-five in the Chicago metropolitan area. Using the analytic technique of LISREL, six models which attempt to explain support for restrictions were tested. It was found that the model best supported by the data indicates that two groups contribute to support for restrictions on HIV carriers — one due to intolerance of homosexuality and one to mistrust of public health officials regarding their control and management of the AIDS epidemic. The relevance of these findings for public health policy makers is discussed.

**KEYWORDS:** Acquired Immuno Deficiency Syndrome. Prejudice.

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### INTRODUCTION

Since the recognition of the Acquired Immune Deficiency Syndrome (AIDS) as a deadly, infectious disease, United States public health officials have consistently advocated individual preventive behavior as the best and most effective means of controlling its spread. For example, a report on the 1987 Project Hope Conference on AIDS found that the consensus of the project members was that "At this time, the best defense that nations can muster to protect their populations against the spread of the disease is to educate people about how to guard against contracting AIDS"<sup>13</sup>. The policy of providing education for the purpose of encouraging preventive behavior was clear too in U.S. Health and Human Services Secretary Otis Bowen's statement at the same conference: "Lacking a cure, our best hope today lies in educating the public about the seriousness of the threat, the ways the AIDS virus is transmitted, and the practical steps that each person can take to avoid acquiring or spreading it"<sup>13</sup>.

Conversely, public health officials have resisted measures which restrict the behavior of people with AIDS and persons testing positive for the human immunodeficiency virus (HIV). As with compulsory testing, it is believed that restrictions "would drive underground the intravenous drug abusers and gay men who most need to be reached"<sup>1</sup>. Therefore, restrictions are seen as inef-

fective. They are also viewed as unnecessary. Here public health officials cite studies such as that conducted by Friedland of New York's Montefiore Medical Center which have found no evidence that casual contact results in the spread of AIDS<sup>9</sup>. If AIDS is not contracted through casual contact, why bar individual HIV carriers from schools or the workplace?

However, a portion of the public is unconvinced that restrictions on people with AIDS and HIV carriers are unnecessary. For example, groups of parents have often attempted to stop AIDS patients from attending their childrens' schools. An extreme case occurred in Arcadia, Florida where the home of a family of three children with AIDS was set on fire and destroyed when the children were permitted to continue attending their school. Yet less violent resistance to AIDS victims' school attendance has occurred in other states as well including New York, Illinois, and Indiana. Restriction of AIDS patients and HIV seropositives from the workplace has also been an issue. For instance, a situation in Illinois addressed this matter with respect to the health care field. At Cook County Hospital in Chicago, Illinois, a physician with AIDS was the center of controversy because he wished to continue providing patient care. Administrators and trustees agreed to allow him to practice medicine but hospital physicians overrode this decision. Though a later compromise allowed the physician to remain at the hospital with re-

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duced patient contact, the physician sued for full reinstatement<sup>12</sup>.

Survey data corroborate the perception that many people support restrictions on people with AIDS and HIV seropositives. For example, Al-lard<sup>2</sup> found that 44% of a general population sample in the Montreal health region favored preventing people with AIDS from holding certain kinds of jobs including jobs in hospitals and restaurants. Twenty percent believed that children with AIDS should not be allowed to attend school with children who did not have AIDS.

Public health officials have attributed support for restrictions to: 1) misinformation about the transmission of the AIDS virus; and 2) prejudice toward the primary group affected by AIDS — that is, homosexuals. For example, it was reported about the passage of AIDS legislation by the Illinois General Assembly, a legislative body, that "Opponents (including public health officials) of the sweeping measures enacted by the General Assembly last spring argued against what they said was an irrational response based on fear and misinformation"<sup>3</sup>. And, job discrimination against AIDS victims and HIV carriers has often been said to have a homophobic basis. In this respect, many public health officials have viewed restrictions as much of the homosexual community does — that is, as a civil rights issue rather than a question of public health practice.

