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Public Reactions to People with HIV/AIDS in the Netherlands

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## Public reactions to people with HIV/AIDS in the Netherlands

## Abstract

A national telephone survey was conducted (1) to assess present-day public reactions to people with HIV/AIDS in the Netherlands, (2) to measure how knowledge about highly active antiretroviral therapy (HAART) is related to public reactions to people with HIV/AIDS, and (3) to investigate determinants of willingness to have personal contact with people with HIV/AIDS. Dutch adults ( $N = 751$ ) participated in a telephone interview conducted to measure cognitive, emotional and behavioral reactions to people with HIV/AIDS. This study has shown that public reactions to people with HIV/AIDS seem to be moderately positive in the Netherlands. Knowledge about HAART is related to lower risk perceptions, a positive attitude towards homosexuals, less fear and more willingness to have personal contact with people with HIV/AIDS. In particular cognitive, but also emotional factors are meaningfully related to willingness to have personal contact with people with HIV/AIDS. Implications for Dutch AIDS educational campaigns aimed at stigma reduction are discussed.

Keywords: AIDS, HIV, cognition, emotion, stigma, aids education

## Public Reactions to People with HIV/AIDS in the Netherlands

Throughout the past two decades a large number of people with HIV/AIDS have been the victim of negative public reactions and stigmatization. For example, people with HIV/AIDS have been fired from their jobs or have experienced the disruption of relationships with family members and friends (Crandall & Coleman, 1992; Herek, 1999). AIDS-related stigmatization does not only have detrimental consequences for personal and social relationships of people with HIV/AIDS, but may also counteract HIV prevention. Fear of stigmatization may be associated with delays in HIV testing for people at risk (Chesney & Smith, 1999) and may result in concealment of one's seropositive status from others (Herek, 1999), which could both lead to the further spread of HIV.

### Determinants of AIDS-related stigmatization

Why do people respond negatively to persons with HIV/AIDS? Research on AIDS-related stigmatization has identified several factors that determine stigmatizing reactions towards persons with HIV/AIDS. First, perceived contagiousness of the disease is related to feelings of fear and stigmatization. (Dijker, Koomen & Kok, 1997; Dijker & Raeijmaekers, 1999; Herek, 1999; Herek & Capitano, 1998a). Although HIV/AIDS is not contagious in normal social interaction, some people still think that HIV can be transmitted through everyday contact. Second, perceived responsibility for becoming HIV-infected is associated with stigmatization of persons with HIV/AIDS (Crocker, Major & Steele, 1998; Herek, 1999; Weiner, Perry & Magnusson, 1988). People tend to respond with less pity, stronger anger and more stigmatization to HIV-infected individuals that are to a high degree responsible themselves for their infection (for example, due to unsafe sexual behavior). The concept of personal responsibility is closely related to blaming patients for their HIV-infection. Research by Dijker, Kok & Koomen (1996) has shown that blaming is negatively related to pity and positively related to anger and stigmatization. Third, negative reactions towards people with

HIV/AIDS often symbolize negative attitudes towards groups associated with HIV/AIDS, such as homosexuals (Crandall, Glor & Britt, 1997; Herek & Capitanio, 1998a; Pryor, Reeder & Landau, 1999). A negative attitude towards homosexuals is related to stronger anger and stronger stigmatization, while a positive attitude towards homosexuals is related to stronger feelings of pity and less stigmatization (Dijker et al., 1996).

#### Public reactions towards people with HIV/AIDS

Public reactions to people with HIV/AIDS may vary in different societies, depending for example on preexisting prejudices within cultures and the local epidemiology of HIV (Herek, 1999). A 1997 national telephone survey in the United States revealed that AIDS stigma still persists in the United States, although extreme negative public reactions had diminished throughout recent years (Herek, 1999; Herek & Capitanio, 1998b). However, compared to a similar survey in 1991 (Herek & Capitanio, 1993), a larger number of Americans overestimated the risk of HIV transmission through casual contact and blamed people with HIV/AIDS for their medical condition. This might imply that public health campaigns in the United States have insufficiently addressed these issues in recent years.

Public reactions to people with HIV/AIDS have been investigated for the last time in the Netherlands in 1994 (NSS/Marktonderzoek, 1994). This national survey revealed that most people in the Netherlands do not respond with strong negative reactions to persons with HIV/AIDS. Only five percent of the respondents reported very strong feelings of fear and 31 percent a little. Moreover, five percent of the respondents indicated to have very strong feelings of anger and 29 percent a little. Further, as much as 38 percent of the respondents reported very strong feelings of pity and 49 percent a little. Finally, this national survey revealed that 15 percent of the respondents found it unacceptable to have close personal contact with a person with AIDS.

