# AIDS IN BRITAIN AND SOUTH AFRICA:

# A THEORY OF INTER-GROUP BLAME

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## ABSTRACT

Inter-group blame for AIDS has been documented across a myriad of cultures. The dynamics of the blame have not been systematically theorised. A cross-cultural study of social representations of AIDS in South Africa and in Britain was used to forge a theory of inter-group blame.

Semi-structured, depth interviews were carried out with sixty young, educated, urban South African and British lay men and women. In both cultures ten white heterosexuals, ten black heterosexuals and ten homosexuals (white and black; a number with HIV/AIDS) were interviewed. Textbase Alpha and SPSS-PC were used to analyse the data. Elements of the social context were content analysed: South African and British Government AIDS campaigns and policy-maker discourse.

A similar **process** of inter-group blame was found in the two cultures: Social representations placed responsibility for the origin and spread of AIDS with out-groups. Groups who were blamed for AIDS by hegemonic thinking held themselves responsible for AIDS. The **content** of the blaming aspersions in the two cultures differed: While colonial, family-centred and individualistic ideologies circulated in both cultures, social representations of AIDS were also infused with Apartheid-linked ideologies in South Africa and with conspiracy theories in Britain. The British data was characterised by high levels of reflexivity concerning AIDS-related blame. The cross-cultural tendency to project blame for AIDS onto others is determined by psycho-dynamic forces. However, historical and ideological forces shape who is blamed and who internalises the blame for AIDS.

Inter-group blame had negative consequences for both the 'blamers' and the 'blamed'. The former felt invulnerable to AIDS. The latter internalised the blame emerging with spoiled identities. The thesis concludes with a set of proposals for modifying the pattern of inter-group blame through mass mediated AIDS campaigns.

To my mother and father

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**ACKNOWLEDGEMENTS**

I would like to thank my supervisor Rob Farr, as well as Patrick Humphreys, for their inspiration, guidance and support. I am also most grateful to my caring parents and to my friends in the Department of Social Psychology at London School of Economics, especially Angela Stathopoulou and Vanessa Cragoe.

This research was made possible by the Minnie Mitchelson Goodall Postgraduate Research Studentship [London University], an Overseas Research Studentship, a London School of Economics Graduate Studentship, and a Tregaskis Bequest.

## GLOSSARY

| | | |
|---|---|---|
| AIDS | = | Acquired Immune Deficiency Syndrome |
| DHSS | = | Department of Health and Social Security, Britain |
| GRID | = | Gay Related Immune Deficiency |
| HEA | = | Health Education Authority, Britain |
| HEC | = | Health Education Council, Britain |
| HIV | = | Human Immuno-deficiency Virus |
| KAP | = | Knowledge, attitudes and practices |
| NAAG | = | National AIDS Advisory Group, South Africa |
| NGO | = | Non-government organisation |
| PWA | = | Person with AIDS |
| STD | = | Sexually transmitted disease |
| THT | = | Terence Higgins Trust |

## OVERVIEW OF CHAPTER ONE

I introduce the reader to the various components of the overall theoretical orientation I adopt. Social representations of AIDS are formed through an interaction of the worlds of science, the mass media and lay thinking. Inter-group blame has been a central factor in thought and talk concerning AIDS since its onset. Certain marginalised groups tend to bear the brunt of the blame. However, when such groups become empowered, they are able to influence dominant thinking in relation to AIDS. Social representational theory is highly appropriate for the examination of the link between AIDS and blame. Yet issues of power are not traditionally deemed central within this approach. This thesis emphasises the role of unconscious forces, including ideology, in the formation of social representations of AIDS. A theory of inter-group blame must take heed of unconscious forces.

# CHAPTER ONE: INTRODUCTION

## 1.1 THE AIM OF THE THESIS

This thesis aims to explore the workings of inter-group blame at a time when a society is faced with a mass crisis, such as AIDS. It examines the process and content of inter-group blame, related to AIDS, in South Africa and in Britain. The hypotheses of the thesis are presented at the end of Chapter Four, following a review of relevant work in the area to date. The *raison d'être* of this thesis is to modify the consequences of inter-group blame: Scapegoating, stigmatisation, spoiled-identity and feelings of invulnerability amongst people who, as a result of such feelings, render themselves more vulnerable to contracting HIV.

## 1.2 THE THEORETICAL BASE OF THE THESIS

In order to understand the explanations which circulate in a given society when a mass crisis strikes, I draw on three disciplines:

- Social Psychology: The theories of social representation, inter-group relations and rhetorical social psychology are used in a complementary fashion.
- Psycho-dynamic theory: The British psycho-dynamic tradition of object relations is used in conjunction with psycho-dynamic representational theory, typified by the work of Sander Gilman.
- Political theory: A structuralist notion of ideology and of power relations and their socio-historical construction is used.

In this chapter the social representational angle of the thesis is developed and the ideological position introduced. In Chapters Three, Four and Five the other theoretical stances are explicated.

## 1.3 AIDS: A CLASSIC EXAMPLE OF INTER-GROUP BLAME

Talk about AIDS represents a particularly interesting example of inter-group blame:

> "The rhetoric of blame is most evident today in the discourse on the causes of diseases such as AIDS or cancer, while historically it appeared in discussions of leprosy, syphilis, or plague" (Nelkin & Gilman, 1988:363).

The earliest account of people who contracted the symptoms of what was later termed AIDS was reported in the American journal **Morbidity and Mortality Weekly** on 5 June 1981. This set of symptoms was referred to as Gay Related Immune Deficiency (GRID) because the symptom-holders were all homosexual. The name of the syndrome was changed when these symptoms became evident in non-homosexual people. In 1983 Acquired Immune Deficiency Syndrome (AIDS) was found to be produced by the Human Immuno-deficiency Virus (HIV) which destroys the body's white blood cells. These cells usually protect the immunity of the body to infection. Thus HIV makes the body vulnerable to infection. The two most common illnesses associated with AIDS are an unusual form of cancer (Kaposi Sarcoma) and an uncommon infection of the lungs (Pneumocystis Carini Pneumonia). It is believed that HIV eventually develops into AIDS in all carriers and that AIDS results in death. An antidote to HIV has not, as yet, been found. Concern about the scale of the pandemic lies not only in the fact that millions, worldwide, are known to have the virus, but also in the fact that it is not known how many additional people carry the virus. There is a period of infectivity, lasting months

or years, in people who may be unaware that they are carrying the virus.

Herzlich and Pierret (1987) show that, while medical debates are rooted in sophisticated epidemiological models, they draw upon observations of collective thinking in the society at large. The fact that medics initially used the word 'gay' in the name of an illness related to immune deficiency indicates that medics draw on terms and concepts from the lay world. Inter-group blame stems from an interaction of the medical, mass media and lay representations of AIDS.

The death of the first British person with AIDS occurred in 1982. The illness received "canonical coverage in the news media and scientific journals" (Vass, 1986). A cycle of panic was set up between medics, journalists, and the public in relation to what was known, in 1983, as the 'killer disease' which, by 1985, had been transformed into the 'gay plague' (Vass, 1986). Wellings (1988a) states that:

> "Before the Equality Council of the National Union of Journalists (NUJ) issued guidance on the reporting of AIDS in 1984 AIDS was virtually synonymous with the term 'gay plague' in national press reportage in Britain" (p.84).

Pinching (1990) supports this idea. The nature of the interaction between the worlds of science, lay people and the mass media forms a motif which recurs throughout the thesis.

While people within the three worlds draw upon similar modes of thinking, there are differences of degree. Contemporary scientific explanations are based upon a belief in cause and effect and upon the probability that an effect is related to a given cause. Lay people's explanations overestimate certainty and consistency. An easy progression is made from description and classification to explanation in lay peoples' construction of an

event. Various sections of the mass media seem more aligned to the lay view of events, while others align themselves with the more cautious scientific perspective.

## 1.4 OLDER IDEAS ABOUT ILLNESS: GAY PLAGUE

Vass (1986) shows that early mass media descriptions of AIDS drew upon images of war and of mass illness. Journalists were making public a set of highly-charged thoughts that reflected memories of past scourges. The first great plague, of which many Western Europeans are aware, is the Black Death which began in the fourteenth century and claimed 26 million lives over the four centuries in which it prevailed (Herzlich & Pierret, 1987).

Halbwachs (1950) offers a phenomenological explanation for the interpretation of illness in the light of collective memory. When new events are encountered individuals draw on ideas and ways of thinking that originate within the groups with which they identify. In the foreground of the memory of these group members are remembrances of concern to the greatest number of people. Grandparents leave their historical stamp on parents who, in their turn, pass it on to their children. Collective memory extends as far back as the groups comprising a particular society and circulates continually.

> "Our agreement with those about us is so complete that we vibrate in unison, ignorant of the real source of the vibrations. How often do we present as deeply held convictions, thoughts borrowed from a newspaper, book or conversation" (Halbwachs, 1950:44).

Collective, deeply held images of earlier, incurable, large scale illnesses became alive in people's minds when news of an acquired immune deficiency syndrome reached the public. They had been kept alive not only by the family but by institutions in the broader society, such as the church. These images entered people's consciousness under the

acronym 'AIDS'. Collective memories, myths, fantasies and social stereotypes dating from ancient plagues live on in this word.

## 1.5 NEWER IDEAS ABOUT ILLNESS: RESPONSIBILITY AND CHOICE

Billig (1987) points out that if a theory appears to be plausible, it pays to reverse it for the reverse will also be plausible. In the same way that collective memory influences the way in which a new crisis is perceived in a society, so current thinking must influence this perception. Incurable mass diseases permit both the perpetuation of old disease myths, and the creation of new myths in both the medical and lay worlds (Herzlich & Pierret, 1987).

The 'new myth' which surrounds disease is that of responsibility or choice. In the Europe of the 1980s the emphasis has been upon appealing to people to assume responsibility for their own health and upon motivating them to modify their behaviour and habits (Herzlich & Pierret, 1987). This stands in stark contrast to an idea that the effects of a plague are inevitable.

For over a century, Europeans have assumed that "the individual is the best judge of his own welfare, and that the aggregate of individual actions produces the optimal collective welfare" (Hardin & Baden, 1977:X). Consequently "extreme forms of individualism become the norm" (p.XII). Mass mediated AIDS campaigns tend to reflect and feed the ideology of individualism: Governments advocate changes in individual behaviour in the hope of curbing the spread of HIV.

I will draw on the multi-media campaign, launched by the British Department of Health and Social Security (DHSS) in Britain, in March 1986, in order to illustrate this point. The campaign was introduced as an attempt to alleviate pressures engendered by medical debates, the press and lay conversations (as will be elaborated upon in Chapter Two). The earliest phase of the campaign (March 1986 - January 1987) was characterised by the following slogans: 'DON'T AID AIDS'; 'DON'T DIE OF IGNORANCE'. The large scale scientific survey, conducted for the DHSS by a private market research company a year into the campaign, found that:

> "There is considerable evidence from these surveys that major progress has been made over the year in terms of the objectives of the Government's publicity campaign to increase awareness and knowledge, to change attitudes and thereby modify behaviour" (DHSS, 1987:13).

Despite the increase in the knowledge of heterosexuals, "no evidence of changes in the past year was found in relation to direct questions on behaviour" (p.19) and there was an "increase in feelings that AIDS sufferers 'only have themselves to blame'" (p.19). So a campaign based on a rationale that knowledge and attitude changes result in desired behavioural change, in fact, sets up a cycle of blame. The messages of the early campaign - epitomised by their slogans - allowed people to associate AIDS with the behavioural choices of ignorant individuals. This has at least two consequences: the vitiation of bad treatment of people with AIDS (PWAs); feelings of invulnerability for individuals and for their in-group.

The model which has been adopted internationally, which relates knowledge and attitude change to desired behaviour change, is inadequate. The knowledge and attitude changes proposed by Government AIDS campaigns are filtered, by the people who see the campaigns, through certain prisms. These prisms contain culturally conditioned

representations of one's own and other groups in one's society, and unconscious fantasy material. Appeals to change knowledge and attitudes, once filtered through these prisms, often have little impact. (These issues will be developed in Chapters Two, Three and Four.)

## 1.6 BLAME IS COMMON TO BOTH OLDER AND NEWER CONCEPTUALISATIONS OF ILLNESS

From the fourteenth century onwards, when the Christian faith held a place of paramount importance in Western Europe, the cause of the Black Death was explained as God's wrath for humankind's sins. This idea pervaded not only the thoughts of the masses but also those of the medical profession itself. Doctors held a belief that medicine begins with purification of the soul (Herzlich & Pierret, 1987). While the belief that God causes illness persists from early Christian times, the linking of this to the inherently sinful nature of humankind has given way, in the modern world, to the idea that illness is God's or nature's punishment of the individual who commits a sin out of choice (Sontag, 1979; Herzlich & Pierret, 1987). This reflects the dominance of the ideology of individualism in the present epoch.

Initially, AIDS was seen to result not from widespread human sin, as was the case in the Black Death, but from the sins of a segment of the population: God's wrath in the face of homosexuality as a contravention of 'nature'. National newspaper headlines, such as 'Virus victims swirling in a cesspit of their own making' (cited in Markova & Wilkie, 1987), based upon the proclamation of a senior police officer, are a testimony to this point. Whilst AIDS is ostensibly the killer, the homosexual person is, in reality, held responsible for the 'plague's' creation. The ease with which the patient rather than the

illness is made culpable is a result of a profoundly individualistic ideology. This concept is developed in Chapters Two, Three and Four.

Despite the fact that plagues, historically, have been seen to be meted out by a wrathful God, human culprits have been found and punished, in the hope of preventing future ills. In the face of such formidable threats, people have needed to find explanations for the involvement of both themselves and others in such events. The attribution of cause, throughout the ages, has served the psychological and social function of providing solutions to society's problems, of 'cleansing society of its ills' (Moscovici & Hewstone, 1983).

## 1.7 ILLNESS AS A MORALITY TALE

The illness which comes to dominate a society's conceptualisation of illness in each epoch acts as a social commentary on dominant thoughts and conflicts of that epoch (Sontag, 1979). AIDS, in its still short history, already dominates many societies' conceptualisations of illness, worldwide.

Illness is a social phenomenon. It has always been used as a metaphor to enliven the charge that certain sectors of society are corrupt (Sontag, 1979).

> "AIDS is a litmus test for detecting fundamental ideological cleavages and conflicts...AIDS sheds intense light on the possibility of linkages between biological and social phenomena" (Herzlich & Pierret, 1989:1241).

Social groups have a stock of scapegoats when events become threatening to them. This is a product of historically created antagonisms and social stereotypes. There may be a

real link between these scapegoats and the threatening event, as with AIDS first manifesting in male homosexuals in the West. On the other hand, there may be no real connection between the scapegoats and the threatening event (as will be explained in Chapter Three). Historically, those who are scapegoated or blamed for large scale illnesses are imagined to practise aberrant sexuality and mystifying rituals (Cohn, 1976; Gilman, 1985). Those with whom perverse sexuality and rituals are widely associated tend to be from marginalised groups who lack power in their societies. This allows certain negative ideas concerning such groups to gain legitimacy.

Powerful ideologies such as those of racism and of homophobia provide the metaphors in which AIDS is couched. These metaphors or social representations can only be challenged once those with a different ideological base gain a voice in the society. This principle is brought to light by the status which the African has come to hold as originator and perpetrator of HIV/AIDS. Africans and Haitians in far-off lands are unable to influence Western social representations concerning the origin of HIV. Consequently, the transfer of HIV from Africa's Green monkeys to its humans is widely believed to be the originator of AIDS despite inconclusive scientific evidence. Chirimuuta and Chirimuuta (1987) argue that the African epidemic post-dated the American epidemic. Whereas there were no allusions to Africa, Africans or travel abroad in the earliest account of AIDS (**Morbidity and Mortality Report, 1981**), the earliest report of AIDS in African medical literature (**East African Medical Journal**, September 1984) was of a Ugandan journalist who had been based in West Germany, London and Nairobi over the years preceding the report (Chirimuuta & Chirimuuta, 1987). Chirimuuta and Chirimuuta (1987; 1989) argue that, while HIV may well have transferred from monkeys to humans, this may have

occurred in a Western research laboratory. There is evidence that laboratories have increased their use of monkeys in recent years. There is no evidence that Africans have changed their pattern of contact with monkeys.

## 1.8 THE MORALITY TALE IS UNDERMINED BY THE HOMOSEXUAL VOICE

Dominant social representations of illness were not substantially challenged by the ill groups, in the past. Plagues struck so fast that sufferers did not remain alive for long enough to have a chance to be heard (Herzlich & Pierret, 1987). In contrast to this, AIDS tends to develop a number of years after HIV enters the body. Mass illnesses seldom strike heterogenous, politically organised groups. The majority of people presently affected by AIDS in the Western world are homosexuals. In the 1970s, many homosexual people organised themselves into various gay rights movements, created a gay press, and were instrumental in abolishing repressive sexual legislation (Weeks, 1977). Homosexuals instigated the fight against the spread of AIDS in Britain, disseminating information and setting up help-lines prior to any Government initiatives. Thus the sufferers of the AIDS 'plague' had unprecedented power. This helped to set up a dynamic relationship between the gay movement and the Government in the creation of a campaign strategy, and has given people with AIDS a voice in this campaign. This voice has been so vociferous that a parliamentary session (16 November 1990) and spate of newspaper articles ("AIDS: The facts" **The Sun**, 17 November 1989; "Daily Mail Comment", **Daily Mail**, 17 November 1989) accused the Government of creating a misdirected campaign in its attempt not to offend homosexuals.

The dynamic relationship between the Government and the gay community can be traced

by looking at this community's influence on the campaign. Firstly, the Government leaflet, distributed to all British households in January 1987, stated that more detailed information was available from, among other organisations, London Lesbian and Gay Switchboard. Secondly, the explicit nature of leaflets produced by gay groups has influenced the Government's campaigns. Gay information leaflets have always talked to PWAs and potential PWAs in a lingo to which they relate, using words such as 'wank' where Government information referred to masturbation, and have casually and explicitly referred to the different types of adult sexual activity. Where early Government campaigns talked of 'rectal sex', later campaigns state: "anal intercourse (when the penis enters the rectum or back passage) may be particularly risky". The discourse of the Government campaign has shifted towards the method of communication initiated by gay groups. Whether the gay community has influenced the process of inter-group blame remains to be looked at empirically.

## 1.9 SOCIAL REPRESENTATION

Social representational theory seems like the perfect starting point for enunciating the relationship between the medical, mass media and lay ideas which relate AIDS to blame. It allows one to explain reactions to a phenomenon, such as mass illness, both in terms of historical and contemporary values.

The French school of social representations holds people's commonsense thoughts, their theories about key aspects of society as its central focus (Moscovici & Hewstone, 1983). It believes that social psychology "has the task of studying the problems of our times and of dealing with them in their historical dimension" (Moscovici, 1987:523). Social

knowledge does not transcend its historical boundaries (Gergen, 1973). It views social psychology, optimally, as a science of culture or an 'anthropology of the modern world' (Moscovici, 1981). In conceiving of social psychology as aligned to anthropology and history one gains a relativist perspective: Beliefs about the world differ from one historical epoch to the next, from culture to culture. This is best illustrated through a study of multiple cultures.

> "Analysis of social representations must by definition be comparative: it involves comparison between groups, comparison between cultures, and comparison between mentalities and ideologies" (Moscovici, 1982:146).

Analysis of social representations does not involve finding universal laws of human functioning which operate regardless of the socio-historical context. In adopting a relativist perspective one holds important the explanations of both the blamers and the blamed. Past studies on blame tend to accentuate the split between its victims and its perpetrators. Perpetrators tend to be middle-class, hegemonic groups and victims, the socially marginalised. While this thesis explores blame from multiple perspectives, it recognises that the social representations of hegemonic groups influence institutions in the society far more than other perspectives do.

The central concept of this thesis - inter-group blame - has been viewed from a variety of perspectives in the history of psychology. In the 1940s and 1950s prejudice or blame was related to the internal structure of the individual. Psycho-dynamically motivated theories, such as those of Adorno, Frenkel-Brunswick, Levison and Sanford (1950), Rokeach (1960) and Berkowitz (1962), dwelt upon the fact that the manner in which individuals are raised determines their dogmatism, aggression or tendency towards

prejudice. The work of Adorno *et al.* (1950) and Berkowitz (1962) is illustrative of the point that certain individuals are 'suggestible' to certain ideas rather than to other ideas. This selective credulity is determined by unconscious forces.

Allport's classic work *The Nature of Prejudice* (1958) adopts the idea that certain individuals are prejudiced and others are not. He relates this to the different cognitive processes of prejudiced and of tolerant people rather than to unconscious forces. However, Allport's book also introduces the idea that all people have a normal and natural propensity to form categorisations and generalisations. Prejudice, in Allport's terms, is a natural by-product of thought (Billig, 1985).

In the 1950s and 1960s Tajfel extended the idea that there is a natural tendency among all people to form generalisations as a way of simplifying an otherwise complex universe. The trend was away from biological explanations such as the frustration-aggression hypothesis (eg. Miller & Dollard, 1941), to purely cognitive models. Coupled with an ethnocentric bias (which means that the in-group is regarded in a more positive light than the out-group), prejudice or blame of other groups was regarded as inherent to human thinking. Attributional theory corroborated these findings at the inter-personal level.

The 'prejudice is natural' theories of Allport, Tajfel and those which developed from them, are problematic in that, as Billig (1987) puts it:

> "If prejudice, or stereotyping, is the outgrowth of normal thought processes, then one can ask how, on this logic, is it possible to have tolerant thoughts" (p.126).

Tolerant thinking or open-mindedness have little chance of arising if people have a

'natural' propensity towards simplification and, therefore, towards stereotyping.

A more general problem contained in the theories of prejudice is that situational factors are absent. Pettigrew (1958) found that prejudice is determined by the socio-cultural norms of dominant groups. Inner causes are less related to the atrocities of Apartheid or the holocaust than are dehumanising ideologies. Prejudiced responses are ideologically imposed by certain societies and are given credence when they are institutionalised by way of law.

This thesis proposes that, while certain individuals are more prone to blame, due to a number of developmental issues, social or external factors activate or constrain blaming tendencies. Mass phenomena such as mass hysteria and mass blame are social facts. Yet there are obviously individual differences within the 'masses'. In forming a hybrid between external and internal forces I dispense with the notion of 'prejudice', which has been associated with an internal structure, and adopt the notion of inter-group blame. I realise that there is a qualitative difference between certain aspects of prejudice and of blame. Blame tends to be triggered by a crisis event, whereas prejudicial thinking forms a more continuous under-current in a society. However, the two concepts overlap in many respects. I return to this issue in Chapter Eleven.

Expressions of inter-group blame can best be explored by way of a social representational theory because the theory is not associated with internal structures. Research in social psychology has generally been within the domains of image, opinion, attitude, belief and personal construct theory. In psychology's emergence from the philosophy of the

sixteenth and seventeenth centuries, psychology came to be based upon an individualist epistemology. The domains which social psychology studies tend to be viewed as static, individual, dispositional states rather than as the dynamic products of social relations. In conceiving of social psychology as aligned to anthropology and history, social representational theory is released from the individualist perspective which dominates social psychology.

The term 'social representation' refers to two things. Firstly, it refers to an abstract category which classifies the **content** of people's ideas about a phenomenon, such as AIDS. Secondly, it refers to a theory concerned with the **process** by which these ideas are shaped.

### 1.9.1 SOCIAL REPRESENTATION: THE CONTENT AND THE PROCESS BY WHICH IDEAS ARE SHAPED

The abstract category 'social representation' refers to socially conditioned ways of understanding the everyday world: People's common-sense thoughts (Wells, 1987).

#### 1.9.1.1 Influence of the sociology of knowledge

The origin of the theory of the content and process of social representation can be found within the work of the fathers of the sociology of knowledge: Weber, Mannheim and Durkheim. Their theories pivot around the assumption that social existence determines consciousness. The sociology of knowledge is characterised by its exploration of the relationship between human thought and the social structures of the particular societies in which those thoughts arise. According to Durkheim (1951, quoted in Deutscher):

> "Simultaneously each one of us has a double impulse. We are drawn in a social direction and tend to follow the inclination of our natures...Two antagonistic forces confront each other. One, the collective force, tries to take possession of the individual, the other, the individual force repulses it" (Deutscher, 1984:79).

This double impulse is central to this thesis. It informs my basic idea that one requires both a theory of ideology and of how the individual comes to draw on these ideologies if one is to truly explain the phenomenon of inter-group blame.

### 1.9.1.2 Contemporary explanatory systems

In the past it was possible to conceptualise humans' explanatory systems in terms of a narrow band of doctrines. Institutions such as the church informed people's thinking about events in their societies. Contemporary institutions differ from the preceding social order in respect of their dynamism and the degree to which they undermine traditions. The period of late modernity is characterised by the disintegration of the power of what were the central institutions and of their doctrines (Giddens, 1991). People are now much more diverse in terms of their ways of thinking.

Social representations theory is based on the idea that there are both central doctrines in the thinking of a set of people within a given society, and that people are able to create new ideas (and to challenge central doctrines). So it is compatible with structuralist theories of ideology, but emphasises a potential for new and dynamic thoughts to arise.

### 1.9.1.3 How social representations are shaped

Social representations originate in the sciences:

> "We take the *transformation* of scientific knowledge to be a fundamental aspect of common sense. Its importance for any theory of explanations was

> shown in the first social representational study (Moscovici, 1961), on how ideas about psychoanalysis have seeped into French society. Individuals assimilate such knowledge (eg. the term 'complex') and use it as a basis for explaining their own and other people's behaviour" (Moscovici & Hewstone, 1983:99).

Scientific knowledge is assimilated primarily by way of the mass media:

> "The revolution in communication has allowed the diffusion of images, notions and vocabularies that science keeps inventing. They become an integral part of the intellectual baggage of the lay person. Everyone today has a more or less vague notion of economic theories, unemployment, inflation, psychological conceptions of neurosis and so forth" (Moscovici & Hewstone, 1983:104).

The 'intellectual baggage' of lay people, in turn, influences the thinking in science and in the mass media. This thesis stresses the fact that the world of science is influenced by the same forces as the lay world. This issue is contentious within the social representational literature. It is discussed in Chapter Eleven.

#### 1.9.1.4 Anchoring

People use various mechanisms in order to absorb new ideas which are conveyed to them. I will focus upon the mechanisms which mould new ideas (for example, those presented by the media) to fit into people's pre-existing set of ideas. Moscovici has termed this mechanism anchoring. All three worlds - that of science, the mass media and lay thinking - are subject to the forces of anchoring.

Unfamiliar concepts are assimilated to more familiar concepts. New phenomena are compared and interpreted in the light of phenomena which the individual already understands. Anchoring, essentially a process of categorisation, is an attempt on the part of the individual to compare the new and the old. The individual's understanding of a new phenomenon is limited by the stock of older social representations. People impose the

historical dimension of phenomena onto new phenomena. Social representations give novel experiences meaning by anchoring them to familiar experiences.

Images from the past remain impressed on the culture and colour the representations that evolve at a later date. Older systems of representation provide insight into forces that shape the present (Gilman, 1985). This can be illustrated by way of two examples. The Black Death or bubonic plague coloured early representations of AIDS. It was dubbed the 'gay plague' from the start. Like the bubonic plague, inter-group blame has been one of the major forces that shape reactions to the 'gay plague'. A further anchor for AIDS was 'sexually transmitted disease (STD)' rather than 'virus'. Nelkin and Gilman (1988) state that from 1981 the syndrome that was later termed AIDS was labelled in professional reports and in the popular press in terms of an STD rather than a virus. Reactions to AIDS would be characterised by the moral censure with which STDs tend to be viewed.

Why do people anchor? Humans have a deep-seated fear of that which is strange because it threatens their established sense of order and their mastery of the world. People therefore anchor strange or unfamiliar phenomena to others with which they are more familiar. Understanding new phenomena is limited by the current stock of older social representations, but the latter do not necessarily dictate the nature of the former. In comparing the new phenomenon to older phenomena, people also differentiate the new from the old. It is important to emphasise that people are not only anchored to social knowledge but are thinking individuals too (Billig, 1991).

Paradoxically, Moscovici's combination of a historically determinist and a non-determinist

view of reality is the most helpful feature of his work. On the one hand "social thinking owes more to convention and memory than to reason; to traditional structures rather than to current intellectual and perceptive structures" (Moscovici, 1984:26). The tension between the unfamiliar and the familiar is always settled in the direction of the familiar. Anchoring and classification have the consequence that those who speak and those who are spoken of are forced into an identity matrix they have not chosen and over which they have no control (Moscovici, 1984). On the other hand, people actively and spontaneously concoct and communicate thoughts: "Events, sciences and ideologies simply provide them with the food for thought" (Moscovici, 1984:16).

#### 1.9.1.5 Objectification

The thought process of objectifying allows people to form concrete realities out of ineffable phenomena. It bridges the gap between a phenomenon and an abstract representation of the phenomenon. Lay people need a concrete representation of a phenomenon which might originate in a reified field such as medicine if they are to understand how it operates. A single image summarises a complex concept. Objectification occurs in relation to place: AIDS is synonymous with Africa in British social representations (Kitzinger & Miller, 1991).

Objectification is functional in that people are enabled to talk about the new phenomenon once it has been objectified. Talking about the new phenomenon enhances people's understanding of it. An objectified concept is able to circulate in the realm of mutually understood conversation.

### 1.9.2 FUNCTIONS OF SOCIAL REPRESENTATION

> "The purpose of all representations is to make something unfamiliar, or unfamiliarity itself, familiar" (Moscovici, 1984:24).

The desire for a sense of control underpins this need to make unfamiliarity familiar. People form social representations, by way of anchoring and objectification, in order to experience control in relation to their everyday worlds. Continuity is affirmed at a time when it has been threatened by the arrival of a new phenomenon such as AIDS. Once a social object has been represented, it becomes less fearsome. New social representations are most likely to arise at a time of crisis.

A further function of the social representation is to permit communication in a society. Communication becomes possible because of shared codes of understanding, based on certain anchors and on certain objectifications, that circulate within a given society. They are propagated by the mass media. Shared social representations, created by way of anchoring and objectification, allow for some degree of consensus in relation to such highly complex issues as HIV transmission or the origin of AIDS. This consensus is reached by way of the countless interactions which people have with one another and with societal institutions.

## 1.10 METHODOLOGICAL CONSEQUENCES OF A THEORY OF SOCIAL REPRESENTATION

Most British and American social psychology ignores the content of the media and of other societal institutions. The strength of social representation theory is that it treats seriously both the contents of the media and of other societal institutions, as well as the contents of individual minds. A plethora of literature disputes the power of the media to

affect people's thinking in a chosen direction. Once the direct relationship between the media and people's thoughts has been challenged, one cannot choose either media or the individual's mind as a way of gauging social representations of AIDS. One has to sample both the thinking of people who operate within these institutions and lay thinking in order to evaluate the workings of phenomena such as inter-group blame.

Socially-based ideas are both exterior and interior to the individual. Exterior cues, such as those in the media, feed the individual's cognition. At the same time, individual cognition shapes the exterior world.

> "To form a representation of something is to apprehend stimulus and response at one and the same time. The response is not a reaction to the stimulus, but, up to a point, constitutes the origin of the stimulus" (Moscovici, 1973: XII).

The media, for example, must speak to the individual's system of meaning, if it is to be understood. If one content analyses either the mass media or lay thought alone, one creates a fictitious abstraction. One needs to sample both. The transformations that occur between the two are the concern of the social representational approach.

Past and present Government AIDS campaigns are an appropriate point of entry into AIDS-related thinking within certain institutions. In order to understand the intentions behind such campaigns one also needs to look at the social representations which AIDS policy-makers wish to convey.

Ideas conveyed by the media are not necessarily absorbed by its audience. A range of filters intervene between the messages which people receive and their thought processes connected to such messages. The contents of such filters can be seen when one analyses

people's social representations. Social representations often mask the unconscious ideas (eg. ideologies or fantasy material) which people hold about various issues. The social representation that homosexuality is perverse, for example, is underpinned by unconscious ideologies and fears that homosexuals have a missionary zeal for converting others to their ways and that the human species is threatened by their activities. The social representation that promiscuity is wrong seems to be underpinned by a similar set of unconscious ideologies and fears. Marriage and the sanctity of the nuclear family are undermined by non-monogamous practices.

## 1.11 INJECTING A CONCEPT OF IDEOLOGY INTO SOCIAL REPRESENTATION THEORY

Social representation theory draws the idea that social existence determines consciousness from the sociology of knowledge. However, social representation theory has not been centrally concerned with power issues which exist in the social world. This thesis is centrally concerned with the influence of power on the way in which certain groups are treated at a time when a society finds itself in crisis. I draw on the work of certain structuralists, which is largely compatible with a social representational approach, in order to address issues of power and ideology.

Ideology is construed as:

> "A socially and culturally constructed way of seeing, interpreting, and evaluating some aspect of the physical and social world and the relation of the self to those worlds" (Crawford, 1980:367).

Ideologies are patterns of belief in a society which partly determine the nature of social representations and which reproduce power relations. The operation of ideology is manifest in the fact that certain meanings of a phenomenon such as AIDS are preferred

over others. As a consequence of ideology some people remain dominant and others subordinate within the society (Thompson, 1984). Ideology takes its power chiefly from the fact that it is based on beliefs which are outside of conscious awareness (Thompson, 1984). Ideological statements are made by individuals, but ideologies are not a product of individual consciousness or intention (Hall, 1981). The ideological component of thinking is an unconscious component (Heck, 1980). Ideology underpins people's thinking but it is difficult to tap.

Certain groups have hegemony in relation to the social representations which become dominant or shared by most people and societal institutions. The phrase 'cultural hegemony' is associated with Gramsci. It signifies the dominance of a single group in shaping the prevailing world view which gives a people an interpretation of the age.

Like the social representationalists, structuralists such as Barthes (1968) stress that structures of meaning are produced within a particular society, class, or period of history. However, for Barthes, 'deciding groups' rather than a consensual mass, determine the structures of meaning. Structures of meaning are coercive in nature and militate against people developing autonomous and creative thoughts. The media's incessant bombardment of people with certain social representations induces people to think in terms of automatic ideological equations which reduce effective cognitive mediation. Barthes maintains that it is in the interests of certain groups, in each society, that people make these equations. The structuralist perspective stresses the coercive nature of social representations, whereas conventional social representational theory is less concerned with the hegemony of certain cultural assumptions or ideologies.

By studying the way in which people talk about AIDS in two cultures - British and South African - the influence of hegemonic ideologies on social representations of AIDS will become obvious. One cannot study the blame process without studying historical and contemporary ideas concerning the crisis event which has evoked the blame. Therefore, a substantial portion of this thesis looks at the historical and social contexts in which British and South African social representations are formed. By examining the historical and cultural origin of a phenomenon, we see that representations of that phenomena are related to socio-historical, as opposed to 'natural' or inevitable, forces. The concept of ideology is further developed in Chapter Five.

## 1.12 CONCLUSION

An inter-disciplinary approach to inter-group blame becomes necessary once history and culture have been deemed central variables. The social cognition approaches (for example, attributional or social identity theory), which could be adopted to explore inter-group blame, are not sufficiently inclusive of these variables. They view individuals as the seat of psychic reality. Other levels, such as the group level of psychic reality, are deemed to be derivative (Moscovici, 1982). I would like to give primacy to the social and cultural factors in the formation of lay thinking. Unlike the social cognition approaches, the theory of inter-group blame which I hope to forge also gives the unconscious a central role. To this end, a social representational-psychodynamic-ideological approach is adopted.

A description and explanation of the workings of inter-group blame can contribute to lessening its harmful consequences: the scapegoating and stigmatisation of certain groups, and the cultivation of feelings of invulnerability to the effects of the crisis in other groups.

## 1.13 OPERATIONALISATION OF CONCEPTS

• The term **'homosexual'** is used throughout the thesis to denote male homosexual identity. The term **'gay'** is used occasionally in connection with the politically organised section of the homosexual population.

• The terms **'out-group'** and **'in-group'** are relative terms. According to Tajfel (1981) the social categorisation process is used to locate people in society. The category in which people place themselves is the 'in-group'. The categories in which people do not feel they belong are termed their 'out-groups'. Out-group often seems to refer to marginalised groups in literature on the history of prejudice (eg. Cohn, 1976). I will attempt to use it as a relative term throughout the thesis rather than using it to signify marginalised groups. When I speak of 'inter-group blame' I refer to the blame meted out by members of groups. By these 'groups' I refer to the myriad social groups with which people identify. This identification may occur purely on the level of thought or there may be some action associated with it.

• I use the concepts **'self'** and **'other'** synonymously with the terms 'in-group' and 'out-group'.

• By **'social institution'** or **'institution'** I refer to the institutions which shape ideology according to Althusser (1971), ie. the church, the school, the mass media, laws, and science.

• The term **'culture'** is closely related to the idea of 'social institution' in this thesis. It refers to the set of symbols (manifest primarily in language), ideas, norms and laws which emanate from the 'social institutions'.

• I use **'the world of science'** to cover the medical as well as the natural sciences.

• In various sections of this thesis the concepts **'discourse'**, **'narrative'**, **'lay theory'**,

**'metaphor'** and **'social stereotype'**, are synonymous with **'social representation'**. I have chosen to use the term 'social representation' consistently, throughout the thesis, because of the importance that it accords to the mass media and to the relationship between science, the mass media and lay thinking. In addition, social representational theorists have produced a body of research on illness which is central to the thesis. While I use 'social representation' as the basic unit of analysis, my conceptualisation of the social representation incorporates ideas beyond its original conceptualisation such as ideological and rhetorical components. I elaborate upon this broader conceptualisation in Chapter Five.