Research on attitudes toward homosexuality in the U.S. has shown that there is considerable disapproval of people who practice homosexuality. The Gallup Report<sup>10</sup> reported that 55% of Americans surveyed in March 1987 opposed the legalization of homosexual relations. Thirty-seven percent believed that homosexuals should not be accepted into the armed forces; 51% believed that they should not be accepted into the clergy; and 60% opposed homosexuals becoming elementary school teachers. Because of findings such as these, it is easy to assume that support for policies which separate and restrict the behavior of people with AIDS and HIV carriers is based on prejudice. Perhaps AIDS has even served as an excuse for supporting what, before AIDS, was unacceptable.

On the other hand, the same Gallup Poll showed that attitudes toward homosexuality had not changed significantly since the last poll on the subject in September 1986. In the Gallup Report<sup>10</sup>, it was concluded that "Despite a reported increase in personal assaults against homosexuals, a new Gallup survey found no evidence of growing public intolerance toward gays and gay lifestyles since last Fall". This finding indicates, perhaps, that AIDS is not being used as an excuse to express attitudes of discrimination.

A study by Triplet and Sugarman<sup>20</sup> also sug-

gests that attitudes toward people with AIDS may involve more than the expression of prejudice. They concluded from their study of a sample of American college students that reaction to persons with AIDS "reflects a fear of the unknown cause of the disease coupled with a general prejudice against homosexuals".

Another factor which may contribute to support for restrictions on people with AIDS and HIV carriers is mistrust of the public officials responsible for controlling the spread of the disease. Mistrust of public officials of all kinds has been studied by political scientists as antecedent to political behaviors such as voting, candidate choice, and political party affiliation<sup>11,16,18</sup>. Research generally indicates that mistrust is a factor in such behaviors. It discourages voting and adversely affects candidate support and party affiliation.

In the case of AIDS, it seems plausible that there would be no support for restrictions among people who trusted the reassurances of public health officials. The message of public health officials is clear: casual contact with HIV carriers does not result in the transmission of the disease, and therefore, restriction of casual contact is unnecessary. Thus, if the originators of the message, that is, public health officials, were trusted, there would be no cause to seek an alternate policy with regard to stemming the spread of AIDS.

In the present paper, an investigation of the correlates of support for restrictions on HIV carriers among the general population in one American city is reported on. Three factors which might contribute to support for restrictions were studied: negative attitude toward homosexuality, mistrust of public health officials, and perceived threat of AIDS to society in general.

## METHODS

### Models

Six models which attempt to explain the formation of support for restrictions on HIV carriers were tested. Each model incorporates controls for respondent age, sex, race and education. Figure 1 displays the models which were used to compare the effects of mistrust of public health officials and negative attitude toward homosexuality on support for restrictions. Four plausible hypothesis were tested. Model 1A represents the Mistrust Hypothesis. It proposes that mistrust of public health officials was the primary explanatory factor underlying support for restrictions on HIV carriers. Model 1B is a representation of the Homophobic Hypothesis which posits that a negative view of homosexuality was the principal cause of support for restrictions. Model 1C proposes that the two factors, negative attitude toward homosexuality and mistrust of public health offi-