More recent information about public reactions towards people with HIV/AIDS is not

available for the Netherlands. However, since mid 1996, the medical treatment of HIV in western societies has much improved. The introduction of highly active antiretroviral therapy (HAART) received a great deal of attention in the Dutch media, with many news papers and television programmes reporting on the relative success of HAART in prolonging the life-span of people with HIV/AIDS. The new and more effective HIV treatments may have changed people's representation of HIV/AIDS from a lethal disease to a more chronic, life-threatening, but potentially manageable disease (Gagnon & Godin, 2000; Kelly, Otto-Salaj, Sikkema, Pinkerton & Bloom, 1998). As a consequence, public reactions to people with HIV/AIDS may have changed accordingly.

Information about current public reactions towards people with HIV/AIDS is an essential component of the development of campaigns aimed at stigma reduction. AIDS educational campaigns will be more effective if they are based on well-founded theories and empirical data (Bartholomew, Parcel, Kok & Gottlieb, 2000). The present study was conducted as part of the development of a new Dutch campaign aimed at stigma reduction. Because of the recent developments in HIV treatment, it seemed essential to assess current public reactions to people with HIV/AIDS in the Netherlands.

#### The present study

The aim of this study was threefold. First, to assess present-day public reactions to people with HIV/AIDS in the Netherlands and to discuss the findings in the light of the available 1994 data (NSS/Marktonderzoek, 1994). The second aim of this study was to examine the relationship between knowledge about HAART and cognitive, emotional and behavioral reactions to people with HIV/AIDS. We expected people with knowledge about HAART to report less negative reactions towards persons with HIV/AIDS than people without knowledge about HAART. The third aim of this study was to investigate determinants of willingness to engage in personal contact with people with HIV/AIDS. In line

with previous research (Dijker et al., 1996), we predicted that higher risk perceptions and stronger blaming would be related to less willingness to engage in personal contact, whereas a positive attitude towards homosexuals would be associated with stronger willingness to have personal contact with persons with HIV/AIDS. Further, we expected feelings of fear and anger to be related to less willingness to have personal contact, and feelings of pity to be related to more willingness to have personal contact. Finally, we expected older people, lower-educated people and men to be less willing to have personal contact compared to younger people, higher-educated people and women (Herek, 1999).

## Method

### Procedure and respondents

A national telephone survey was conducted in July 1998. Respondents were drawn at random from a database of the Dutch National Telephone Company (PTT), which contains almost all telephone numbers in The Netherlands. The random sampling was conducted by means of a computer programme that is commonly used to draw random samples. The sample did not contain telephone numbers of businesses and institutions. A letter was sent to 1200 households in advance, announcing that the University Telephone Service was to contact them for a ten-minute interview about 'diseases and medicines'. In order to avoid non-response among those with a negative attitude towards people with AIDS, the subject of AIDS was not explicitly mentioned in this letter. Approximately one week later the research group selected was contacted by telephone. The first respondent at home, aged 16 years or older, was asked to participate in the telephone survey. In the beginning of the interview, compassion was measured for patients who suffer from various serious diseases (cardiovascular diseases, cancer, AIDS or asthma). After this, the interview focussed exclusively on AIDS.

A total of 1042 households could be reached and 751 interviews were completed, yielding a response rate of 72 percent. Reasons for non-response were recorded: most non-responders (52%) were not interested in a telephone survey and a smaller group (11%) didn't have the time to participate.