## OVERVIEW OF CHAPTER TWO

In this chapter I explore the forces which affect the creation and reception of a government sponsored AIDS campaign. The British AIDS campaign is used to illustrate various issues. Government sponsored AIDS campaigns develop through an interplay of medical, media and lay pressures. The number and status of those who have AIDS in that society determine the point at which campaigns are launched. Political concerns influence this process too. The messages chosen for the campaigns reflect hegemonic ideologies circulating in the particular society. Previous anchors, as well as ideological and emotional forces, affect the way in which these messages are absorbed by the lay people at whom they are targeted. The British AIDS campaign has drawn, from the start, on the ideology of individual responsibility. This blames the PWA for contracting AIDS. The campaigns have attempted to convince their target audience that the PWA could be 'self'. However, the fear in which AIDS has been couched from its inception, combined with the use of fear tactics, induces emotional defensiveness in the target audience. 'Not me' feelings are also evoked due to the lingering effects of the AIDS anchors. While the campaigns hoped to inform their target audience that AIDS could affect them, in fact, they reinforced a cycle of inter-group blame and the feeling of personal invulnerability. Social representations transmitted by the media do not necessarily correspond with those absorbed by its target audience.

# CHAPTER TWO: THE SOCIAL PSYCHOLOGY OF A HEALTH CAMPAIGN

## 2.1 INTRODUCTION

Social representations of AIDS arise from scientific knowledge which is conveyed to individuals by mass communications. All forms of the mass media have been involved in the diffusion of knowledge about AIDS. Yet government sponsored health education campaigns form the mass media focus of this thesis. They reflect an amalgamation of the perspectives of the Government, the medical world, market research findings concerning the population at large, advertising agencies, and the other mass media. They are likely to be useful indicators of the dominant social representations held by medics, policy-makers and lay people, and of the ideologies which exist within the cultures in which they are made. They are infused with cultural assumptions. Campaigns are a litmus test or microcosm of what Governments would like lay people to be thinking about AIDS. If social psychological theorising in connection with AIDS is to have an impact, it is most likely to influence the representations conveyed by AIDS campaigns.

This chapter illustrates the interplay of various forces in the evolution of a Government sponsored mass mediated health campaign. It also addresses the social psychological issues involved in the reception of a mass mediated health campaign. It is argued that the traditional concern with the relationship between the mass media, and knowledge, attitude and behaviour change is misdirected. This concern fails to recognise two unconscious forces: Firstly, the role of defence mechanisms in the absorption of knowledge, and in changes in attitudes and behaviour; and, secondly, the fact that ideas transmitted by the media are appropriated only when they fit with the existing ideology of audience

members. While AIDS campaigns have had a massive impact in terms of knowledge, some reject the ideas transmitted by the media because its messages do not fit with the ideologies which they hold, or because they become defensive in the face of certain material. This chapter uses the British AIDS campaign to illustrate these points. Many of the tenets which apply to the evolution and impact of this campaign apply also to other countries' Government sponsored health education campaigns. The early South African campaign, in particular, appears to have been influenced by the British campaign.

## 2.2 THE EVOLUTION OF A NATIONAL HEALTH CAMPAIGN

Health education priorities in Britain are determined by a combination of three factors: Epidemiological issues arising in the medical sphere; medical, media and lay pressures on the Government; and the proven effectiveness of previous campaigns in relation to the particular health issue (Naidoo, 1986). This section explores the influences of these factors on the evolution of the British Government's AIDS campaign.

### 2.2.1 SCEPTICISM, COMPLACENCY AND IRRESPONSIBILITY

Health has become a highly salient social representation over the past two decades (Herzlich, 1973; Herzlich & Pierret, 1987; Jodelet, 1984a). The diseases which cause the majority of deaths - heart disease, cancer, strokes and AIDS - have not succumbed to medical science. They have all been convincingly linked to lifestyle factors, and these links have been widely publicised.

Despite the fact that many health issues are more closely linked to behavioural than to medical factors, British national health education has always been part of a specifically

medical hierarchy, led by a Medical Officer (Naidoo, 1986). Traditionally health education has been the Cinderella of the medical profession (Fee & Fox, 1988). The notion of prevention is a more recent concept than that of cure.

> "Although much lip service is paid to the proposition that prevention is better than cure...for many people it is far from self-evident. Since diseases that are prevented are necessarily unreported, the success of a preventative procedure is more difficult to demonstrate than that of therapy" (Smith & Jacobson, 1988:3).

Prevention can appear to be less cost-effective than other measures since the target audience comprises a large number of well people. Many have little or no possibility of contracting the disease. While prevention is known to be cheaper than cure, medics are cynical in relation to statistics concerning the effectiveness of preventative medicine (Smith & Jacobson, 1988). Social scientists also tend to be sceptical of models of prevention, especially those which involve mass media campaigns. They argue that:

> "The ultimate criteria by which such a model of health education should be judged is its contribution to the decrease in morbidity and mortality for a particular condition. By this measure we lack any convincing evidence that changes in individual behaviours brought about by health education have had any effect on public health" (French & Adams, 1986:73).

Scepticism concerning the usefulness of preventative measures was compounded by complacency, in the world of the medical epidemiologist, when AIDS was initially recognised. American medics initially perceived the newly discovered illness, Gay Related Immune Deficiency (GRID), in terms of its relationship to homosexuality rather than to other known illnesses. AIDS seemed to be confined solely to the male homosexual community.

Until late 1983, when AIDS was found to be caused by a virus, the fact that AIDS had

principally affected homosexual men prompted medical researchers in search of a cause to look for distinctive features related to homosexual behaviour (Wellings, 1988a). Medics tended to favour lifestyle theories. An article in the **Lancet** (1982), for example, postulated that the drug Butyl Nitrite ('poppers'), widely used in the American homosexual community, might impair the body's immune system (Goedert, Neuland, Wallen *et al.*). Lacey and Waugh's (1983) article in the **Lancet**, posited that homosexual coitus causes immuno-suppression. Many articles in medical journals suggested that the lifestyle which American homosexuals were living was over-loading their immune systems and thereby causing them to stop functioning.

The homosexual lifestyle theories failed to explain the increasing infectivity of people who were not homosexual. When the viral component was discovered in 1983, notions of immune overload temporarily faded from the medical literature. However, the link between the 'homosexual lifestyle' and AIDS lingered in the media. The issue in which an event is initially anchored has consequences for the social representations which subsequently develop. AIDS was anchored to issues of sexuality and of lifestyle rather than to other viral illnesses. Homosexual activity and sexually excessive lifestyles have continued to be implicated in the genesis of AIDS. Homosexuality and promiscuity have not been seen merely as a facilitator of the spread of, but as a cause of, AIDS.

In the early days, the homosexual lifestyle theories had the consequence that medics were interested in this mysterious, homosexually targeted, illness but did not anticipate that it would threaten the remainder of the population. Less than 10% of the British population is thought to be homosexual. This small group is often perceived as a discrete entity,

separate from the 'general public'. Some argue that this group was also considered expendable (eg. Watney, 1988a). Medics did not immediately force Governments to act on the problem, even when the theory of blood transmission of a virus proved accurate and cases appeared outside of the homosexual community and in all parts of the world.

I have attempted to show that the British Government was not forced to act on AIDS in the early 1980s due to scepticism in relation to preventative health models and complacency in relation to the containment of the illness within the homosexual community. This sluggishness was also related to the social representation of the homosexual as irresponsible. The British Government hold the philosophy that:

> "Much of the responsibility for ensuring his own health lies with the individual" (DHSS, 1976:95).

And that:

> "Modern western diseases are related less to a man's environment than to his own personal behaviour; what might be termed 'our lifestyle'" (DHSS, 1976:17).

Originally, the lifestyle of homosexuals, in whom HIV was initially found, was implicated in regard to the cause of AIDS by medics. This lifestyle is also regarded as irresponsible in the eyes of various religious and legal institutions. Either way, homosexuals were seen to have brought AIDS upon themselves. The implication of the lifestyle of homosexuals in the creation of AIDS hindered early action to prevent the spread of the virus.

A historical account of the British Government's AIDS campaign demonstrates its unwillingness to allocate substantial sums of money to an AIDS prevention campaign prior to the infection of heterosexuals. Once it was realised that all individuals were at risk, and that they could only behave 'responsibly' once they obtained knowledge about

the illness, a large proportion of the money allocated to AIDS was given over to education and to persuasive campaigning in the mass media. In line with its philosophy that a responsible lifestyle is the main contributor to health, the Government saw persuasive education as the most appropriate method of addressing the spread of AIDS. Unlike other measures, health education does not override individual free choice and responsibility (Naidoo, 1986). Fox, Day and Klein (1989) point out that, while the British Government gave priority to education and to drug programmes, the Swedes, for example, have emphasised testing and contact tracing.

### 2.2.2 THE PRESSURES WHICH LED THE BRITISH GOVERNMENT TO ALLOCATE MONEY TO AIDS HEALTH EDUCATION IN THE MASS MEDIA

- October 1984: **Science** magazine published an article entitled 'HTLV-III in saliva of people with AIDS-related complex and healthy homosexual men at risk of AIDS' (Groopman, Salahuddin, Sarngadharan *et al.*).
- January 1985: The Government set up an Expert Advisory Group on AIDS in response to fear in the public concerning heterosexual infection.
- 9 February 1985: The Haemophilia Society's newly formulated recommendations on high-risk activities, in relation to contracting HIV, were published in the **Guardian**. This included an extensive list ranging from the use of condoms during sexual intercourse, to using only paper handkerchiefs and disposing of them carefully. While these recommendations related to precautions to be taken when living with an HIV infected haemophiliac, they were translated, by the media, into general advice on how to avoid catching HIV.
- 15-19 February,1985: As a result of the publication of the Haemophilia Society's recommendations and of ideas concerning the presence of HIV in saliva, the mass

media presented a united front, calling on the Government to launch a campaign to inform the public about AIDS. The **Guardian** editorial (19 February 1985) expressed the fact that "no everyday human act, it seems, is too innocent to escape the menace of the 'gay plague'".

- 15 March 1985: Medical experts were quoted in the **Guardian**, regarding their feelings of dissatisfaction with the Government's neglect of the medical profession. They challenged the DHSS to declare how it intended to protect hospital staff from the risk of infection.
- 16 March 1985: The Chief Medical Officer of the DHSS, Doctor Donald Acheson, who had previously seen the panic related to AIDS as 'unfounded' (Vass, 1986), was reported to have said that AIDS was "the biggest health problem since WW2" (**Daily Mail**). He announced that 4 million pounds was to be spent on the identification of infected blood in the blood pool.
- 19 March 1985: AIDS became subject to the Public Health Act of 1984, which allows for medical examination of people believed to have AIDS. Under the Public Health (Infectious Diseases) Regulations of 1985, they could now be removed to hospital and detained there by force.
- 22 March 1985: The voice of the gay community was heard in the press. It claimed that the new legislation was an overreaction to the infectious nature of AIDS. Government action was creating an environment that was even more adverse to homosexuals than that which existed prior to the Act.
- March 1985: The press (eg. the **Guardian**) began a long series of articles alluding to the fact that AIDS originated in Africa.
- April 1985: The blood screening program, in which all donated blood would be tested,

was announced by Barney Hayhoe, Minister of Health. The Government issued guidance for staff in health care, social and other services about dealing with AIDS and began funding the training of counsellors. Prior to these steps the Government's involvement in AIDS prevention had been minimal. It had only introduced the coercive measure mentioned above and taken certain steps in connection with blood:

-> Since 1982 HIV and AIDS cases had been voluntarily reported to the Communicable Disease Surveillance Centre.

-> Since 1983 blood donors had been warned that those in 'high-risk' groups should not give blood.

-> Since 1984 heat-treated American Factor Eight, the clotting factor which is deficient in haemophiliacs, had been available. It has been produced artificially in Britain since 1985.

- 24 July 1985: Rock Hudson, a leading American celebrity, died of AIDS. The British media emphasised the extent to which his death had mobilised American AIDS research funding.
- 20 August 1985: There were renewed attempts, on the part of newspapers, to call for preventative measures: "We have reached the stage when inaction may be a greater danger than alarm" (**Guardian** editorial 'Time to fund AIDS research').
- 6 November 1985: The **Guardian** editorial attacked 'Government lethargy'.
- 20 November 1985: The Government allocated 20 million pounds to a national public information campaign concerning the risk of contracting AIDS.

Pressures brought to bear by the mass media had resulted in the dedication of money to a health campaign. While the full unfolding of the campaign appears in Chapter Eight, it is important to be aware of the five slogans which have given the campaign its unity from the start:

'Don't aid AIDS'

'AIDS: Don't die of ignorance'

'AIDS: You know the risks, the decision is yours'

'AIDS: You're as safe as you want to be'

'Choose safer sex'

These slogans stand in direct contrast to the idea of 'gay plague'. They are not connected with a risk group ideology, with the early 'gay plague' anchor. While the early mass media had linked AIDS to a particular type of person, these campaigns began to link it to particular types of behaviour. The campaigns attempted to replace a risk group ideology with an individualist ideology. AIDS campaigns have attempted to correct what are seen as the incorrect impressions which have been formed in relation to earlier mass mediated ideas. This chapter explores the extent to which the individualist ideology which they convey, which centres around the notion of responsibility, is likely to permeate lay people's explanations of AIDS.

### 2.2.3 EVALUATION OF THE EVOLUTION OF THE CAMPAIGN

> "The major wave of media hype and public panic which began in early 1985, fuelled by fears of widespread transmission, has its origins in an article published in **Science** magazine with the title 'HTLV-III in saliva of people with AIDS related complex and healthy homosexual men at risk of AIDS'" (Wellings, 1988a:97).

The combination of this type of scientific article with the Haemophiliac Society's 1985 recommendations concerning measures to prevent the spread of HIV, had the consequence that professionals in the medical world and in the media began to pressurise the Government to produce a health education campaign.

> "It is not being suggested here that government action merely occurred as a result of televised [and newspaper] publicity - preparations were certainly being made - but the nature and timing of the ensuing campaign may well be credited to concerns that were shared amongst the responsible authorities in the fields of medicine, government and communication" (Wober, 1988:20).

In the absence of an antidote to HIV, a growing emphasis upon health education has been manifest both in Government funding and in its oral declarations. Whereas 2.5 million pounds had been allocated to AIDS education for 1985, 20 million was allocated for 1986.

The coercive measure called upon in 1985 (The Public Health Act of 1984), in which PWAs could be detained, by force if necessary, represents the Government's early attempt to quell fears, mainly within medical circles, of casual transmission of HIV. Homosexuals were feared to be infecting heterosexuals, in the various environments in which they mix (Vass, 1986). This measure was used on only a few occasions, but it is indicative of the fearful frame of mind in which the Government, the medical and lay communities encountered the threat posed by AIDS. Yet there was an attempt to override these early reactions, linked to a historical fear of plague, with the individualist philosophy which dominates contemporary Western culture. In the place of coercion, education. Education allows individuals to make responsible choices, assuming that individuals can control the transmission of the virus. This thesis argues that emotions such as fear have continued to inform reactions to AIDS despite attempts to forge a link between AIDS and more conscious factors such as responsibility and control.

The phenomenon of AIDS was conceptualised as an issue of leakage from an infected source to a vulnerable 'general public'. The 'gay plague' had leaked. Watney (1988a) points to the irony contained in one of the central slogans of the early AIDS campaign: 'AIDS: Don't Die of Ignorance'. **British Medical News** alerted the medical profession to preventative steps for HIV on 15 August 1983. It recommended that homosexual men use condoms routinely as part of their sexual practice. Yet this message was not disseminated to the homosexual community by the Government. The Government, medical and lay communities' (a) regard of this group as 'disposable' (Watney,1988a), (b) their confidence that it would be confined to this small group, and (c) their scepticism concerning prevention, effectively prevented an early start to curbing the spread of the illness.

Government bodies in countries such as Norway, Denmark, the Netherlands and Switzerland had involved themselves in the epidemic far earlier. Moerkerk and Aggleton (1990) suggest that these countries, which involved themselves from 1983/4, had a 'pragmatic' approach to the AIDS epidemic. Britain and other later starters, had a 'political' response. While the 'pragmatic' countries had a long-term strategy to give information and to prevent hostility toward certain groups, the 'political' countries developed their AIDS policies in line with what was politically desirable. Governments dictated the strategies to be adopted and anti-discrimination was not a central focus. Within the 'pragmatic' countries non-governmental organisations (NGOs) had a large impact on the Government strategies.

While the argument that Britain's response was 'political' has validity, Chapter Eight will

demonstrate that NGOs and anti-discriminatory ideals also played a part in the formation of the British campaign. Models such as those of Berridge (1991) indicate that there was no recognised policy community between 1981 and 1986 and this allowed for policy input from NGOs.

Between the **British Medical News'** editorial of August of 1983 and the first mass media campaign (in March 1986), people who had sex without a condom were running risks but they were not taking risks. They had not been formally warned that they were actively taking risks. It was the authorities who were taking the risks by not relaying known information to this group. The cultural assumption that risk-taking originates at the level of individual behaviour was reflected in and fostered by the early slogan: 'AIDS: Don't die of ignorance'.

## 2.3 THEORETICAL DEBATES CONCERNING THE IMPACT OF CAMPAIGNS ON INDIVIDUALS

It has been established that the British Government's decision to create a health campaign is predicated upon pressures from the medical, mass communications and lay worlds. The choice of a specific message is then based upon a combination of:

- The Government's understanding of the medical facts, its perception of what will be acceptable to the public, and its financial constraints.
- The market researchers' findings concerning the target audience combined with the theoretical standpoints which they accept.
- The advertising agencies' understanding of the market research brief and the creative licence which they bring to bear on these data.

All of these factors influence the shape of a campaign, but the campaign operates within the following model:

> "Most often campaigns seek to increase knowledge or change attitudes, assuming that behaviour change will follow. This is an important belief of contemporary public information campaigns: increases in knowledge will affect attitudes which in turn predict subsequent behaviour" (Wallack, 1981:219).

A plethora of British studies has shown that the behaviour change which the British Government campaigns hoped to effect, operating within this model, has not materialised. In the heterosexual sample of the DHSS' (1987) large scale survey of knowledge, attitudes and behaviours which existed prior to and after the first year of campaigning, "no evidence of changes in the past year was found in relation to direct questions on behaviour" (p.19) and there was an "increase in feelings that AIDS sufferers 'only have themselves to blame'" (p.19). Subsequent studies have, consistently, found low levels of safer sex behaviour among heterosexuals (eg. Dockrell, Joffe & Blud, in press). Therefore, this section challenges the assumptions of what I term the KAP (knowledge, attitudes and practices) model of health education. The assumptions of this model, in themselves, are a reflection of the individualist ideology which has crept into communications theory. They are a function of the individualism of a great deal of 'social' psychology in North America and in Britain. Many arguments which pertain to the KAP model in mass communication pertain also to AIDS research which has tended to rest on the assumption that changes in knowledge and attitudes lead to behaviour change.

The KAP model focuses on conscious information processing. It ignores the effects of unconscious forces (eg. defence mechanisms and ideologies) on absorption of knowledge

and changed attitudes and practices. A campaign based on a rationale that knowledge and attitude changes result in desired behavioural change, as did the early British campaign, in fact, sets up a cycle of blame. The messages of the early campaign - epitomised by the slogans mentioned above and by a fearful tone - allowed people to associate AIDS with the behavioural choices of ignorant individuals. People also imposed a risk group ideology on the campaigns, spurred on by reference to homosexuals and to drug-users within the campaigns and within other sections of the mass media. The DHSS (1987) study of knowledge, attitudes and practices prior to and after the first year of the campaign verifies this. Not only was there no heterosexual behavioural change, an increased belief that PWA only had themselves to blame and that 'promiscuous people' were most at risk of getting AIDS, there was also a slight increase in the feeling 'I don't feel sorry for homosexuals who have caught AIDS, because it's their own fault'. Over half of the heterosexual respondents endorsed this statement. A campaign, based on the KAP model, increased blame of, and decreased compassion for, PWAs.

### 2.3.1 MEDIA EFFECTS

Those who devise campaigns draw on outdated and oversimplified visions of the relationship between mass mediated information and behaviour. The World Health Organisation's Global Program on AIDS has increasingly recognised that this relationship is more complex. There is, indeed, a consensus among contemporary theorists that knowledge about a behavioural risk factor is a necessary but not a sufficient condition to facilitate behaviour change (Leventhal & Cleary, 1980). This finding has been validated in relation to HIV (Morin, 1988; Wober, 1988). Yet, if one looks at the papers presented at the International AIDS Conference in Amsterdam in 1992, assumptions concerning a

linear relationship between knowledge, attitudes and behaviour still inform many AIDS campaigns and AIDS research projects worldwide.

The relationship between messages emitted by the mass media and behavioural change was the central focus of what is termed the administrative (or Yale or Columbia) tradition of mass communications. Increasingly, theories developed within this tradition and their offshoots advocated the importance of interpersonal communication if mass mediated messages were to effect behaviour change. The early debates live on in the social marketing and mass communications literature. They fail to recognise subsequent developments in media theory and in European social psychology. I will outline the relevant debates in the history of mass media effects.

Lazarsfeld and Merton's (1948) theories on the effective communication of ideas are believed, by market researchers, to have stood the test of time (Wallack, 1981). Three special conditions result in the effective use of the mass media for relaying health-related messages: monopolisation; canalization; and supplementation. Monopolisation is met when little or no communication of opposing values competes with the communication. Canalization is the channelling of existing attitudes or behaviour in a different, though similar, direction to present attitudes or behaviour. Finally, the mass media must be supplemented with personalised communication.

In the 1950s and 1960s Lazarsfelt, Merton, Katz and Klapper rectified what they saw as the overestimation of the power of the mass media to induce behavioural change which had occurred in the early laboratory work on mass media effects. Katz and Lazarsfeld's

(1955) 'two step flow hypothesis' or 'personal influence theory', for example, posits that the relationship between a communication and its audience is mediated by 'opinion leaders'. These 'opinion leaders' exert personal influence on friends and relatives. This points to the salience of interpersonal influence in the flow of information.

This idea marked the start of studies which showed that the media have minimal effects. Klapper (1960) found that reinforcement of opinion is the dominant effect of the mass media. Minor changes, such as a change in intensity of opinion, may also occur. Conversion of opinion is most rare. Only when opinions on an issue are not yet formed, can the media play an influential role. Following a similar rationale, Rogers' (1971) theory of innovation posited that the mass media are able to increase knowledge, but that attitudinal and behavioural changes are more likely to occur through interpersonal communication.

This line of thinking augments the assumption that knowledge and attitude change precede and lead to behaviour change, encouraging health educationalists to add a personal dimension at the attitudinal and action stage of the equation. A variety of studies challenge this assumption. They have not gained recognition. Lazarsfeld and Merton (1948) posit that the media has a 'narcoticizing dysfunction'. News media lead people who regularly use it to believe that because they hold opinions about various topics, they have taken action. This would have the consequence that regular exposure to AIDS messages would lead people to believe that they had taken the required action to prevent themselves from acquiring HIV. Further psychological theories, such as Festinger's (1957) theory of 'cognitive dissonance' also challenge the fact that knowledge leads to changed

attitudes and to action. For Festinger action precedes thought. People act and then rationalise their actions.

A further line of reasoning which deviates from the traditional KAP model is the notion that the social environment in which attitudes and behaviour take place is shaped by the mass media. The mass media are shapers of norms rather than prescribers of knowledge, attitudes and practices. Having reviewed the history of research into smoking, drugs and alcohol, Wallack (1981) concludes:

> "The evidence on smoking campaigns is mixed. On one hand, the campaigns appear to have had very limited direct impact in getting individuals to stop smoking. On the other hand, the environment in which smoking takes place has been drastically reconstructed, non-smokers have organised and, in general, within the broad middle-classes, the social pressures not to smoke appear to greatly outweigh the pressures to smoke" (p.228).

The notion of reconstructing the social norms in which individual behaviours take place seems to be a more effective entry point than a strict interpretation of the influence of mass mediated messages on individual minds. This is compatible with the 'agenda setting' function of the media put forward by McCombs and Shaw (1972). They propose that the media tell people what to think about. It does not tell them what to think and, by extension, how to act. They found, in the 1968 American presidential campaign, that the correlation between the major items emphasised in the campaign and voters' judgements of what were the important issues was .967.

The mass media are powerful in terms of conveying awareness of an issue and in terms of transmitting knowledge. In fact, television has an enduring and powerful effect in relation to these aspects (Wellings & McVey, 1990).

> "Surveys, such as those conducted for the Research Unit for Health and Behavioral Change consistently report that people cite television as their most important source of information about AIDS (36 per cent), followed by the newspaper (31 per cent)" (Kitzinger, 1990:319).

High numbers report that they have seen AIDS campaigns on television and memories of the campaigns linger months after they have passed. People are able to echo the media's language, concepts, explanatory frameworks, statistics, images and presentational techniques (Kitzinger & Miller, 1991). Yet there is a gap between this awareness and any behavioural change (Wellings & McVey, 1990).

There can be no doubt that the mass media, especially television, has a massive impact on people's thoughts about AIDS. It influences the way in which people think about their social and political reality. I wish to challenge the fact that these thoughts are purely conscious. When she was head of the HEA's AIDS research, Wellings stated that:

> "The impression is that in the period when AIDS public education has been in abeyance, myths and misinformation have soon been revived. This suggests the need to repeat and re-emphasise even when the general feeling is that people must be bored by the same information" (Wellings, 1988b:35).

I propose that repetition does not iron out myths. There is a level of functioning which the administrative tradition and the theories on normative environments have not addressed because they operate within the confines of a stimulus-response model. They fail to address the unconscious level at which the media's audience functions.

The effectiveness of a health campaign is mediated by the ideological filter through which the suggested changes in knowledge, attitudes and practices must flow. This ideological filter contains a variety of myths, social stereotypes and fantasies which stem from the historical and cultural experiences of the society in which they arise. The contents of these

ideological filters will form the basis of the following two chapters. I will argue that certain ideologies conveyed by the mass mediated health campaigns, such as the ideology of individual responsibility, 'fit' with ideologies held by audience members. Yet audience members filter the campaign messages through other ideologies which prevents them from perceiving the relevance of the responsibility ideology to themselves. I give a role not only to the unconscious process of ideology but to emotion and the unconscious defence against overwhelming emotion, in the absorption of AIDS messages.

### 2.3.2 THE ROLE OF EMOTION AND OF THE UNCONSCIOUS IN THE ASSIMILATION OF IDEAS

The history of commercial advertising has shown almost no use of fear in order to persuade its audience. Yet efforts to change perceptions of health issues frequently involve threatening material (Leventhal, 1970). In fact, fear-arousal campaigning was initially used by the British Government, in its 'tombstone' and 'iceberg' AIDS campaigns.

Certain theorists believe that people find threatening material compelling and subsequently deal with it creatively (Kirscht & Haefner, 1973). At the opposite end of the spectrum, there are those who believe that, when fear is used, audiences protect themselves from their anxiety with defence mechanisms such as denial of the severity of the threat (Tripp & Davenport, 1988/9).

Following the first phase of mass mediated campaigning, the British heterosexual population had a low level of perceived risk of contracting HIV (Stockdale, Dockrell & Wells, 1989) and, as I have mentioned, an increased feeling that those with AIDS only had themselves to blame (DHSS, 1987). This supports the theory that defence mechanisms

are brought into play by fear-arousing campaigns. Fear-arousal techniques, coupled with previous fearsome mass media material which related AIDS to certain groups, and references to these groups in the campaigns, caused the audience to defend against the possibility that they might be at risk. They attributed the disease to those 'others' with whom AIDS had been associated since its entry into the mass media. People had absorbed the ideology of individual responsibility which had been proposed by the campaigns, but projected this responsibility onto 'others'. This indicates that the conscious level of information processing accessed by the KAP studies is not sufficient for analysis of a health campaign and the ideas which it conveys to people. Psychology has tended to be defined as the science of the conscious mind (Moscovici, 1982; Markova & Wilkie, 1987). This thesis attempts to delve into both conscious and unconscious mechanisms.

### 2.3.3 THE ROLE OF INDIVIDUAL RESPONSIBILITY VERSUS SOCIAL CHANGES

> "In the contemporary American context the rhetoric of blame has been most evident in the discourse on preventive medicine and its emphasis on individual responsibility" (Nelkin & Gilman, 1988:371).

The ideology of individualism has pervaded the vast majority of AIDS campaigns to date. Of course individual responsibility, to a certain extent, is involved in contracting AIDS. Yet the 'rhetoric of blame' often goes well beyond the realms of science. This can be illustrated by way of reference to cancer. While 70-90% of cancers are environmentally caused (Crawford, 1977), there seems to be great reluctance in Western societies to bring this fact to light (Nelkin & Gilman, 1988). Instead, cancer is linked, in popular consciousness, to individual irresponsibility in terms of adopting a healthy lifestyle.

The focus on the role of personal behaviours in the production of illness frequently

involves notions of blame and responsibility. Under the rubric of self-responsibility, a moralisation about health tends to occur.

> "The idea that disease arises from problems of personal behaviour, and the implication that one is responsible for one's own health easily slides over into the view that illness reflects personal failing" (Ray, 1988:3).

British health promotion has suggested, since the 1970s, that individuals have ultimate control over certain critical aspects of their lives (Karpf, 1988). Illness becomes a matter of choice for an individual divorced from social pressures and constraints. In addition, 'being ill' is redefined as 'being guilty'. This issue forms a central focus of this thesis:

> "Unfortunately, this sense of personal power is in large measure a delusion. Individuals can influence their fate, but only to a limited degree. Moreover, emphasis on the small domain over which the lone runner can have an effect, instead of on the large domain over which no individual has control - including the realms of heredity, culture, and chance - has the consequence of shifting responsibility for environmental change from society to the individual, and of redefining 'being ill' as 'being guilty'" (Gillick, 1984:384).

Gillick (1984) pursues this line of reasoning in a succinct way:

> "Surely one of the major triumphs of the past hundred years has been the relocation of the basis of disease in science rather than in sin, a development which health promotion, for all its virtues, is at risk of undermining" (p.384).

The individual is asked to make behavioural changes while the social mores which allowed the illness to escalate, are not challenged. Interestingly, accounts of disease, especially in America, are often linked to an affluent lifestyle (Crawford, 1977). Western countries are familiar with representations of heart disease and strokes, for example, in terms of an indulgent lifestyle, in terms of excess. This obscures an important reality. Social inequalities account for many health inequalities. The massive impact of AIDS on

the under-developed world and among under-privileged communities in developed countries is linked to a lack of access to health care. Yet individuals are seen as free agents divorced from the social structures. The 'it is up to you' message constructs a view of disease as an a-social process (McGrath, 1990).

The context in which people develop their lifestyles is important. The collective nature of public health problems are brought to light by the following analogy:

> "The problem of sewage in drinking water was not solved by ignoring the environment and appealing to individuals to boil their drinking water. In contemporary terms, responsibilities for public health are not met simply by telling people to 'look after themselves', to 'adopt healthy lifestyles', and to 'be responsible'" (Draper, Griffiths, Dennis & Popay, 1980:494).

While people are self-determining, choice is limited. Health choices are linked to financial status, employment, and social class, as well as with psychological well-being (French & Adams, 1986). People make choices according to what is logical to them, within their social realities.

Minkler (1989) proposes that an alternative to the individual lifestyle vision of health promotion emerged in the mid-80s. The new health promotion focuses upon the importance of access to health, the development of an environment conducive to it and to the strengthening of the social network. This vision has been encapsulated in the World Health Organisation's Global Program on AIDS over the past few years. The British Government increasingly recognises that social factors are important. In addition to its mass media initiatives, it supports needle-exchange schemes, and free distribution of condoms. However, the ideas which reach the public at large still tend to be based within an individualist ideology which fosters social representations that allow for a linkage to

be made between AIDS and inter-group blame.

## 2.4 CONCLUSION

I have indicated that British national health education has always been part of a specifically medical hierarchy, led by a Medical Officer. This is not optimal in helping people to prevent getting infected with HIV:

> "In most biomedical approaches to transmissible disease, preventing transmission takes precedence over helping persons prevent getting infected. "Populations" are seen atomistically as collectivities of individuals "choosing lifestyles". "Behaviours" are considered the consequence of wilful, unmeditated decisions" (Herrell, 1991:202).

It seems 'obvious' or 'natural' to the Western thinker, that the sexual behaviours of individuals need to be targeted in order to allay the spread of HIV. In fact this targeting fails because inter-group blame or the association of AIDS with the 'other' allows the majority of the population to feel immune to the illness. Campaigns targeted at sexual behaviour may have no influence upon these feelings of immunity and invulnerability. While much work has been done in relation to how these feelings may be changed within an information-processing model, little work has been done on the role of unconscious forces in the production of feelings of invulnerability.

Certain of the debates concerning mass media effectiveness lead one to question why mass mediated campaigns have been used, worldwide, to prevent the spread of HIV. However, there are a variety of findings which attest to the vast impact of the mass media, especially television, even if this is purely at the level of its ability to give salience to an issue in the minds of people. But to what extent does inter-group blame interfere with absorption of campaign messages? The theory of social representations and much

media theory attests to the circulation of ideas between the mass media and lay people. While this issue will be tested empirically, one expects that lay people will both absorb and deal creatively with the ideas which circulate in the mass media AIDS campaigns. It must be remembered that these ideas, anyway, are a product of lay thinking too, due to the centrality of market research findings in AIDS campaigns.

There is likely to be a degree of match between audience ideas and campaigns in the same way that Kitzinger and Miller (1991) found a match between audience ideas and television news items on AIDS. Thus, the ideology of individual responsibility is likely to pervade audience representations of AIDS. At the same time, early AIDS anchors influence the way in which messages are comprehended, as do defensive and ideological filters. Responsibility for the origin and spread of AIDS is thus more likely to be placed with the 'other', rather than with the 'self'.

Hartmann and Husband's (1974) seminal work on the mass media concludes that, although Western people draw on the mass media for their knowledge on specific topics, they also make use of personal experience, especially when they live in a cosmopolitan environment. This reminds us of the complex nature of the source of information for social representations related to AIDS, ranging from the mass media, everyday talk, textbooks, advertisements, films and literature to comics (van Dijk, 1991). The debate on 'media effects' has vacillated between the minimal and total effectiveness of the media. This thesis adopts the 'active audience' position: People are able to derive discordant messages from those intended (Eco, 1986), but still absorb the central ideologies conveyed. This issue is developed in Chapter Five.

## OVERVIEW OF CHAPTER THREE

In this chapter I aim to establish, theoretically, that allocating responsibility is tantamount to blaming. I look at why, in the late modern period, where people are regarded as responsible for the outcomes which befall them, this responsibility is applied to others and not to the self, in the case of events which have a negative outcome. Psycho-dynamic factors are at the root of this process. I also explore which events are most likely to trigger inter-group blame and which groups tend to be blamed in a particular society. In order to establish the nature of blaming aspersions, they must be viewed in their historical dimension. In addition to the ascription of responsibility to an out-group, blame can be related to issues of 'pollution' and of conspiracy. Because thinking is argumentative, strategies of blaming co-exist with non-blaming strategies.

# CHAPTER THREE: TOWARDS A THEORY OF INTER-GROUP BLAME

> "Another popular coping game the Lebanese played was called 'Conspiracy'. During the entire time I was in Beirut I don't remember more than one or two cases where the perpetrators of a car bomb, an assassination, or a major killing were ever identified, caught and punished. This always compounded the anxiety of living in Beirut, because not only was there constant random violence but you could never savour the peace of mind that comes from knowing that at least one of the killers was off the streets and safely behind bars. Beirut was all crime and no punishment... In an attempt to make the anxiety this produced more controllable, the Lebanese would simply invent explanations for the unnatural phenomena happening around them; they would impose an order on the chaos. Their explanation for why someone was killed or why a certain battle broke out was usually the most implausible, wild-eyed conspiracy theory one could imagine. These conspiracies, as the Lebanese painted them, featured either the Israelis, the Syrians, the Americans, the Soviets, or Henry Kissinger - anyone but the Lebanese - in the most elaborate plots to disrupt Lebanon's naturally tranquil state" (writes the journalist Thomas Friedman in his account of Lebanon's civil war in From Beirut to Jerusalem, 1989:36).

Friedman continues:

> "In order to continue functioning, Beirutis always had to find some way to differentiate themselves from the victim and to insist that there was a logical explanation for why each person died, which, if noted, would save them from a similar fate. Without such rationalisations no one would have left his home" (p.37).

## 3.1 INTRODUCTION

This chapter aims to provide a plausible theory of inter-group blame. A theory of inter-group blame must determine:

- Process (how group members blame)
- Function (why group members blame)
- Structure and contents (which groups are blamed, when this blame occurs and the nature of the blaming aspersions)

This thesis argues that inter-group blame can be explained by a hybrid of socio-historic, psycho-dynamic and social psychological forces. Inter-group blame is operationalised as the tendency by people to imagine that events which have negative consequences do not strike the groups with which they identify and that groups, countries or continents other than those with which they do identify are responsible for these events. Ascription of responsibility to the 'other' is sufficient evidence of inter-group blame.

## 3.2 THE CONCEPT OF BLAME

### 3.2.1 BLAME AND THE INDIVIDUAL

Shaver (1985) offers a theory, grounded in philosophy and social psychology, of the process and functional elements of inter-personal blame:

> "An assignment of blame is a social explanation. It is the outcome of a process that begins with an event having negative consequences, [and] involves judgements about causality, responsibility and possible mitigation" (Shaver, 1985:VII).

Shaver posits the existence of three sequential steps in the blame process: Judging causality, assessing responsibility and, finally, blaming. His central argument is that both human causality and responsibility must be established before inter-personal blame occurs. I will briefly outline his conception of human causality and of responsibility in an attempt to demonstrate that the two are not, in fact, distinct concepts.

Certain philosophical writings on human causality see human agency and volition as fundamental. The human is blameworthy either because he/she caused the event which had negative consequences or because he/she failed to stop it from occurring. The actor's perceived responsibility, on the other hand, involves perceived evil intent and the absence of an acceptable excuse. Shaver (1985) is influenced by Heider's (1958) idea that

perceived responsibility is positively related to the personal (rather than to environmental or situational) forces which are thought to be involved. The actor is assumed to have some freedom of action or choice. With self-control the actor could have avoided the negative outcome. The actor is imagined, therefore, to have been aware of the consequences of the action for which he/she is subsequently blamed. The notion that the voluntary nature of action is related to blame was established empirically by Shaver (1985) among both 'experts' and lay people.