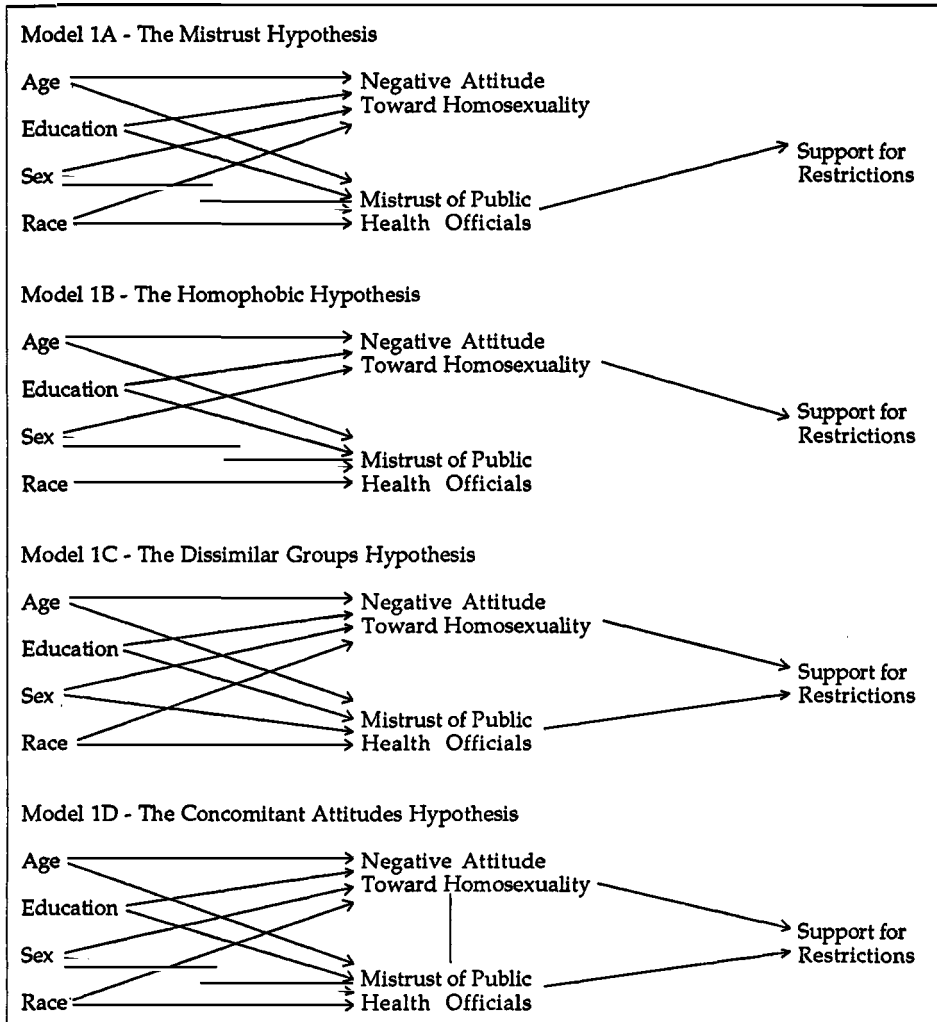


Fig. 1 - Possible models explaining support for restrictions on AIDS carriers and victims.

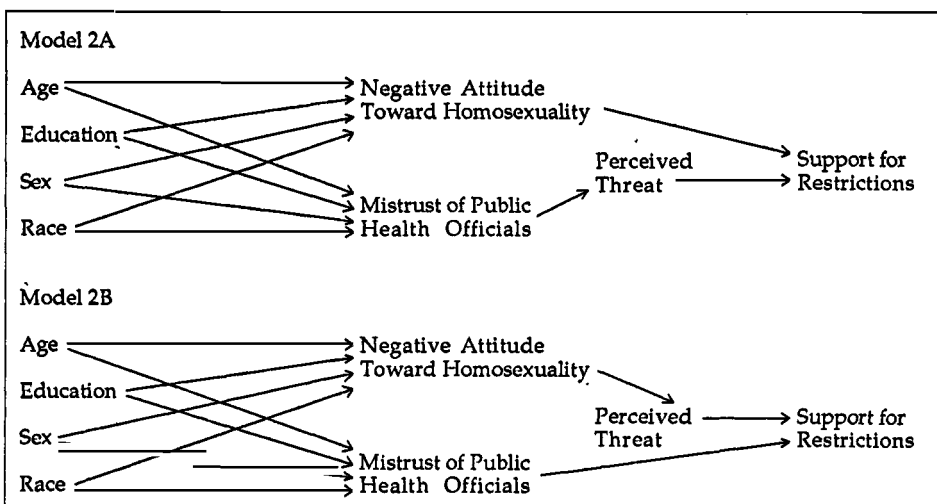


Fig. 2. - Models investigating the role of perceived threat of AIDS to society.

cials, both contributed to support for restrictions but were not related to each other. This model suggests that two groups supported restrictions, one based on prejudice and the other on mistrust of public health officials. Model 1C might be said to represent the Dissimilar Groups Hypothesis. Model 1D suggests, to the contrary, that mistrust of public health officials originated with negative attitudes toward homosexuality. That is, only one group supported restrictions for HIV carriers, and its members both mistrusted public health officials and held negative attitudes toward homosexuality. This might be called the Concomitant Attitudes Hypothesis.