### Measures

First, compassion for patients with cardiovascular diseases, cancer, AIDS or asthma were each measured using a single item (e.g. 'To what extent do you feel compassion for AIDS patients?') on a 3-point scale (1 = no compassion, 2 = a little compassion, 3 = strong compassion). After this, cognitive, emotional and behavioral reactions towards people with HIV/AIDS were measured, using identical measures as Dijker, Kok and Koomen (1996) and NSS/Marktonderzoek (1994). Cognitive reactions refer to risk perceptions, blaming and attitude towards homosexuals, emotional reactions concern fear, pity and anger, and behavioral reactions focus on willingness to have personal contact with people with HIV/AIDS. Risk perceptions were measured using five items (e.g. 'Imagine that someone is shaking hands with a person with HIV/AIDS. To what extent does this person run the risk of getting infected with HIV?'), measured on a 3-point-scale (1 = no risk, 2 = small risk, 3 = large risk). These five items were combined into a risk perception scale (Cronbach's alpha = .83). Blaming was measured using one item ('People with HIV/AIDS have to blame themselves for it') on a 3-point scale (1 = disagree, 2 = disagree/agree, 3 = agree). Attitude towards homosexuals was measured using one item ('What is your general attitude towards homosexuals?') on a 5-point scale (1 = highly negative, 5 = highly positive). Emotional reactions (fear, pity and anger) were each measured using a single item (e.g., 'When I think about people with HIV/AIDS, I feel anger') on a 3-point scale (1 = not at all, 2 = a little, 3 = very strong). Willingness to have personal contact was measured using a single item ('To what extent do you find it acceptable to have personal contact with someone with AIDS') on a



4-point scale (1 = highly unacceptable, 4 = highly acceptable). Knowledge about HAART was measured with two questions. First, respondents were asked if they had heard about HAART, a new approach to the treatment of HIV/AIDS. If respondents answered affirmatively, they were asked to give a short description of HAART, which was later assessed by one of the researchers. Respondents who were able to give a good description, were classified as persons with knowledge about HAART. Other respondents were classified as persons without knowledge about HAART. Finally, background variables were recorded (gender, age and level of education).

## Results

### Sample characteristics

Of the 751 respondents, 42 percent was male and 58 percent was female. The average age of these participants was 48, ranging from 16 to 91. Thirty-eight percent had a low, 34 percent a medium and 28 percent a high level of education.

### Public reactions to people with HIV/AIDS

Risk perceptions were quite realistic: most of the respondents held the belief that HIV could not be transmitted by shaking hands with people with HIV/AIDS (91%), kissing a person with HIV/AIDS on the cheek (88%), sharing an office with a person with HIV/AIDS (87%), sharing a drinking glass with a person with HIV/AIDS (77%), or being served by a waiter with HIV/AIDS (74%). Blaming was reported by a small number of respondents: 11 percent held the opinion that people with HIV/AIDS have to blame themselves for it. A small minority of respondents (13 percent) held a negative attitude towards homosexuals. Only 5 percent of the respondents reported very strong and 21 percent a little fear. Eight percent of the respondents indicated that they feel very strong anger and 22 percent a little. Forty-one percent of the respondents reported very strong pity and 47 percent a little. Ten percent of the respondents found it unacceptable to have personal contact with people with HIV/AIDS.

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Insert Figure 1 about here

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Figure 1 shows the mean scores on compassion for persons suffering from AIDS, cancer, cardiovascular diseases and asthma. Although public reactions towards HIV/AIDS seem to be moderately positive, feelings of compassion for AIDS patients were lower ( $M = 2.12$ ) than feelings of compassion for patients suffering from other serious diseases, like cancer ( $M = 2.73$ ,  $t(745) = 22.87$ ,  $p < .001$ ), cardiovascular diseases ( $M = 2.43$ ,  $t(743) = 10.44$ ,  $p < .001$ ), and asthma ( $M = 2.31$ ,  $t(744) = 6.36$ ,  $p < .001$ ).

#### Knowledge about HAART

Of the respondents, 39 percent had knowledge about HAART. T-tests were conducted to investigate differences between respondents with and respondents without knowledge about HAART on the following variables: risk perceptions, blaming, attitude towards homosexuals, fear, pity, anger and willingness to have personal contact (see Table 1).

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Insert Table 1 about here

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Respondents with knowledge about HAART reported lower risk perceptions ( $t(687) = 2.70$ ,  $p < .01$ ), a more positive attitude towards homosexuals ( $t(743) = 1.99$ ,  $p < .05$ ), less fear ( $t(746) = 2.40$ ,  $p < .05$ ) and stronger willingness to have personal contact with people with HIV/AIDS ( $t(725) = 6.88$ ,  $p < .001$ ), compared to respondents without knowledge about HAART. Both groups did not differ on the other variables<sup>1</sup>.

### Determinants of willingness to have personal contact with people with HIV/AIDS

Table 2 gives an overview of the intercorrelations between risk perceptions, blaming, attitude towards homosexuals and emotional reactions. Risk perceptions were related to stronger fear ( $r = .23$ ) and stronger anger ( $r = .16$ ). Blame was related to stronger anger ( $r = .12$ ) and less pity ( $r = -.15$ ). A positive attitude towards homosexuals was related to stronger pity ( $r = .21$ ).