The choice or self-control of a human agent lies at the root of Shaver's conception of both human causality and responsibility. In this chapter I propose that establishing responsibility is a sufficient condition for establishing blameworthiness. Shaver approaches the process of blame from the perspective of the individual actor. I would like to approach the process, function and structure of blame from the vantage point of culture and ideology, from the perspective of the deeply ingrained cultural assumptions which people have and which are outside of their conscious awareness. These cultural assumptions serve to generate and to sustain power relations in society (Thompson, 1984).

### 3.2.2 BLAME AND CULTURE

Blame and responsibility have an intrinsic link in societies which have been influenced by Protestantism and/or by capitalism. The fundamental cultural assumptions about 'the individual', in these societies, plays a large part in the casting of blame (Ichheiser, 1949; Farr, 1987). The dominant notion of 'the individual' in such societies is linked to issues of responsibility due to various socio-historical factors.

The simultaneous presence of Protestantism and capitalism in Europe, in the nineteenth century, had powerful consequences for the notion of blame. The Protestant ethic, like the Capitalist one, is the pursuit of individual salvation through hard work, thrift and competitive struggle (Weber, 1904/5). The notion of self-control of one's destiny is central (Whyte, 1957). In pre-capitalist European thought the society was analogous to a biological organism which required each individual for its functioning (Lukes, 1973). Individuals had no function in and of themselves. Modern capitalist philosophies, however, centre around the relation between individual attributes and the social order.

Tawney (1936) stated that the main objective of Calvinism was "the insistence on personal responsibility" (p.112). Personal responsibility came to be enshrined in human thinking and in many social institutions. The legal systems and languages of Western societies hold people responsible for their actions unless certain factors which diminish their control over their mental faculties are also present.

The dominant ideology concerning the 'individual' in Protestant and/or capitalist influenced societies is of a person who is responsible for his/her actions, and who must, therefore, be blamed if his/her actions have negative consequences and praised if his/her actions have positive consequences (Farr, 1987). The blame is increased when his/her irresponsibility has consequences for ourselves.

In the late nineteenth century, social scientific theories mirrored the sentiments of the ideology of individualism (Ryan, 1971). Social Darwinism was the orthodox doctrine in the social sciences. Adapted analogically from Darwin's writings on evolution, it gave

vitality to ideas of 'natural selection' and the 'survival of the fittest'. Twinned with Capitalist and Protestant ethics, social science gave legitimacy to ideas about the successful as the 'fit', 'the selected' and the unsuccessful as the 'unfit', the 'inferior'.

> "The misinterpretations which consist in underestimating the importance of situational and in overestimating the importance of personal factors do not arise by chance. These misinterpretations are not personal errors committed by ignorant individuals. They are, rather, a consistent and inevitable consequence of the social system and of the ideology of the nineteenth century, which led us to believe that our fate in the social space depended exclusively, or at least predominantly, on our individual qualities - that we, as individuals, and not the prevailing social conditions, shape our lives" (Ichheiser, 1943:152).

Kon (1984) juxtaposes Western, European notions of the 'self' with Eastern and Asiatic concepts of 'self'. Cultural assumptions are central to the judgements people make. The 'self' in the Western, European tradition has mostly positive value and a unified, autonomous identity, whereas the Eastern and Asiatic model stresses the need for liberation from one's multiple and fluid selves. Whereas within traditional Japanese culture the personality was the sum total of several areas of duty determined by the society, "European mentality tries to explain man's behaviour 'from within': whether it is motivated by gratitude, patriotism, greed and so forth on the moral plane, decisive importance is attached to the motive of the action" (Kon, 1984:41).

A dominant social psychological theory, attribution theory, views lay people as information-processors who make certain errors when they explain the causes of certain phenomena. The most fundamental of these errors is the tendency to over-estimate the role of dispositional factors, and to under-estimate the role of situational factors in the explanation of negative events which befall other people. The worse the consequences of

the negative event, the greater the personal responsibility assigned to the other person (Walster, 1966). Rather than providing an explanation for human thinking, attribution theory models how individuals embedded in a certain cultural context explain events.

Many theorists argue that the ideology of individualism has declined or changed since the early twentieth century. Whyte (1957) argues that it was replaced by a 'social ethic' after the First World War because of the demands of organisational bureaucracies. For Bell (1976) the ascetic value base of individualism died with the decline of the religious impulse. I adopt Giddens' (1991) idea that late modernity - the period in which we currently live in the West - is defined both by continuity and change of the institutions and ideologies of the past. One factor which contributes to this is that institutions and ideologies are reflexive. Reflexivity is defined as:

> "The susceptibility of most aspects of social activity...to chronic revision in the light of new information" (Giddens, 1991:20).

Institutions and ideologies continually incorporate critiques of themselves. Social sciences are inherent elements of this reflexivity, as are an assortment of other writings, including commentaries on social activity within the mass media. The growth of research into a social activity tends to accelerate reflexivity in relation to the issues it explores in the everyday world (Giddens, 1992).

Ryan (1971) demonstrates one of the ways in which both change and continuity have occurred within the ideology of individualism. He points out that there has been an increasing awareness, in America, that certain inequalities are socially rather than personally constructed. Cultural deprivation, for example, is seen as a contributing factor to weak academic performance in schools. Yet the ideology of 'blaming the victim',

which locates defects which a victim has inside of his skin, persists. The victim is often seen to be at fault 'through no fault of his own'. When you get into a cycle of asking 'what is wrong with the victim?' you forget to ask about the circumstances which contributed to his failure (Ryan, 1971).

The ascription of responsibility to a human agent is a necessary component of the act of blaming. The human agent is often also seen as the cause but this is not a necessary condition for blame. Intentional causality, which is often seen as a separate variable in the psychological literature on blame (eg. Brewin, 1984; Shaver & Drown, 1986), is intrinsic to the ideology of 'the individual' in contemporary Western-influenced societies. The ideological level of explanation is fundamental to a theory of inter-group blame. As a consequence of the ideology of individualism, individuals are considered responsible for their actions. Consequently, they are blameworthy for the consequences which befall them.

The excerpts at the start of the chapter indicate that people tend to associate negative events with a different group to their own. If the notion of responsibility lies at the root of modern Western societies, why do people not hold both 'self' and 'other', both 'us' and 'them' responsible for negative events?

Social psychological theories propose that two motivations are at work when 'other' rather than 'self' is blamed: self-protection and control. Farr (1987) posits protection of a positive self-esteem within the ideological climate mapped out above. The motivation to enhance or protect self-esteem is borne out empirically by a number of attributional theorists (eg. Zuckerman, 1979; Kruglanski, 1987) and a number of social identity

theorists (Tajfel & Turner, 1979; Turner, 1981; Turner, 1982). Both the self-protective and control motivations form the basis of the 'just world hypothesis' (Lerner, 1970). It postulates that people believe that the plight of other people is deserved. This belief enables people to confront the physical and social world as though it were orderly and predictable (Furnham, 1985; Zuckier, 1987). Misfortune is justified by attributing responsibility to the victim or, at least, to a specific agent, due to a general fear of indeterminacy.

The self-protection and control motivations are obviously at work when the 'other' is blamed for a negative event. This chapter suggests that these motivations are related to unconscious mechanisms. Defence of a threatened identity needs to be brought explicitly to the centre of a theory of inter-group blame. I will divide the discussion into the process and function, and then the structure and contents of inter-group blame.

## 3.3 THE PROCESS AND FUNCTION OF INTER-GROUP BLAME: A PSYCHO-DYNAMIC BASE

### 3.3.1 THE INFLUENCE OF EARLY OBJECT RELATIONS ON COGNITIVE-EMOTIONAL DEVELOPMENT

I will adopt ideas arising from the British object relations school of psycho-dynamic theory to look at the relationship between cognitive-emotional development and inter-group blame. Infants' early relationships to the primary object in their environment - often the mother - influence their cognitive-emotional development. Feelings aroused within these relationships become the foundations of their responses to the world outside in later life. The infant uses defence mechanisms in order to protect itself from anxieties which arise. These self-preservation devices ward off the anxiety which results from feelings that

the infant's sense of order, stability and control is under threat. Residues of the early feelings and defences remain with the individual throughout life. They become a part of the vicissitudes of everyday interaction (Bion, 1961; Young, 1991) which are rekindled when the individual experiences helplessness in relation to objects in the external world. These feelings arise at a stage when the infant is at its most helpless and so recur in situations of helplessness.

### 3.3.2 THE PARANOID-SCHIZOID POSITION

All infants pass through the paranoid-schizoid position when they begin to interact with their primary objects. According to Klein (1952) the position comprises a combination of three factors: Anxiety in relation to feeling persecuted, the adoption of the defence mechanism termed 'splitting' and experiencing powerful destructive impulses.

The infant's relationship with the primary object is, by definition, both gratifying and frustrating. This results, among other things, from the inability of the primary object to fathom or to respond to all of the infant's needs (e.g. for food, for love). At times when its needs are not fulfilled, the infant experiences the primary object as persecutory. Because the infant has not, as yet, established a boundary between itself and the primary object, it also experiences itself as persecutory. Similarly, when its needs are fulfilled it experiences both its primary object and itself as satisfying and loving. At this point in its cognitive-emotional development the infant experiences the objects outside of and within itself in polarised terms: There are bad, persecutory objects and good, loving objects. When the infant undergoes a persecutory experience, feelings of hate and destruction are evoked. Destructive feelings are accompanied by feelings of extreme anxiety. The infant

is paranoid that destructive forces within or outside of itself are motivated to harm it. In order to maintain its experience of nurturance and satisfaction with its primary object and, therefore, with itself, it must find a way of warding off this anxiety.

Hateful feelings in relation to the primary object are dispensed with by splitting them off from the loving feelings which the infant wants to hold onto. Splitting, an unconscious mechanism of defence, is associated with the incorporation/introjection of good experiences and feelings, and the casting out of/projection of bad experiences and feelings. Splitting, with its two components, introjection and projection, is "a way of dealing with persecutory anxieties arising from paranoid feelings" (Lawrence, 1986:221). Splitting, introjection and projection are among the first active mental processes of the infant. These primary mental processes aim to keep bad objects - associated with the others onto whom they are projected, away from good objects - which are introjected into the self. Thus human mental processes are built upon an inner-structure which distinguishes between a good self and a bad other.

The splitting mechanism which operates between the infant and its primary object has a social counterpart (Jaques, 1977; Sherwood, 1980; Lawrence, 1986). People split the 'objects' or people in the world around them into good and bad groups. The distinction between 'us' and 'them' is fundamental to cognitive-emotional functioning. It manifests itself most powerfully when the anxiety level of individuals is raised. The projection of bad onto other groups, imagining that the bad lies within them rather than within the in-group, is what is meant by inter-group blame.

### 3.3.3 SOCIAL IDENTITY THEORY AND THE LIGHT IT CASTS ON THESE PSYCHO-DYNAMIC IDEAS

The psycho-dynamic literature does not explain how the social counterpart of splitting operates at an inter-group level. Social Identity Theory (SIT) is, covertly, drawn upon in making the transition from the inter-personal to the inter-group level. SIT proposes that social identity is a part of personal identity (Tajfel & Turner, 1979). The laws pertaining to inter-personal explanation therefore pertain to the inter-group level too. In the course of identifying with a group, the need to perceive oneself positively, on the inter-individual level, translates into a need to regard one's group favourably. SIT asserts that in certain situations individuals act as group members rather than as private individuals. Within these situations self-concept and social identity have the same meaning:

> "When a particular group membership does constitute a salient aspect of the momentary self-image, the individual will come to apply the norms and stereotypes associated with the [in-group] category to the self and will hence come to regard self as interchangeable with other in-group members" (Condor & Brown, 1988:10).

In the process of forming a personal identity, values and ideologies are imbibed from the social environment. Certain groups are integrated into the 'good' self and others are construed as the 'bad' other.

SIT is also useful in its emphasis on the fact that the process of categorisation is a basic element of thinking which minimises the differences between people within a category and amplifies the differences between people in different categories (Tajfel, 1981). Differences between members of the in-group are minimised and differences between in-group and out-group members are exaggerated.

SIT also casts empirical light on the psycho-dynamic notions of the good 'us' and the bad

'them'. The process of ethnocentricism, of in-group bias, mirrors the concept of splitting. Mullen, Brown and Smith (1992) integrated the results of 137 experiments of the in-group bias hypothesis and found empirical support for the fact that there is a positive evaluation of the in-group relative to the out-group. This indicates that the cultural assumption of responsibility is applied to the other but not to the self in relation to negative events. Psycho-dynamic factors are at play.

The SIT literature documents instances where in-group bias is less likely to occur. This is termed 'out-group preference' (Tajfel, 1982). This indicates that psycho-dynamic factors do not operate alone. Ideological forces are also integral to the process of inter-group blame. The interplay of psycho-dynamic and ideological forces lies at the root of my theory of inter-group blame.

## 3.4 THE STRUCTURE AND CONTENT OF INTER-GROUP BLAME

Psycho-dynamic historians have been interested not only in the process and the function of defences, but in the structure and contents of inter-group blaming reactions including: when inter-group blame occurs; which groups are the recipients of inter-group blame; the nature of the blaming reactions. These features are central to a theory of inter-group blame.

### 3.4.1 WHEN THE BLAME OCCURS

Factors within the individual's social environment either activate or constrain the use of defence mechanisms (Sherwood, 1980). Change in the social environment, such as the rising presence of a mass illness, is one of the ways in which psychotic anxiety is evoked

within group members. Such changes make for insecurity which exacerbates people's unresolved identity conflicts (Sherwood, 1980). In the face of a mass crisis, in which people perceive their world to be out of control, with their protection compromised, inter-group blame is most likely to occur. In fact, it is in the face of new events that social representations are formed by way of the processes of anchoring and objectification (as I explored in Chapter One). New ideas are anchored and objectified in order to ward off the fear of the unknown.

### 3.4.2 WHO BEARS THE BRUNT OF THE BLAME

Certain groups have repeatedly represented the bad 'other' within certain societies:

> "Every social group has a set vocabulary of images for this externalized Other. These images are the product of history and of a culture that perpetuates them. None is random; none is isolated from the historical context. From the wide range of the potential models in any society, we select a model that best reflects the common presuppositions about the other at any given moment in history" (Gilman, 1985:20).

Each social group had various 'repositories' (Sherwood, 1980) or 'defenceless groups' (Gilman, 1988; Andreski, 1989) as potential targets for their blame. The 'common presuppositions' about these groups arise from social representations concerning these groups. I have indicated (in Chapter One) that social representations reflect the history or collective memories of the society as well as the thinking which circulates in the scientific community, the mass media and in everyday conversation. People's knowledge concerning groups who can be targeted for blame is constructed by these social forces. While different groups in a society will have different 'repositories' for their blame, the dominant ideologies within a society tend to propagate an image of specific groups as the entire society's 'other'. Homosexuals tend to be one of the groups which occupy this position in Western societies.

By way of contrast to a social constructionist perspective certain writers posit that realistic features of certain groups evoke blame. This debate is particularly important in relation to AIDS: The link between the homosexual group and AIDS is construed as 'natural' within certain debates because (what was later termed) AIDS was initially identified in homosexuals. Fenichel (1946) is among those who propose that **real differences** between the defenceless group and the dominant group precipitate the unconscious projections of the dominant group at times of extreme crisis. He draws an example from history. The ghetto system was designed, in Europe, to exclude Jews from participation in the culture of the host population. Jews accepted the system and retained elements of it, such as resistance to assimilation to their host population and the code of dress, long after fashions had changed within the host culture. The different mental culture, religion and code of dress has maintained the image of the Jew as a foreigner, as a constant repository for projection, throughout history. Fenichel's argument can easily be challenged by way of counter-examples. The Jews of Berlin, whom the Nazis exterminated, were highly assimilated into the host community.

Perhaps one needs to rethink the notion of 'real difference' rather than attempting to find examples which support or refute the hypothesis that real differences precipitate blame. That which is 'real' is constructed by the society's institutions - churches, schools, legal systems, mass media and languages. These institutions are subject to the forces of fantasy, myth and social stereotype. Social representations are a product of fantasies, myths and social stereotypes which have been sanctioned throughout the history of specific cultures. The association of Jews or homosexuals with crises in a society is related to the fact that those who need to explain the crisis - including scientists - are likely to be suggestible to

associations between certain groups and the crisis because of their social representations concerning those groups.

I will now look at certain fantasies, myths and social stereotypes which have influenced society's institutions historically. Fantasy concerning the **rituals** of the out-group allows the out-group to be construed as a threat by the in-group (Cohn, 1976). Mass blame in history, or the witch-hunt mentality, can be traced back to the second century A.D. The Romans, within the Roman Empire, saw the rituals of the Christians, an out-group, as a threat. Excessive eating and drinking were inherent to the Christian Agape or love-feast, in which baptised Christians feasted communally, with the intention of affirming Christian fellowship. The Romans imagined this to be similar to their Bacchanalia or nocturnal orgies. Romans interpreted these activities in terms of erotic debauches, cannibalism and infanticide. Medieval Christendom revived the Roman tales of eroticism, cannibalism and infanticide, and applied them to religious out-groups:

> "Again and again, over a period of centuries, heretical sects were accused of holding promiscuous orgies in the dark ... of worshipping the devil" (Cohn, 1976:54).

> "When it came to discrediting some religious out-group, monks would draw on this traditional stock of defamatory clichès" (Cohn, 1976:56).

Throughout history fantasies about the rituals of certain out-groups have contained notions of erotic perversion, cannibalism and infanticide.

### 3.4.3 THE NATURE OF THE BLAMING REACTIONS

Fantasies concerning out-groups allow people to project those facets of themselves, which they and their societies find unacceptable, onto others. The way in which people perceive others at times of crisis is connected to their dislikes concerning themselves. Perverse

sexuality and inferior racial identity tend to be at the core of blaming aspersions (Gilman, 1988). Discovering 'savagery' within the victims of blame is often a pre-requisite for blaming them (Ryan, 1971).

### 3.4.3.1 The role of science in undermining certain groups

Science has been used in the history of European culture to legitimise certain forms of inter-group blame. It has given legitimacy to the view that certain groups are inferior - less human than other groups. This inferiority has been connected both with racial identity and with sexuality. Race provided Europeans of the colonial and slavery era with a way of both categorising humans and of explaining a wide range of social differences. The function of social differentiation is to justify the superiority of one's in-group (Tajfel, 1981). Ideas of racial superiority emanated from social scientific thinking (Husband, 1982), scientific reasoning, literature and the media of Europe, the colonial empires and North America prior to the second world war (Boonzaier, 1987a).

The 1950s saw a turning point. The aftermath of an era of colonisation and slavery, combined with a realisation of the atrocity of Hitler's applied eugenics, caused many Western scientists to dissociate themselves from social representations of racial superiority. Lay people were less quick to respond (Boonzaier, 1987a). Thompson offers an explanation for this:

> "This was partly because the racist paradigm...satisfied the European and white American sense of identity, self-esteem and self-interest" (1985:5).

Jensen's work in the 1960s allowed for a return to ideas of racial superiority, as did the work of Garrett (1962) and Shuey (1966). Eysenck's work of the 1970s, which was

disseminated through magazines and the press, propagated the idea of the racial superiority of certain groups in intelligence and kept alive the notion that race is genetically, rather than culturally, determined (Husband, 1982). Sociobiology, popularised in the 1970s, was a restatement of these trends. The adaptation of Darwinian ideas concerning 'natural selection' and the 'survival of the fittest' allowed Westerners to feel superior because their culture had gained world hegemony. Their culture is 'the fittest'. The debate concerning racial superiority has undergone a number of transformations in the Western world, but remains alive.

An argument that runs parallel to the idea that those who are different are regarded as inferior is one in which the different are invested with emotionality and with spirituality. Fanon (1992) notes that people who are not seen to have kept pace with the evolution of the human race are believed to possess Black Magic, primitive mentality, animism and animal eroticism. Hall (1991) has suggested that prejudice, especially racism, tends to be a combination of degradation, envy and desire. Various diagrams and exhibits of the genitals of Hottentot women were on show in various European museums in the nineteenth century. The difference between their sexual parts and those of Western women was used to indicate that they were a lower species. At the same time, Hottentot women were depicted as highly sexual objects in the art of the day. European voyeurism was evident in a fascination with black women's genitals as well as in other factors. The zoos of Germany, Austria and Budapest contained people from Africa, prior to the first world war (Gilman, 1985). These 'tribal' people were viewed as they went about daily activities, such as eating.

The term 'tribe' is generally used in the context of labelling cultural curiosities in under-developed countries. Implicit in the idea of 'tribe' is the notion that some people are still tribal whereas others have advanced beyond this developmental stage, to the modern nation. Conceptually opposed to 'tribe' are the categories 'nation' and 'civilization' (Skalnik, 1988).

Inter-group blame exists in order to control that which threatens our feelings of omnipotence. Emotionality, spirituality and our instinctive (animal) side, historically associated with people from under-developed countries, threaten this omnipotence.

### 3.4.3.2 The process of dehumanisation

The tendency to dehumanise people who are a threat to one's group's sense of control and protection is conclusively documented (Sherwood, 1980; Bar-Tal, 1990). Dehumanisation involves categorising a group as inhuman either by using categories of sub-human creatures, such as animals, or by using categories of negatively valued creatures such as demons (Bar-Tal, 1990). Bar-Tal refers to the Nazi texts which dominated German thinking between 1933 and 1945 in order to illustrate this point. Jews were described as 'vermin', 'bacteria', 'pests' and 'international maggots'. They were also described as 'satanic', 'devils' and 'demons'. Once dehumanised, a group can easily be construed as 'other'.

The rituals of bestiality and cannibalism have existed in various parts of the world. Talbot (1927) documents ritual bestiality with dead antelopes in Southern Nigeria, while Hogg (1966) writes about the existence of cannibalistic rituals in parts of Nigeria. Similarly,

there may have been a certain amount of cannibalism when Columbus arrived in the Americas. While there is likely to be a 'real difference' of rituals in different societies, the central point is that this difference is used towards certain ends. Cannibalism played a key role in denunciating Indian civilisation (Thomsen, 1987). European conceptions of the 'New World' "merged into a strange brew of myths and fairy tales,...into collective fantasies, which to a considerable degree contained and reflected unsolved European problems and tensions" (Thomsen, 1987:42).

Columbus created a basic distinction between 'good' and 'bad' Indians (Trevistan, 1986; Thomsen, 1987). The 'good' Indians were noble savages - beautiful, naked and sexually desirable. The 'bad' Indians were cannibals, devilish and promiscuous. Those who followed Columbus to the 'New World' augmented these ideas, constructing a trinity of cannibalism, witchcraft and satanism, very much in accord with the European ideologies of witch-hunting. Thomsen (1987) notes that Oviedo, a chronicle writer of the king of Spain:

> "proceeded from [the] homosexuality practised by some Indians, and, in a direct line of associative thinking arrived at cannibalism practised by some as well, but generalized, it looks as if most of them practice both sins...they throw overboard any sound and moral Christian education. Their indomitable sexuality finally equates them to animals" (p.44).

Dehumanisation is certainly a way in which hegemonic groups have undermined out-groups throughout history. Bestiality and cannibalism are imagined to be ritualised in Africa and in the Americas. By linking sexuality with the 'other' one need not deal with the taboo-breaking fantasies which lie within oneself.

Many argue that certain groups are viewed in a dehumanised way so that they can be badly treated (eg. Zimbardo, 1970; Thomsen, 1987). Subordination and genocide are laudable unfoldings of natural law. The European ideology of racial superiority was used to exploit, oppress and exterminate non-Europeans from early imperialist expansion until the Holocaust (van Dijk, 1991). The Europeans were able to distance themselves from feelings of weakness and vulnerability, at times of despair, with delusions of greatness and of purity. Dehumanising social representations of Jews served as a boundary around 'pure' Germans, splitting them off from the inhuman creatures which threatened their survival. The introjection component of the splitting defence is ever present as we imagine a 'good' and pure self and a 'bad' and perverse other.

## 3.5 EXTREME FORMS OF INTER-GROUP BLAME

### 3.5.1 CONTAGION AND POLLUTION - BREACHING THE BOUNDARIES BETWEEN 'US' AND 'THEM'.

I have stated that the ascription of responsibility to a human agent is a necessary component of a blaming reaction but that blame is likely to increase when the human agent's 'irresponsibility' has consequences for ourselves. My discussion, so far, has indicated the fundamental need to maintain a boundary between a 'good' 'us' and a 'bad' 'them'. Inter-group blame is likely to be intensified when 'we' begin to feel that 'they' will invade our boundaries. A fear of contagion or of pollution expresses a worry that the bad will invade the good. Images of contagion have, historically, been used to suggest that the order and control of the in-group is under threat.

Douglas (1966) states that people construct symbolic systems of purity so as to order the chaotic set of stimuli which exist around them. Those elements which cannot be classified

within the system threaten its order and are, therefore, both dangerous and powerful. These elements are regarded as potentially polluting in that they can potentially cross over into the order and destroy it. Thomas (1971) asserts that the practice of magic is an attempt to attribute agency to some force, when a negative event befalls the community, so that control can be reasserted. The control motivation lies at the root of both Western and non-Western blame. The construction of the 'other' as polluted and polluting is a result of this motivation. This construction is likely to become prominent when a group begins to feel that a crisis event, formerly associated with the 'other', is beginning to affect it.

### 3.5.2 CONSPIRACY THEORIES

Blatant inter-group blame results not only from a fear of invasion, but from a fear that one group actively conspires against one's own group. Zuckier (1987) explains the functional need to implicate or scapegoat a certain group:

> "Most people, scientists and laymen alike, experience a profound unease - Ubehagen, in Einstein's terms - towards indeterminacy in history...[They] impute whatever happens in society - including, of course, all afflictions, calamities and predicaments - to the design of some powerful individuals or groups" (p.89).

People spontaneously seek causal explanations for events. This finding has empirical backing (Heider & Simmel, 1944; Michotte, 1946). Humans are fascinated with elementary and exhaustive causality or 'first cause' (Poliakov, 1980; Jodelet, 1984b). "Faced with a new event or object, about which we know nothing, explaining it by finding a causality is a way of representing it" states Jodelet (1984b:377). Lay thinking tends to move quickly from the level of description and classification to explanation. While the scientific world hedges its way around problems with statements of correlation, lay people

are often quick to infer causality.

Conspiratorial explanations of events "make 'objective' sense by suggesting forms of causality, and restore to people a subjective psychological sense of control, freedom and responsibility" (Zuckier, 1987:90). People grope for a sense of control in uncontrollable circumstances. This is related to feelings evoked by the persecutory experiences which the individual had in the first stage of infancy.

Conspiratorial thinking is characterised by an under-estimation of the complexity and dynamics of an event. A linear mode of thinking operates, in which results of an action are ascribed to intention. Two events are seen to be connected by a causal nexus which is not demonstrable.

Conspiracy theories form a subset of inter-group blame. Blame is always linked with the responsibility of human agent/s, but an explicit cause and intention, as I have stated previously, are not necessary components of a blaming reaction. Western thinking connects responsibility with cause and intention and control anyway. At certain times this is more blatant than others.

## 3.6 POWER AND THE ASYMMETRY OF BLAME

A pivotal aspect of a theory of inter-group blame is the nature of the power-relationships within a society. SIT and related theories have tended to concentrate on in-group bias (Hinkle & Brown, 1990). But this does not always occur. Groups which are regarded as inferior by various institutions within a given society often derogate their own in-group

and show positive attitudes to out-groups. Out-group favouritism has been found in South African blacks (Tajfel & Turner, 1985). This finding must be explained by means of the ideological workings of society. Certain social representations of events have more legitimacy than others and are adopted by the society's institutions such as by the mass media and by scientists. This has implications for group members and their evaluation of their own groups. Groups who are constantly an object of blame in a society's representations, will, to a varying degree, come to blame themselves.

## 3.7 THE CONVERSE OF BLAME: TOLERANCE

Billig notes that, if a theory appears to have plausibility, it pays to reverse it because the reverse will also be plausible (1985, 1987). The theory which I have sketched appears fatalistic: Inter-group blame appears to be an inherent part of human thinking at times of mass crisis. Yet, just as there is a tendency to blame other groups, so there is a tendency to be tolerant of other groups. In addition, people will not necessarily link an entire category of people to the mass crisis, but may regard it as situationally determined. Perhaps this stems from the fact that people think creatively. One cannot infer from the proliferation of the ideology of individualism that all people will subscribe to this ideology. They may have heard counter-arguments to the one which flourishes in the institutions around them. These arguments induce reflexivity (see Section 3.2.2).

The argumentative nature of blame-related thinking is illustrated by the fact that a differentiation is often made between victims of negative consequences who are responsible for the consequences, and those who are not. Certain victims are seen to have had choice, while others are seen to have had no choice. Consequently, certain groups are

viewed sympathetically while others are not. The process of blame is argumentative. Some people may draw only on the counter-blaming aspects without imputing responsibility at all. This makes a close look at the language which people use in talking about the crisis event which is being studied so important.

The object relations school of psycho-dynamic theory offers a plausible explanation for the cognitive-emotional tendency towards tolerance. Infants tend to move through the paranoid-schizoid position into the depressive position. Within this position the infant realises that both 'good' and 'bad', nourishment and deprivation, satisfaction and persecution, derive from the same primary object. It needs to reconcile the polarisation, between good and bad objects, which had been established in an earlier stage of development. It enters the depressive position when it begins to mourn the loss of the idealised self and the idealised primary object. If mourning takes place the infant acquires an ability to tolerate ambivalence. Toleration of ambivalence is central to a non-split way of looking at the world.

I do not want to separate the actor from the social environment. In the same way that certain individuals are able to see the world in non-polarised terms, so certain non-polarised ideologies exist. In the same way that blaming ideologies are given credence by certain institutions, so ideologies of tolerance can be given credence. Racial equality laws in much of Europe constrain inter-group blame, in much the same way as Apartheid and Nazi laws activated it.

## 3.8 CONCLUSION

This chapter highlights the centrality of the ideology of individualism, with its focus on individual responsibility, to a theory of inter-group blame. At the same time, it calls for a recognition of the role of unconscious defence mechanisms. Defensiveness motivates group members to view themselves as pure and other group members as polluted and polluting. The fantasies, myths, social stereotypes and images which exist in a particular culture embrace the defensive thinking which has existed in its history. Inter-group blame involves an interplay of unconscious forces. These forces can be modified by the reflexive thinking which characterises late modernity. This process will determine whether patterns of inter-group blame are activated or constrained. I will apply the theory of blame which I have mapped in this chapter, to AIDS, in Chapter Four. It will then be empirically tested in the studies reported in subsequent chapters.

## OVERVIEW OF CHAPTER FOUR

While in the previous chapter I look at blame for a crisis in generic terms, in this chapter I review the literature directly concerned with the relationship between illness and blame. I explore the factors likely to influence social representations of AIDS in the South African and in the British contexts. This includes references to studies conducted in each of the two countries, which cast light on the relationship between AIDS and blame. I emphasise the roles played by the unconscious forces of fantasy and of ideology in the representation of AIDS.

# CHAPTER FOUR: THE APPLICATION OF A THEORY OF INTER-GROUP BLAME TO AIDS

> "Although white clients generally pay better than their black counterparts, I will never go to bed with a white man unless he wears a condom. As far as I am concerned AIDS is a white man's disease" (**Lagos prostitute's statement** quoted in Sabatier, 1988:94).
>
> "Today pornography in western cities conveys a lurid tale of a society which has gone berserk in its sexual habits [with] negative consequences for world public health" (feature article in the **Nigerian magazine African Concord**, quoted in Sabatier, 1988:90).
>
> "I have no sympathy with gays whatever their problem or bisexuals who are the real murdering culprits for introducing the disease into the innocent heterosexual world who are now paying for their filthy behaviour" (**British male** respondent quoted in Clift, Stears, Legg, Memon & Ryan, 1990:60).
>
> "I think there should be a law against gays and lesbians because they are not natural and if it wasn't for them then we would have the cure [for AIDS]. Also the foreigners should be kept in their own country because they are spreading the disease" (**British female** respondent quoted in Clift *et al.* 1990:60).

## 4.1 INTRODUCTION

In Chapter Three I forged a theory of inter-group blame. I will now attempt to apply this theory to the trigger situation which is the focus of this thesis: the origin and the spread of AIDS. I will draw on illness research and, specifically, on research into social representation of mass incurable illnesses.

A review of the literature in several disciplines indicates that mass illnesses have evoked reactions of inter-group blame throughout history, within a myriad of cultures. Sabatier (1988) has documented the tendency, on an international level, to 'blame others' for AIDS. Foreign continents and countries, and certain racial and 'high risk' groups within

one's own country are blamed for the origins and the spread of HIV/AIDS. On the basis of anecdotes collected internationally, she asserts that AIDS has been associated with foreignness. There is a universal tendency to deny that AIDS affects one's own community. Denial is followed by blaming others for introducing and spreading the virus.

## 4.2 SOCIAL REPRESENTATION OF 'OTHERNESS'

Fifteenth century writings on syphilis render what has become a classic picture of inter-group blame:

> "It was the 'French pox' to the English, morbus Germanicus to the Parisians, the Naples sickness to the Florentines, the Chinese disease to the Japanese. But what may seem like a joke about the inevitability of chauvinism reveals a more important truth: that there is a link between imagining disease and imagining foreignness" (Sontag, 1989:47).

This 'foreignness' may be constituted by foreigners within or outside of one's own society, or by out-groups within the society concerned. AIDS is 'women's disease' among certain ethnic groups in Uganda and in Thailand (de Bruyn, 1992). Ghanaian soldiers perceive themselves to be at risk of AIDS only when they are on operation outside of the country (Apeagyei *et al.*, 1991). AIDS is 'gay plague' to many Westerners. It is a black disease to many white South Africans (Sifris, 1991), a disease of foreigners and of white homosexuals to many black South Africans (Bates Wells Partners, 1990).

'Foreignness' or 'otherness' may be related to certain groups. It may also be related to a toxic, urban space beyond the boundaries of the self. Herzlich's (1973) study, of the social representations of urban and rural French people, found that illness tends to be represented as something which emanates from the outside, while health is perceived as the natural state of the individual. The link she makes between illness and foreign forces

is pertinent to AIDS research despite the fact that she does not study mass incurable illness.

Herzlich (1973) argues that one of the major forces outside of the individual which is linked to illness is the urban lifestyle: "The responsibility for the actual beginning of the illness belongs to the way of life" (Herzlich, 1973:50). Herzlich (1973) sees lifestyle as a force which is external to the individual, whereas many theorists (eg. Naidoo, 1986; Aggleton, 1989) link lifestyle to forces within the individual, to the individual's behavioural choices. While this point remains debatable, it is the content of the lifestyle-based social representations, to which she alludes, which is highly salient to a study of AIDS. The urban lifestyle is assigned a major role in the genesis of illness. Its influence is always undesirable. This way of life weakens the individual, producing a world of fatigue and of nervous tension. The decline in health produces increased vulnerability to illness. Herzlich (1973) found that urban living was regarded, by two thirds of her respondents, to be unhealthy in that the urban environment was 'toxic'. The idea of toxicity might be central in the social construction of a modern disease such as AIDS. Aggleton, Homans, Mojsa, Watson and Watney (1989) found that certain young people saw AIDS as a consequence of pollution or of ecological instability, triggered by man meddling with the environment.

I have argued in Chapter One that the disease which characterises the age acts as a social commentary on the conflicts of that age. Many of the concerns of the present age are related to the environment. More specifically, they are related to abuse of the environment in the modern period, through the placing of excessive emphasis on consumption. Coupled

with Herzlich's findings, social representations of AIDS are likely to link AIDS with a toxic urban lifestyle.

## 4.3 SOCIAL REPRESENTATION OF AIDS AS A DISEASE CAUSED BY ITS 'VICTIMS'

Herzlich's (1973) work is also relevant to social representations of AIDS in that she finds that, in making a link between lifestyle and illness, people often imagine that lifestyle causes illness. The argument that the urban way of life facilitates the attack, by germs or viruses, on the immune system, slides easily into an argument that urban living causes/generates the germs or viruses themselves. This conceptualisation is relevant in that it points out that people confound the issues of 'origin' and 'spread' of an illness, with the 'cause' of that illness. Her work provides a useful inroad into a discussion of the issues of responsibility and pollution which are central to inter-group blame.

AIDS provides an excellent example of people's tendency to transform the knowledge that a virus causes AIDS into an argument that certain lifestyles cause AIDS. People understand that a virus causes AIDS but still hold certain groups responsible for its presence. Vass (1986) found that 44% of his British sample felt that homosexuality itself was the cause of AIDS. Only 14% identified a viral cause. Interestingly, Schlebusch, Bedford, Bosch & du Preez (1991) found that 19% of a sample of South African health care professionals agreed with the statement 'Homosexuality causes AIDS'. The ideology of individualism eclipses the virological explanation of AIDS - even among health care professionals. People easily enter into a cycle of asking 'What is wrong with the victim?' They forget to ask about factors which contributed to the victim's failure.

Writing about epidemics of cholera, Rosenburg (1989) states that people have sought to gain a sense of control in the face of an epidemic by minimising their own sense of vulnerability. People have done this by explaining the differential susceptibility of particular individuals. This has been expressed in terms of their behaviour, their style of life and the environment they inhabit. Sexual promiscuity, alcoholism, gluttony and filthy personal habits were widely accepted as predispositions to cholera. Environmental ideas co-existed with the 'style of life' ideas. People were seen to be predisposed, by their environment, to excessive drinking. Yet they were still held responsible for the consequences of this indulgence. This supports Ryan's (1971) idea that victims of crises are often seen to be at fault 'through no fault of their own'. Rosenberg (1989) contends that the same process occurs in relation to AIDS.

The World Health Organisation's Global Program on AIDS holds social inequalities responsible for the spread of AIDS: gender inequalities (women not being able to insist on using a condom); poverty (not being able to prioritise or afford condom-use); and problems associated with migrant labour (which cuts off people from their culture so they are not reached by safer sex messages). Yet lay people do not tend to view the spread of AIDS in terms of social factors. A dominant social representation of AIDS associates it with the irresponsibility of certain individuals or of certain groups rather than with social factors. This social representation reflects the ideology of individualism as well as the notion of illness as punishment.