The relationship of fear to support for restrictions was also investigated (see Figure 2). The hypothesis that mistrust of public health officials lead to a sense of threat which resulted in support for restrictions was posited. Model 2A represents this hypothesis. It suggests that people who mistrusted public health officials believed that AIDS was a significant health threat to the society. This sense of threat resulting from mistrust lead to support for restrictions. In this model, negative attitude toward homosexuality has a direct effect on support for restrictions in accord with the view that support for restrictions on AIDS carriers is not an appraisal but the unreasoned result of prejudice. Model 2A was contrasted with Model 2B to investigate the possibility that negative attitude toward homosexuality also lead to fear about AIDS which resulted in support for restrictions on HIV carriers.

### Sample

The data were collected via a telephone interview by a major survey research laboratory. The sample is a directory-based, random digit dialed sample of the Chicago Standard Metropolitan Area. Inclusion in the sample was restricted to adults between the ages of 18 and 65 years. Each respondent was the household member whose birthday was the most recent. Data collection took place in August and September, 1987. There were 200 interviews completed. The response rate was 74%. Non-responses included 38 screening refusals, 17 interview refusals, and 15 never able to interview contacts. The characteristics of the sample are presented in Table 1.

### Measures

Three of the measures are multi-item scales including mistrust of public health officials, support for restrictions on HIV carriers, and negative attitude toward homosexuality. Cronbach's alpha was used to assess the internal consistency of each of these measures. These values are .73, .84 and .75, respectively. Each scale is scored so that increasing scores indicate more of the attitude; that is, more mistrust, more support for restrictions, or

more negative attitudes toward homosexuality.

We used Barber's concept of trust<sup>4</sup> which defines trust as the expectation of: 1) The continuation of the natural and moral social order; 2) technically competent role performance; and 3) fiduciary responsibility and obligation. Only the dimensions of competence and fiduciary responsibility were used in this investigation. Thus both dimensions were operationalized in the measure of mistrust of public health officials.

The measure of perception of AIDS as a health threat to society (perceived threat of AIDS to society) is a single item — the question, "How serious a problem do you think AIDS will be five years from now?". The possible responses were coded as follows: not at all serious = 1, not very serious = 2, somewhat serious = 3, and very serious = 4.

In addition, information on the age, sex, race, and education of each respondent was used. Age was coded in years, sex was coded 1 = male and 0 = female, and race was coded 1 = white and 0 = minority including black, Hispanic, Asian, and other. Education was coded in completed years of schooling.

### Analysis

The models were analyzed using LISREL VI<sup>15</sup> and the maximum likelihood method of estimation. The chisquare:degrees of freedom (CS:DF) ratio was used to assess the adequacy of models 1A and 1B. Following Carmines and McIver<sup>5</sup>, a chisquare:degrees of freedom ratio greater than 2-3 was used to indicate inadequate fit. Following Schmitt, a ratio less than one was used to indicate that the model fitted too well since "such a model would be unlikely to remain stable in future samples"<sup>19</sup>.

Second, Models 1A and 1B were compared to Model 1C to indicate if both negative attitude toward homosexuality and mistrust of public health officials contributed to support for restrictions. In order to indicate if this model was an improvement over Models 1A and 1B, the difference in chisquare test appropriate for nested models was used, that is, for "models where no new variables are specified, and we impose or relax constraints while holding specification in the rest of the model constant"<sup>21</sup>. Third, Models 1C and 1D were again compared using the difference in the chisquare test.