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Insert Table 2 about here

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Three different regression analyses were performed to measure the contribution of cognitions, emotions and person variables in predicting willingness to have personal contact with people with HIV/AIDS (see table 3).

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Insert Table 3 about here

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First, we regressed willingness to have personal contact on risk perceptions, blaming and attitude towards homosexuals. Risk perceptions ( $\beta = -.37$ ) and blaming ( $\beta = -.17$ ) were related to less willingness to have personal contact, whereas a positive attitude towards homosexuals was related to stronger willingness to engage in personal contact ( $\beta = .20$ ). Together, these factors explained 28 percent of the variance. Second, willingness to have personal contact was regressed on emotional factors. Fear ( $\beta = -.18$ ) and anger ( $\beta = -.11$ ) were related to less willingness to engage in personal contact, whereas pity ( $\beta = .16$ ) was related to

stronger willingness to have personal contact. However, emotional factors only explained 7 percent of the variance. Finally, willingness to have personal contact was regressed on risk perceptions, blaming, attitude towards homosexuals, emotional factors and background variables. Together, these factors explained 32 percent of the variance. In comparison with the second regression equation, pity and anger no longer contributed to willingness to engage in personal contact. Background variables were related as follows: older people were less willing to have personal contact ( $\beta = -.08$ ) and people with a higher level of education were more willing to engage in personal contact ( $\beta = .16$ ). The gender of the respondent was not related to willingness to engage in personal contact with people with HIV/AIDS<sup>2</sup>.

### Discussion

The aims of the present study were to assess present-day public reactions to people with HIV/AIDS in the Netherlands, to examine how knowledge about HAART is related to public reactions to people with HIV/AIDS and to investigate determinants of willingness to engage in personal contact with people with HIV/AIDS. Public reactions to people with HIV/AIDS seem to be moderately positive in the Netherlands. Stigmatizing responses were reported by a relatively small number of people. This pattern of results largely corresponds with previous favourable findings of NSS/Marktonderzoek (1994). Compared to the 1994 study, slight improvements were found on some stigma measures. For example, a smaller proportion of people considered personal contact with a person with HIV/AIDS as unacceptable. Although it appears that most people in the Netherlands do not respond negatively to people with HIV/AIDS, respondents reported less compassion for AIDS patients than for patients suffering from other serious diseases. This relative lack of compassion may also be experienced as stigmatizing by people with HIV/AIDS and may also have a negative impact on their well-being.

Consistent with our predictions, respondents with knowledge about HAART reported

less negative reactions towards people with HIV/AIDS than respondents without knowledge about HAART. However, due to the correlational nature of our study, we are unable to draw conclusions about the causal relationship between knowledge about HAART and public reactions to people with HIV/AIDS. On the one hand, it might be possible that knowledge about HAART leads to less negative reactions towards people with HIV/AIDS. On the other hand, people with a positive attitude towards people with HIV/AIDS might be more interested in information about HIV/AIDS and therefore be better informed about HAART.

The present study also examined determinants of willingness to have personal contact with people with HIV/AIDS. In general, cognitive and emotional factors contributed to the willingness to engage in personal contact with people with HIV/AIDS (cf. Dijker et al., 1996). Specifically, risk perceptions, blaming and fear were associated with less willingness to have personal contact, whereas a positive attitude towards homosexuals was related to more willingness to have personal contact. Further, older and lower-educated people were less willing to engage in personal contact with people with HIV/AIDS. Our results demonstrate that emotional factors contribute to willingness to have personal contact with people with HIV/AIDS. However, cognitive factors (risk perceptions, blaming and attitude towards homosexuals) have a stronger influence on willingness to have personal contact than emotional factors. This might explain why pity and anger did not significantly contribute to willingness to have personal contact in the final regression equation.

One methodological limitation of the present study should be noted. Due to the limited duration of each interview, a large number of our constructs were measured using single items. Single-item measures may contain nuances of meaning and undertone that have unintended effects on respondents' responses (Eagly & Chaiken, 1993, p.79). However, Jaccard, Weber, and Lundmark (1975) demonstrated that single-item measures can be as reliable as multiple-item measures, if the single item taps an overall evaluation of the attitude

object. Our single-item measures were constructed in such a way that they involved the central aspect of the particular construct. In addition, it should be noted that most of our single-item measures have been used in previous studies (Dijker, Kok and Koomen, 1996; NSS/Marktonderzoek, 1994) yielding similar results, thus suggesting that these measures were indeed reliable and valid.