## 4.4 SOCIAL REPRESENTATION OF AIDS AS PUNISHMENT

There is an ancient, universal view of illness as punishment. Two theories of illness as

punishment co-exist. Firstly, God deliberately punishes offenders in retribution for an offence. Secondly, in its more modern form, people contract illnesses as a result of their choice of unhealthy lifestyles.

The lasting influence of Protestant and Capitalist ethics correlates with Western culture's blame of the victims of a disease for their own outcomes. But an older representation, the biblical notion of divine wrath, still pervades the collective memory. It determines which anchors people use in order to represent a new mass illness. One expects the social representations of lay people to reflect both the older and the newer notions of punishment. In fact, Rosenberg (1989) states that spiritual assumptions have co-existed with secular explanations of epidemics since the sixteenth century.

Since HIV transmits easily by way of anal sex, which is regarded to be both illegal and sinful within many countries, including Britain and South Africa, AIDS is easily seen as punishment. The old testament links sexual intercourse, disease transmission and a lack of hygiene with divine punishment (Rosebury, 1971). Anal sex continues to be used synonymously with the term 'sodomy'. This reference is, of course, biblical. As in the time of Sodom and Gomorrah, God or 'nature' is perceived to have sent a plague/micro-organism with the intention of punishing certain groups for their unhealthy lifestyles. Theories of illness as punishment are likely to be prevalent in more moralistic and religious societies. Yet collective memory is likely to preserve these theories in societies whose current religious orientation has diminished.

Western societal disdain for homosexuals seems to stem from a number of social

representations. Firstly, homosexual behaviour is synonymous with anal sex or sodomy. Sodomy is linked to sin, in the religious realm. Anal sex is linked to deviancy in terms of a more secular set of explanations. Homosexuals are deviant in that their behaviours are not practised by the majority in the society and their sexual acts are non-procreative:

> "There can be little real argument about the basic stance of Christianity. Since sex, according to Christian teaching, was given to man solely for the purposes of reproduction and for no other reason, any form of sexual activity which did not lead or could not lead to procreation was a sin against nature. Sins against nature specifically included bestiality, homosexuality and masturbation" (Richards, 1990:132).

The terms sodomy and sodomite were used in the Middle Ages for anal sex, masturbation, bestiality and non-procreative sex (Richards, 1990).

There is a further social representation in which the homosexual is viewed as narcissistic. This is reflected in the practice of paedophilia in which older homosexuals perpetuate the notion of male beauty by worshipping young boys. In addition, social stereotypes of homosexuals view them as feminised men. Attitudes to homosexuals are highly correlated with attitudes to women. Societal disdain for women is cast out onto homosexual men.

The theory that 'sufferers only have themselves to blame' for contracting the HIV, has characterised the relationship of lay people to HIV and AIDS ever since its discovery (Vass, 1986; DHSS, 1987; Stockdale, Dockrell & Wells, 1989; Nutbeam, Catford, Smail & Griffiths, 1989). A moral quality is integral to this blame. Clift and Stears (1988) interviewed 184 people before and after the British Government's first AIDS television campaign. They found that, while the majority rejected the notion that AIDS was a divine intervention, a substantial proportion saw AIDS as a reflection of low moral standards. This increased after the screening of the campaign. Boyle *et al.* (1989) found that many

young British people claimed that AIDS was everybody's problem and nobody's fault. They recognised the dangers of scapegoating. At the same time, the language used in talking about various groups contained terms such as 'innocent', 'responsible' and 'not at fault'. Liberal claims and illiberal language existed alongside each other.

Within the South African context many people hold a social representation of AIDS as 'punishment' for an unhealthy lifestyle. Fifty three per cent of a sample of South African health care professionals agreed with the statement 'Homosexuality is immoral' (Schlebusch *et al.*, 1991). In a large scale South African survey (The McCann Group, 1988) 28% of English-speaking South Africans, 42% of Afrikaans-speakers, and 38% of blacks agreed with the statement: 'Anyone who catches AIDS has only themselves to blame'. Fifty six per cent of the English speakers, 72% of the Afrikaans speakers, and 71% of the blacks agreed with the statement: 'If everyone acts responsibly AIDS will be kept under control'. Twenty eight per cent of English-speaking South Africans, 50% of Afrikaans-speakers, and 50% of the blacks agreed with the statement: 'If people are informed, then catch AIDS, I won't feel sorry for them'. These statements assume that individuals have control over their destinies and are therefore blameworthy for the outcomes which befall them. Like Clift and Stears' (1988) finding in the British context, the survey indicates that South Africans were more inclined to blame after the screening of the first government mass media campaign than they were beforehand. Afrikaaners have a greater tendency to cast blame. This may be attributed to the powerful influence of Calvinism (The McCann Group, 1988). The moralistic stance of black South Africans was corroborated by the more qualitative work done by Mathews, Kuhn, Metcalf, Joubert, & Cameron, (1990):

> "Explanations of risk also tended to take on moralistic overtones, and 'dirty people', 'bad people', 'people who don't attend clinics or are careless about their health' were some of the responses to the question on students' beliefs about who has AIDS" (p.515).

Certain types of people are considered responsible for infection with HIV, whereas others are seen as innocent victims. The individuals who are considered responsible for their infection are believed to have control over their actions - their actions are seen as 'stupid', 'wilful' or 'wrong' - whereas those who are considered the 'innocent victims' are seen to have no control over events. During the syphilis epidemic the wives and infants of syphilitics were the 'innocent victims' (Rosenberg, 1989). Haemophiliacs, blood transfusion recipients, babies and heterosexuals are often regarded as the 'innocent victims' of AIDS. This is related to a connection between volition, behaviour and the negative consequence - acquiring HIV. If you become afflicted you have obviously transgressed. Transgression implies punishment. Thus a division occurs between the deserving and the 'innocent' victims. Perceived innocence or guilt of specific groups is not only related to the volition or control which these groups had over their behavioural choices and their consequences, but to the status of that group prior to the entry of HIV into their society.

Even when an illness is associated with God or with nature's punishment, people look to human behaviour in order to understand the reasons for this punishment. If human responsibility can be fixed, perhaps something can be done, perhaps order can be reasserted in an otherwise disruptive situation (Nelkin & Gilman, 1988).

## 4.5 WHICH GROUPS ARE BLAMED FOR AIDS?

Which groups are chosen as exemplars of 'irresponsibility'? This choice is based upon both emotional and ideological factors. Inter-group blame is related to defence of an identity threatened at a time when changes in the social environment occur. A variety of large-scale Western studies on AIDS show that males are more likely to blame than females (Clift *et al.*, 1990; Connors & Heaven, 1990) and are more homophobic (McDevitt, Sheehan, Lenon & Ambrosio, 1990). In addition, while boys tend predominantly to blame homosexual men for AIDS, girls also blame foreigners and prostitutes for AIDS (Clift *et al.*, 1990). Clearly, Western men are more threatened by AIDS because it has tended to affect men.

AIDS was initially identified, by the scientific community, with homosexual men. The media broadcast this finding. In addition, homosexual men have continued to dominate the official AIDS statistics in the majority of Western countries. Yet the blame of a certain group for AIDS is not necessarily related to the fact that it forms the majority within the particular country with AIDS. Black South Africans did not see whites as exemplars of irresponsibility at a time when well over 70% of people reported to have AIDS in South Africa were white. A study conducted in high-schools in the townships of Cape Town, South Africa (Mathews *et al.* 1990) illustrates this point:

> "Students did not acknowledge that AIDS could affect them directly, and attributed the problem to prostitutes and 'promiscuous' people in 36.4% of responses, and to 'white' people in 23.8% of responses" (p.511).

So only 23.8% of blacks associated AIDS with whites at a time when over 70% of PWAs in South Africa were white. Though similar information does not exist for whites,

anecdotal information points to the fact that AIDS was seen as a black disease by whites (Bates Wells Partners, 1990).

Two theories concerning the origin of syphilis exist in European writing. "We are not likely ever to know beyond a doubt how syphilis began, or when. But the question continues to be asked, and answered" (Rosebury, 1971:49). One theory (often termed the Unitarian theory) posits that the syphilis of the fifteenth and sixteenth century European epidemic was an African disease imported by the slaves of West and North Africa to the Iberian peninsula. A second theory, the Columbian theory, asserts that sailors on Columbus' ships brought it back from the American Indians with whom they had contact in the New World (Morton, 1971). Neither theory imagines Europeans as the possible origin of syphilis. Yet in texts from the under-developed world diametrically opposite theories exist: Syphilis is imagined to have been brought to the underdeveloped world by way of slave-traders, missionaries, colonisers, and Western travellers (Trevistan, 1986).

Like the origin of syphilis, so the origin of AIDS tends to be seen as non-Western by Westerners. The origins of AIDS is very widely viewed as African in the West (Chirimuuta & Chirimuuta, 1987). South African whites, who regard themselves as Westerners, appear to follow this pattern too. Seventy three per cent of whites who ventured an opinion on the origin of AIDS, thought it was African. Twenty five per cent of this group thought it was American (The McCann Group, 1988).

Black Africans tend to view the origin of AIDS as Western. A Ugandan doctor states:

> "Some people here would classify AIDS as a colonial disease. In African traditional culture, boys and girls would never be able to play around

> because they had to get married: boys when they reached eighteen years, girls at around fourteen. In the colonial culture people don't get married until much later than this. This in itself tends to encourage promiscuity and, when copied in our culture, it has had the same effect" (Hooper, 1990:227).

The perception that Westerners brought AIDS into Africa is strong. Hooper (1990) found that there was a strong belief in Uganda that AIDS got into Ethiopia by way of a number of foreign relief workers. There can be no doubt that Africans originally anchored AIDS to the West, though they no longer do so:

> "Gone are the days when African governments took the position that AIDS was primarily an American problem, or that it was limited to homosexuals, drug users or other specific groups" ("Facing the crisis", 1990:6).

The American anchor exists among South African black people too. All of those who ventured an opinion on the origins of AIDS felt that it was American; 18% thought that it may be African in origin (The McCann Group, 1988). This is corroborated in terms of more qualitative, anecdotal references:

> "Do you know that some people in the townships still think that AIDS only exists in America?" states actor/writer Peter Ngwenya ("Pied Piper Peter", 1991:9).

## 4.6 'SIN COCKTAILS': THE NATURE OF SOCIAL REPRESENTATIONS OF INTER-GROUP BLAME

Inter-group blame is ideological as well as emotional. Certain groups repeatedly become the scapegoats in a given society and the content of the blaming aspersions is moulded by the central ideologies of the society. Historically, disease has been used to enliven the charge that sectors of the community are morally depraved (as I have discussed in Chapter One). The secret rituals and aberrant sexuality of out-groups are imagined to be involved in the genesis of the crisis situation. It is these rituals and sexualities that are represented

as threatening to the society.

Syphilis characterised moral depravity in the nineteenth century Western culture (Gilman, 1985). Black women and prostitutes were regarded as the main carriers of the illness. Both groups were associated with unbridled sexuality. Black females represented both hyper-sexuality and the exotic. Black women were widely perceived to possess both a 'primitive' sexual appetite and the external signs of this: 'primitive' genitalia. Black women were imagined to copulate with apes (Gilman, 1992).

Like fantasies concerning syphilis, fantasies and social stereotypes relating to AIDS have centred on ideas of difference, on facets which society regards as perverse. Like the social representations which surrounded syphilis, a powerful blend of fantasies about bestiality, dirt, promiscuity and homosexuality have sprung up in response to AIDS. Like Columbus' chroniclers, who over-generalised the extent to which certain rituals were practised and who imagined that people combined a number of different practices (eg. cannibalism, bestiality and infanticide) (Thomsen, 1987), so the British tabloids describe PWAs as practising a number of rituals. I will term these combinations 'sin cocktails'. The life of a person who has HIV immediately gets scrutinised for the multiple 'sins' which it might contain. The 'Birmingham case' which appeared in the tabloids towards the end of June, 1992, for example, combined allusions to promiscuity, heterosexual anal sex (termed 'unnatural sex' and 'homosexual sex') and prostitution. This case inspired a spate of tabloid articles including one in **The Sunday Sport** entitled "HIV nympho age 16 had sex with 20 men".

Sin cocktails have also been evident in Western constructions of African sexuality, at this time of AIDS. Widespread ideas about African inferiority predate the onset of AIDS in the social representations of Westerners (see Chapter Three). The mass media can be used as a gauge of such representations. There is, in fact, a paucity of images of Africa other than in relation to famine, militant governments and now, AIDS.

The media see AIDS in terms of the 'third world' culture of poverty, ignorance and promiscuity. The 'first world' is perceived as the benefactor of the incompetent 'third world' in line with the colonial way of thinking. The dualism implied between these two worlds has two consequences. Firstly, it endorses the notion that each world contains an undifferentiated 'us', rather than a mixture of races and classes. Secondly, it enables people who identify themselves as 'first world' people to feel superior.

Various overviews of race-related discourse in the British media demonstrate that, on a daily basis, the media renew stereotypes and ideologies which cast citizens of African and Caribbean descent into debasing categories (Downing, 1985; Kitzinger & Miller, 1991; van Dijk, 1991). Kitzinger and Miller (1991) found that Africa is seen as a vast, undifferentiated mass where various tribal rituals occur:

> "Above all AIDS is blamed on African sexuality which is presented as primitive and perverse and associated with homosexuality and bestiality" (Kitzinger & Miller, 1991:12).

Fantasies about dirt, disease and sexual promiscuity come readily to the Western mind when thinking about Africa (Dada, 1990). Like the ideas put forward in Chapter Three about Romans imagining the Christian Agape to be debauched, incestuous and cannibalistic, so the African 'other' is seen to practise rituals which contravene taboos in

the West.

The Green monkey theory became popularised in 1985 when two Harvard professors isolated an HIV-like virus from wild Green monkeys. Many newspapers published stories related to these findings in 1985 (Vass, 1986), linking the Green monkey theory to Africa. Sections of the medical world appear to have reached a consensus in relation to this link. A haematologist from an eminent Cambridge department writes, in **Nature** magazine:

> "There is now little doubt human AIDS began in Africa. Not only is the disease widely spread in central Africa, but only in Africa are the monkey species naturally infected...Although the first such virus was isolated from the macaque, that animal was probably infected in captivity with... the African sooty mangabey monkey" (Karpas, 1990:578).

In fact, the macaque monkeys from which the HIV-like virus was initially isolated were in an American laboratory at the time and are Asian in origin (Chirimuuta & Chirimuuta, 1987). Other findings cast further doubt on the African origin of HIV: The African Green monkey is not unanimously assumed to harbour a precursor to HIV that crossed the species barrier, in the scientific literature; hypotheses concerning a laboratory origin are beginning to appear in the mainstream scientific literature (Chirimuuta & Chirimuuta, 1989).

The link between Africa, monkeys and AIDS gained popular medical and lay attention because it fitted into preconceptions concerning the disease-ridden nature of the African jungle. The tendency towards the creation of 'sin cocktails' means that the Green monkey theory may be elaborated in terms of other rituals associated with Africa. The scientific literature has been forthcoming in elaborating such rituals. Karpas (1990) suggests that

the cross-species transfer of an HIV-like virus may be related to the sexual habits of the people of the large African lakes. These people are injected with monkey blood to induce them to intense sexual activity.

Farmer (1992) points out that European and American scientists and commentators linked the origin of AIDS to Haiti, in the early 1980s. More specifically it was linked to voodoo practices:

> "North American scientists repeatedly speculated that AIDS might be transmitted between Haitians by voodoo rites, the ingestion of sacrificial animal blood, the eating of cats, ritualized homosexuality and so on - a rich panoply of exotica" (Farmer, 1992:224).

Farmer's 'rich panoply of exotica' mirrors what I term the 'sin cocktail'. Métraux (1972) points out that 'voodoo':

> "conjures up visions of mysterious deaths, secret rites - or dark saturnalia celebrated by 'blood-maddened, sex-maddened, god-maddened' negroes" (p.15).

Ideas relating to voodoo entered prestigious medical journals, and then flowed between journalists and medics. The validity of the research was only challenged later, due to pressure exerted on medics by the stigmatised group themselves.

It is important to note that I am not 'accusing' scientists of inter-group blame. I am merely attempting to provide evidence for the fact that people, including scientists, are more suggestible to certain avenues of thinking than to others. This suggestibility tends to be linked to in-group preference and, consequently, to a suspicion that illness is more likely to be associated with 'other' than with 'self'. This is illustrated by the fact that scientific research in relation to the origin of the virus has centred on Haiti and on Africa. It is in the transformation of these ideas by the mass media and by lay people that these

ideas are imputed with additional fantasy material.

The medical, media and lay worlds' fascination with homosexuality and with African sexuality, in this time of AIDS, is evidence of the element of desire which accompanies blame and the dehumanisation of out-groups. Satisfaction is gained from voyeurism in relation to the sin cocktails practised by the 'exotic' out-groups. In addition, there can be no doubt that there is a fit between historically and socially accepted ideas concerning African sexuality and the ideas which take hold in the medical, mass media and lay worlds. Farmer (1992) asks:

> "Why was so much attention paid to the red herring of voodoo? Why were such theories so widely and uncritically accepted? What might explain their resonance among North Americans in the popular *and* scientific sectors?" (p.221).

He answers that there were pre-existing 'folk models' of Haitians which included images of 'filthy squalor', 'voodoo' and 'cannibalism'. Discovering savagery is an essential component of inter-group blame.

While both medical and lay theories draw on a stock of 'folk models' or fantasies, lay people are likely to go further into the realm of fantastical explanation of the origin of HIV. As discussed previously (see Chapter Three), lay people move easily from description and classification to explanation, while the scientific world tends to hedge its way more carefully around the data. The virological, epidemiological and clinical medical world has never, for example, suggested bestiality as an explanation for a cross-species transfer of an HIV-like virus, as has been suggested by lay people (eg. see Kitzinger & Miller, 1991). Sections of the mass media and lay people transform representations which exist around them in accordance with pre-existing fantasies concerning out-groups.

Two further points need to be made in regard to the content of people's social representations of AIDS. Firstly, lay people often link illness to excess (Kleinman, 1980). Excessive sexuality, or promiscuity, is likely to be seen as illness generating. In the case of AIDS the lay theory has been reinforced by findings in the medical world, at various stages of the epidemic. AIDS was linked to excess both early on and more recently when a number of doctors posited that AIDS was related to immune overload rather than to a virus. This finding, disseminated through the mass media, appeals to existing ideas concerning excess. Excess is possibly viewed with disdain due to the influence of a Protestant ethic of moderation.

Secondly, there seems to be an urge to "place" AIDS in a particular geographical region. The link between the African continent and AIDS can be construed as an objectification of AIDS. Places form powerful cultural symbols of various emotions/ideas.

## 4.7 EXTREME FORMS OF BLAME: POLLUTION AND CONSPIRACY THEORIES

### 4.7.1 SOUTH AFRICA, MISCEGENATION AND POLLUTION

I have so far indicated both theoretically (in Chapter Three) and empirically that there is a fundamental need to maintain a boundary between a 'good' 'us' and a 'bad' 'them'. The division between us and them often rests upon racial and sexual divisions. At the very time when European and North American scientific and political social representations began to challenge the racist paradigm, South Africa began to entrench the racist paradigm by way of law. Racial divisions form a central boundary in the South African context. The Apartheid laws institutionalised boundaries between the races. The Population Registration Act (1950) classified South Africans into different racial groups. The Prohibition of Mixed

Marriages Act (1949) prevented people of different racial groups from marrying one another. The Group Areas Act (1950) prevented people of different racial groups from living in the same areas. While these laws were repealed early in 1990, their legacy must have a continuing and powerful impact. Most of all they demarcate differences which are often more subtle in other cultural contexts. Race is an all-pervasive notion in the South African context:

> "The term "race" when applied to humans is essentially social and political, rather than biological. In South Africa, more so than anywhere else in the world...The term is part of our ordinary everyday vocabulary. We hear it used on radio and television, we read it in newspapers and magazines, and we use it in daily conversation. And even when race is not explicitly used, it is clear that ideas and assumptions about innate racial differences permeate much of South African thinking" (Boonzaier, 1987b:1)

The purity of these innately different races is of the utmost importance. The concept of miscegenation is relevant in this cultural setting:

> "Miscegenation is a word from the late nineteenth century vocabulary of sexuality. It embodies a fear not merely of interracial sexuality, but of the supposed result, the decline of the population" (Gilman, 1985:107).

Some South Africans relate miscegenation to AIDS. Of 17 black female interviewees in a study by Jochelson, Mothibeli, and Leger (1991), 4 women spontaneously gave inter-racial explanations of the origins of AIDS. One woman blamed whites for the origin of AIDS. Three women blamed black ethnic groups for the disease. A Sotho woman explained:

> "I think Basotho [Sotho] men don't have AIDS. I don't have sex with other race groups. I think AIDS is common among Shangaans and amaXhosa [Xhosa] workers, even Bapedi...People told me that if you have sex with many men of different race groups you get AIDS" (p.169).

Miscegenation fantasies remain active in South Africa because they are central to both

black and white people's cultural assumptions. Miscegenation fantasies are at the heart of Zulu ideologies concerning disease. Disease can result from spirit possession due to violations of balance (Ngubane, 1977). The notion of evil spirit possession is a post-colonial concept. Evil spirits are spirits of aliens. Two forms of possession by evil spirits relate to the intrusion by alien people into Zulu culture. One form, known as *indiki* occurs due to violation of principles of patrilineage, often believed to occur when non-Zulu men have relationships with Zulu women. Another form of spirit possession is called *ufufunyane* in which thousands of spirits of various races are believed to possess a person. Violent, hysterical and suicidal behaviour are indications of this form of possession. Foreigners disturb the balance of one's community.

Leaders of the 20,000 strong pan-African Traditional Healers Association held an emergency meeting in Johannesburg on 24 January 1990 to deal with the growing AIDS threat. The healers shared the belief that AIDS is a disease (a word synonymous with 'curse') of Africa which has been present throughout time. The curse was kept under control by the fact that people followed traditional African beliefs and by the power of the traditional healers. AIDS entered the West from Africa. This curse re-entered Africa at a time when traditional values and African culture were so weak that the continent was unable to protect itself. Those in African culture who interact most with Western culture were the first to succumb. It is noteworthy that the traditional healers believe that AIDS has always been present in Africa. This is a far cry from the 'not my continent' views of Western scientists. While the traditional healers believe that AIDS began on their own continent, they believe that it gained a hold due to the Western influence.

In keeping with the idea that certain places become objectifications for ideas, the suburb of Hillbrow in Johannesburg represents mixed racial living for many South Africans. It is a symbol of breached boundaries. The Apartheid laws, mapped out above, have always been contravened by a tiny number of individuals, but mass contravention began in the 1980s when blacks, Asians and 'coloureds' [people of mixed race] started moving into urban areas allocated to whites, illegally. They sought out jobs and accommodation due to mass shortages in the areas which had been allocated to them. They moved, primarily, into the densely populated suburb called Hillbrow. Hillbrow has been a centre of entertainment and of night life, including prostitution, for many years. The social representation of Hillbrow in the minds of many South Africans and in that of many journalists is well captured in the following description:

> "Even in biblical times the cities of Sodom and Gomorrah were stigmatised by immorality and idolatry. The greater freedom enjoyed here [in Hillbrow] often leads to wrong choices...The resulting evils of prostitution, drug and alcohol abuse and sexual promiscuity are legion" ("In the Heart of Hillbrow", 1991:10).

### 4.7.2 BRITAIN, BISEXUALITY AND POLLUTION

In keeping with the idea that breached boundaries threaten the 'purity' of groups, bisexuals are likely to be the target of a lot of blame for AIDS. The disdain with which we regard the 'irresponsible' behaviour of those around us is heightened if their actions have consequences for ourselves. Stereotypes of and fantasies about AIDS, for the majority of people, have been formed without any direct experience with the disease: "For most people it has been fear of contagion rather than experience of loss which has made the disease a reality" (Altman, 1986:1). The illness has been conceptualised as one that leaked from an infected homosexual source to the rest of the world (Watney, 1987). A

fear of pollution/contagion intensifies the need to blame. People are uncomfortable with boundaries which become blurred - such as those between blacks and whites, homosexuals and heterosexuals.

A sexual orientation which forms a bridge between pure homosexuality and pure heterosexuality is threatening to both homosexuals and heterosexuals. The threat springs partly from the psycho-dynamic mental process which differentiates between 'self' and 'other'. However, these mechanisms are activated by way of the institutionalisation in British society, by way of law, of the fear that homosexuality will invade heterosexual purity. Section 28 of the British Local Government Act of 1987-8 prohibits the promotion of homosexuality by teaching or by publishing material. The parliamentary supporters of Section 28 took for granted the fact that sexual normalcy exists and that it is threatened by the invasion of homosexuality. This issue is elaborated in Chapter Eight.

Homosexuality has been linked to pollution in this time of AIDS. In the early years of the epidemic:

> "US (white) homosexuals were said to have made their bodies something of the order of the sewerage system of a Third World country - free running waste being a prominent western image of underdevelopment" (Patton, 1990:34).

Similarly, in certain European public health models of the nineteenth century, prostitutes were equated with pollution in the same way that French sewers were (Gilman, 1992). As I have mentioned in Chapter Three, people construct symbolic systems of purity so as to order the chaotic set of stimuli which exist around them (Douglas, 1966). One's in-group comes to symbolise purity and one's out-group, pollution and contagion. Hitler's Mein Kampf describes the Jew as 'a plague worse than death', 'mankind's eternal germ of

misunion', 'the spider that slowly sucks the people's blood at its pores' (Jackel, 1981), 'cultivator of cholera germs', and 'inspirers and originators of dreadful catastrophes' (Bar-tal, 1990).

Ideologies and their institutionalisation by way of law activate patterns of inter-group blame. A law introduced at the Nuremburg Rally in 1935 dealt with the 'protection of German blood and honour' by way of forbidding marriage between Aryans and non-Aryans (Bar-Tal, 1990). The fear of crossed boundaries and of miscegenation, in particular, has been institutionalised by way of law historically, within a variety of societies.

### 4.7.3 CONSPIRACY THEORIES

Inter-group blame is heightened not only when there is a fear that the boundary between one's own group and the diseased group will be crossed but when it is believed that a certain group actively conspired to infect one's own group. The first large-scale plague - termed the black death - occurred in Europe in the middle of the fourteenth century. The poor died in the greatest numbers. It seemed to the people of the time that the plague was triggered by a certain group. A dominant theory of the day held that Jews bribed lepers into infecting the poor, because neither rich nor poor Jews got the plague (Cohn, 1976). Jews were imagined to have conspired with the devil, whose agents they were, against Christianity (Groh, 1987).

There is a widespread tendency to experience paranoid anxiety in the face of a threat. This anxiety translates into a belief that AIDS was manufactured in a research laboratory, in

connection with genetic engineering or biological warfare. Aggleton *et al.* (1989) found, in a British sample, that the CIA or FBI is blamed for AIDS.

Farmer (1992) views the conspiracy theory of AIDS as a mechanism of **counter-blame** devised by groups who have been blamed for AIDS. While the conspiracy theory did not serve this function at the time of the Black Death, Farmer's argument is convincing in relation to AIDS. Conspiracy theories in relation to AIDS were initially espoused in Haiti in 1982 (Farmer, 1992). A flier denounced AIDS as 'an imperialist plot to destroy the third world'. Subsequently, conspiracy theories have received regular attention in the gay press of North America and of Europe (Farmer, 1992) and in the under-developed world (Sabatier, 1988). Precisely those who have been accused of introducing HIV/AIDS to the Western world have been the chief purveyors of conspiracy theories. Conspiracy theories are the "rhetorical defence of powerless victims" (Farmer, 1992:247). They have their discursive roots in their resistance to colonialism (Treichler, 1989).

Social representations of conspiracy were not common in the South African context at the time when my study took place in 1990. The only evidence of conspiracy existed in jokes which were bandied about. Two answers to the 'What does AIDS stand for' joke existed among South African blacks: American Idea to Discourage Sex and Afrikaans Invention to Destroy Sex. The theory that AIDS is a conspiracy against black people was subsequently espoused in **Drum** magazine, a South African urban black general interest magazine. It quotes Professor Small of City College, New York:

> "Our whole relationship to whites has been that of their practising genocidal conspiratorial behaviour on us from the whole slave encounter right up to the Tuskegee study" ("Is AIDS a Conspiracy", 1991:17).

**Drum** goes on to explain that the Tuskegee study was a syphilis experiment in Alabama, where, from 1932 to 1972, 600 black males with syphilis were intentionally denied treatment so that researchers could observe the progress of the disease. The fact that this article relies on American sources indicates that conspiracy theories had not captured as much attention in South Africa as one might have imagined. The **Drum** article provides a clear indication that group identity determines who one imagines to be conspiring against one's group. The fact that the suggestion of conspiracy appears in a black-targeted magazine supports Farmer's (1992) contention that it is a form of counter-blame used by powerless groups.

## 4.8 POWER DIFFERENTIALS AND BLAME

All groups tend to project responsibility for AIDS onto the 'other'. This has the consequence that the 'self' feels invulnerable. However, the fact that the more powerful groups in a society have greater control over social representations of AIDS has the consequence that inter-group blame is not symmetrical. Certain social representations in society carry greater weight than others. On an international level, Western ideas seem to have hegemony (Polier & Rosebury, 1989). This must, at least partially, emanate from Western domination of the mass media. While each country has its own media, the under-developed world relies upon television programmes and films made within the ideological culture of Western countries. Africans are likely to be aware that their continent is regarded as infested with and decimated by AIDS, whereas Westerners are not aware that Africans see Western ways to be the root of AIDS.

In their British sample, Clift *et al.* (1990) found that the two groups most often mentioned

with respect to collective blame regarding the origin and the spread of AIDS were homosexual men and drug users. While blamed groups may use conspiracy theories as counter-blaming strategies, they may also incorporate the blame cast upon them. Homosexuals view their lifestyle in a critical manner - where once sexual conquests were regarded with sanction and support, one is now regarded as a potential HIV carrier if one pursues these activities (Isaacs & McKendrick, 1992). By incorporating a stigmatised identity, many homosexuals come to disapprove of themselves. This results in a 'spoiled identity' in Goffmanesque terms (Isaacs & McKendrick, 1992). The tendency to internalise blame is evident in relation to the 'victims' of other illnesses. People with cancer often attribute their plight to their own past misdeeds. Shame, guilt and self-reproach result from society's victim-blaming. Or, in social identity theory terms, out-group preference (Wortman, 1976). Yet, as I have explored in Chapter Two, there are voices of dissent from the dominant ideas in social representations of AIDS. These are likely to create reflexivity among blamed groups, to make them aware of the blame to which they are subjected. This awareness, in turn, may allow them to resist internalisation of the blame which is cast onto them.

## 4.9 THE PROCLIVITY FOR TOLERANCE

Voices of dissent have an influence. In the AIDS scenario, these voices have opposed the splitting of society into 'good' and 'bad' groups. As a result of these voices and, possibly, of certain developmental factors, many people hold representations of AIDS which are not linked to inter-group blame. Echabe and Rovira (1989) asked a random sample of Spaniards about the cause of AIDS, about groups affected by AIDS and about modes of transmission. They found that 61% limited AIDS to certain groups and blamed them, but

that 39% rejected ideas that the disease was associated with certain groups only. The ideas that not everyone blames is echoed in the work of Kitzinger and Miller (1991), in which certain British respondents claimed that the association of AIDS with a fringe group such as Africans, was tantamount to blame. However, we need to look at which people oppose the blame. In the Kitzinger and Miller (1991) study, the respondents who claimed that the association of AIDS and certain groups was tantamount to blame were generally black.

In a study (Schlebusch *et al.*, 1991) of South African, predominantly white (82%), health care professionals surprisingly few agreed with the statements: 'Black people engage in more perverted sex than other races' (8%); 'Black people are more promiscuous than other races' (31%); 'Black people are responsible for bringing AIDS to South Africa' (16%); 'AIDS will spread faster among blacks because they care less about their hygiene' (19%). Social and political conditions in which black people live were believed to put blacks at greater risk of contracting AIDS by 55% of the respondents and the authors conclude that those conditions were not considered to be of their own making.

These researchers inadvertently suggest an explanation for the above findings: "Attitudes and biases to the disease may not necessarily be overt or conscious" (p.253). I would suggest that their chosen methodology may have elicited more liberal responses than a more qualitative one would have (see Chapter Five). At the same time, one must also accept that there is a proclivity for tolerance.

The social sciences, historically, have focused more on the blamers than on the blamed (eg. Ryan, 1971; Gilman, 1985). This is not surprising. Opinion polls and other gauges

of public opinion are relatively new institutions. Prior to their existence, the collective representations of the ruling institutions might be known, but that of the masses would have gone unheard. I would like to explore the extent to which both the blamers and the blamed blame one another.

## 4.10 CONCLUSION

It is not surprising that when a crisis strikes a society we behave in line with age old patterns. Our language preserves memories of ancient diseases. For example we 'avoid something/someone like the plague'. The blaming social representations which arise will represent a fit between historical, societal, and ideological forces on the one hand, and the group membership and the psyche of the individual on the other.

Assuming that the process of anchoring is at work, we know that the way in which mass illness has been viewed in the past will shape current social representations of AIDS. This chapter has explored the anchors which people use to give meaning to the novel phenomenon of AIDS. The hegemonic social representations which blame certain groups for AIDS act as a litmus test of a society's anxieties.

The general tendency to blame others has at least two consequences. Firstly, blamed groups become subject to verbal, physical and sometimes legal abuse as seen by 'gay-bashing' and laws such as the British Section 28. This may lead to an internalisation of the blame, in the form of a spoiled identity. Secondly, health-related behaviours are affected by inter-group blame. When AIDS is associated with other groups, people feel that their in-group is invulnerable to it. Placing blame draws boundaries between the

healthy and the ill, thereby allowing for a sense of control. An example from the South African context illustrates this point. While 9.2% of respondents (N=373) in the Mathews *et al.* (1990) study felt that there might be people with AIDS in their own township, 72.9% of respondents (N=369) believed that only people in other parts of South Africa had AIDS:

> "The students do not perceive themselves to be at risk. AIDS is attributed to groups outside the student's immediate ambit, and risk is conceptualised in racial terms" (p.515).

The conceptualisation of AIDS as 'other' abounds internationally. In a study of native Americans 26.8% of the sample believed that 'being Indian is a protection for AIDS' (Rolf *et al.*, 1991)). In response to a similar problem the logo of the Phillipines' AIDS campaign in the early 1990s read: 'Anyone can get AIDS, even Phillipinos'.

## 4.11 HYPOTHESES OF THE THESIS

*The behaviour of individual humans, rather than situational determinants, collective sin, luck or a virus, is deemed responsible for the spread/cause of AIDS.*

*Responsibility for the origin and spread of HIV/AIDS is placed with the 'other' rather than with the 'self'.*

*The 'other' is imagined to be involved in the practice of sin cocktails.*

*The 'other's' behaviour is perceived as potentially polluting of the 'self'.*

*Certain groups, who have been marginalised in their society historically, and who have been linked to AIDS in the hegemonic ideology, cast responsibility inward rather than outward.*

*There will be a 'fit' or overlap between messages contained in the AIDS campaign and lay thinking. However, people are active in terms of the messages which they receive. They transform aspects of such messages in accordance with emotional and ideological needs.*

## OVERVIEW OF CHAPTER FIVE

In this chapter I develop the methodological approach which I use to analyse my empirical data. I use the social representation as the basic unit of examination, but incorporate a number of components which are compatible with, and enrich, the traditional notion of a 'social representation'. These additional components are drawn from Billig's work on thinking as a debate between different positions, from Giddens' work on reflexivity, from the psychodynamic notion of defensiveness and from the structuralist notion of ideology. In addition to the development of a methodological approach, I evaluate the relative advantages of the group, versus the individual, interview, and discuss issues which are particular to the social scientific study of AIDS.

# CHAPTER FIVE: TOWARDS A CONCEPTUAL FRAMEWORK: A METHODOLOGY FOR SOCIAL REPRESENTATIONS

## 5.1 INTRODUCTION

In this chapter I aim to clarify the methodological position which I adopt in this thesis for the purposes of a social psychological study of inter-group blame. The thesis is concerned with analysing the contents of people's beliefs, in line with the social representational tradition. This tradition is not aligned with a particular methodological position. The methodological approach of this thesis is drawn from aspects of both structuralist and of post-structuralist methodologies. Facets of these methodological approaches are well articulated by Billig and by van Dijk. Billig's work is strong in terms of its emphasis on the debates upon which individuals draw when they talk about issues, such as the origin and spread of AIDS. Van Dijk's methods have been centrally concerned with prejudice. His conceptualisation of prejudice overlaps with, what I term, inter-group blame.

The methodological approaches which I combine share certain assumptions. Firstly, they presuppose the social construction of reality. The individual thinker is not regarded as the locus of thought. Rather, there is an interplay between the social context and the individual thinker in terms of the social representations which circulate in a given society. Secondly, they favour a theoretically driven rather than an empirically driven methodology. Conclusions to be drawn from empirical work are not grounded purely in empirical findings, but are guided by theory.

The thesis does not aim to be cross-cultural in the traditional sense, though similar

methods and samples will be used in both South Africa and Britain. Cross-cultural work is an ideal way of revealing the extent to which ideas about a life-threatening phenomenon, such as AIDS, are constructed differently in different societies. Cross-cultural work has the capacity to demonstrate that there are no universal laws. All psychological 'laws', in fact, pertain only to a particular culture or set of cultures within a particular period in their history.

I have shown, in the previous chapters, that there is an interplay between the medical sciences, policy-makers, the mass media and lay thinking in the formulation of social representations of AIDS. The methodology which I evolve must, then, be appropriate for the analysis of the content of mass mediated AIDS campaigns, and of interview material gleaned from policy-makers and from lay people concerning AIDS.