Last, Models 2A and 2B was compared. As these models are not nested, we could not use the difference in chi-square test to judge if one fitted the data better than the other. Instead, the chisquare:degrees of freedom ratio for each was evaluated and the significance levels of the parameter estimates inspected. Joreskog and Sorbom state

TABLE 1  
 Characteristics of the Sample (n = 200) investigated in the  
 Chicago Metropolitan Area, 1987.

Sample Characteristics	Number	Percentage
Sex		
Male	90	55.0
Female	110	45.0
Total	200	100.0
Race		
White	151	75.5
Non-White Including Black, Hispanic, Asian, and Other	44	22.0
Missing	5	2.5
Total	200	100.0
Age		
Age<26	41	20.5
25<Age<36	62	31.0
35<Age<46	45	22.5
45<Age<66	51	25.5
Missing	1	.5
Total	200	100.0
Marital Status		
Married	97	48.5
Unmarried Including Never Married, Divorced, Separated, Widowed, and Living With Another	103	51.5
Total	200	100.0
Residence		
Chicago	85	42.5
Suburbs	114	57.0
Missing	1	.5
Total	200	100.0
Education (In Years)		
8	2	1.0
9	4	2.0
10	4	2.0
11	10	5.0
12	47	23.5
13	20	10.0
14	29	14.5
15	14	7.0
16	49	24.5
17	7	3.5
18	14	7.0
Total	200	100.0
Income (In U.S. Dollars)		
Under 10,000	12	6.0
10,000≤Income<20,000	30	15.0
20,000≤Income<30,000	40	20.0
30,000≤Income<50,000	57	28.5
50,000≤Income<70,000	19	9.5
Incomes≥70,000	17	8.5
Missing	25	12.5
Total	200	100.0

that "parameters whose t-values are larger than two in magnitude are normally judged to be different from zero"<sup>15</sup>.

## RESULTS

Table 2 presents the correlations between the measures. It indicates that negative attitude toward homosexuality and lower education were moderately related to support for restrictions on HIV carriers. Mistrust of public health officials and perceived threat of AIDS to society were also correlated, but to a lesser degree, with support for restrictions. Therefore, a first inspection of the data suggested that the Mistrust Hypothesis might not be supported.

Table 3 presents the LISREL results for Models 1A through 1D. The evaluation of Models 1A and 1B indicated that neither model was a good representation of the data. The chi-square:degrees of freedom ratio for Model 1A is 7.8 (CS = 46.7; 6 df). The chi-square:degrees of freedom ratio for Model

1B is 4.4 (CS = 26.6; 6 df). Both are greater than 3.0, indicating poor fit.

A comparison of Models 1A and 1B to Model 1C indicated that Model 1C is a statistically significant improvement over both of them. The chi-square difference between Model 1A and Model 1C is 29.7 (1 df; probability < .005). The chi-square difference between Model 1B and Model 1C is 9.6 (1 df; probability < .005). Model 1C also has a nearly acceptable chi-square:degrees of freedom ratio (3.4).

Model 1D is not, however, better than Model 1C. The chi-square difference between these models is 0.0 indicating that specifying the parameter between negative attitude toward homosexuality and mistrust of public health officials did not result in improved fit. Also we found that this parameter was not statistically significant ( $t = .016$ ).

In summary, these analyses suggest that Model 1C representing the Dissimilar Groups Hypothesis is the best representation of the relationship

TABLE 2  
Correlations between the measures for the sample investigated of the Chicago Metropolitan Area, 1987.