The present study has provided useful information for the development of new Dutch educational campaigns dealing with the issue of AIDS stigma. The moderately positive representation of people with HIV/AIDS in the Netherlands, seems to require a two-way AIDS educational approach. On the one hand, mass-media campaigns could be used to maintain (or improve) moderately positive public reactions to people with HIV/AIDS. Among other things, these AIDS educational campaigns should reinforce knowledge about HIV transmission through casual contact. Negative reactions towards persons with HIV/AIDS may recur if knowledge about HIV transmission declines, as suggested by the negative influence of risk perceptions on people's willingness to have contact with people with HIV/AIDS. However, our results indicate that these mass-media campaigns should also focus on ways to intensify people's involvement with HIV/AIDS and increase feelings of compassion for people with HIV/AIDS. In addition to AIDS educational activities aimed at the population in general, it may be useful to develop and execute specific stigma-reduction interventions. These interventions should be aimed mainly at situations where people with HIV/AIDS experience unsupportive or stigmatizing reactions (for example, at the workplace). Our analysis of willingness to have personal contact with people with HIV/AIDS indicates that these interventions should be particularly targeted at lower-educated and older people, and must address, among other things, people's knowledge about HIV transmission in everyday contact.

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## Footnotes

1. There were no gender differences with respect to knowledge about HAART.
2. There were gender differences on the mean scores of a number of cognitive, emotional and behavioral reactions towards persons with HIV/AIDS. Men reported stronger blaming, a less positive attitude towards homosexuals, less pity, more anger and less willingness to have personal contact with someone with HIV/AIDS, in comparison with women. In this study, however, we focussed on the contribution of cognitive and emotional factors on willingness to have personal contact with persons with HIV/AIDS. Although men and women differ in their reported level of cognitive, emotional and behavioral reactions, cognitive and emotional factors contribute to willingness to have personal contact with someone with HIV/AIDS in a similar way for men and women. In other words, gender does not moderate the influence of our cognitive and emotional predictors on willingness to have personal contact with someone with HIV/AIDS.

Table 1

Mean scores on cognitive, emotional and behavioral reactions to people with HIV/AIDS as a function of knowledge about HAART

	Knowledge about HAART		T-value
	No	Yes	
Risk perceptions	1.19	1.12	2.70**
Blaming	1.71	1.62	1.75
Attitude towards homosexuals	3.66	3.83	1.99*
Fear	1.34	1.25	2.40*
Pity	2.30	2.30	0.15
Anger	1.42	1.36	1.30
Willingness to engage in personal contact	2.96	3.25	6.88***

Note \*  $p < .05$ , \*\*  $p < .01$ , \*\*\*  $p < .001$

Table 2

Intercorrelations and descriptive statistics for risk perceptions, blaming, attitude towards homosexuals and emotional factors

	<u>M</u>	<u>SD</u>	<u>N</u>	<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>	<u>6</u>
1. Risk perceptions	1.16	.33	690	-	.08	-.22**	.23**	-.10	.16**
2. Blaming	1.67	.67	745		-	-.22**	.03	-.15**	.12*
3. Attitude towards homosexuals	3.72	1.15	745			-	-.09	.21**	-.08
4. Fear	1.31	.56	749				-	.13**	.23**
5. Pity	2.30	.66	741					-	.02
6. Anger	1.39	.64	738						-

Note \*  $p < .01$ , two-tailed. \*\*  $p < .001$ , two-tailed

Table 3

Determinants of willingness to have personal contact with people with HIV/AIDS

<u>Predictors</u>	<u>Regression equation</u>		
	1	2	3
Risk perceptions	-.37***		-.29***
Blaming	-.17***		-.12***
Attitude towards homosexuals	.23***		.20***
Fear		-.18***	-.10**
Pity		.16***	.05
Anger		-.11**	-.06
Gender			.02
Age			-.08*
Level of education			.16***
R <sup>2</sup>	.28	.07	.32
Model F	85.41***	18.51***	32.71***
N	668	708	651

Note \*  $p < .05$ , two-tailed. \*\*  $p < .01$ , two-tailed. \*\*\*  $p < .001$ , two-tailed. Coefficients are standardized regression weights (Betas).

Figure Caption

Figure 1. Mean scores on compassion for persons suffering from AIDS, cancer, cardiovascular diseases and asthma.