This chapter refers to the mass mediated AIDS campaigns as 'campaigns' and to the text arising from interviews with the policy-makers and with lay people as 'text'. 'Text' is also used in its more conventional sense, to denote the variety of texts produced by the mass media and by publishing companies. Campaigns and texts comprise a number of images, words, concepts or 'themes'.

## 5.2 FOUNDATIONS OF THE METHODOLOGY ADOPTED IN THIS THESIS

### 5.2.1 STRUCTURALIST METHODOLOGICAL FOUNDATIONS

Structuralist or semiotic methodology assumes that human thinking is socially constructed. It is centrally concerned with the notion of 'commonsense'. This relates to the fact that people tend to view events which occur in a society, and the thinking that arises in

relation to such events, as 'natural'. People are unaware of the fact that cultural, societal and historical forces influence the way in which they think about or explain events which occur. This, the process of 'naturalisation', is ideological in that the configuration of ideas which circulate in a society are viewed as natural and therefore inevitable (Barthes, 1977; Masterman, 1984). This allows relationships between groups with power and other groups to remain unchanged.

Structuralist methodology applies linguistic concepts to phenomena such as campaign and text analysis. It is centrally concerned with the levels on which any image, word or concept operates. Images, words and concepts do not have a 'natural' meaning. They acquire meaning through a network of relationships (Berger, 1982). I will focus on a number of these relationships.

Images, words and concepts have both a denotative and a connotative meaning:

> "Surface events and phenomena [denotative level] are to be explained by the structures, data and phenomena below the surface [connotative level]" (Barthes, 1968:XII).

The 'structures', 'data' and 'phenomena' below the surface are "fragments of ideology" (Barthes, 1968:91). Each image, word or concept can be viewed both in terms of its denotative and its ideological levels of meaning.

The meaning of the image, word or concept which one analyses is connected to other levels too. Structuralist methodology posits a syntagmatic relationship between images, words and concepts. This is the relationship of the image, word or concept to other images, words or concepts within the particular piece of text or campaign which one

analyses. The emphasis is on the patterns into which elements of the text fall, rather than on single elements in the text.

These 'patterns' of images, words and concepts are related to ideologies beyond the text. This is termed the paradigmatic level:

> "Large fragments of the denotated discourse can constitute a single unit of the connotated system" (Barthes, 1968:91).

The paradigmatic level tends to involve culturally and historically informed ideas or ideologies. The semiologist aims to decipher or to 'decode' the culturally and historically shaped meanings of the images, words and concepts in campaigns and in texts.

### 5.2.2 POST-STRUCTURALIST METHODOLOGICAL FOUNDATIONS

Post-structuralism, a theoretical development of structuralism, attempts to move away from the idea that ideological forces determine the way in which people think about certain events in their societies. Post-structuralism attempts to open out what it sees as the closed system of meaning which the structuralists devised. For the post-structuralists, ideology does not have a direct, fixed influence on people's thinking. The individual or 'subject' in post-structuralist terms:

> "is composed of, or exists as, a set of multiple and contradictory positionings or subjectivities" (Hollway, 1989:31).

Post-structuralism emphasises the divergent and contradictory nature of people's texts.

> "This approach reflects the development of theories of meaning from structuralist premises, with their emphasis on what is static and universal...The theory does not therefore account for multiplicity of meaning and changes within it... Foucault's historical approach to discourses emphasised their multiplicity and potential contradictions at any time" (Hollway, 1989:53).

The philosophy is bound together by a rejection of the notion of coherence. Different

people within a single society have different forms of 'commonsense' and it relates to socio-cultural, religious and ethical factors as well as to tastes, psychological forces and value systems. The 'commonsense' ideas alter as the individual is exposed to new ideas and texts.

Post-structuralism has also been associated with the idea that texts only relate to other texts, rather than to systems of meaning beyond those texts. While this position does not encompass all the meanings of a text, the proliferation of texts in contemporary Western society means that, in order to understand one text, one often needs to be familiar with other texts. Texts are often cross-referential.

### 5.2.3 BILLIG'S CONTRIBUTION TO THE METHODOLOGICAL FOUNDATIONS

Billig (1991) views thinking as both ideological and rhetorical. He draws his notion of ideology from the structuralist notion of 'naturalisation'. The time and place in which people live affects their thinking. People use a commonsense which they do not invent. Commonsense has a wider history and has a relationship to patterns of power and domination in a given society. The commonsense of a community maintains power relations within that community.

Billig's ideas concerning the contradictory nature of thinking lie somewhere between the structuralist and the post-structuralist positions. From ancient texts he draws the idea that thinking is argumentative: "Thinking is like a quiet internal argument" (Billig, 1987:118). He subscribes to a dialectical strategy, in line with the Hegelian stance. This strategy recommends that, for any given psychological process, one should look for an opposing

process.

The thinking/language which people use is embedded in the social context. Thoughts cannot be interpreted in a way that isolates them from the debates in which they are situated. Using language involves both a repetition of a system set up by others, and an autonomous use of bits of the system by the respondent. The system contains social stereotypes but the person using the system also challenges these stereotypes.

Billig's approach to the issue of consistency within data is also useful. Influential psychological theories of the 1950s and the 1960s suggest that we have a desire to order our thoughts and actions in a consistent way. Festinger's Theory of Cognitive Dissonance (1957), for example, posits that, if there is a discrepancy between one's attitudes and one's actions, under certain conditions, the attitudes will be changed to be brought into line with the action. Billig (1987) understands this in terms of a rhetorical motivation. There is an inter-personal motive to be consistent: It wards off criticism that you are contradicting yourself in the eyes of others. Psychologists, like lay people, have tended to valorise this culturally favoured notion. Thinking is not consistent but we have a tendency to make it so in order to be persuasive. Billig (1987) posits that we do not resolve inconsistency. We merely have strategies for coping with it.

People use additional strategies to enhance positive impression formation in relation to an interviewer, in a research context. If they want to show prejudice in a society where the social institutions indicate that prejudices are bad, they have to cover up. People 'cover up' in terms of the content of their language (Billig, 1985). Of course this is difficult to

evaluate. If one adheres to Billig's (1987) notion that for every psychological process that exists, an opposing one exists too, one needs to discern whether a non-prejudiced response is, in fact, a 'cover up', or a function of a non-prejudiced way of thinking.

### 5.2.4 VAN DIJK'S CONTRIBUTION TO THE METHODOLOGICAL FOUNDATIONS

Van Dijk's work is highly complementary to that of Billig in terms of the relationship it posits between the thinking which occurs in the social context and lay thinking. Van Dijk's empirical work demonstrates which institutions in a thinker's social context are formative of prejudiced thinking. The mass media, school textbooks, official (political/legal) discourse and everyday conversation form ideologies, such as racism (van Dijk, 1984). Since 'elite' or dominant groups control many of the public means of communication, "our earlier research strongly supports the seemingly bold hypothesis that a country or society is as racist as its dominant elites are" (van Dijk, 1991:6). Prejudice and stereotypes are not innate:

> "They are acquired, largely by text and talk...the media play a vital role in this reproduction process" (van Dijk, 1991:150).

While the mass media play a vital role in the development and propagation of ideologies, they also provoke counter-ideologies. This occurs more in dominated than in dominant groups but it can occur within both.

In parallel with Billig's ideas, van Dijk (1984) posits that there are social norms concerning what can and what cannot be expressed in a given context. Discourse is adapted to the constraints of the social setting. The norms of Western based societies are morally and legally opposed to prejudice. So a strategy of denying prejudice arises to deal with knowledge of this norm. As a consequence of this positive self and in-group

presentation strategy, "one of the crucial properties of contemporary racism is its denial" (van Dijk, 1992:87). Again the question of whether non-prejudiced statements are a 'cover up' or are indicative of a counter-ideological stance arises.

## 5.3 APPLICATION OF THESE FOUNDATIONS TO THE METHODOLOGY OF THE THESIS

### 5.3.1 THE APPLICATIONS OF STRUCTURALISM

The structuralist methodology is drawn upon in a number of ways in this thesis. Firstly, structuralism's division between the connotative and denotative levels of meaning is at the root of my own approach. It is used directly in my analysis of campaign material, and is tacitly present in my analysis of the texts produced by AIDS policy-makers and by lay people. The connotative level is informed by 'fragments of ideology'. These ideologies are constructed by societal, cultural and historical forces (Barthes, 1968). I aim to decode those ideas which people see as 'natural', by considering the societal, cultural and historical forces which shape these ideas. A cross-cultural study is a particularly useful way of highlighting the extent to which cultural, societal and historical forces influence what is construed as 'commonsense'.

Secondly, the notion of the syntagmatic relationship or 'patterning' of the data is central to my methodology. This represents a departure from traditional content analysis, in which data are fractured so that they can be grasped and manipulated. A sense of the relationship between the various elements of the data is easily lost (Jones, 1985).

It must be noted that the approach which I adopt bears a relationship to traditional content analysis. Traditional content analysis (eg. Holsti, 1968) tends to focus on the repeatability

of a theme: The themes around which there is consensus are deemed salient because of this consensus. Similarly, within the social representational approach, a theme or idea which is shared by many holds the consensual status of a social representation. While the notion of a 'theme' is broader within the social representational approach than within the traditional content analytic approach, the two are similar in that they deem as salient those themes around which there is a consensus.

Thirdly, structuralism's paradigmatic level is an essential component of my methodological approach. It relates 'patterns' within the text (the syntagmatic aspect) to cultural, societal and historical factors beyond the text. Ideology and issues of power are central aspects of the paradigmatic level. Moscovici's notion of anchoring (delineated in Chapter One) is compatible with the idea that a theme relates to historically determined ideas. Moscovici states:

> *"To understand a representation it is necessary to start with that, or those, from which it was born" (1984:13).*

Certain themes arise because new information has been processed in terms of old information which circulates in the particular culture in which respondents are embedded. People have certain representations of events such as AIDS because they have anchored AIDS to older representations which exist in the society. A primacy effect occurs. The way in which a crisis in a society is represented initially, lasts.

Structuralism's paradigmatic level also encompasses Moscovici's notion of objectification (elaborated in Chapter One). Themes within a text relate to culturally determined ideas. People need to form concrete realities out of ineffable phenomena such as AIDS. They use certain cultural symbols or objectifications in order to gain a greater sense of

understanding of new phenomena. Objectification seems to have occurred in relation to place in the social representation of AIDS: AIDS becomes synonymous with Africa in Western social representations.

Objectifications of a concept often overlap with anchors of that concept. The historical ideas used to anchor and to objectify an event will be determined by ideological factors. I will investigate the anchors, objectifications and issues of power associated with AIDS.

### 5.3.2 THE APPLICATIONS OF POST-STRUCTURALISM

Post-structuralist methodology or discourse analysis contributes various ideas to this thesis. It challenges the inevitability of certain patterns of inter-group blame. People are more active and creative in their thinking than structuralist positions allow for. People simultaneously adopt and challenge the ideologies which circulate around them. Not all people will adhere to the ideologies of individualism and of racism in their texts. Some will associate with opposing ideologies or will construct idiosyncratic explanations of events.

One explanation for the rise of counter ideologies can be found in Giddens' work (1991, 1992), although his overall position is not post-structuralist. The concept of reflexivity is central (see Chapter One and Section 3.2.2 in Chapter Three). Due to the increasing popularisation of social scientific research in the late modern period, lay people become reflexive in relation to their patterns of thinking and acting. This reflexivity transforms their future patterns of thinking and acting. Commentaries relating to the 'prejudice' and 'homophobia' which surround AIDS have abounded in countries such as Britain.

Awareness of one's own proclivity to blame may well influence the process of inter-group blame.

Post-structuralist methodology highlights the fact that people's understanding of texts (or campaigns) relates to their exposure to ideas contained in other texts. Firstly, the texts which people have read previously influence the way in which they understand new texts. Secondly, people who read certain newspapers and magazines would be likely to think in terms of different sets of images and ideas from those who read other texts. Black and white South Africans, generally, are exposed to different newspapers and to different television channels. Different magazines target British homosexual men and British heterosexual men. In other words, the group membership of a person will affect the person's exposure to a particular social representation (Breakwell, 1991/2). Of course exposure is not a sufficient condition for absorption of information. The level of attention paid to a particular phenomenon will differ according to one's group membership. If a disease is labelled 'gay plague' gay people may well have stronger reactions to it (Breakwell, 1991/2).

Despite its appeal, a post-structuralist methodology contains a central pragmatic difficulty. Social scientists generally aim to reduce a set of data so that it becomes more manageable and, consequently, more understandable. Post-structuralism often augments small data pools, seeking out large numbers of possible meanings.

### 5.3.3 THE APPLICATIONS OF BILLIG'S IDEAS

Billig (1987) posits that thoughts cannot be interpreted in a way that isolates them from

the debates in which they are situated. It is on the basis of this argument that I analyse the mass media and policy debates in which lay thinking is situated (both in South Africa and in Britain) as well as the lay thinking itself. This choice is compatible with social representational ideas concerning the interplay of science, the mass media and lay thinking. The scientific and mass media levels are part of what I term the 'social context' in which thinking takes place. One takes the ideas which respondents mention, as indicators of the arguments in the social context which appeal to them and to which they ascribe.

I accept the position that thinking is argumentative. Contradictory views co-exist and must be accepted as such. The attitudes which we tap into as psychologists seem ambiguous and complex because: "Attitudes are not neat bundles of responses, awaiting the opinion-sampler's clipboard, but they represent unfinished business in the continual controversies of social life" (Billig, 1987:225). Our commonsense contains contrary elements which pose dilemmas for us. The consistency of a text is not valorised in this thesis. People's ideas about AIDS are expected to be contradictory.

Billig (1987) suggests that for any given psychological process there is an opposing process. The opposite process to inter-group blame would be one which does not hold other individuals or out-groups responsible for the origin and spread of AIDS. Consideration of situational, rather than personal, variables in the origin and spread of AIDS is one form of opposition to inter-group blame. This thesis investigates people's thinking in terms of both the blame process and its opposition. I assume that non-blaming ideas are not merely gestures towards self-presentation but represent the co-existence of

rival social representations.

### 5.3.4 THE APPLICATIONS OF VAN DIJK'S IDEAS

It seems likely that van Dijk's work on prejudice and racism will generalise to other areas of prejudice or to the similar process of inter-group blame. Van Dijk (1990) prescribes that "both text and context need explicit and systematic analysis, and this analysis must be based on serious methods and theories" (p.8). Van Dijk's perspective is more specific than that of the social representationalists or of Billig in relation to the institutions which constitute the "context". The mass media, school textbooks, official (political/legal) discourse and everyday conversation among groups in power constitute the social context of lay thinking (or of the 'texts' which lay people produce). A systematic analysis of lay thinking or texts concerning AIDS must be mapped onto a systematic analysis of the social context. I will systematically explore only a part (ie. Government sponsored AIDS campaigns and AIDS policy debates) of the social context in which lay thinking takes place. Other parts of the 'social context' (eg. laws and political reaction to AIDS) have been examined in previous chapters.

Van Dijk's work (1984) is also useful in terms of its emphasis on strategies of self-presentation in relation to prejudicial or blaming material. When people talk about an issue such as AIDS they are likely to 'cover up' their inter-group blame due to the negative light in which prejudice is regarded. However, van Dijk's work also shows that a country is as racist as its dominant elites. Therefore, there is less likely to be a need to 'cover up' inter-group blame in South Africa than there is in Britain. Inter-group hostility has been enshrined in South African law for the past forty years (see Chapter Four).

## 5.4 A CONCEPTUAL FRAMEWORK FOR EXPLORING SOCIAL REPRESENTATIONS

Before providing a conceptual framework which incorporates the above influences, two issues need to be elaborated: the 'fit' between social context and lay thinking, and the role of emotion in the empirical work.

### 5.4.1 'FIT' BETWEEN SOCIAL CONTEXT AND LAY THINKING

On the basis of the ideas articulated by Billig and by van Dijk above, I seek to analyse the ideas concerning AIDS which exist both in the social context and in individuals' minds. From the outset it must be stated that I do not view these two spheres as independent. I do not imagine that the social context is the stimulus, in response to which people form social representations. My aim is compatible with that of the sociology of knowledge: exploration of the relationship between human thought and the social structures of the particular society in which these thoughts arise (see Chapter One).

The empirical work which follows explores South African and British social representations of AIDS, related to blame, separately. It examines two aspects of the 'social context':

1. Relevant **policy-makers'** views of the origin and spread of HIV/AIDS, and of actions to be taken to contain the spread.
2. Government sponsored **national newspaper campaigns'** messages relating to the origin and spread of HIV/AIDS, and of actions to be taken to contain the spread.

It then goes on to examine **lay thinking** in relation to the origin and spread of HIV/AIDS, and of actions to be taken to restrict the spread. The lay samples, in both South Africa

and in Britain, include heterosexual and homosexual urban, educated young adults. Whites and blacks are equally represented. A small portion of the sample has HIV or AIDS. (The composition of the sample and demographic characteristics are discussed in detail in Chapters Seven and Nine.)

One of my hypotheses (see section 4.11) relates to whether there is a 'fit' between the ideologies which exist in lay people's and in policy-maker/campaign's text concerning AIDS. I need to provide a tool with which to evaluate this 'fit'. Hall (1980) posits that there are three different ways in which lay people interact with media messages:

- In the 'dominant-hegemonic position' the lay person decodes the message in terms of the ideologies with which the message has been encoded.
- In the 'negotiated position' the lay person decodes the message in terms of the ideologies with which the message has been encoded, but reserves the right to oppose certain elements of the ideologies which exist in the encoded message.
- In the 'oppositional position' the lay person understands exactly what ideologies are being encoded by the message but opposes them or sees them in a different way to that intended by the message and the message-makers.

I have argued (see Chapters One and Two) that one cannot talk of the direct effects of the media. Rather, one talks of whether the ideologies concerning AIDS which circulate in the media run parallel to those which circulate in lay thinking. While the mass media foster a reading which is appropriate to the hegemonic ideologies, the reader struggles to use the mass media for personal ends (Adams, 1986). I would expect people's social representations of AIDS to lie along a continuum which runs from the 'dominant-hegemonic position' to the 'oppositional position'. Yet, the pluralism which a post-

structuralist approach advocates will not be present. I intend to evaluate the data in terms of Hall's (1980) hypothesis which posits that while polysemy or multiple readings of the media will exist, readings which rest within the hegemonic ideology are likely to dominate. By looking at people's social representations we can observe the way in which lay thinking transforms ideas which circulate in the social context. Knowledge is the outgrowth of a chain of transformations (Moscovici, 1987).

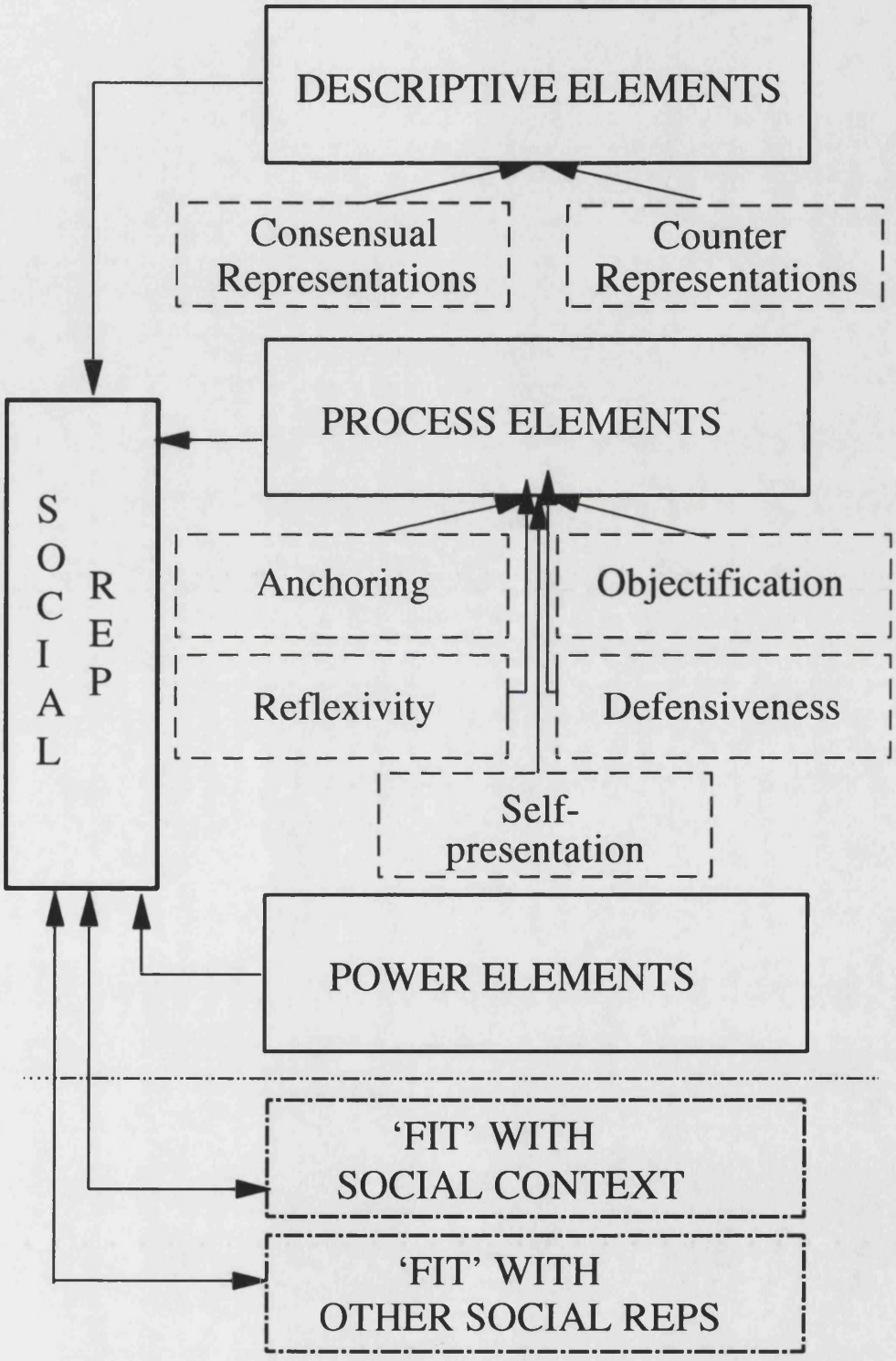
### 5.4.2 THE ROLE OF EMOTION IN THE EMPIRICAL WORK

I have stated that this thesis differs from KAP studies (appraised in Chapter Two), not only in its focus on the social contextual level, but in giving a role to emotion and to defences against overwhelming anxiety. Media and cultural theorists of AIDS (eg. Kitzinger & Miller, 1991) also tend to neglect this level. People filter ideas transmitted by the mass media through a sea of emotions. People transform ideas emitted by institutions in the social context as a result of unconscious psychic processes. People may reject the media's messages when the content or form of the messages evokes anxiety. By definition, the defence against emotion is difficult to tap directly. Yet, defences manifest themselves indirectly by way of jokes, taboos and denial concerning the potential effect which AIDS could have on oneself. In addition, the blaming of 'others' for the origin and spread of AIDS, and imbuing them with responsibility for AIDS, reveals defence against overwhelming emotion.

### 5.4.3 A VISUAL SUMMARY OF THE CONCEPTUAL FRAMEWORK

This thesis aims to explore social representations of AIDS in South Africa and in Britain on the basis of the methodological suppositions mapped out above. These methodological suppositions are theoretically driven. The figure which follows provides a visual summary of the aspects which I regard as central in looking at policy-makers' and lay social representations of AIDS. Many people who work in the field of social representations lack a conceptual framework with which to construct a social representation. My combination of aspects, all of which carry complementary assumptions, is a useful methodological device. The conceptual framework extends the traditional components of the social representation - consensus, anchoring and objectification. It includes counter-representational elements as well as reflexivity, defensive thought processes and self-presentation. It also includes an ideological component. The 'fit' between ideas which circulate in the social context and the thinking of the individual who forms the social representation is integral. Finally, it gives salience to the 'fit' between various social representations.

Figure 1. The conceptual framework for exploring social representations



This conceptual framework provides a valuable framework within which to consider data. However, I present the framework with some hesitation, for a number of reasons. Social representations evolve over time. Yet, in order to analyse them, they must be fixed in time. The above framework deliberately presents a static model of the elements which constitute a social representation. It also separates social representations from one another. In addition, it isolates processes and elements which may, in reality, overlap. This is done purely to assist in the analysis of an otherwise complex set of interlinking components. When I apply the conceptual framework to my data I point out areas of overlap, of inter-linking and of evolution.

The texts produced by both policy-makers and lay thinkers are coded, in the following four chapters, in terms of a variety of aspects which relate to the 'boxes' within the conceptual framework. Each 'box' represents features which have been comprehensively discussed in previous sections of this chapter. I will provide a brief summary of the constituents of each of the three elements:

- The **descriptive element** of each representation is composed of a theme around which there is a high degree of consensus, as well as counter-arguments. Thinkers will often propose a certain theme and then argue with themselves in relation to its validity. In addition, idiosyncratic responses, or those which are not mentioned by many people, are discussed under the rubric of 'counter-representations'.
- A variety of **process elements** are involved in the construction of a social representation. People use both anchors and objectifications in order to grasp a new issue such as AIDS. In addition, they may be reflexive in relation to various debates concerning AIDS. Overlapping with reflexivity is the notion of self-

presentation. Since people are reflexive, they are aware of how unacceptable it is to advocate an argument which blames certain groups for AIDS. Thus they present a socially desirable argument, often alongside a blaming one.

- The **power element** shows that fragments of ideology underpin the consensual representations, and counter-representations.

In addition to these three elements, two issues of 'fit' are integral in the formation of a social representation. The issues of 'fit' are only relevant to lay thinking:

- The **'fit' with the social context** is the relationship between the social representations put forward by individuals and ideas which circulate in their social context. The 'social context' is constituted, in the empirical study which follows, by both Government sponsored mass mediated AIDS campaigns, and the discourse of AIDS policy-makers. In addition, ideas discussed in Chapter Four, concerning South African and British cultural assumptions and laws, are part and parcel of the 'social context'.
- The **'fit' with other social reps** is the relationship between the various representations which an individual has of AIDS.

I use the above approach to analyse policy-maker and lay texts. Analysis of the AIDS campaigns follows the lines of a simple structural or semiotic approach, in line with the tenets of structuralism (see sections 5.2.1 and 5.3.1). Elements of a campaign are viewed both in terms of their denotative level and of the ideologies which sustain the denotative meanings.

## 5.5 METHODOLOGICAL ISSUES ASSOCIATED SPECIFICALLY WITH AIDS

Certain methodological concerns are specific to a study of AIDS-related thinking. Having reviewed the social and psychological research concerning knowledge, beliefs and attitudes held by different groups, regarding HIV infection and AIDS, Clift *et al.* (1990) conclude "The techniques most commonly used to collect information are self-completion questionnaires and structured interviews" (p.54). They add that "little attention has been given to identifying the principal dimensions involved in lay constructions of AIDS and in developing instruments to assess these" (p.55).

With certain exceptions (eg. Pill & Stott, 1982; Warwick, Aggleton & Homans, 1988; Ingham, Woodcock & Stenner, 1991b), qualitative methods, which tap into lay constructions, have not been commonly used to study health related issues. There is, however, a need to extend the use of such approaches in the AIDS field:

> "Given the relative lack of previous work in this area, a host of methodological and theoretical issues needed to be faced urgently. For the same reason, it is important that a variety of approaches is used to provide complementarity and alternative types of data and levels of analysis" (Ingham & Woodcock, 1990:2).

The nature of the subject matter in an AIDS-related interview presents specific problems. Ingham, Woodcock and Stenner (1991a) and Ingham (1991) argue that the way in which sex is viewed in conversations with parents, teachers, the media and peers encourages the development of a mystique around sexuality. It is talked about by way of jokes, double *entendres* and evasiveness. There is also evidence that some adults hold moderately negative values about sex in general (Bullough, 1976; Reiss, 1986).

The interviewer needs to approach an AIDS related interview with the knowledge that this is a difficult subject area for respondents. This is compounded by the fact that the homosexual sample contravenes the code of normative behaviour in society. Heightened sensitivity can be further expected due to the legal implications of the respondent's activities. In Britain, under the Sexual Offences Act of 1967, any man under 21 cannot lawfully have sex with another man. Section 32 of the Sexual Offences Act of 1956 deems it illegal for men to meet or attempt to meet in a public place, with a view to arranging sexual relations. In addition, a variety of local bye-laws prohibit forms of homosexual activity. In South Africa the Immorality Act 23 of 1957 is the principal legislation related to homosexual behaviour. It legislates against: any male who commits or attempts to commit an immoral or indecent act with a boy under 19; any person who entices, solicits or importunes in a public place for immoral purposes; a person who publicly commits an act of indecency; acts committed between men at a party, calculated to stimulate sexual passion or give sexual gratification (Isaacs & McKendrick, 1992).

Dockrell and Joffe (1992) found that the combined use of the semi-structured interview and the questionnaire is well suited to acquiring lay constructions of HIV/AIDS. In the semi-structured interview the interviewer is a participant. Meaning can be negotiated. The questionnaire, on the other hand, is appropriate for the investigation of intimate details such as the respondent's sexual orientation. It is commonly used for this purpose (Fitzpatrick, McLean, Boulton, Hart & Dawson, 1989; Sherr, 1987). The questionnaire, administered in private, is an appropriate way of acquiring data which may well be talked about in an evasive manner. Breakwell (1990) has noted that, in sensitive areas of questioning, respondents are often more willing to disclose information to the unseeing

page than to the interviewer.

It is unlikely that even the most sophisticated questionnaire would allow respondents to display inconsistencies which exist in their thinking. I have stated that consistency is valued in Western culture. It is far more difficult to maintain a contradictory stance in a questionnaire because one has visual evidence of previous answers. In the interview situation the respondent is less self-reflexive in connection to his or her consistency.

## 5.6 PILOT WORK

The researcher seeking out responses to issues such as the origin and spread of AIDS is faced with a dilemma concerning the relative usefulness of the focus group and individual interviews. The researcher strives to minimise self-reflexivity on the part of the respondent in order to attain 'naturally' occurring text. The group interview is likely to lessen awareness of the interviewer's presence. However, social psychologists who have analysed group dynamics are unsure of their effects (Galam & Moscovici, 1991). Many have argued that consensus takes place around an extreme position close to the dominant norms of the population, in a group situation. Others argue that a group averaging effect occurs.

The pilot work which I conducted was concerned with whether group or individual interviews would be used for the investigation of inter-group blame. It was also concerned with the salience of the media and, specifically, of government AIDS campaigns in people's accounts of AIDS. I also hoped to gain a picture of the range of issues which might arise in relation to questions concerning the origin and spread of AIDS. The more sophisticated methodology which I have devised results from this pilot phase. Systematic

pilot work, which involved individual and focus group interviews, was conducted on a British sample due to the constraints on my time in South Africa. The method and results of the British pilot work appear in Appendix A.

### 5.6.1 RELATIVE USEFULNESS OF GROUP VERSUS INDIVIDUAL INTERVIEWS

Certain theoretical and methodological findings indicate that group interviews would be more appropriate for the present study. In a one-to-one situation the respondent tends to be self-conscious, and therefore cautious concerning the content of his or her ideas. This tendency is heightened when discussing sensitive subject matter. Respondents also feel the need to present consistent, logical content:

> "Participants usually strive for coherence and consistency in the narratives they produce (for research as for other purposes). This is one effect on subjectivity of the dominant Western assumption of the unitary rational subject; we attempt to construct our experience within its terms. The remainder - if unacceptable and in contradiction - is repressed" (Hollway, 1989:43).

When the direct scrutiny of the interviewer is removed, representations are more easily shared. The process by which they are generated and maintained can also be brought to light by way of observing the interaction between subjects.

> "The group process engages people in relaying information, anecdotes, jokes, and opinions and often generates ideas, arguments and interactions which would probably not occur in a one-to-one interview. Group sessions encourage the kind of acting out that goes on among peers (where they provide an audience for each other) that might not occur in an interview" (Kitzinger, 1990:321).

On the other hand, the group interview may be dominated by 'gate-keepers' or opinion-leaders who prevent the expression of certain ideas. I will illustrate the difference between the individual and group interview data by way of extracts from the pilot work. In an

individual interview a respondent was asked how he thought AIDS began:

> *"I've always had this feeling that it is like the product of biological experimentation. Things like viruses can stem from these. But I have also been quite taken by the view that it is actually about the way that we are living in today's modern society has suppressed our immune systems to that extent that it [HIV/AIDS] is developing in us, and not necessarily outside".*

His account, in the individual interview situation, was striking in that it contained a lot of doubt and an ability to view issues from many different perspectives. His language was fairly neutral or impartial. Within the group context the form of his account changed radically:

> *"I was flabbergasted, the other day I went into a shop and they had this debate on the radio with obviously quite a lot of people in the studio, obviously straight macho. It was coming out with all this bigotry like 'I don't think that I am at risk'. They were saying 'I don't think I need to use a condom'. That was like a thermometer in the melting pot. That is the real reaction amongst the general public".*

A little later in the same group session he said of the homosexual community's reaction to AIDS:

> *"It is like things are going to self-destruct on themselves. The whole thing has brought more oppressive forces down on people, they are turning it on themselves, instead of fighting together as one, against an objective".*

Respondents seem to talk less scientifically, more forcefully and confidently in the group interview. The content of the accounts is richer in unconscious or non-rational material. Fantasies pertaining to the African origin of the disease abounded in pilot Group 2:

> *"**Interviewer:** A few of you seem to agree that it may have originated from an animal. How did it then get into humans?*
> ***Respondent 4:** Bestiality, I wouldn't rule it out.*
> ***Respondent 5:** Or they could have killed them or something for food.*
> ***Respondent 3:** Yeah, but usually they cook it, and when they cook it they char it.*
> ***Respondent 5:** As you can catch it from an open cut, I suppose a bit of the blood might have got on them,*

***Respondent 4:*** *Or as he is picking it up, the monkey gets irate and scratches him. Then he slept with his wife and she slept with her boyfriend and he slept with his boyfriend. The virus just popped up like daffodils everywhere".*

And a little later on, in the same group:

*"**Respondent 3:** The reason for presuming that it was Africa was because Africa was one of the last places to be explored by man and it hasn't been found in as great numbers anywhere else on the planet, so it is such a large number of the population in Africa suffer from AIDS and HIV.*
***Respondent 1:*** *That is why we assume it is Africa but unless people actually go out and see for themselves they can't really assume it is from Africa.*
***Respondent 3:*** *You can't say for definite that it is from Africa but all the pointers seem to be that it originates there, because of the number that are suffering, because Africa wasn't really explored until the last century really.*
***Respondent 4:*** *The other thing is that Africa is a promiscuous society. They sleep around.*
***Respondent 3:*** *Or a dead man's wife is his brother's when he dies.*
***Interviewer:*** *So your notion of Africa is that people sleep with more people there than they do here?*
***Respondent 1:*** *Developing countries, you know...*
***Respondent 5:*** *Lots of wives..."*

The voice of liberalism then interjects. The accounts then fluctuate between liberalism and racism:

*"**Respondent 4:** It could just be that different people have different customs and different attitudes.*
***Respondent 3:*** *That is right [unanimous agreement]. You look at Great Britain, it is still considered very Victorian when you discuss sex. I think it is because Africans haven't had the Puritan influence that comes from Christianity I suppose, they just bonk whenever.*
***Respondent 6:*** *Are you sure you haven't read the **Sun**? [Jokingly]. I think it is all conditioning, the way you are brought up.*
***Respondent 4:*** *Oh yeah but, this will probably sound very racist, but if you are just wandering around in the jungle, and you get an urge, you just react on that urge, and don't worry about the consequences or who you are affecting".*

These data are rich in fantasy material and express a number of ideologies, which do not come to the fore in the individual interviews. The clause *"this will probably sound very*

*racist, but..."* also reflects the reflexive and self-presentational elements evident in van Dijk's (1984) finding that one of the crucial elements of contemporary racism is its denial.

People become involved in the process of group discussion and cease to present the more consistent facade evident in many of the individual interviews. Consequently, a group-based methodology represents a critique of the unitary individual respondent which is the norm in much Anglo-American psychology. A respondent who stated, in the individual pilot interview, that he always used condoms, implied, in the context of group discussion, that he had had an unsafe one-night stand recently:

> *"People just take sex as a game. To a certain extent they will go off to a club, they are having a good time, go up to a fella, see what he is like, go home with him. I do that at times, but thinking of it now worries me".*

Condom use and the 'responsible attitude' which it signifies, is perceived to be socially desirable behaviour for homosexuals, and so may be over-estimated in self-disclosures to a researcher, in the individual interview.

In the light of this account, it may seem surprising that I have chosen to utilise individual interviews as the basis of my empirical work. The group situation has many disadvantages. It can inhibit certain types of discussion. It may be more difficult to express intimate personal experiences in the forum of the group. Furthermore, a group consensus can be reached which systematically excludes certain items. In pilot group 1 this problem became salient. In response to the question 'Where did AIDS begin?', the strongest, most vocal, and most political member of the group replied:

> *"It doesn't matter where it started, where it started is irrelevant, I don't think anyone knows where it started. It is like blaming the common cold on where it started".*

This set the tone for all other responses in the group. No-one had any theories of blame and all members endorsed the fact that the issue was irrelevant. When I 'negotiated' this account by pointing out that I had the feeling, from interviewing some of them privately, that many had strong feelings about the origins of HIV/AIDS but that they knew that the subject was socially unacceptable in the gay community, they offered a few meagre accounts of origin.

Due to (a) the problem of gate-keepers blocking certain debates, (b) the difficulty in systematically analysing group data, and (c) the taboos surrounding AIDS, the final study utilised the individual interview complemented by a questionnaire. Details concerning these tools are given in Chapters Seven and Nine.