Factors	Age	Male	Race	Ed	ATH	PTA	MPH	SFR
Age	1.00							
Male	.04	1.00						
White	.15	.05	1.00					
Education	.00	.03	.11	1.00				
Attitude Toward Homosexuality	.17	.09	-.02	-.27	1.00			
Perceived Threat of AIDS	.01	-.05	.00	-.03	.05	1.00		
Mistrust of Health Officials	.01	-.21	.09	-.09	.00	.25	1.00	
Support for Restrictions	.02	.03	-.09	-.35	.37	.20	.20	1.00
Mean	37.0	-	-	14.0	2.4	2.7	2.8	2.0
SD	12.6	-	-	2.3	.7	1.4	.4	.7
Range	18-65	0-1	0-1	8-18	1-4	1-4	1-4	1-3
N	200	200	195	200	199	195	200	200

ATH = Negative Attitude Toward Homosexuality  
PTA = Perceived Threat of AIDS to Society  
MPH = Mistrust of Public Health Officials  
SFR = Support for Restrictions on HIV Carriers

between these factors. Model 1C suggests that two groups support restrictions on HIV carriers, one because of intolerance of homosexuality and the other because of mistrust of public health officials' handling of the AIDS epidemic. The hypothesis is given further support by review of the effects of the control variables. While age and lower education are significantly related to negative attitude toward homosexuality ( $t= 2.455$  and  $3.945$ , respectively), they are not significant predictors of mistrust of public health officials. Rather, being a woman is the only individual characteristic which is significantly related to mistrust of public health officials ( $t= 3.042$ ). Race is not significantly related to either factor.

The last analysis is displayed in Table 4. A comparison of Models 2A and 2B indicated that 2A is the better of the two and the best of any of the models previously tested. Model 2A has an acceptable chi-square:degrees of freedom ratio of 2.2. In contrast, Model 2B has a ratio of 5.4, which

is greater than 3.0. Furthermore, the parameter estimate for the path between negative attitude toward homosexuality and perceived threat of AIDS to society in Model 2B is not significant ( $t= .673$ ) while the parameter estimate for the path between mistrust of public health officials and perceived threat of AIDS to society in Model 2A is significant ( $t= 3.601$ ). This analysis supports the hypothesis that mistrust is linked to support for restrictions through fear.

The major findings of these analyses can be summarized as follows:

1) Two groups support restrictions on HIV carriers. The first is comprised of those who hold negative attitudes toward homosexuality. This group is characterized by lower education and by higher age. The second group consists of those who mistrust public health officials regarding the containment of the AIDS epidemic. Members of this group are likely to be female.

TABLE 3  
Results of LISREL analyses for models 1A through 1D.  
Chicago Metropolitan Area, 1987

Parameters	Parameters Estimates*			
	1A	1B	1C	1D
Age				
MPH	.000(ns)	.000(ns)	.000(ns)	.000(ns)
ATH	.169	.169	.169	.169
Education				
MPH	-.095(ns)	-.095(ns)	-.095(ns)	-.095(ns)
ATH	-.270	-.270	-.270	-.270
Male				
MPH	-.212	-.212	-.212	-.212
ATH	.092(ns)	.092(ns)	.092(ns)	.092(ns)
White				
MPH	.113(ns)	.113(ns)	.113(ns)	.113(ns)
ATH	-.015	-.015(ns)	-.015(ns)	-.015(ns)
MPH   SFR	.204	-	.203	.203
ATH   SFR	-	.366	.366	.366
ATH   MPH	-	-	-	-.001(ns)
R <sup>2</sup> for SFR Equation	.04	.13	.17	.17
Goodnes-of-fit				
Chi-Square	46.7	26.6	17.0	17.0
Degrees of Freedom	6	6	5	4
CS: DF Ratio	7.8	4.4	3.4	4.3

ns = Not Significant

\* = Standardized Maximum Likelihood Estimators

MPH = Mistrust of Public Health Officials

ATH = Negative Attitude Toward Homosexuality

SFR = Support for Restrictions on AIDS Carriers

TABLE 4  
Results of LISREL analyses for models 2A and 2B.  
Chicago Metropolitan Area, 1987.

Parameters	Parameters Estimates*	
	2A	2B
Age		.000(ns)
MPH	.000(ns)	.169
ATH	.169	
Education		-.095(ns)
MPH	-.095(ns)	-.270
ATH	-.270	
Male		-.212
MPH	-.212	.092(ns)
ATH	.092(ns)	
White		.113(ns)
MPH	.113(ns)	-.015(ns)
ATH	-.015(ns)	-
MPH   PTA	.251	.048(ns)
ATH   PTA	-	.165
MPH   SFR	-	-
ATH   SFR	.359	.159
PTA   SFR	.183	
R <sup>2</sup> for SFR Equation	.16	.05
Goodnes-of-fit		59.5
Chi-Square	24.3	11
Degrees of Freedom	11	5.4
CS: DF Ratio	2.2	

ns = Not Significant

\* = Standardized Maximum Likelihood Estimators

MPH = Mistrust of Public Health Officials

ATH = Negative Attitude Toward Homosexuality

SFR = Support for Restrictions on HIV Carriers

PTA = Perceived Threat of AIDS to Society

2) The effect of mistrust of public health officials on support for restrictions is indirect, through perceived threat of AIDS to society. The path through perceived threat of AIDS indicates appraisal of health threat, and links previous research findings on fear to this research on the relationship of mistrust of public health officials and support for restrictions. In contrast, the direct effect which negative attitude toward homosexuality exerts on support for restrictions suggests that, among members of this group, prior beliefs which have no bearing on assessment of present health threat motivate support for restrictions.

#### DISCUSSION

The results of these analyses indicate that neg-

ative attitudes toward homosexuality contribute to support for restrictions on HIV carriers and AIDS patients. Indeed, of the factors we studied, negative attitude toward homosexuality was the strongest predictor of support for restrictions. However, the perception of many health professionals involved with AIDS patients that all support for restrictions is motivated by intolerance of homosexuality was not corroborated. It was found that a portion of support for restrictions could be explained by mistrust of public health officials. Since this is the more unexpected and unstudied finding, this discussion focuses on this result. It is a phenomenon with important implications for compliance with health policy.

A certain amount of mistrust of government actions and scrutiny of policy-makers is basic for de-



mocracy. Therefore, a level of mistrust is appropriate, and some questioning of official actions is a healthy citizen reflex. Yet expecting citizens to question public policy does not mean that officials have no obligation to address the public's concerns. That is, it is also important that officials respond to the mistrust of citizens. While a certain amount of mistrust is expected and healthy, there is a danger that high levels of mistrust could incapacitate government officials and the general population in emergency situations. Disregarding credibility may lead to noncompliance with policy or extreme actions contrary to that policy. Furthermore, present mistrust may have consequences for the acceptance of future policy regarding the same issue or even other issues.

In the case of AIDS, public health officials have dismissed those who support restrictions by labeling them as intolerant and/or misinformed. Yet the findings of the present study suggest that some Americans are simply uncertain about the credibility of the officials from whom they have received information regarding control of AIDS. They doubt that their policy of risk-reduction education alone will stem the spread of AIDS.

Perhaps these findings should not have been unexpected, however. It was found that mistrust of health officials was associated with perceiving AIDS as a threat to society. Therefore, fear was an intervening variable between mistrust and support for restrictions. But Triplet and Sugarman<sup>20</sup> and Allard<sup>2</sup> also found that fear was related to attitudes about AIDS and people who had contracted AIDS. Allard, for example, reports that support for restrictions was more common in those "having a high level of one or more of these beliefs about AIDS: perceived severity, susceptibility, preventability, and barriers to treatment"<sup>20</sup>. Furthermore, a large body of literature which examines public attitudes toward disease and its victims indicates that perceived threat of disease predicts public reactions to it and the people who contract it. For example, research has found that treatability and preventability are important predictors of attitudes toward cancer and cancer patients<sup>17</sup>.

Our findings raise two questions. First, where did mistrust of public health officials come from? Two possibilities will be discussed. It may have been preexisting; the people interviewed may have had little trust in public health officials, or public officials of any kind, prior to the advent of AIDS. This could be due to Chicago area history or to national events such as Love Canal, Three Miles Island, Times Beach, and atomic testing in Utah. Alternatively, development of mistrust may have been AIDS-specific. That is, mistrust was an appraisal based on what was known about the events of the epidemic and public health actions. This is an area requiring further investigation.