## 5.7 METHODOLOGICAL ASSUMPTIONS OF THE THESIS

This thesis holds a number of methodological presuppositions which differ from those of traditional social psychology. Firstly, a study of inter-group blame, using a social representational approach, cannot be replicated because it is more similar to a historical than to a scientific piece of work (Farr, 1992). Secondly, because individuals are social beings, the content of their discourse reflects ideas which circulate around them. By looking at the dialogue of a small number of people, one taps into the wide set of arguments which circulate in a particular society. Ecological validity (whether the social context of the study was true to life) is established, not only by sampling the arguments/social representations of a small number of people, but by looking at the social context in which their text is situated. Generalisability is not easy to establish by way of this method:

> "Generalisability is not automatic in this method and has to be established according to theoretical rather than statistical principles" (Hollway, 1989:16).

This method of sampling is largely influenced by anthropological methods. Within the 'comparative method', sampling is based upon differences and similarities within the sample. I am interested in the social representations of young adults in three sub-groups within South African and British culture: black heterosexuals, white heterosexuals, and homosexuals (both black and white). Young adults are likely to have been exposed to the stock of arguments concerning HIV/AIDS. I purposefully selected respondents who were not 'officially' racist, such as certain sectors of the Afrikaans community in South Africa. This enables a more direct comparison between South African and British samples to be made. The homosexual sample includes people with HIV and AIDS. This ensures a voice for those who may be blamed for the disease.

There is a great advantage in working in the AIDS field. Since governments have poured money into this area, large-scale, representative samples have been investigated in relation to many aspects. Blame related issues are no exception. The traditional concerns of the social scientist, that the chosen sample is unrepresentative, is not as great an issue in this case. One can draw on statistics generated by the comprehensive surveys (eg. DHSS, 1987; The McCann Group, 1988). Quantification of blame-based assumptions is of less importance than the need to explain the process and content of inter-group blame.

Unlike opinion polls which attempt to determine the manner in which people will vote, when one attempts to canvass social representations of a phenomenon, all individuals'

ideas are not equal. Certain people have a greater influence upon the stock of arguments, as is encapsulated in the notion of 'opinion-leaders' (Katz & Lazarsfeld, 1955) (see Chapter Two). Policy-maker and media arguments weigh heavily within social representations concerning AIDS and blame.

## 5.8 CONCLUSION

Sampson (1989) claims that the essence of structuralism and post-structuralism is the same. The essence of each is to "search for basic processes that lie beyond individuality and human awareness and out of which the individual-as-such is constituted" (Sampson, 1989:6). In order to decipher these basic processes one turns to language and to symbolic practices. The lesson of structuralism is that each individual, from birth, is subjected to the structure into which he/she is born. The post-structuralists, like the social representationalists, accept this but give human agency and creativity a role too.

This chapter has provided a general methodological overview which informs the following five chapters. At the start of each of these chapters a more detailed account of how the study was carried out is presented. The South African and British studies are treated separately in the following four chapters. They are compared in Chapter Ten. The South African and British studies were carried out in as similar a way as possible in order to allow for cross-cultural comparison. Unfortunately, in the chapters which treat the two countries separately, a fair amount of repetition occurs. It allows the reader who is interested in only one of the societies to get as full a picture as possible of the study conducted in that society.

## OVERVIEW OF CHAPTER SIX

In this chapter I analyse the social representations of AIDS, related to blame, which circulate in the South African social context. These social representations form the backdrop to the thinking of lay respondents. One is struck by the extent to which Africa is 'other' to the white policy-makers who are interviewed. There is a denial that their country is situated within Africa, and a great affinity with 'the West', in keeping with a colonial outlook. The migrant worker is the symbol of pollution from an HIV/AIDS contaminated 'other' to a pure 'self'. The ideology of Apartheid features prominently, as an influence both in the accounts of policy-makers, and in the AIDS campaigns themselves. Promiscuity is regarded as a central evil in the spread of HIV. Social representations of AIDS in the South African social context absorb and reflect the society's central concerns.

# CHAPTER SIX: THE SOUTH AFRICAN AIDS CAMPAIGN: EXPLICIT AND IMPLICIT AGENDAS

## 6.1 INTRODUCTION

In this chapter I deal with the social representations of AIDS which circulate in the South African social context. The notion of 'social context' has been fully discussed in Chapter Five. Lay thinkers draw on ideas which circulate in the social context when they contemplate issues such as the origin and spread of AIDS. Lay thinking, in turn, influences the ideas which circulate in the social context.

In this chapter I examine two aspects of the 'social context':

1. Relevant **policy-makers'** views of the origin and spread of HIV/AIDS, and of actions to be taken to contain the spread. This is based upon depth interviews with one key policy-maker and two subsidiary policy-makers.
2. Government sponsored **national poster campaign** messages relating to the origin and spread of HIV/AIDS, and to actions to be taken to contain the spread. This is based on an analysis of the first South African Government sponsored national AIDS campaign.

The two aspects of the social context are treated separately.

## 6.2 BACKGROUND ISSUES: SOCIAL AND MEDICAL REALITIES OF THE SOUTH AFRICAN AIDS EPIDEMIC

### 6.2.1 AIDS STATISTICS IN SOUTH AFRICA: DECEMBER 1988

Despite the popular perception that Africa, as a continent, is AIDS-ridden, among South Africa's thirty million people there were only 166 reported cases of AIDS by 14 December 1988 ('Update AIDS in South Africa', 1988):

- 82% were white.
- 13% were black.
- 4% were 'coloured' [of mixed racial origin].
- 1% were Asian.
- 75% contracted HIV through homosexual or bisexual transmission. Whites accounted for the vast majority of the homosexual and bisexual PWAs.
- 15% contracted HIV through heterosexual transmission. Blacks accounted for the vast majority of heterosexual PWAs.
- 8% contracted HIV through contaminated blood.
- 2% contracted HIV through mother-to-infant transmission.
- There were no intravenous drug users among the AIDS statistics.
- 92% of the PWAs were men; 8% were women.

The South African statistics reflect a unique dynamic. While there were 166 South African PWAs at this time, there was a total of 191 PWAs in South Africa. Twenty five of the PWAs were foreigners, the majority from the bordering states of Malawi and Zambia. The statistics differentiate between the South Africans and the foreigners who have AIDS in South Africa. This differentiation reflects the status of migrant workers in South Africa, which is central to the conceptualisation of AIDS.

### 6.2.2 MIGRANT WORKERS AND AIDS IN SOUTH AFRICA

South Africa imports vast numbers of migrant workers from the neighbouring states for its Government-controlled mining industry. Miners, both South African and migrant, live in men-only hostels. They have eleven-month contracts and return home for the twelfth

month. While some men form relationships with women in the surrounding villages, the hostels are all serviced by local prostitutes whose services are heavily utilised by the men. In addition to this, it is widely believed that many men adopt unsafe homosexual practices in the absence of their regular partners. If a sexually transmissible virus were to enter such a hostel, it would have great potential to spread. This issue is contentious. Jochelson *et al.* (1991) found that, while many men adopted practices which might be construed as homosexual, the practices were safe in terms of the transmission of HIV. The men practised what is termed inter-thigh sex with other men. Anal sex, which is a high risk practice in terms of the transmission of HIV, was not common.

Despite this contention, the mines are regarded as a hot-bed for the spread of HIV. Eighteen miners of Malawian and Zambian origin, were found to have AIDS in 1988. As a result, all Malawian and Zambian miners were expelled from the South African mines in 1988. By expelling these miners South Africa both diminished its AIDS statistics and hoped to eliminate the risk of the spread of HIV in the mines. If the infectious, polluting 'other' could be forcibly removed, South Africa could remain AIDS-free.

### 6.2.3 THE EXTENT TO WHICH THE SOUTH AFRICAN GOVERNMENT SHOULDERED RESPONSIBILITY FOR AIDS

The expulsion also illustrates the attitude of the Government to health care in South Africa. South Africa does not have a national health service or a social security system. South Africans are not automatically entitled to medical care. People are means tested. Only the poor are entitled to Government health care. The medical entitlement of migrant labourers is unclear. The mines were under no obligation to give medical care to migrant workers who had AIDS.

The issue of a private health care system is central to the manner in which the South African Government has handled AIDS. It conceives of itself as a junior partner in the fight against AIDS. While responsibility is explicitly placed upon the private sector, upon individuals themselves, the Government has amended certain regulations in the light of AIDS. In October 1987 it amended the Health Act to include AIDS as a communicable disease. This means that people with AIDS, and HIV, can be subject to compulsory medical examination, hospitalisation and treatment (Pegge, 1990). In addition, regulations concerning entry into the country were changed. Like those with cholera and yellow fever, HIV positive people can be denied entry into the country. This has been used in relation to denying black mine workers from central Africa the right to enter (Pegge, 1990).

### 6.2.4 CONFLICTS WITHIN THE AIDS POLICY-MACHINE

The first national group to deal with AIDS, the National AIDS Advisory Group (NAAG), was not Government funded. It was constituted solely by medics, none of whom represented the homosexual or the black communities. The influential policy-makers who ran it held independent and, at times, opposing views to those of the Government. Certain non-Government members felt the Government to be conservative, illiberal and right-wing. However, all members played a part in the creation of the first national AIDS campaign.

Despite a belief in private sector responsibility, the Government was forced to fund the first national AIDS campaign in January of 1988. Factors which led to the formation of the campaign are similar to those mapped out in Chapter Two. They spent between one and one-and-a-half million rand (at that time equivalent to between £250,000 and

£375,000) on the campaign. It is claimed that 82% of whites and 78% of blacks saw at least one component of the campaign (The McCann Group, 1988).

### 6.2.5 THE RELATIONSHIP BETWEEN THE MASS MEDIA AS A WHOLE AND GOVERNMENT-SPONSORED AIDS CAMPAIGNS

The tight control which the Government exercises over the mass media has had the consequence that very little sensationalism has entered into the reporting of the AIDS epidemic. The messages contained in the AIDS campaign are likely to have had a strong impact because other sectors of the mass media were not sensational in their coverage of the epidemic. Certain factors outside of the campaigns are likely to have impinged on lay thinking in South Africa. Firstly, black and white people are exposed to different mass media. They are likely to approach campaigns from a different perspective. Secondly, programs concerning the life stories of American people with AIDS abounded in the mass media. American programs on the Central African origin of the disease were also screened, on various occasions, in the 1980s. These American products were likely to provide convenient anchors for the formation of social representations of AIDS on the part of South Africans.

### 6.2.6 AIDS MISINFORMATION LEAFLETS: TEST THE BLOOD OF YOUR BLACK SERVANTS

AIDS misinformation leaflets were widely distributed in urban areas in 1989. Leaflets entitled 'Facts on AIDS the press won't print' and 'AIDS - hushed -why??', distributed late in 1989 (see Appendix B), express the extent to which AIDS syncretises various political fears which characterise the final stages of Apartheid. Basing their information upon the putative prevalence of AIDS in the rest of Africa, the two misinformation

campaigns (which are almost identical in content) state that *"ALL the South African blacks will be infected by 1992"*. Their 'Measures to avoid AIDS' include regular testing of the blood of 'black servants' and avoiding all 'multi-racial' public facilities. While this type of misinformation, distributed to 20,000 people in certain right-wing constituencies, may appear tongue-in-cheek to the outsider, within the South African context, it is entirely plausible. It was issued at the time that the Government had begun to lift laws which segregated black and white public amenities, and had begun to consider the release of Nelson Mandela from prison.

### 6.2.7 NO ROLE FOR MARGINALISED GROUPS IN THE DEVELOPMENT OF AN AIDS STRATEGY

No official black voice existed at the time that the studies reported in this and the following chapter were undertaken. There had, however, been a legacy of anti-Apartheid movements operating both within and outside of South Africa. They had stressed the significance of social conditions, rather than of individual factors, in creating South Africa's problems. At this time the gay voice in South Africa was also rather muted. Like the black voice, it was not consulted in the early policy and campaign decisions which are reported here. It is against the social and medical background mapped out above that the South African study took place.

## 6.3 INTERVIEWING AIDS POLICY-MAKERS: METHOD

NAAG was established early in 1985 by the health authorities when they recognised AIDS as a potentially serious health problem in South Africa. NAAG was the central forum for policy debate concerning a national AIDS strategy. I contacted NAAG when I visited South Africa in December 1988. An interview was set up with a clinical psychologist

loosely affiliated to NAAG. This one hour interview took place on the fourth of January 1989. I was then directed to a Professor of Infectious Disease, who was affiliated to NAAG. This hour-long interview took place on the ninth of January 1989. I was advised to speak to a certain member of the Government's Department of National Health. This interview took place on 12 January 1989 and lasted for two hours. The policy-makers gave me reports, speeches and leaflets, which documented the AIDS situation in South Africa at that time. Each of them was informed, in the telephone conversation or faxed message that preceded the interview, that I was a social psychology doctoral student, working on a comparison between ideas about AIDS in South Africa and in Britain. All interviews were audio-recorded and transcribed onto a word-processing package.

For ethical reasons, I refer to the Government member as X, to the Professor of Infectious Disease as Y and to the clinical psychologist as Z. In so doing, I hope to downplay the individuality of each of the three individuals and to emphasise that their views represent social representations which are shared by dominant or hegemonic group members.

McCann, the advertising agency who produced the first national AIDS campaign, was contacted. While all key producers of the campaign were on vacation, they agreed to send me copies of the entire campaign.

A former head of the Gay Association of South Africa (GASA) was contacted. A short telephone conversation with him and calls to other members of the gay movement gave me a picture of the involvement of the gay community in the Government's initiatives.

This chapter deals only with ideas concerning AIDS which circulated in the South African 'social context' in 1989. The data concerning South Africa in Chapter Four is complementary. Ideas concerning the social context of AIDS form the backdrop to the lay sample's social representations of AIDS, which were investigated early in 1990 (and which are reported in the following chapter). Massive changes occurred in the South African social context early in 1990 with the release of Nelson Mandela from prison and the repealing of the Apartheid laws. While the potential impact of these changes will be mentioned in Chapter Eleven, the empirical study reported here and in the next chapter must be discussed in terms of the historical context in which it was conducted.

## 6.4 RESULTS: THE TEXTURE OF POLICY-MAKER THINKING

The three policy-makers addressed my questions from the perspective of their own particular role in relation to AIDS. X offered the statistics and rhetoric that one expects from Government officials. Z addressed many of my questions from an educational and a clinical psychological perspective. Y held the role of 'AIDS educator' in the mass media as well as in schools, and spoke from an educational perspective.

I will analyse social representations which connect AIDS and blame in the texts of these policy-makers. This analysis is carried out in accordance with the three elements which constitute a social representation. This is shown in Figure 1 (Section 5.4.3, Chapter Five).

The views expressed in the interviews clustered around three social representations:

A. The social representation of responsibility and punishment.
B. The social representation of out-group responsibility.
C. The social representation of in-group pollution.

## A. THE SOCIAL REPRESENTATION OF RESPONSIBILITY AND PUNISHMENT

DESCRIPTIVE ELEMENTS

**Consensual representations**

> *"If everybody just lead a normal life, a non-promiscuous life, then the Government wouldn't need to put anything into it [AIDS campaigning]"* (Y).

Because people don't conform to Y's idea of the 'normal life', he proposes that *"you have to educate them not to sleep around"*. X shares his starting point:

> *"If the human race, in our country, and in the whole world, only had sex with one person and that person only had sex with them, in other words, two faithful people, we probably wouldn't have had, I don't know, ten or a hundred cases of AIDS in the world, it would defeat itself".*

X almost said that we wouldn't have had AIDS, but stopped himself. AIDS, here, is explicitly connected with the unfaithful, the abnormal, and a promiscuous lifestyle. Whether they connect in terms of spreading the virus or in terms of causing or 'generating' the virus is not clear from these two accounts.

Morality and AIDS are closely linked. Y, whose discourse was characterised by multiple allusions to promiscuity, states that:

> *"The church has failed as far as promiscuity [is concerned], so we need to go to the children".*

This is the discourse of a man who is clearly not concerned about 'promiscuity' purely in terms of its consequences for the spread of AIDS. Promiscuity, for him, is morally reprehensible. In talking, above, about the *"normal"*, and in relating AIDS to excess or to *"sleeping around"* we can detect traces of the social representation of AIDS as punishment.

The irresponsible, blame-worthy lifestyle is centrally linked to AIDS, in the accounts of Y and X. X is concerned about the 'worried well' especially among those *"adhering to a monogamous relationship"*. He worries that *"to scare people, you scare them too"*. These are his 'innocent victims'. The non-monogamous deserve to be scared.

Fewer allusions were made to homosexuality, prostitution or drug-use than to promiscuity. The intravenous drug using lifestyle was not regarded as a major factor in the spread of HIV in South Africa. It was only mentioned by X in his comment on the AIDS statistics. It was mentioned as an absence - there were no drug-related AIDS cases in South Africa at this time.

While X called for a partnership between the public and private sectors in the fight against AIDS, responsibility was placed squarely on the private sector at many points in the interview:

> *"We feel that this is the responsibility of the community, you cannot enforce it by law"*.

The other policy-makers were extremely sceptical about the Government's commitment to AIDS prevention but felt that the private sector would probably be more effective as preventers of the spread of AIDS.

**Counter-representations**

Interestingly, both Y and X counter their own arguments that monogamy could have curbed AIDS at a later point in their interviews. Y states that sex is the most basic of drives and that, in order to fulfil it, in the past, people married at an early age. He states that his grandmother got married at 14. The fact that this no longer occurs, because people

want career and financial stability before they get married, means that people need to have pre-marital sex. X disputes his own judgement that faithfulness would have been the answer to AIDS by stating that:

> *"In some of our population groups it is ethically, morally accepted that a man may have more than one wife, he may have extra-marital sex".*

Despite the astounding number of allusions to promiscuity in the texts of the two men, they were absent from Ms Z's account.

PROCESS ELEMENTS

**Anchoring**

Not found.

**Objectification**

AIDS is objectified in terms of war in X's account: X talks of needing to *"combat"* the AIDS problem, and of the need to convey that having multiple partners *"can really kill"*. He also says that AIDS would *"defeat itself"* if people were monogamous.

**Reflexivity**

X intercepts his own dialogue at one point where he is about to state that monogamy would lead to their being no cases at all of AIDS. This implies that what he terms *"multiple partner"* relationships are a central cause of AIDS. At the same time, by intercepting his own dialogue, he shows that he is aware that this is a problematic position.

**Defensiveness**

X and Y believe that, if all people had faithful relationships with just one partner, there would be no need for Government intervention on AIDS. Even without considering the range of relationships in black South African society, they deny, in their simplification, the existence of serial monogamy in white South African society.

**Self-presentation**

The two male policy-makers indicated that it was legitimate to link AIDS to promiscuity but not to homosexuality. The linking of AIDS to behaviour rather than to risk groups was regarded as legitimate. However, when it came to distinguishing between the relative risks of black and of white groups, opinions were readily offered:

> *"I see our major problem in a few years time in the black community, as opposed to the white"* (**Y**).

Talk of behaviour is eclipsed by the mention of a risk group.

Homosexuality received very little attention in the accounts given by the policy-makers. This may reflect a reluctance on the part of the policy-makers to raise the issue in conversation with a female researcher.

While there is a detectable trace here, of a social representation of punishment, one has the feeling that the social norms and the roles of these two individuals as health professionals, prevent the policy-makers from developing this line of reasoning. Of course, this is only conjecture.

POWER ELEMENTS

While the fact that homosexuality was not mentioned very much may be related to a self-presentational strategy, it may also reflect a view that this group is 'disposable'.

A highly individualistic tone runs throughout the interviews with all three interviewees accepting that the Government should not be the primary source of AIDS prevention:

> *"**Interviewer:** Do you feel that the Government has put enough money into campaigning?*
> ***Y:** I never understand why everybody points a finger at the Government, when they themselves do nothing to curb this disease. If everybody just lead a normal life, a non-promiscuous life, then the Government wouldn't need to put anything into it".*

Y is not a Government official and states that he opposes its conservatism. This is not a self-defensive response on his part, as it might be if X had made it. This is a response which reflects a deep-seated ideology. The individual gets what he deserves for the irresponsibility of his promiscuous lifestyle.

## B. THE SOCIAL REPRESENTATION OF OUT-GROUP RESPONSIBILITY

DESCRIPTIVE ELEMENTS

**Consensual representations**

All three policy-makers sharply differentiated the South African AIDS situation from the AIDS epidemics in the rest of Africa. They did this by stating that the numbers affected by AIDS are small in South Africa:

> *"But you see our figures, of course we are glad about them, but it is hard to really scare the people"* (**X**).

X also differentiated between the rate at which people contracted AIDS in South

Africa and the rate in Western countries. It had been far slower in South Africa. The reason which he gave for the slow increase was that:

> *"I think we are fortunate in so far that we are far away from the rest, where AIDS originated".*

When asked where it originated, he was initially reluctant to give an answer (as were the other two policy-makers, initially), but went on to say that:

> *"We are lucky in so far as geographically we are fairly isolated. The travel between the rest of Africa and our country is limited".*

And:

> *"The spread of the disease originating from somewhere presumably near Lake Victoria in Central Africa, spreading from there to Haiti, from there to the USA, and from there ... to the rest of the world".*

The other two policy-makers did not commit themselves, although both felt that there were far more people with AIDS in Africa than anywhere else. Y felt that statistics under-reported the African situation which he described as 'alarming', while Z implied a belief in high African numbers when she said that:

> *"South Africa is in many respects like a Western country. We have a very low incidence of AIDS".*

Furthermore, the policy-makers stated that the South African situation was different from the African situation in terms of the pattern of spread and reporting of AIDS. The South African pattern was seen as more similar to that of Western countries, than to other African countries. South Africa's teaching hospitals, like Western hospitals, would be likely to know of all PWAs, and had compiled complex information on PWAs, quite unlike other African countries, where the authorities had no idea of their AIDS statistics. In addition, the pattern of spread in South Africa, to date, was mainly through white homosexual and bisexual activity, as it had been in the West. The

manner in which the policy-makers allied themselves with the West, rather than with Africa, reflects the extent to which most South African whites do not perceive themselves to be living in Africa. This implies that AIDS, which these policy-makers construe as an African problem, is represented as a problem of the 'other'. The 'other' or out-groups, for the policy-makers, tend to be blacks and, to a lesser degree, homosexuals.

There is a constant reiteration of consideration for, and respect of, cultural difference in the South African context:

> *"We are such a plural society, you have to be aware of all levels, all ages, all cultures"* (**Z**).

At the same time, blacks are regarded as, at best, less educable, and, at worst, promiscuous and stupid:

> *"I've done a number of live phone-ins [on AIDS]. And the type of questions, even in the blacks, you get informed [opinions], the questions testify to the individual being informed [about AIDS]"* (**X**).

X is clearly surprised that black callers are well informed about AIDS.

**Counter-representations**

There is a line of reasoning throughout the Y and Z interviews which opposes the government's stance on a number of issues. This line of reasoning emphasises safer sex in place of the morality which is emphasised by 'officialdom':

> *"There should be a television program on condoms. I talk about it on television, but I am sure that if I showed one there would be an outcry. So you must realise that we are working in a very conservative country. Officialdom is very very conservative"* (**Y**).

PROCESS ELEMENTS

**Anchoring**

Under-developed 'Africa', a place to which these policy-makers feel little or no affiliation, is their anchor for AIDS.

**Objectification**

South Africa, and white South Africa in particular, is constantly juxtaposed to the more permissive West. Britain and America often embody this permissiveness:

> *"We don't have condoms advertised on TV. There are adverts, especially in the UK, with condoms hanging from every piece of the person's anatomy to try and inform people. We are very conservative"* (**Z**).

**Reflexivity**

Whilst the policy-makers construed AIDS as a problem of the 'other', each of them showed an awareness that casting the problem onto the other implied blame. Awareness was indicated by an initial reluctance to answer the 'Where did AIDS originate?' question. When asked where he thought AIDS originated, Y said:

> *"Sure, the Americans like to blame Africa, the Africans love to blame the United States".*

**Defensiveness**

The attempt, by the three policy-makers, to diminish the potential seriousness of AIDS for South Africa and specifically for white heterosexual South Africans, is a way of maintaining a sense of control in the face of an extremely threatening situation.

There is a strong denial, in the interviews, of the fact that South Africa is situated

within Africa. X even states that South Africa is far from the place in which AIDS originated. He believes that AIDS originated near Lake Victoria. This allows the policy-makers to deny the likelihood of the spread of the virus to heterosexual whites. None of the three mention this possibility. AIDS is a problem of the 'other'.

**Self-presentation**

The policy-makers were initially reluctant to give an answer to the question concerning the origin of AIDS. This is related to both a reflexivity concerning the link between positing origin and blame and a desire not to appear to blame.

POWER ELEMENTS

The South African policy-makers experience the problem of AIDS as a non-Western phenomenon, and clearly align themselves with all that is Western. By aligning themselves to a Western pattern of AIDS, they dissociate their plight from that of the rest of Africa. This is a residue of colonialism. In fact there is an attempt to align South Africa with Western standards of medicine:

> *"In 1985 screening tests first became available and we introduced screening of all blood transfusions, all blood, which was the same time as in England"* (**X**).

White South African policy-makers tend to align themselves to advancement in contrast to the notion that South Africa is an under-developed country. Policy-makers who feel that the West has a low prevalence of AIDS align themselves to this aspect of the West:

> *"South Africa is in many respects like a Western country. We have a very low incidence of AIDS"* (**Z**).

Policy-makers, on the other hand, who view the West as high in its AIDS prevalence, differentiate themselves from the West in order to emphasise their low AIDS statistics:

> *"If you compare, for instance, Australia, with South Africa, population wise it is more or less comparable. They also had their first case in 1982, they have had a total of 1000 cases now. If you compare it to the United Kingdom, alright they have got a higher population than we have, but they also saw their first case in 1982. They now have 1800"* **(X)**.

## C. THE SOCIAL REPRESENTATION OF IN-GROUP POLLUTION

### DESCRIPTIVE ELEMENTS

#### Consensual representations

Each of the policy-makers continually refers to what are termed *"cultural differences"* within the *"South African context"*. Cultural difference, inevitably, means racial difference. When asked what she meant by her constant allusions to the 'South African context', Z stated:

> *"The cultural thing. By culture I am not only looking at colour...".*

Similarly, when X initially described who had AIDS in South Africa, he not only mentioned homosexuals, but he described the colour of the homosexuals. He reconsidered the figures and pointed out that 20 cases amongst blacks had recently been discovered. The colour issue was again implied when he attempted to assert that it was <u>not</u> a central issue: *"Who should we target?"* he asked himself. Without any prompt from the interviewer he answered:

> *"Everyone who is sexually active or potentially sexually active. There's no preference to race or colour...".*

The issue of racial difference is central to a discussion of AIDS in South Africa. All three policy-makers considered each issue which was raised by the interviewer in terms of a black versus a white perspective. Y talked about the problems which people have with condoms. Before mentioning problems which people have with them he remarked that:

> *"There are a number of reasons why even whites don't want to use condoms".*

Racial difference is construed as problematic, in terms of the spread of HIV/AIDS, by the policy-makers. X recognised that an inter-racial mix is also present in other countries. But, for him, the South African situation is different:

> *"Alright, UK also have different races, but not to the proportion that we have, not number-wise the same problem that we have".*

The number of blacks in South Africa is a 'problem' because blacks do not interpret the world around them in the same way as whites do. This is a highly salient theme in all three accounts. Each policy-maker offered two fairly detailed anecdotes relating to the fact that blacks are more literal in their interpretations than whites, who are able to be more abstract. The most striking of these anecdotes was the one related by X, in which he explained that blacks are unable to relate an enlarged image of a mosquito, as might appear in a malaria prevention campaign, to the mosquitoes which they encounter in their environments. This makes health campaigning especially difficult.

Y and Z felt that they were grappling with an almost insuperable problem. According to them, blacks see AIDS as a white man's disease and whites see it as a homosexual disease. Both talked of an attempt to publish a poster (non-governmentally sponsored)

which dispelled this myth:

> *"Do you know how long it took us to decide what to do about that because we didn't know what people to put on the posters. We would have put men, people would say it's a gay disease; if we would have put whites then blacks would have said it is a white man's disease; if we would have put blacks they would have said it's a black man's disease. Do we put male or female? Then they would have said, 'what about the colour bar?' These are major problems. We settled for two females [one black, one white]"* (Y).

The 'colour bar' to which Y refers, was the law, [later overturned], that blacks and whites could not have sex together or marry one another. The policy-makers' social representations of AIDS reflect the obsession with race which permeates all spheres of South African life.

While each racial group is generally confined to its niche, Y, in particular, stressed the potential for 'leakage' or contagion of the virus from the out-group to the in-group:

> *"Do you know that in England there seems to be a marked increase in the heterosexual population. It is coming from contact between black and white, between visitors".*

He went on to support the ban on entry into South Africa of migrant labourers from Malawi, and to say that the free entry into South Africa, of foreign homosexuals, should also be questioned.

While the notion of 'pollution' was generally raised in terms of a potential transmission of AIDS from one racial group to another, X also raised the notion of AIDS as a modern, urban disease:

> *"All along the world, where do you find AIDS? It is a metropolitan disease. So it is not a matter of being white or black, it is whether you live in metropolitan areas or you don't. The risk of being exposed certainly gets higher in metropolitan areas than it is in the rural areas".*

**Counter-representations**

X's quote concerning the link between urban living and AIDS, asserts that AIDS is not *"a matter of being white or black"*. While I have stated that each issue that is raised by the policy-makers is linked to racial difference, the fact that there is often a denial that race is central reflects that this issue is a matter of debate. Y and Z's attempt to make an AIDS prevention poster with which all groups would identify is a testimony to awareness of inter-group blame in South Africa. This overlaps with the section of reflexivity, below.

PROCESS ELEMENTS

**Anchoring**

Not found.

**Objectification**

Y views 'black visitors' as a source of AIDS in England. This fear concerning 'black visitors' is echoed in various allusions to migrant workers. The migrant worker is the symbol of pollution from an HIV/AIDS contaminated 'other' to a pure 'self'.

**Reflexivity**

While Y and Z viewed the thinking of blacks and whites as different from one another, they questioned the use of separately targeted AIDS campaigns in order to address this difference. They had reflected upon the fact that each group associates AIDS with the 'other'. X's position, on the other hand, endorsed the differentiation, pointing to examples which 'prove' the differing mental faculties of blacks and whites.

**Defensiveness**

The world of the black and of the white person appeared so different from each other in the discourse of the policy-makers that they did not express a strong fear of pollution or leakage from the out-group to the in-group. One might view this in terms of defensive thinking or purely in terms of ideology, as discussed below.

**Self-presentation**

Each policy-maker, at some point in the interview, referred to an issue (eg. sexual activity or culture, as quoted above) and told the interviewer that 'colour' was not of the utmost importance in their consideration of this issue. This appears to indicate a self-presentational need not to appear over-concerned with racial issues. They fear that this might be construed as racist by the outsider.

POWER ELEMENTS

The boundary between black and white, enshrined in law for forty years in South Africa, prevents white policy-makers from expressing a strong fear that the illness of the 'other' will invade the 'self'. The borders around the self have not been invaded by this African, homosexual, disease. Each policy-maker addressed the issue of differences between racial groups at the first available opportunity, even when it had not been implied in any question. The ideology of Apartheid, clearly, is very much at work.

Part of this ideology, which is evident in the interview with X in particular, is that of racial inferiority. The suggestion that black people are concrete thinkers and white

people more abstract is evocative of early debates on racial differences in intelligence which have since been declared as both inaccurate and racist (I discuss related issues in Chapter Three).

## 6.5 A LOT REMAINS UNSAID

All three policy-makers spoke in a guarded way. Doctor X, in particular, was very concerned that I might be an under-cover journalist. All three became far more animated when the tape-recorder was switched off, and offered 'off the record' information. They showed a self-consciousness when contentious issues, such as AIDS in the mines, were brought up. There was obviously a lot that went unsaid. This is indicative of the politically sensitive nature of the topic of AIDS in South Africa.

## 6.6 ANALYSING SOUTH AFRICAN AIDS CAMPAIGNS: METHOD

In January of 1988 the South African Government launched an AIDS campaign in the mass media. The national AIDS campaign exhibits a number of facets characteristic of South African society. Firstly, blacks and whites were targeted through two completely separate campaigns. The campaigns ran simultaneously, contained the same textual message and logo, but used diametrically opposed visual images and slogans. The workings of ideology are clear. It appeared 'natural' to the array of people involved in the creation of the campaign, that the two groups should be targeted separately. The ideology of Apartheid is so deeply inscribed in the minds of the professionals involved in the campaign that it did not occur to them that they might target along the lines of age, sexual orientation or, indeed, target the 'general public', as occurred in the initial national British campaigns. The notion of a general public does not exist.

Each of the two campaigns revolved around a particular theme, which was depicted in a television campaign, a double-page colour spread in the Sunday newspapers and in a poster. The black campaign was characterised by the use of a funeral scene. The white campaign was characterised by a graffiti-ridden wall.

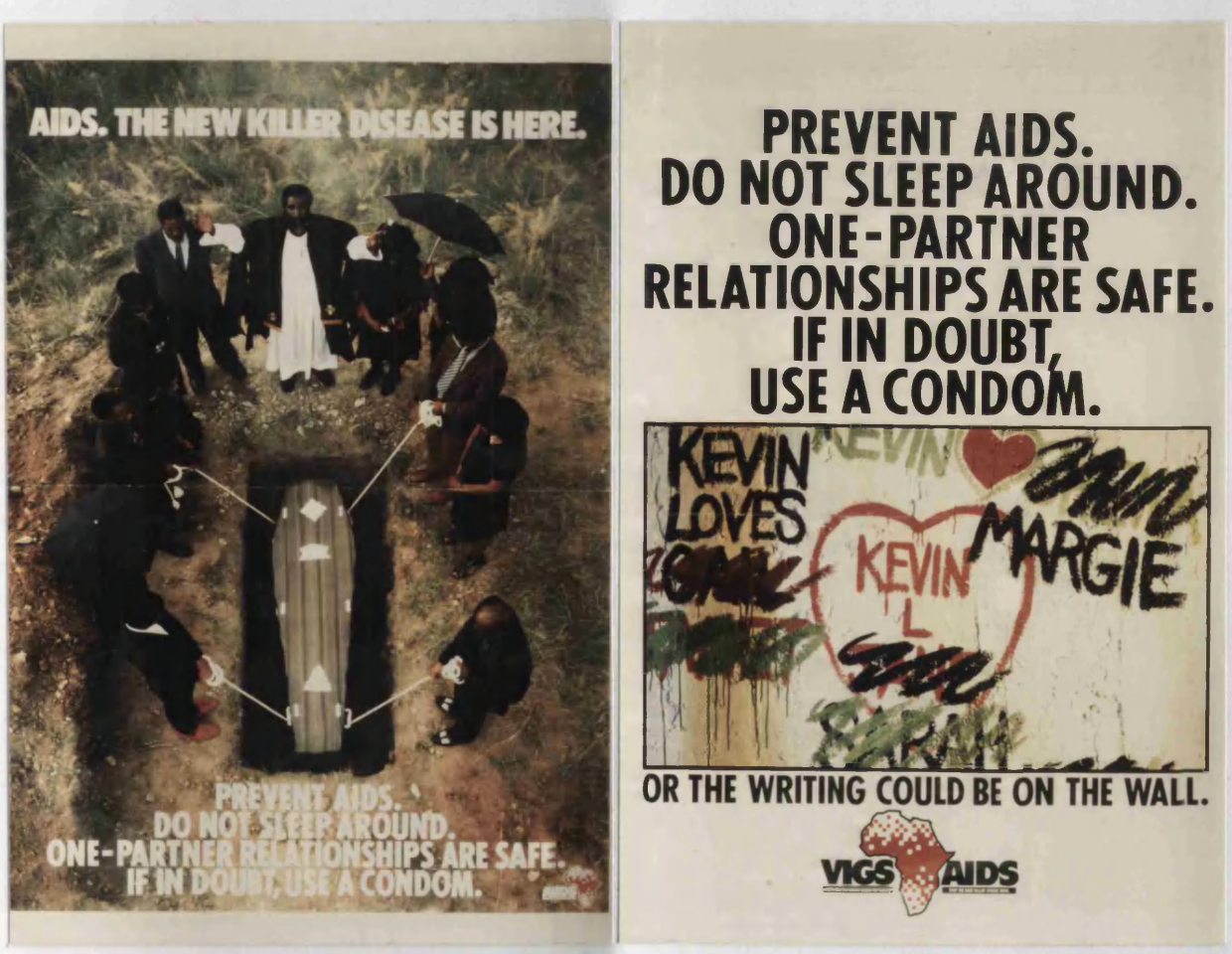
McCann, the advertising agency who made the campaign, sent a full example of the campaign to me. I have chosen to focus on the posters. The three prongs of the campaign (television, newspaper and poster) were almost identical in content and so the analysis of one prong covers many of the issues pertaining to all three. In addition, I chose the poster for analysis because the television campaign was seen by very few blacks (The McCann Group, 1988). The poster images formed the central images of the black and white newspaper campaigns (in which text was merely added alongside the images) and formed the final shots of the television campaigns. The three policy-makers talked about the poster more than about any other facet of the AIDS campaign.

In Chapter Five I outlined the structuralist levels of analysis: explicit and implicit. It is useful, in analysing campaigns, to make this broad distinction. I will focus upon the messages which the campaign was intended to convey, rather than upon my perception, as a social scientist, of the campaign. I have the advantage of having heard, from those who conceptualised the campaign, what the intended messages were.

## 6.7 RESULTS OF THE ANALYSIS OF THE CAMPAIGNS: EXPLICIT MEANING

The posters will be analysed in terms of four components: the block of text; the logo - depicting a map of Africa; the one line slogans 'or the writing could be on the wall' and 'AIDS. The new killer disease is here'; and the central visual images. They appear in Figure 2.

Figure 2. The South African poster campaigns of January 1988, targeted at blacks and at whites respectively.



**a. The block of text**

The block of text, which appears in both posters, contains, firstly, an anti-promiscuity message and secondly, a condom-use message. According to Doctor X:

> *"What we were saying was, number one, be responsible in your sexual contacts. We didn't state homosexual contact, bisexual contact, heterosexual contact...so we proposed a monogamous relationship".*
>
> *"What it says is, if you have multiple sexual partners, you are at risk".*

The inclusion of the condom was highly contentious, according to Ms Z:

> *"I think it was a little bit of this almost Christian National attitude of monogamy or abstention before marriage".*

**b. The logo**

The same logo appears at the bottom of the white-targeted poster and at the bottom-right hand corner of the black-targeted poster. It depicts a map of Africa in which the north and south are white whilst central Africa is red. This map symbolises the AIDS-ridden nature of central Africa. One implication is that South Africa, presently in a fortunate position because of its 'geographical isolation', might become red or polluted with HIV, if it does not heed the poster's message. The other is that AIDS is a problem of the 'other' rather than of South Africans.

**c. The slogan**

The slogan on the black-targeted poster - 'AIDS. The new killer disease is here' - suggests two central ideas. Firstly, with few reported cases of AIDS amongst blacks at the time of the poster's publication, there was little worry among blacks. At the same time, alarming accounts of AIDS in neighbouring African states were reaching policy-makers. Blacks needed to be told that this was not the 'white man's disease' which it

appeared to be if one watched the television documentaries about the deaths of scores of Americans. Secondly, the gravity and inevitability of this new disease was suggested by the term 'killer disease'.

The white-targeted slogan was very different. If they did not heed the anti-promiscuity message above, they were in for some trouble - 'the writing could be on the wall'. This does not suggest the inevitable nature of their deaths, as is suggested in the black poster. The white slogan suggests that whites have more volition, more control over this disease. It is not an indiscriminate 'killer' for them. In addition, the white-targeted slogan is more abstract. Rather than a threat by a killer they are subtly reminded of the potential threat.

**d. The image**

The funeral scene in the black-targeted campaign is a direct allusion to the death of an individual from AIDS. Very little is left to the inferential powers of the viewer. The graffiti-ridden wall in the white-targeted poster refers to a concept, rather than to a concrete reality. The wall documents the love-life of Kevin, a male who has a high turn-over of partner changes. The viewer needs to infer that Kevin's activities are, firstly, representative of the concept of promiscuity and, secondly, that they are life-threatening. As Doctor X puts it:

> *"In the black one, the message was the same, except that the fatalness was more emphasised, because of the funeral scene. This disease could really kill".*

The image within the white poster belies X's assertion that this was targeted at people

of any sexual orientation. Kevin does not inscribe any 'Johns' in his hearts. Heterosexual, non-monogamous sex, is clearly the danger for whites. Sexual orientation is not alluded to in the black image.

## 6.8 RESULTS OF THE ANALYSIS OF THE CAMPAIGNS: IMPLICIT MEANING

The block of text in both posters clearly implies an individualist ideology: People need to take responsibility for the consequences of their sexual lifestyles. A differentiation is made between salubrious and, by implication, responsible, sexual partners and insalubrious sexual partners: If you are not 'sure' about your partner, use a condom. While policy-makers used the term 'monogamy', the poster euphemistically talks of 'one partner relationships'. Practices which take place outside of such a relationship allow AIDS to spread.

The logo and slogans each speak to different aspects of Apartheid. Apartheid, with its basis in colonial ideas, allows white South Africans to perceive themselves as non-Africans. South Africa is represented as the white tip of Africa within the logo. As non-Africans, whites are almost immune to the disease. They need not feel heavily threatened. Blacks, who associate with other Africans in places of work, such as the mines, need to receive a stern warning.

The different images blatantly capture the acute nature of the threat for blacks. A 'killer disease' in some way suggests an indiscriminate, war-like force, which is coming for them, as blacks. The threat is far more individualised for whites: Each Kevin needs to be careful of who he sleeps with. Whites are clearly perceived to be

capable of taking on the individual responsibility which is suggested in the text. Blacks, with their inability to understand the workings of illness, need to be scared into sexual immobility, if the disease is to be prevented from taking hold among them.

## 6.9 CREDIBILITY OF THE CAMPAIGNS

One expects that source credibility would militate against the absorption of the messages of the poster by black South Africans. Y highlights the central problem of the campaign for black people:

> *"We have a number of problems in this country such as political. When you think that, the Government and the Department of Health seem to carry a lot of problems. It is a Government ploy to stop population growth, anything that comes from the Government is recognised. I heard a terrific joke the other day. I don't know if you saw that Government poster where they were lowering that coffin into the ground? There was a picture of that up in Mamelodi [black suburb]. And the doctor for the American embassy happened to be there and he said to them what did they think of that poster. So the one chap turned around and said 'this is a wonderful monument to Sharpville [in which the police shot 60 demonstrators]'. So you can see that it was completely wrong: the way the people are dressed, everything. It was completely wrong".*

At the time when this poster was published, funerals were the only forum at which black political sentiments could be expressed, due to the imposition of a five year State of Emergency in South Africa. With all their allusions to the importance of 'cultural context', the policy-makers and the advertising agency McCann failed to take this into account in their creation of an AIDS campaign.

In addition to this overriding problem, many of the 'facts' presented in the text are inaccurate. While many Governments implied, in their early campaigns, that one partner relationships gave one some sort of immunity from the disease, or that one

should use a condom only if one was not 'sure' of the particular partner's respectability, we have to remember that this campaign was issued in 1988. Medical science had disproved these assertions by then.

## 6.10 SYNOPSIS OF THE SOUTH AFRICAN SOCIAL CONTEXT UP UNTIL 1989

AIDS was anchored to America and to an African origin in the early South African mass media. Migrant labourers came to symbolise those representatives of Africa who could pollute an otherwise pure, and geographically separate, South Africa with AIDS. Blacks, rather than whites, would be affected by this pollution. Whites were imagined to be at little risk of contracting HIV.

The AIDS policy arena included no black or gay voice. The Government saw itself as a minor partner in the drive to prevent AIDS. Individuals themselves were expected to take responsibility for their own behaviour. Promiscuous behaviour was regarded as a central evil in relation to the spread of HIV.

## 6.11 CONCLUSION

The lay sample, whose social representations will be described in the following chapter, had been exposed to one additional Government-sponsored campaign in September 1989. The newspaper campaign appears in Appendix C. A pamphlet which accompanied it was similar in form and in content. Perlman and Pogrund (1989) question:

> "the suitability of a pamphlet consisting of eight closely typed pages in a country with low literacy rates among sections of the black majority" (p.3).

The density of the text alone suggests that there would have been a low absorption of the information it offered. The posters which I have analysed are more likely to have had an impact upon lay social representations of AIDS, with the McCann group (1988) claiming that 82% of whites and 78% of blacks recognised some aspect of the campaign which I have analysed. The philosophy of private responsibility for AIDS has meant a proliferation of AIDS campaigns made by local authorities and by NGOs. These have not been examined here.

Subsequent to these interviews there has been a huge increase in the number of black PWAs and pronouncements of doom abound. I made subsequent field trips after these changes had occurred and found that the AIDS scenario had changed dramatically. This work is not reported in the current thesis. The only policy-maker who appeared to feel that the situation might become disastrous at the time of these interviews was Ms Z:

> *"In South Africa we are in the initial stages of the epidemic...I think a lot of hysteria [is] perhaps founded, about what is going to happen".*

Behind closed doors and strictly off the record, I was told, early in 1989, that:

> *"X has said, behind closed doors, that the Government is putting so little money into AIDS because it sees the potential for population control in this strategy - it knows that it is going to become rife among blacks".*

I turn now to the study of the social representations of AIDS, connected to blame, held by the black and white recipients of the South African Government's campaign. People live in a complex environment. The mass media operate within this environment. We cannot talk about 'effects', about whether the messages which policy-makers attempted

to convey, via the campaign, were received. We can, however, look at the extent to which social representations embodied in the campaign and in policy-maker discourse overlap with social representations held within various sections of the South African population. In the instances where they differ, this cleavage will require explanation.

## OVERVIEW OF CHAPTER SEVEN

In this chapter I explore the nature of South African lay thinking in relation to AIDS and blame. The majority of the sample hold certain people responsible for contracting HIV/AIDS. Paradoxically, this responsibility tends to be applied to others or to out-groups rather than to the self. The 'other'/'self' division in South Africa tends to occur in terms of race, as well as sexual orientation. People provide reasons for why they and their in-group are not at risk of contracting HIV/AIDS. At the same time, they view the practices of the 'other' in a negative, moralistic light. There is a tight 'fit' between messages transmitted by the mass mediated AIDS campaigns and lay thinking. The division between the racial groups, and between monogamous and promiscuous behaviour, evident in the AIDS campaigns, is reflected in lay thinking. However, lay thinkers transform various media messages in terms of fantasy-based imagery.

# CHAPTER SEVEN: THE TEXTURE OF SOUTH AFRICAN LAY THINKING

## 7.1 STUDYING SOUTH AFRICAN LAY THINKING: METHOD

### 7.1.1 SAMPLE SELECTION

Several methods were used in selecting the three groups which comprised the sample: heterosexual whites, heterosexual blacks and homosexuals (both black and white; a number with HIV/AIDS). What I term the homosexual 'group' comprised blacks and whites. A basic criterion for selection of all three groups was that members were urban, young adults with a baseline education of 'matric' (which is equivalent to a point in between British 'O-levels' and 'A-levels'). Heterosexual whites were approached at a technical school (Technicon - the equivalent in standard to a British polytechnic), at a university (University of the Witwatersrand), and at a police barracks (all South African white men are compelled to serve in either the army or the police force). Heterosexual blacks were approached through a social worker who had previously run a youth group in Soweto, through a teacher's training college (Johannesburg School of Education - equivalent in standard to a British polytechnic), and through a university (University of the Witwatersrand). Many homosexuals remain 'undercover' in South Africa. The homosexual sample was initially approached through private contacts. This lead to contact with a group run for, and by, people who are HIV positive or who have AIDS (Body Positive), and to contact with a Soweto AIDS prevention project (Township AIDS Project or TAP). All of these institutions were in the Johannesburg area.

### 7.1.2 APPROACHING THE SAMPLE

Interviews were arranged either by approaching individuals directly at the above-

mentioned locations, or by asking leaders within the groups to arrange the interviews. Interviewees were asked if they were prepared to discuss their ideas about AIDS. They were told that they would be paid R10.00 (£3.00 at that time) for a 40 minute interview. Two white homosexual men refused the invitation to participate.

### 7.1.3 SAMPLE CHARACTERISTICS AND DEMOGRAPHIC DETAILS

Thirty respondents took part in the study:

- 10 heterosexual whites
- 10 heterosexual blacks
- 10 male homosexuals
    - 6 white and 4 black
    - 4 with HIV/AIDS, of whom 1 was black and 3 white

Half of the 20 heterosexuals were male and half female. The mean age of the total sample was 23 with a range of 17 to 37 years of age (and a standard deviation of 6). The term 'black' is often used to designate all people who are not white in South Africa. With the exception of one man who was of mixed racial extraction, the black respondents in this study were of African origin.

The vast majority (27/30) of the total sample were at least of 'matric' level in their education, with many having recently embarked on some form of higher education. Two thirds of the respondents were college or university students. Others, in more or less equal numbers, were business people, in the army, clerical workers or unemployed. The higher status parent of the majority of the respondents was either lower middle class (14/30) or

a professional (10/30).

Of those who affiliated themselves with a religion, 12 were Protestants, 3 were Catholic, 6 followed forms of Christianity indigenous to South Africa, 5 were Jewish and one respondent adhered to a 'New Age' religion. Half (15/30) of the sample attended a place of religion regularly, a third (9/30) attended occasionally. Only 5/30 never attended. Blacks were significantly more likely to attend a place of religion regularly than whites were ($\chi^2$=4.8; $p<0.05$, two-tailed).

The mean number of sexual partners which heterosexuals had ever had was 3.5 (with a standard deviation of 3). The mean number of sexual partners which homosexuals had ever had was 600 (with a standard deviation of 810). It is known that the homosexual definition of a 'sexual partner' differs from that of a heterosexual. Homosexuals do not have to have penetrative sex in an encounter to construe it as sexual.

### 7.1.4 PROCEDURE

The study was carried out between January and June of 1990. A third of the study was carried out by the author and two-thirds by a researcher, with the same academic qualifications as the author. The researcher was trained to conduct the study in a manner consistent with that used by the author. Firstly, the researcher carried out a mock interview with the author. The researcher also carried out two audio-recorded pilot interviews with respondents which she then transcribed. The author requested that she make certain changes in her technique. The transcription of the third interview demonstrated that the techniques of both author and interviewer were comparable.

Respondents completed a semi-structured interview. Following the interview, respondents were asked to complete a questionnaire. At the start of the interview, respondents were told that the data would be kept confidential. Furthermore, they were told that there were no correct or incorrect answers: They were asked merely to express personal ideas about the topics which arose. They were told that they would be paid R10.00 (£3.00 at that time) and that the session would last for approximately 40 minutes. They were also informed that they could ask the interviewer about the study after the interview and questionnaire had been completed. After the interview, respondents were handed a questionnaire and an envelope in which to seal the questionnaire once it had been completed.

They were told that they should feel free to request clarification of the meaning of questions used in the questionnaire. The envelopes were coded by the respondent's number after the respondent had left the room.

### 7.1.5 TECHNIQUES USED

#### 7.1.5.1 The interview

A semi-structured interview was conducted, based on the interview-guide which appears in Appendix D. Broadly speaking, the interview was designed to elicit social representations of the origin and spread of AIDS in the respondent's own country. While there were a number of topics which the interviewer covered with each respondent, these were not raised in a fixed order. The interviewer followed the line of thinking which appeared spontaneously within the respondent's discourse. This is compatible with the practice of others who use semi-structured interviews to explore social representations (eg.

Herzlich, 1973).

The interviews were audio-recorded and transcribed onto a word-processor. Themes emerged from close scrutiny of the interview material and categories were set up to reflect these themes (see Appendix E). Each interview was then coded in accordance with these categories, using Textbase Alpha. Textbase Alpha provides both a qualitative and a quantitative data-base. Coded data was then used to (a) build up a picture of the social representations of AIDS which relate to blame and (b) test hypotheses in a quantitative manner. The quantitative aspect was analysed using SPSS-PC. All chi-squares are computed without the Yates correction. When I use the term 'significant' I refer to statistical significance at the 0.05 level.

#### 7.1.5.2 The questionnaire

The questionnaire, which appears in Appendix F, was used to ascertain the demographic characteristics and sexual activity of the sample. It was modelled on successful questionnaires previously used in the field by the author (eg. see Dockrell, Joffe & Blud, in press). The details gleaned from the questionnaire are reported in section 7.1.3 above.

### 7.1.6 OFFICIAL AIDS STATISTICS

When these interviews took place early in 1990, there were 326 known PWAs of South African origin in South Africa. Figures released on 12 February 1990 showed that ('AIDS in South Africa', 1990):

- 71% were white.
- 24% were black.

- 4% were 'coloured' [of mixed race].
- 1% were Asian.
- 88% of the whites were homosexual.
- 76% of the blacks were heterosexual.
- 8% contracted HIV through contaminated blood.
- 4% contracted HIV through mother-infant transmission.
- There was 1 intravenous drug user.
- 86% of the PWAs were male; 14% were female.

## 7.2 RESULTS OF THE ANALYSIS OF LAY THINKING IN SOUTH AFRICA

The views pertaining to blame, expressed in the interviews, clustered around three social representations. In this chapter I elaborate the three social representations which underpin blaming responses in relation to AIDS in South Africa. The same three broad areas of representation pertaining to AIDS and blame are present in policy-makers' and in lay discourse in South Africa:

A. The social representation of responsibility and punishment
B. The social representation of out-group responsibility
C. The social representation of in-group pollution

The findings are mapped out in terms of the conceptual framework developed in Chapter Five (see Figure 1). Each social representation is examined in terms of the three elements which I identify in this figure, as well as in terms of 'fit' with the social context. This refers to 'fit' with ideas presented in the previous chapter, as well as in Chapter Four. The final aspect of the conceptual framework, 'fit' between representations, is analysed towards the end of this Chapter.

It must be remembered that the interview is semi-structured. Not all respondents address each issue. They sometimes provide more than one response to an issue. Thus the categories are not mutually exclusive. If a respondent makes multiple allusions to the same category, the response is only counted once under that category.

In order to satisfy criteria for the limited number of statistical tests which are carried out on these data, a respondent cannot respond in terms of more than one of the categories which appear in the test. When this is necessary, the response which the respondent expresses first is used in the test.

## A. THE SOCIAL REPRESENTATION OF RESPONSIBILITY AND PUNISHMENT

### DESCRIPTIVE ELEMENTS

**Consensual representations**

- Two thirds (19/30) of the South African sample imagine that certain people are responsible either for contracting, spreading or 'causing' HIV/AIDS.

They imagine that the choice of the human agent is involved in the spread of AIDS. This has the tendency to spill over into the argument that human agents caused AIDS rather than that HIV causes AIDS. There is a significant difference between blacks and whites in terms of responsibility ($\chi^2$=4.7; $p<0.05$, two-tailed). Whites are more likely to adhere to the notion of responsibility than are blacks. There are no gender, sexual orientation or religious differences.

A classic example of the link between responsibility, care and AIDS is:

*"See, people who get it in the first place, the way I see it, aren't really caring, stable folk in the first place. So they aren't going to be that responsible in the first place"* **(White heterosexual male 9).**

The role of choice or volition is central to many accounts of how people contract HIV/AIDS:

*"I don't think there is any necessity that I should go crawling the streets and try to pick it up. Because that is what you do: You try to pick it up"* **(White homosexual male 4).**

Respondents feel that the level of awareness concerning AIDS indicates that people are 'in the know' about AIDS. This knowledge should facilitate rational action:

*"Now, if you get AIDS, with the amount of education there is, everyone should be much more cautious then they are and you should take precautions"* **(White heterosexual female 8).**

*"The people who initially got infected with that disease didn't know it had that slow process, didn't know that one day they'll die.*
***Interviewer:** And today?*
***Respondent:** We hear it on a daily basis in the TV and pamphlets. I don't think people might be that naive to that disease"* **(Black heterosexual male 1).**

There is a clearcut distinction between those who are responsible, 'at fault' and therefore guilty for contracting and spreading the illness and the 'innocent' who contract it through 'no fault of their own'. There is a lot of debate concerning fault and faultlessness. A white heterosexual subject holds both a representation of the responsibility of the individual, and a powerful counter-argument, an argument which states that contracting HIV is random rather than wilful:

*"I think it's reached a stage now, or we're soon reaching a stage - in six months or a year's time, when lifestyle, financial circumstances, sexual habits will have nothing to do with it. Anybody can get it. Just if you come into contact with the same person through no fault of his own. It can just strike you down and you won't be responsible or have done anything wrong. You might have chosen the one guy in the world and you might have chosen him. And he, before he started going out with*

*you, was in contact with someone, through nobody's fault that you can trace"* (**White heterosexual female 4**).

This argument appears to run counter to the 'you are at fault for contracting HIV' line of thinking. In fact, it is embedded in the debate concerning the 'faultlessness' of many people but the 'fault' of an original, untraceable carrier of the virus: a division between the innocent and guilty PWAs. Someone, somewhere was at fault, although that person's subsequent lovers are faultless because they chose an infected lover without knowing that he was infected. They *"won't be responsible or have done anything wrong"*. By corollary, the person back to whom it might hypothetically be traced, will be responsible.

There is a trend in the data to divide between the blameworthy and the non-blameworthy contractors of HIV:

> *"There are two different versions [of PWAs]. Someone who is down and out, real scum of the earth. Or someone who's a professional, who also happened to get it"* (**White heterosexual female 5**).

Some respondents explicitly mention specific groups in connection with the guilty and innocent parties. Blood transfusion recipients tend to be seen as innocent. Prostitutes, homosexuals, bisexuals, truck drivers, migrant workers and 'scum' are among the guilty groups identified in the debate concerning fault and faultlessness:

> *"That's what's written in the Torah: that man shouldn't be with man. But I don't think that's fair because there are a lot of innocent people getting it, not only the homosexuals"* (**White heterosexual male 9**).

> *"Truck drivers - especially that goes from town to town and stop and sleep overnight. They don't care"* (**Black homosexual male 5**).

Often the 'innocent' are not without fault. The following respondent feels that blood

transfusion recipients could take greater care of the consequences which befall them:

> *"If he got it through a blood transfusion it could be his fault if he didn't get the blood checked. If I was going to get blood I'd practically wait two weeks to get that blood checked, to see it was really pure before it came into my body. If he got it through sex, drugs, I'd consider him bad, that's really his fault* (**White heterosexual male 10**).

The consequences which befall people tend to be viewed as controllable. Contracting AIDS is related to a choice. Responsibility tends to lie with the human 'victims' even when non-human agents are apparently blamed for AIDS. It would seem that humans rather than a virus are implicated not only for the spread of AIDS but for 'causing' AIDS:

> *"I don't think that if you have a very healthy environment and there are regular health inspections that the disease is going to come about because it seems that in that environment it is not going to initialise anyway.*
> ***Interviewer:** A clean environment...*
> ***Respondent:** A clean and healthy environment and sensible people who are aware of what is going on. The problem is in other areas where the disease is getting spread and it is quite obvious there are no health inspections.*
> ***Interviewer:** Why would it spread more in those areas?*
> ***Respondent:** Because of the people in those areas. Probably the inspection comes and it is too late"* (**White heterosexual male 9**).

While the dominant debate in relation to responsibility hinges around the issue of 'fault', there is also a debate concerning whether AIDS results from bad luck or from choice. As I have indicated, black respondents are significantly less likely to enter the responsibility debate. When they enter it, it is sometimes in terms of the luck-volition debate:

> *"I think it's bad luck and not playing safely"* (**Black homosexual male 8**).

Many respondents complement their distinction between innocent and guilty parties in terms of a moral judgement concerning the 'usefulness' of AIDS:

> *"I feel it [AIDS] is good in a way. And yet at times innocent people are dying. I'm sure it cut down on the immorality in the world and so maybe it's good. But maybe it's bad"* (**White heterosexual male 1**).

Thus the notion of 'AIDS as punishment' forms a distinct part of the social representation of responsibility:

- 8/30 respondents view AIDS as a punishment meted out by God: 5 of these respondents are black and three white.
- 7/30 respondents view AIDS as a punishment meted out by nature: 4 are white and 3 are black.
- 2 of these respondents, 1 white and 1 black, view AIDS as both a punishment meted out by God and by nature.

Protestant respondents are more likely than the remainder of the sample to believe that AIDS is a form of punishment, from either nature or God ($\chi^2$=4.4; $p<0.05$, two-tailed). Attendance of a place of worship is not significantly associated with a punishment theory, and nor is colour, gender or sexual orientation.

While God or nature is seen as the agent or cause of AIDS, human behaviour is imagined to have elicited God's or nature's wrath. God tends to be seen as punishing humans for sex outside of marriage. The social representation of God's punishment is expressed by way of coupling AIDS with interdictions laid down by the ten commandments: *"sodomy"* and *"adultery"*. It is also expressed by way of a reverse reasoning:

> *"The bible says avoid sex before marriage. And if people did that I don't think it [AIDS] could have spread even if it was there"* (**Black**

**heterosexual male 8).**

*"It can go somehow with a punishment from God because I've never heard of a married man or a married woman having AIDS"* **(Black heterosexual female 4).**

Nature's punishment tends to be linked to the idea that humans have tampered with nature's balance. Nature is conceived of as self-correcting. AIDS is a way of restoring balance:

*"Nature has a natural kind of balancing. If something gets too much something happens to balance it out...Now in the sixties you had a total freak-out after the previous era which was very protected and you didn't talk about sex: It was wrong. You had to one extreme, then right back to the other extreme. Now you have to balance it back"* **(White heterosexual female 2).**

*"It may just be a way of the earth keeping the population down...like a natural disaster, like an earthquake or something"* **(White heterosexual female 5).**

*"AIDS has bred out of a strain in our lifestyle...if it is not balanced in your life something is bound to go wrong somewhere. AIDS is, unfortunately, that thing...The gay thing is a very young thing. If you are young you are in the count. But as you grow older you drop by the wayside...We are scared of growing old and that is why AIDS has happened"* **(White homosexual male 3).**

*"It [AIDS] has always been there. It is just manifesting itself now as a means of letting the world know that what we are doing is wrong...We are living without restrictions and restraints in our lives...Humans don't live like that. They need restrictions and restraints"* **(White homosexual male 6).**

One line of reasoning connects the representations of AIDS as God's and AIDS as nature's punishment. This is the idea that God punishes humans for tampering with the 'natural' order of things. A respondent who views AIDS as God's punishment for 'sodomy' also says of homosexuality:

*"I don't think it's a normal instinct. It's not what they are born with. It might be that experiences after birth make them tend towards that"* **(White heterosexual female 2).**

AIDS also tends to be linked to a general decline in the morality of a society. This is often connected to a backlash from what is viewed as the 'sexual revolution' of the 1960s. God masterminds this backlash. In this context, as in the punishment themes mentioned above, AIDS is judged to be a good thing, a restorer of balance and of order.

**Counter-representations**

One black heterosexual opposes the division between innocent and guilty parties. All people are equally guilty in his eyes:

*"If god was punishing us for AIDS each and every one of us would be dead because every person in this world is doing evil. All of us are sinners. Why didn't he send it to all the people to show 'you have sinned a lot'"***(Black heterosexual male 7).**

He subscribes to a collectivist, rather than to an individualist, notion of punishment.

Another way of countering the dominant tendency to believe in individual responsibility is to posit situational determinants of AIDS. A small number of respondents (3/30), of whom two are homosexual whites and the other a heterosexual black, do this. All three are from marginalised groups in their society:

*"The only reason why it affects gay people the most is because they are so bloody promiscuous. If they had to introduce [homosexual] marriage into this country, like they are doing in Denmark, I am sure it is going to stop...it is going to make these homosexuals cut down 90%"* **(White homosexual male 1).**

*"There are certain things wrong with the way we are living our lives,*

*whether its group karma, planetary karma or anything like that. It is something that you have to take collectively and work on it. You cannot just accept it as a personal thing"* **(White homosexual male 6).**

*"If ever it [AIDS] was here in Soweto, that would be because we don't behave well here in Soweto and there is no life, and I cannot blame us, I mean the Government is also a contributing factor to what is happening here"* **(Black heterosexual male 2).**

PROCESS ELEMENTS

**Anchoring**

- 9/30 respondents anchor AIDS to the notion of morality or punishment.

Many examples of this anchor are remarkably similar to one another:

*"It was put here for a purpose, that was my first reaction, to stop the immorality of the world today"* **(White heterosexual male 1).**

*"I came across it because everyone was saying that it was the result of the sexual freedom of the sixties, a backlash against that. That it was wrong and the whole big religious aspect of it"* **(White heterosexual female 2).**

Many more whites than blacks are likely to have 'morality' as the anchor or seed of their social representation of AIDS: 8/9 of those who anchored AIDS to punishment were white. It is surprising, then, that more-or-less equal numbers of blacks and whites adhere to notions that AIDS is punishment, in the here and now.

**Objectification**

The concept 'safer sex' and, more specifically, the condom, serve as symbols of responsibility. By corollary, 'unsafe sex' and non-condom use serve as symbols of an irresponsible and blameworthy outlook.

The notion of 'promiscuity' forms a distinctive objectification of the excess which

leads to God's or to nature's punishment.

- An astounding 27/30 respondents link AIDS to excess, often to promiscuity, at some point in the interview:

> *"AIDS is caused by people sleeping together. To stop AIDS people must somehow stop sleeping around"* **(Black heterosexual female 10).**

**Reflexivity**

One white homosexual indicates that AIDS has been constructed as an issue of personal responsibility:

> *"You cannot just accept it as a personal thing: I have done something wrong and I am going to be blamed now because I was a homosexual or [took] drugs or led an hedonistic lifestyle of some sort. You must take a larger viewpoint of it...it has just been manifesting itself now as a means of letting the world know that what we are doing is wrong"* **(White homosexual male 6).**

The account of this man is discussed in greater detail in terms of a defensive strategy: The man is HIV positive.

**Defensiveness**

Despite the powerful emphasis upon personal responsibility, it is 'the other' rather than 'the self' who is conceived of as contracting (and, consequently, of spreading or 'causing') HIV/AIDS. The vast majority of the sample (22/26) (excluding those with HIV/AIDS) believe that their own chances of contracting HIV are below average. This belief is manifest in all groups in the sample (with no significant gender, colour or sexual orientation differences):

- All 10 white heterosexuals feel that their chances of contracting HIV are below average. When chances are given in percentage terms, they range

between 1-25%. Reasons for below average risk are not partaking in 'casual' sex, and condom use. The only possibility entertained within this group is that one might get it from a blood transfusion.

• 7/10 black heterosexuals believe they are at below average risk. The prime reason given is low partner numbers. The other 3/10 blacks believe that they are above average in terms of risk.

• Of the 6 homosexuals without HIV, 5 state that their risk is below average, with only one feeling that he is above average in his risk. Few give reasons for below average risk. When a reason is given, it is that the individual refrains from 'casual' sex:

*"If I stick to one partner I can be a survivor"* **(Black homosexual male 8).**

When one checks this statement in relation to questionnaire data one finds that this man has had 11-20 partners in the past six months. The gap between the spoken approach and the reported behaviour may indicate the use of a defensive strategy.

Those who are held responsible for AIDS may well attempt to find another agent onto whom blame can be projected. This is evident in the account of an HIV positive man:

> *"There are certain things wrong with the way we are living our lives, whether it's group karma, planetary karma or anything like that. It is something that you have to take collectively and work on it. You cannot just accept it as a personal thing: I have done something wrong and I am going to be blamed now because I was a homosexual or [took] drugs or led an hedonistic lifestyle of some sort. You must take a larger viewpoint of it...it has just been manifesting itself now as a means of letting the world know that what we are doing is wrong...It is not homosexual, it is not heterosexual, it is a thing that has been given to the world"* **(White homosexual male 6).**

This respondent blames the collective forces of 'group karma' or 'planetary karma' for

AIDS. He opposes the idea that AIDS is the personal responsibility of homosexuals, drug-users or those who have led a hedonistic life. This is his method of defending himself from the consequences of blame, such as feelings of spoiled identity or guilt.

The division between 'good' and 'bad', which is characteristic of the earliest developmental phase of the infant - the paranoid-schizoid position (see Chapter Three), comes to light in social representations of responsibility and punishment. In order to gain a sense of mastery and of control, at a time of crisis, the world is split into good and bad individuals or groups. Those who contravene the bible's or nature's prescriptions are punishable. Many of the respondents who adhere to the 'AIDS is punishment' idea, believe that punishment of the evil-doers is favourable.

**Self-presentation**

Not found.

POWER ELEMENTS

Certain groups are innocent and others guilty not only in relation to contracting and spreading, but also 'causing', AIDS. This has consequences for the parties who are blamed. While it might cause them to project the problem onto another source, it can result in introjection of the blame. This manifests itself primarily in the accounts of black heterosexuals and of black and white homosexuals. These findings are elaborated more fully in the 'power elements' of the 'social representation of out-group responsibility'.

I have indicated that a large number of respondents frown upon excess. People are implored not to yield to temptation, to remain moderate in their sexual appetite:

> *"I know people who can't have one girlfriend at a time. They can't stick to one relationship. They release themselves to temptation"* **(White heterosexual male 1).**

Both heterosexuals and homosexuals espouse this viewpoint. The homosexual viewpoint often appears self-blaming:

> *"Those [gays] we call 'queens' don't have a true love, so they are playgirls. I'd also discourage them from being playgirls and to look for someone and settle down"* **(Black homosexual male 8).**

While some homosexuals appear to have introjected the blame cast upon them, the respondent quoted above may well differentiate between his own and the 'queens'' identity. For him the 'queen' may belong to an out-group. However, self-blame is at the heart of the very need to differentiate oneself from sections of one's in-group whom one feels undermine the status of the in-group.

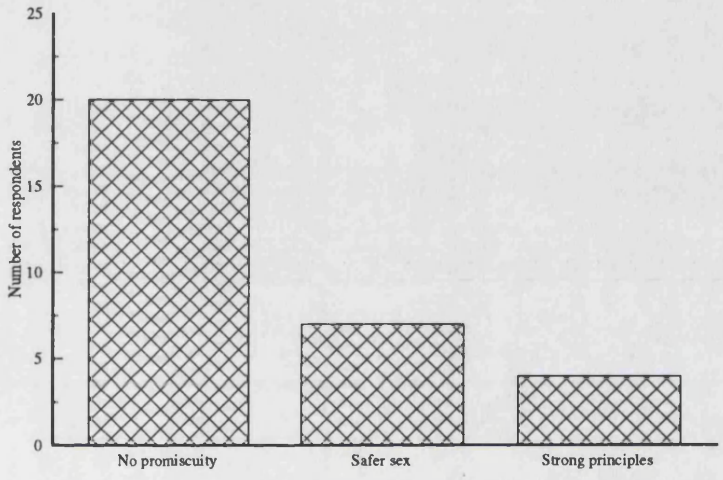
The notion of punishment is ideological. That which is 'natural' is regarded as good. Homosexuality and excessive sexuality are censured as contraventions of 'nature' with the implication that the natural is the ideal.

### 'Fit' with the social context

The notion of responsibility which manifests itself in the lay interviews corresponds to the message conveyed by the Government campaigns and by policy-makers. In talking about protection against HIV/AIDS, a lifestyle without promiscuity, safer sexual procedures and strong principles are the main modes mentioned by lay thinkers (Figure 3). This maps closely onto the textual message of the campaign analysed in the

previous chapter, with its allusions to the safety of 'one partner relationships' and to salubrious versus insalubrious partners. It also maps closely onto ideas put forward by the South African AIDS policy-makers, among whom there was a feeling that if everybody was monogamous there would be no AIDS problem.

Figure 3. Protection against HIV/AIDS: South Africa




Despite the correspondence between lay thinking and that in the social context, only 7/30 respondents spontaneously mention the campaigns in the course of the interview. This is not surprising in light of the low budget and low media coverage that the South African campaigns received. In addition, most respondents claim that they heard about AIDS prior to 1988, the year in which the campaigns began. The campaigns do not appear to have been instrumental in the formation of the link between AIDS and responsibility. There is also mixed evidence concerning whether the mass media, in general, actually brought AIDS onto their agenda. When asked how they first heard of

AIDS, non-media sources (friends, lovers, or school) (16/30) were almost as likely to be mentioned as the media (19/30).

The 'fit' between lay thinking and that in the social context is strong, despite a lack of evidence concerning the direct effects of the media. Powerful cultural ideas concerning the link between illness and irresponsible behaviour circulate in South Africa. This link is more pronounced in whites than it is in blacks. This is reflected and perpetuated by the white-targeted campaign which is more responsibility orientated.

The plea for moderation within the campaign, embodied in the message 'Don't sleep around', corresponds with the association of AIDS with excess. In the accounts of the South African policy-makers there are only traces of the punishment debate. This may be related to self-presentational and to reflexive strategies on the part of the policy-makers. Such strategies are not evident in the accounts of many lay people. Words such as 'sodomy' and 'adultery' are used, and the bible is used as a source of evidence for the explanation of AIDS in terms of punishment.

There appears to be less 'fit' between lay thinking and the social context in terms of punishment than in terms of responsibility. I have explained this in terms of self-presentation and reflexivity on the part of the policy-makers. It may also relate to the fact that lay thinking syphons messages which circulate in the social context through certain 'filters'. In this case, an emotional filter may have intervened between thinking which circulated in the social context and lay thinking. Lay people may have been made anxious by illnesses such as AIDS through the content of reports on AIDS in the

media, and through the fearsome tone in which the early campaign was presented. The 'AIDS as punishment' theory gives people a sense of control.

## B. THE SOCIAL REPRESENTATION OF OUT-GROUP RESPONSIBILITY

### DESCRIPTIVE ELEMENTS

**Consensual representations**

The most forceful trend in the data is to view the 'other' or 'out-group' as responsible for the origin, spread and 'cause' of AIDS. The 'other', rather than the 'self' is blameworthy.

#### ORIGIN OF HIV/AIDS

- The majority (27/30) of the sample view the origin of AIDS in terms of a continent.
- 89% of this group (14/15 whites and 10/12 blacks) imagine that AIDS originated on a continent other than the one with which they identify (see Table 1); 11% of this group (1/15 whites and 2/12 blacks) imagine that AIDS originated on a continent with which they identify.
- The 14 whites who imagine that AIDS originated on a continent other than the one with which they identify believe that it originated in Africa; the one white who imagines that it originated on a continent with which he identifies believes that it originated in America. White South Africans do not identify themselves as living in Africa (this issue is discussed further in Chapter Ten).
- The 10 blacks who imagine that AIDS originated on a continent other than

the one with which they identify believe that it originated in America, England or 'The West'; The 2 blacks who imagine that AIDS originated on a continent with which they identify imagine that it originated in Africa. This data is presented in Table 1.

Table 1. Where did HIV/AIDS originate? (South African responses)

| | AIDS ORIGINATED ON CONTINENT OTHER THAN THE ONE WITH WHICH IDENTIFY * | AIDS ORIGINATED ON CONTINENT WITH WHICH IDENTIFY |
|---|---|---|
| WHITES | 14 (93%) | 1 (7%) |
| BLACKS | 10 (83%) | 2 (17%) |

* This table includes only those respondents who answer the question above in terms of specific CONTINENTS (15 out of the 16 whites in the sample; 12 out of the 14 blacks in the sample).

The tendency to believe that AIDS originated with the 'other' is not significantly different when comparing whites and blacks (Fisher's Exact:p=0.57, two-tailed). Both groups believe that AIDS originated with the 'other' (for both groups, Binomial:p<.05, two-tailed).

GROUP WORST AFFECTED BY AIDS IN SOUTH AFRICA

- Almost two thirds of the sample (18/30) believe that blacks are worst affected by AIDS in South Africa.

Whites are significantly less likely to believe that their own group is worst affected by AIDS ($\chi^2$=5.2; p<.05, two-tailed). Both whites and blacks see blacks as worst affected by AIDS (see Table 2).