Second, what should be done about the mistrust which exists? It is to be recognized that there may be as many answers to this question as there are readers. However, it is suggested that a more open dialogue between officials and the public about the uncertainties and risks of policies regarding AIDS would be helpful. This may have little effect on the opinions of those whose support for restrictions is based on intolerance of the people in the high risk groups. However, it is believed that for those who mistrust officials and who view AIDS as a serious threat to the society, frank discussion about policy options and their implications would increase support for public policies. Communication directed toward this group by public health officials would develop public trust in AIDS policies.

A National Academy of Sciences report similarly argue that effective communication has reduced the fear of AIDS in the general population and must be continued. "The next few years will be crucial to efforts to slow the spread of HTLV-III/LAV infection. Widespread education about risk factors and the feasibility of different public health measures should begin now, while the audience is still receptive. Prompt action could forestall hysteria over a problem that will continue to be part of American society for the foreseeable future"<sup>14</sup>.

#### Limitations of the Study

We did not explicitly investigate the inaccurate information theory. Reports have shown that a very high percentage of people have accurate knowledge about the most likely modes of AIDS transmission. For instance, a study conducted by the National Center for Health Statistics (NCHS)<sup>7</sup> found that 92% of those sampled said that it is very likely that an individual will get AIDS from having sex with a person who has AIDS, and 91% said it was very likely by sharing needles for drug use. A study in Illinois reported similar findings<sup>8</sup>. However, each of these studies and others have concluded that many people have inaccurate information regarding AIDS transmission based on their responses to questions about casual transmission. For example, in the NCHS sample, 21% believed that working near someone with AIDS, 47% that sharing eating utensils with a person with AIDS, 31% that using public toilets, and 38% that being bitten by mosquitoes were likely to lead to AIDS.

It is possible, however, that these questions confound inaccurate information about AIDS transmission with mistrust. That is, many people who believe in casual modes of transmission may hold these beliefs because they do not believe the information they have received about AIDS, not because they have never received accurate information.

Also there are many other sources of information about AIDS which affect public attitudes. These include the mass media, legislators, and interest groups. Each competes with public health for public influence.

Since the present study was conducted only in Chicago, other studies are necessary to confirm our findings. If this present study is upheld, policy makers should address not only the concerns of the high-risk groups but those of the general population as well. Even though at lower risk, they are constituents and should be not ignored or treated as a homogeneous group.

A possible systemic problem which has not been taken seriously was identified. This subtle bias may be natural in an overcrowded agenda for solving the AIDS crisis. It is argued, however, that not addressing the issues raised by this re-

search will affect future reciprocal alliances. The general population has a legitimate claim to part of the agenda. Conrad<sup>6</sup> writes "We need to develop policies that focus on changing the image of AIDS and confront directly the stigma, resistance to information, and the unnecessary fears of the disease". In conclusion, regarding AIDS, the goals which are necessary to accomplish, can be derailed by our not taking cognizance of potentially powerful opponents and by authentically diffusing potential conflict.

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**RESUMO:** São discutidas possíveis explicações para as restrições impostas a pacientes aidéticos e indivíduos HIV positivos nas várias esferas da vida social. A diversidade de interesses e valores que permeiam as atitudes em relação a este grupo da população foram analisados através da técnica de LIS-REL. Coletaram-se informações de 200 adultos (idade entre 18 e 65 anos) residentes em Chicago, Illinois, USA, através de entrevistas telefônicas. Conclui-se que os dados apontam como explicação à observada discriminação, a intolerância à homossexualidade e a falta de credibilidade nas intervenções originárias das políticas de saúde do processo para controle da epidemia de AIDS. São discutidas as conseqüências destes achados para o estabelecimento de prioridades e de possíveis programas.

**DESCRIPTORES:** Síndrome de Imunodeficiência Adquirida. Preconceito.

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