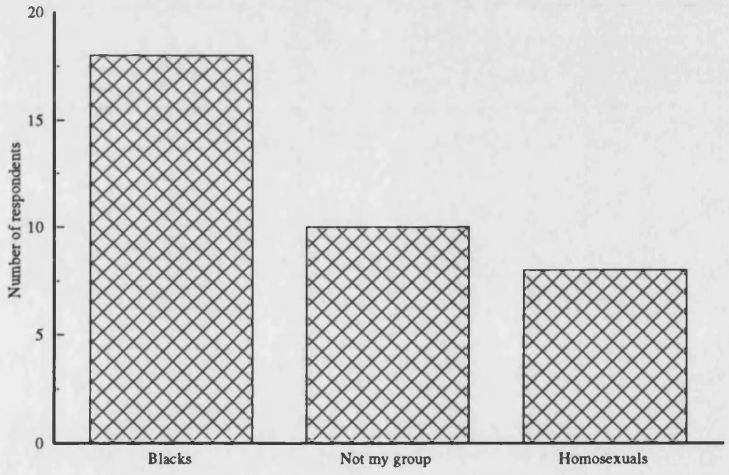
Table 2. Which group is worst affected by AIDS in South Africa?

| | OTHER GROUP IS WORST AFFECTED BY AIDS * | OWN GROUP IS WORST AFFECTED BY AIDS |
|---|---|---|
| WHITES | 10 (83%) | 2 (17%) |
| BLACKS | 5 (38%) | 8 (62%) |

* This table includes only those respondents who answer the question above in terms of RACIAL groups (12 out of the 16 whites in the sample; 13 out of the 14 blacks in the sample).

South African respondents tend to answer the question 'Which group is worst affected by AIDS in South Africa?' in racial terms. They tend to interpret the concept 'group' in terms of race. Other responses are illustrated below (see Figure 4).

Figure 4. Responses concerning group worst affected by AIDS in South Africa



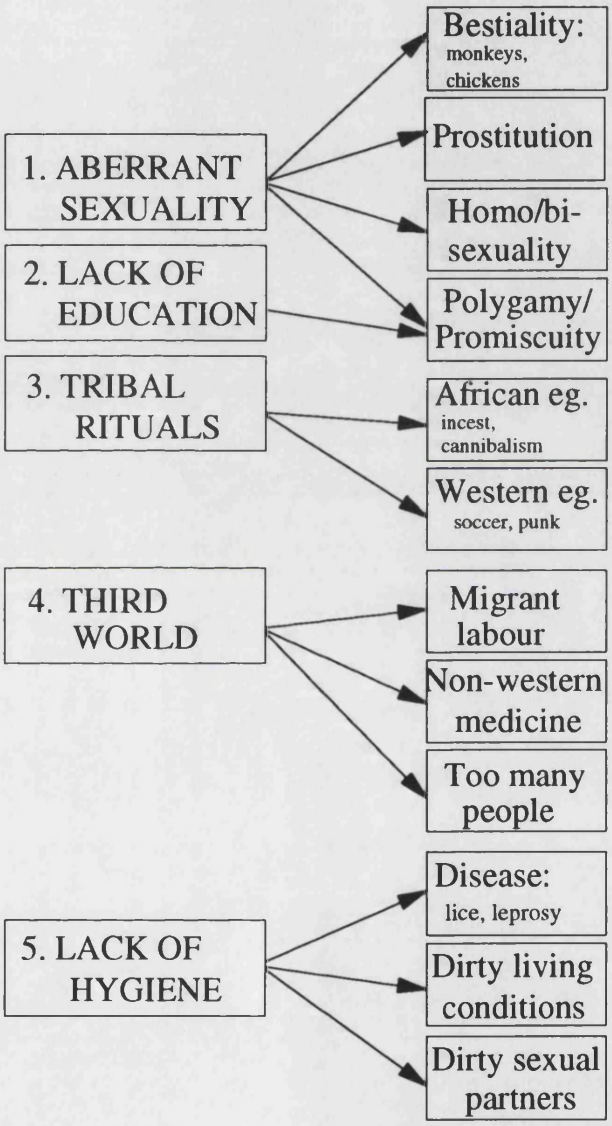

## 'CAUSES' OF HIV/AIDS: SIN COCKTAILS

- Over a third of the sample (11/30) held an intricate set of fantasies (see Figure 5) concerning the way in which the 'out-group' became infected with HIV/AIDS.

This portion of the sample believe that at least two of the following five factors are

involved in the origins of AIDS:

Figure 5. South African sin cocktails: Fantasies concerning the origin of AIDS



23/30 adhered to at least one of the five factors. Without exception, white respondents imagine that these practices occur in parts of the world with which they do not identify. Black respondents, on the other hand, are more likely to associate other blacks with these rituals. Yet the blacks whom they associate with these rituals tend to be involved in the more traditional African world such as the world of traditional healers. Perhaps, then, they also associate these rituals with their 'other'. I will present a case study of one white heterosexual, one white homosexual and one black heterosexual's sin cocktail. Each represents a typical process of thinking.

A white respondent (**heterosexual female 2**) begins with an account of the origin of AIDS in terms of African bestiality:

> *"From what I know it started in Africa. I think it's from chickens...And then it spread to America.*
> ***Interviewer:** How?*
> ***Respondent:** I'd assume there was...[inaudible].*
> ***Interviewer:** Did you say Africans sleeping with chickens?*
> ***Respondent:** I don't really know, I think so".*

She then launches into an explication of the tribal rituals which take place in Africa - the rituals are associated with an aberrant sexuality:

> *"What I know of the tribes, especially in northern Africa, they do not allow women to have sex before they come of age. And actually tie their legs together so it actually grows together a little bit. I'd assume that there is a lot of sex between guys. But I have read a bit about that...I think just the way in which the disease was contracted, it was sodomy...Theoretically if the women were more sheltered there was more sexual activity among the men. That's why it started amongst the gays".*

The quasi-anthropological theory which she expounds transforms from its 'scientific' tone to one of disgust concerning the unsavoury/unhygienic nature of the PWA:

> *"Your immediate response to a person with AIDS is like you'd respond to lice in your hair. But that's the instinctive reaction. You paint this*

*despicable picture. You don't want to be near them. Like leprosy. Obviously it's not. It's just an unfortunate incident. Your rational mind says to you 'that person is normal, it could be you'. But without knowing the person, he has this ghoulish impression".*

A white South African respondent (**homosexual male 1**) offers a vivid account unfettered by the self-awareness contained in the account above. He talks about black people:

*"Those people don't wash. I mean, I am not trying to be prejudiced [lowered voice, due to servant in house] but you don't know where they have been, I mean the women are sat vuil [Afrikaans for:very dirty], really they are dirty, unbelievably dirty. I mean there is no, I don't think they have toilets, they sit and urinate where they sleep and they desecrate [asks me if this is word he wants, I suggest defecate] defecate where they sleep. I mean it is bound to cause some sort of reaction".*

Dirty habits are likely to cause *"some sort of reaction"*. This reaction, in the context of this account, is AIDS. Consequently, the respondent is asked if he thinks that AIDS comes about due to the factors mentioned above:

*"I don't think it is because of that [that AIDS comes about] but it is because sex is so misused and it becomes so filthy. I don't know, with chickens, I don't know what they use, I think they are into bestiality, I wouldn't know. But I personally think it is because of those things".*

*"You won't believe how many mine-workers sleep with each other. Because there is no women on the mines. It is only men, so it is the next best thing. If you starve a man of a woman, obviously they are going to go for men. And one thing is going to lead to another. I mean the Zulus play around terribly. I mean it is so accepted, AIDS in that community, I mean being gay , it is unbelievable".*

Thus far he has associated a lack of hygiene, the conditions of migrant labour and aberrant sexuality with AIDS. He also views traditional black medicine as a cause of AIDS:

*"And drugs, intravenous drugs. Because you know, we don't, I personally think that, whites have a certain type of drug, a more*

*advanced drug like cocaine, heroine, but I think there they have like herbs. I don't know. I am just going on pure feeling. And because they are like roots, I am sure that it comes from some sort of thing. I don't know".*

He moves smoothly between discussion of the lack of advancement of traditional black drugs, and various tribal rituals associated with under-development or the 'Third World', and stupidity:

*"You wouldn't know, because it could be because of incest, that the brain has now given up on the person because these people [lowered voice] don't know. They will marry their sister tomorrow".*

A black South African's account (**heterosexual male 7**) begins with notions of excessive sexuality and bestiality:

*"I first heard it's a type of sickness that comes mainly after you having sex with many person or if a person is having sex with a monkey. There must be something wrong. The virus of the monkey comes to the person who immediately becomes sick with AIDS...For me it's true that AIDS can be found from monkeys because one thing's for sure. They are animals. They do not intercourse once. It intercourses once and then again. Because it has that strength, that power...that animalism in it. If a person goes there and intercourses with that monkey he does not know how many times that monkey has intercoursed with fellow monkeys and what diseases they each had. So he automatically gets AIDS".*

The respondent connects AIDS, animal-like sexuality, excessive sexuality, and sexually transmitted disease. He is then asked where he thinks this took place. He then begins to discuss the 'tribal' rituals and lack of hygiene of the 'other':

*"As I heard it started in England...It started between a monkey and a person after a person intercoursing with a monkey...after the person is intercoursing with the monkey he never washed and he went to his partner. Then they intercoursed. Then the partner couldn't hold herself, went and intercoursed with someone else and that is how it spread. He never washed before going to soccer and so AIDS was transmitted to people...because in soccer they sweat. Then after getting that sweat he touch me with it and then I've got AIDS".*

He then follows the spread from England to Ethiopia - which is the place from which

AIDS entered Africa. The interviewer asks 'Why Ethiopia?':

> *"I understand that people in Ethiopia are suffering from hunger. When the soldiers brought them food they meet automatically. Soldiers take some time to return home. Whereas when they were still in Ethiopia they met girlfriends and they made intercourse".*

While the structure of the black and white sin cocktails are remarkably similar, the black sin cocktails are less likely to include a homosexual dimension. Those whom one constitutes as 'other' tend to be involved in the acts associated with the sin cocktail. Principally, the 'other' practises strange rituals (eg. soccer, tying legs together, cannibalism, incest) and has an aberrant sexuality (eg. homosexuality, bestiality, promiscuity). Whites tend to confound polygamy and promiscuity. Less educated people are regarded as promiscuous.

**Counter-representations**

A small number of respondents reject the notion of origin. They refuse to hold a specific continent responsible for the origin of AIDS. Their refusal is based either on the fact that AIDS is seen as a global phenomenon, or because positing origin is equated with blame. This is addressed in the section 'reflexivity' below.

PROCESS ELEMENTS

**Anchoring**

- 9/30 respondents initially anchored AIDS to the notion of a 'gay plague'.

This provides an anchor both for the social representation of punishment, and for the association of an out-group to this punishment. The seed of the social representation which links homosexuality to AIDS reappears in terms of lifestyles which are

responsible for the spread of AIDS:

- 11/30 respondents (evenly spread across the sample) posit a link between homosexuality and the current spread of AIDS.
- 7 of these respondents blame anal sex, outdoor sex ('cottaging'), prison practices and the night-club scene for the spread of AIDS.
- 2 believe that while AIDS was originally spread by homosexuals it is now everyone's problem.
- 2 cite a difference between African and Western patterns in the spread of the disease: The African is heterosexual and the Western, homosexual.

**Objectification**

- 3/30 respondents objectify AIDS in terms of Ethiopia.

Ethiopia forms an objectification of a lack of a hygienic, an unhealthy environment and, more generally, of 'Third Worldness':

> *"If I had to think about it I'd say Ethiopia's desolate at the moment and a lot of people probably leave there. So that is how it could have spread to a lot of other countries: People leaving because of starvation and a bad health situation"* **(White heterosexual male 9).**

The Ethiopian objectification appears to reflect a confounding of the words 'AIDS' and 'AID'. For this white respondent it is also related to the conception of Africa as a disaster-ridden continent, devoid of an ability to help itself in the face of disease and starvation. For one of the two black respondents who use this objectification, Ethiopia is also the place in which Western soldiers have sex with black women, giving them AIDS (see section on 'consensual representations' above).

While Africa is the seat of the sin cocktail for the whites, the West tends to be the seat of the sin cocktail for the blacks. There is also a common objectification of AIDS: America.

- 5/30 respondents link the 'American lifestyle' and AIDS.

America stands for: *"problem with drugs", "They are involved in lots of drugs in America, stealing cars in America, carrying guns in America", "the 'Hollywood syndrome' (excessive wealth and consequent boredom and promiscuity)", "American approach: Do whatever you have to do, whatever makes you happy".*

**Reflexivity**

- 3/30 respondents reject the notion of origin. All three are members of marginalised groups.

In response to the question 'Where did AIDS originate?', the following responses occurred:

> *"Not important. It is a global thing"* **(White homosexual male 6).**
>
> *"The origins are not important. It distracts from the issue that it is here and we have to do something about it. It is like trying to put blame on something which is really unimportant"* **(White homosexual male 7).**
>
> *"It's a mud-slinging exercise. There are people who said it started in Africa. But <u>we</u> just heard about it in America"* **(Black heterosexual male 1).**

In addition to the awareness inherent in these responses, the sin cocktail of white heterosexual female 2 (see section on 'consensual representations' above), shows an awareness of a difference between her *"rational mind"* which says *"that person is normal, it could be you"* and that part of her which equates AIDS with leprosy, lice and ghoulishness.

**Defensiveness**

The notion that 'the other' or out-groups are responsible for AIDS is a powerful indicator of defensive thinking. The fact that the practices of these out-groups are linked to perversity and the exotic indicates that unconscious fantasy material has been evoked at a time when anxiety concerning AIDS is present.

There are a number of concrete indicators of this tendency to defend the self and the in-group against the consequences of AIDS. Firstly, when asked 'Which group is worst affected by AIDS in South Africa', a third (10/30) imply 'my group does not have AIDS' (depicted in Figure 4). There are no significant colour or sexual orientation differences, but, interestingly, there is only one woman among the 10 respondents who advocate this. The difference between men and women, on this variable, is almost significant ($\chi^2$=3.7; p<0.055, two-tailed). A white and a black heterosexual response illustrate the 'my group do not have AIDS' idea:

> *"Whites, I don't know so much, but I'm prone to be biased. But I'd say in this country we're a little bit more educated and aware. Sure you get the exceptions, but mainly its blacks"* (**White heterosexual male 9**).

> *"In South Africa we do have immorality but we do have people who stick to their principles: the blacks"* (**Black heterosexual male 1**).

Many respondents' theories concerning who has AIDS in South Africa are designed to exclude themselves:

> *"I see it as rich people and very very poor [people who have AIDS]. The blacks being the poor people because you get very few blacks, rich blacks, in South Africa. So the rich whites and the poor blacks"* (**White heterosexual male 1**).

> *"Very small proportion of women [have AIDS]. I'd say largely heterosexual and homosexual men"* (**White heterosexual female 5**).

> *"Most of them are coloureds [people of mixed race], they are followed*

*by whites...and then Indians and then blacks"* (**Black heterosexual male 2**).

A number of homosexuals put forward the 'my group does not have AIDS' response. Being white and Western is seen as a protection against AIDS, as is the avoidance of the 'club scene':

> *"If you take the bar/club sort of gays it would be high [numbers with AIDS], but if you took the relation-type of people who don't go out it would be very very low"* (**White homosexual male 2**).

Similarly, in response to the question 'Where do you think AIDS comes from?', one respondent offers a powerful 'not my country' response:

> *"I don't know the country, but it wasn't South Africa. But as the time goes on I see it's already here in South Africa. But I can't understand how it came here.*
> ***Interviewer:*** *What continent might it be from?*
> ***Respondent:*** *Another continent.*
> ***Interviewer:*** *What country?*
> ***Respondent:*** *I think somewhere overseas"* (**Black heterosexual male 6**).

This respondent is intent on placing the origin of AIDS outside of his own country. This is linked to the notion of the purity of the self which is elaborated within the 'social representation of in-group pollution', which appears below.

A further indication of defensiveness is the tendency either to comment that AIDS is not spoken about with ease or to relate jokes connected with AIDS.

- 6/30 respondents do this.

In essence, AIDS is construed as *"something people joked about, that gay people got"* (**White heterosexual female 5**). Homosexuals counter this construction with jokes of

their own: *"It was a standing joke: If AIDS is a gay disease, then homophobia is a straight disease"* **(White homosexual male 1).**

**Self-presentation**

One of the accounts (white heterosexual 2) within the section on 'consensual elements' of this social representation above, indicates that bestiality is not an easy topic to discuss. The respondent becomes inaudible once the topic has been raised. Not only is she uncomfortable with certain ideas, she is uncomfortable with her own feelings towards PWA. She wants to present herself as rational and so deems her sin cocktail 'irrational'.

Presentation of an acceptable self is also evident in the tendency to attribute statements which one does not deem socially acceptable to some other agent. A respondent who had been talking about the homosexual origin of AIDS was asked:

> *"**Interviewer:** So it started mainly among homosexuals?*
> ***Respondent:** So the research says"* **(White heterosexual female 4).**

In addition, black respondents claim that they are unable to think of certain words in English despite having spoken fluent English throughout the interview:

> *"You can say that people are over-doing it.*
> ***Interviewer:** What do you mean by that?*
> ***Respondent:** If they have a relationship they tend to do things that are more or less unnecessary.*
> ***Interviewer:** Like what?*
> ***Respondent:** I can't say it in English"* **(Black heterosexual male 3).**

Respondents often present accounts of sin cocktails in a tentative fashion. They are prepared to reveal fantastical thinking but do not seem to want the interviewer to view

them as deranged:

> *"I don't know because my knowledge is limited. What I know of the tribes in Africa they do not allow women to have sex before they come of age and actually tie their legs together..."* **(White heterosexual female 2).**
>
> *"I've heard something about it starting in Africa amongst the monkeys. I mean I don't actually know..."* **(White heterosexual female 4).**
>
> *"I don't know. People say from some tribe in Africa and homosexuals. But I've really got no idea..."* **(White heterosexual female 7).**

POWER ELEMENTS

- 4/10 black heterosexual respondents and 4/10 homosexual respondents (2 black and 2 white) introject the blame associated with AIDS. Being marginalised (ie. being from the homosexual group or from the black heterosexual group) is significantly associated with self-blame in relation to AIDS ($\chi^2$=4.6; p<0.05, two-tailed). Neither colour nor sexual orientation alone is significantly associated with self-blame.

Homosexual and black heterosexual respondents identify more closely with AIDS than do white heterosexuals. The following accounts provide evidence of self-blame or guilt in relation to AIDS:

> *"When they told me I was infected with HIV it was a relief because I think in the back of every gay guy's mind, they all think they are positive. You don't know. We haven't been angels. We have slept with lots of people and you always think that you could be infected. When I was told that I was HIV positive...for the first time in my life I felt guilty about being homosexual, I have never ever had that issue of feeling guilty because I am gay, but at that time I felt immense guilt. And you know why? Because society was pointing a finger at me"* **(White homosexual male 3).**

> *"I was afraid because AIDS was mentioned to be a disease for gay people, so I thought maybe it could attack me"* (**Black homosexual male 9**).
>
> *"I felt, somehow, it affected me. I saw people on TV saying they had AIDS. And even if they told us about the symptoms I was very much careful of myself, I watched to see if I had AIDS"* (**Black heterosexual female 4**).

A number of other homosexuals explicitly mention experiencing guilt in relation to AIDS. This points to the fact that they feel they had a part in creating or in 'generating' AIDS, rather than purely in being its 'victims'.

One black heterosexual, frightened that he may have AIDS, uses blackness to symbolise the foreboding appearance of a PWA. He appears to be drawing on a vision of a person with Karposi Sarcoma, the cancer which produces black blotches on the skin:

> *"I think now I have got the AIDS so I said I better stop [sexual activity]...I just imagine that his [a PWA's] appearance, he is black, I mean he seems to be a dark, dark black, and then starts sometimes to become thin. Others become fat. Then start having these big, big things. I don't know what you call it...people are running away from him, the way he looks. Terrible, terrible person"* (**Black heterosexual male 2**).

'FIT' WITH THE SOCIAL CONTEXT

As stated within the section 'anchoring' above, while 9/30 respondents initially anchored AIDS to 'gay plague', 11/30 associate it with a homosexual lifestyle in the here and now (see Figures 6 & 7). The link between AIDS and homosexuality is not a salient aspect of either the campaigns or of policy-maker discourse in South Africa. If anything, both the campaigns and policy-makers make little mention of homosexuality, emphasising the dangers of promiscuity instead. Many lay thinkers 'filter' the

information given to them through a prism. The prism contains a risk group ideology. Films and gossip magazines seem to feed this ideology. The association between America, fast cars, drugs, crime and the 'Hollywood syndrome' attests to this.

Voices in the social context do not emphasise the different risks faced by homosexuals as opposed to heterosexuals. Yet blacks are regarded as more at risk than whites. This is evident not only in the content of the policy-makers' discourse, but in the more fearsome tone of the black versus the white campaign. Both white and black lay thinkers have ingested this message. Both whites and blacks see blacks as worst affected by AIDS (see Table 2). This representation is interesting because, at the time when these interviews were conducted, 71% of the PWAs in South Africa were known to be white, and 24% were known to be black. However, one needs to remember that the number of blacks who were found to be HIV positive was increasing rapidly.

Like the white policy-makers, white lay thinkers tend to think in terms of a colonial ideology: Africa is a place 'out there', in which strange rituals and aberrant sexuality are common. This allows white heterosexuals to feel that AIDS will not affect them: All ten white heterosexuals feel that they are at minimal risk of contracting HIV/AIDS.

Lay thinkers differ from the policy-makers in their readiness to elaborate intricate sin cocktails. The sin cocktails appear to be transformations of ideas relayed in sections of the mass media. For example, lay people appear to have transformed the 'Green monkey theory' of the origin of AIDS into a theory linked to bestiality. Lay thinkers appear to transform ideas which circulate within the social context through their own

fantasies.

## C. THE SOCIAL REPRESENTATION OF IN-GROUP POLLUTION

### PART I: INTER-RACIAL SEXUALITY, BISEXUALITY AND TRAVEL BETWEEN COUNTRIES

#### DESCRIPTIVE ELEMENTS

**Consensual elements**

- Almost one third (8/30) of the respondents allude to inter-racial sexuality in connection with the spread of AIDS. There are no colour, gender or sexual orientation differences.

The direction of the pollution or 'leakage' is always from the respondent's out-group to his or her in-group:

> *"I think during the intercourse of people from different nations. Like I am from the Zulu nation, or let me say Black nation. Someone is an Indian and I am a black guy and sleep with a girl from an Indian nation...that is what I think causes AIDS, like the sleeping of a coloured [mixed race person] and a black man, instead of sleeping with a coloured..."If you sleep with your girlfriend and you are not sure about her or either she has lived with someone from a different nation, then it comes to you and that is where you get AIDS...Don't bother yourself with AIDS, usually they say, AIDS is with whites. So if you want to have AIDS just go to Eldorado, location of coloureds [people of mixed race], and you will get AIDS. But here in Soweto there is no AIDS"* **(Black heterosexual male 2).**

> *"The blacks - I am sure that it was from people coming from further up in Africa and spreading it. I don't know about the whites. I'm sure there must have been cross-breeding between the blacks and the whites, like that"* **(White heterosexual male 3).**

The two agents of pollution, mentioned above, are 'coloureds' [people of mixed race], and those who migrate from their own location in Africa, to South Africa. While the allusion to the 'coloured' group only recurs occasionally in this data set, this provides

some evidence that there is discomfort with 'coloureds' for they contravene the boundary between black and white. In addition, the migrant, generally linked to mining in the data, is a foreigner who contravenes the boundary between South African and foreign identities.

• 20/30 respondents link travel between their own and other countries to the spread of AIDS. They tend to believe that foreigners infect South Africans.

It is imagined that cross-national sexual activity transmits HIV/AIDS from country to country.

The concept of 'leakage' between groups is also likely to centre around the notion of sexual orientation:

• 10/30 respondents view bisexuals as principal agents of the spread of AIDS. There are no significant colour, gender or sexual orientation differences.

Those who hold this idea tend to believe that AIDS first manifested itself among homosexuals and then spread to heterosexuals by way of bisexual conduct. A typical response, among blacks and whites, runs as follows:

> *"Well it started with the gays. Then I'd assume you get the bisexuals getting it from the gays. And then from the bisexuals it spreads to the normal heterosexuals"* (**White heterosexual female 2**).

However, black respondents do not tend to be set on this order. It may be that AIDS first manifested itself among heterosexuals and then spread to homosexuals by way of bisexuality:

> *"Bisexuals: I mean when someone is involved with a woman, then a man, AIDS can develop"* (**Black homosexual male 8**).

> *"Maybe that man slept with a woman and he gets it and then he sleeps*

*with another man and he [that man] gets it"* (**Black heterosexual female 10**).

PART II: THE POLLUTING EFFECTS OF MODERNITY

- 7/30 respondents connect a modern, urban lifestyle with AIDS, while 7/10 respondents link AIDS to man having tampered with the earth by way of technology. There are no significant gender, colour or sexual orientation differences.

A number of the consequences of modern living are lumped together. Overall it is the permissive, tradition-free nature of such living which is linked to AIDS. When asked where AIDS began a respondent answers:

> *"I can say that in areas which are highly polluted, or have the most people. People believe that they can do some things very free so it's not difficult for anyone to get an affair or get anything they want to get.*
> ***Interviewer:** What do you mean by polluted?*
> ***Respondent:** I mean the land it's over-polluted, there's no space, and, like Johannesburg, has so many buildings and people...USA's a place that is highly polluted by people, and the economy is very high. So people travel to USA and come to Africa to do research and duties. So some of the people come this side not knowing what disease they have.*
> ***Interviewer:** You said polluted: lots of people and buildings. What lifestyle do people in a polluted society have?*
> ***Respondent:** It's very fast. Each individual likes to try a new individual, likes to try a new style each and every year. The lifestyle's very very fast...urban areas.* (**Black homosexual male 9**).

This 'polluted', 'polluting' lifestyle is linked with urban living and, more specifically, Americanness. In fact, the 'fast' lifestyle in South Africa is seen to be *"imitating that USA style"* (**Black heterosexual male 2**). There is a debate concerning the 'openness' of various societies. This openness is associated with the 'fast' lifestyle and with a tradition-free, permissive set of rituals which lead to AIDS:

> *"If you think of highly religious societies, like Muslims, who are one-*

*woman people, in those societies there'd be less [AIDS]. It'd probably be heightened in your African cultures although I don't know too much about them. And in your Western society, where we've had our sexual revolution"* (**White heterosexual female 4**).

This respondent then links AIDS directly to God's punishment:

*"I think we're going too fast and quickly and the world's going haywire. And this is the way He's trying to curb us, to make everybody a hell of a lot more cautious and more responsible".*

There is also a link made between freedom, urban spaces, homosexuality and AIDS:

*"It's more likely to be found in urban areas. I think that homosexuals do tend to live in cities because cities are more free thinking, rather than small towns"* (**White heterosexual female 5**).

In a similar vein to the connection between the modern, urban lifestyle and AIDS, AIDS is linked to man having tampered with the earth by way of technology. The Green-house Effect is used to represent this - man is blamed for upsetting the balance of traditionalism with modernity. There seems to be a confounding of the 'Green-house Effect' and the 'Green monkey theory':

*"I look at the 90s as a decade that is going to be severely hampered by different viruses and different illnesses. The Green-house Effect, the ozone layer, those are the things which contributed to the virus being activated...I think it has got a lot to do with nature. The effects of the Green monkey in mid-Africa. Yes I do believe it to a certain extent, I do believe that the virus could have been activated in mid-Africa and perhaps contracted through the Green monkey"* (**White homosexual male 2**).

**Counter-representations**

Idiosyncratically, one respondent equates freedom from Apartheid with the 'permissive era':

*"People say that they need freedom so they no more choose a partner [carefully]. You want to satisfy yourself so you take any partner - black,*

*white, to satisfy yourself. To show 'I am free now, I can do whatever I like'"* **(Black heterosexual male 7).**

Apartheid's institutions, such as the Group Areas Act, were being eroded at this point in time. However, at this stage, the laws had not been repealed.

PROCESS ELEMENTS

**Anchoring**

• 4/30 respondents (2 black and 2 white) initially anchored AIDS to America.

AIDS was associated with America due to the compromised morality of the highly urban American lifestyle. This is elaborated in 'objectification' below.

**Objectification**

America symbolises a land without limits or boundaries:

*"The quality of life isn't correct. We live in an entertainment prone era and we are living without restrictions and restraints in our life. Very American approach: Do whatever you have to do. Whatever makes you happy, do it. Humans don't live like that. They need restraints and control"* **(White homosexual male 6).**

Homosexuality and prostitution also represent the abandonment of constraints.

A major objectification of mixed racial sexuality is place:

• One fifth (6/30) of the total sample mention Hillbrow in connection with AIDS.

Hillbrow was one of the first suburbs legally demarcated for 'whites' which black people entered. Hillbrow is used as a symbol of mixed racial, high-density living and prostitution:

*"I mean now these prostitutes in Hillbrow, I am not even going on colour, I am just saying prostitutes in general. I mean they are not interested. As long as you have got the bucks, they are not going to tell you they have got AIDS"* **(White homosexual male 1).**

*"Like those people who are tourists here. I don't know, I am not sure. If they spend lots of their time there then some of them keep some boyfriends, girlfriends, something like that. Sleep with them, that's when it's going to spread. Like in Hillbrow, most of the girls in Hillbrow are prostitutes, you will sleep with them and then after that that's where it spreads"* **(Black heterosexual male 2).**

*"As I know there are people in Hillbrow, let's say I meet her this weekend and next weekend she meets another guy and she makes sure that when they meet they intercourse. She changes guys like underwear"* **(Black heterosexual male 7).**

In Part II (above) there is evidence that the Green-house Effect symbolises man tampering with the earth. This forms an objectification of AIDS. Wider fears concerning environmental damage are echoed in discourse concerning AIDS.

**Reflexivity**

Not found.

**Defensiveness**

A desire to maintain the purity of 'the self' and of the in-group is evident in statements pertaining to the fact that one's own group does not have AIDS (illustrated in the 'social representations of responsibility' and of 'out-group responsibility'). This relates to the fact that one's country is a more moral place than other countries and, more specifically, that one's in-group is principled:

*"There is immorality being practised in South Africa but it is not at the same level like in America...In South Africa we do have immorality, but we do have people who stick to their principles: the blacks...I've never*

*come across a man who has contracted the disease. I think there are none in the black population"* **(Black heterosexual male 1).**

This inter-group projection is complemented by an inter-individual projection. 4/30 respondents felt protected from AIDS by way of their own principles:

> ***"Interviewer:** The girls you meet in the next few years, do you think they'd be at risk for AIDS?*
> ***Respondent:** The girls I associate with have the same moral approach as me"* **(Black heterosexual male 1).**

**Self-presentation**

Racial identity and differentiation issues reveal themselves in terms of the interaction between a black respondent and the white interviewer:

> *"If it [AIDS] could come here, I mean in our place, I mean because this thing [AIDS] started there in your place. That is why there are lots of them [white PWAs]. But if it could spread here in our place, I think the rate would be higher than whites because sometimes we black guys, lots of black youngsters, they enjoy sex very much from the age of 14"* **(Black heterosexual male 2).**

While this respondent is able to see that AIDS may become rife in the black community, it is still confined to *"your place"* in the here and now.

POWER ELEMENTS

In a certain way this representation contains less of an imbalance of power than the other representations which have been described. There is a certain symmetry in terms of groups not wanting other groups to transgress their boundaries. The threat is posed, to both blacks and whites, by anomalous persons such as bisexuals, 'coloureds' and migrants.

'FIT' WITH THE SOCIAL CONTEXT

The message of separation enshrined in the Apartheid laws is clearly evident in the social representation of in-group pollution. This social representation reflects a system in which racial groups are legally classified in terms of their differences, and are prohibited from living in the same areas and from marrying across the 'colour bar'. While boundaries between groups play a critical role in the human imagination, in South Africa they have been made concrete by way of laws which demarcate the areas in which separate groups are allowed to live, and the racial groups with whom they are legally allowed to have sex.

The tremendous emphasis on racial difference among policy-makers and within the campaigns (see previous chapter) is mirrored by this emphasis in lay thinking. In addition, the emphasis on migrant workers as a potential source of pollution with 'AIDS', is evident in both the social context and in lay thinking. However, lay thinkers are more elaborate in terms of their theories and objectifications concerning the transmission of HIV/AIDS. This may attest to the difference between lay thinking and a more scientific outlook. Lay people are quick to jump to the level of explanation, without necessarily questioning the foundations of the explanation. However, it may attest to self-presentation and reflexivity on the part of the policy-makers.

## 7.3 'FIT' BETWEEN THE SOCIAL REPRESENTATIONS IN SOUTH AFRICA

None of the three social representations, described in section 7.2, is discrete. In talking about issues of responsibility and of punishment respondents argue in terms of blameworthy/guilty versus faultless/innocent groups. Thus the social representation of

out-group responsibility is inherent in the social representation of responsibility and punishment.

Part I of the social representation of in-group pollution overlaps with that of out-group responsibility. In both, people imagine that responsibility for the spread of AIDS rests with the out-group. However, in the social representation of in-group pollution, the salient fact is that the out-group is involved in pollution of the in-group. It appears (in Part II of the social representation of in-group pollution) as if the toxic urban space pollutes the in-group. This echoes Herzlich's (1973) findings. However, these spaces often gain their reputation as toxic due to the behaviours that occur within the toxic urban space, rather than due to the space itself: The 'fast' lifestyle of the urban person; prostitution in Hillbrow; soldier-native contact in Ethiopia.

Paradoxically, in all three representations, individual behaviour **and** certain groups are held responsible for AIDS.

## 7.4 DISCUSSION OF SOUTH AFRICAN LAY THINKING

I will discuss the findings in terms of the hypotheses (emphasised here in bold-type) delineated in section 4.11 (Chapter Four):

> **Responsibility for the origin and spread of HIV/AIDS is placed with the 'other' rather than with the 'self'.**

There is a certain symmetry in the process of inter-group blame. There is a significant tendency, among both the black and the white groups, to imagine that the origin of

AIDS rests with a continent with which they do not identify. This corroborates the McCann Group's finding (1988) that whites saw the origin of AIDS as African, and blacks saw it as American. Furthermore, a third of the sample, both black and white, state that their own group does not have AIDS. In addition 85% (22/26 - excluding those with HIV/AIDS) of the sample, spanning all groups, believe they have a below average risk of contracting HIV. This is a 'not me' illness.

**The 'other' is imagined to be involved in the practice of sin cocktails.**

The symmetry of dehumanisation of 'the other' is striking. A third of the sample, both black and white, combines at least two of the following factors in talking about how AIDS came about: aberrant sexuality; tribal rituals; Third Worldness; a lack of education; and a lack of hygiene. It is in the elaboration of such factors that we often see that the in-group, be it black or white, views its behaviour as more principled, and often more 'civilized', than that of the 'other'.

**The 'other's' behaviour is perceived as potentially polluting of the 'self'.**

The content of thinking about the 'other' centres not only around 'sin cocktails' practised by the 'other', but around how this 'other' may pollute one's 'in-group'. Bisexual practices facilitate 'leakage' of AIDS to the in-group, as do inter-racial sexuality, the practices of migrant workers, and cross-national travel. The implication is generally that the members of one's out-group bring AIDS to the in-group. The notion of the pure self and the contaminated other pervades social representations of

AIDS.

The contaminated 'other' is sometimes a toxic environment, rather than a group. Over a third of the respondents blame AIDS on the polluting effects of modernity. The Green-house Effect and other environmental problems are linked to AIDS. However, my findings indicate that it is not generally the toxic, urban space that is blamed for AIDS. Anti-traditionalist, fast living humans within that space are held responsible.

**Certain groups, who have been marginalised in their society historically, and who have been linked to AIDS in the hegemonic ideology, cast responsibility inward rather than outward.**

This is the asymmetrical component of the blame process. Both blacks and whites see **blacks** as the group in South Africa which is worst affected by AIDS. Blacks, then, connect 'self' with AIDS. This representation emerges at a time when 71% of PWAs in South Africa are white. In addition, the marginalised groups (in relation to hegemonic ideology concerning AIDS in South Africa), homosexuals and black heterosexuals, are more likely to feel in some way responsible for AIDS than are heterosexual whites. In talking about the effect of AIDS on the homosexual group, Isaacs and McKendrick (1992) see self-blame as evidence of a 'spoiled identity'. This challenges the notion that responsibility is always cast out, and corroborates Tajfel and Turner's (1985) conclusion that out-group favouritism is evident among South African blacks. It points to the fact that issues of power are at work when one attributes responsibility for AIDS.

**The behaviour of individual humans, rather than situational determinants, collective sin, luck or a virus, is deemed responsible for the spread/cause of AIDS.**

The language of two thirds of the respondents indicates that human behaviour is held responsible for the spread of AIDS. The dominant debate hinges around the issue of fault. The language of fault is significantly more pronounced in whites than it is in blacks. Though not statistically significant, all of those who pointed to situational determinants, collective sin or luck as factors in the spread of AIDS were from marginalised groups. These findings contradict those of the McCann group which found that blacks endorsed statements about the link between individual control and AIDS (see section 4.4). Blacks tend to have a collectivist, rather than an individualist, approach to blame: God does not punish individuals - God punishes the world for the sinful nature of humankind. This fits well with Ngubane's (1977) position concerning the more collectivist perception of sin and illness in the segment of South African black culture which she analysed. One may explain this in terms of blacks being less influenced by the forces which shape the capitalist and protestant spirit of Western-influenced thinkers.

The implication of human behaviour in the spread (and often the cause and origin) of AIDS is often indistinguishable from a moral judgement concerning the character of the individuals involved. Protestants are the single group significantly more likely than other religious groups, to think of AIDS as punishment. The language of the South

African sample, as a whole, contains a lot of morally-loaded words such as 'sodomy' and 'adultery'. More pronounced are allusions to a lack of moderation, to giving in to 'temptation'. This reflects the Calvinist ethic in which the country is steeped.

**There will be a 'fit' or overlap between the messages contained in the AIDS campaigns and lay thinking. However, people are active in terms of the messages which they receive. They transform aspects of such messages in accordance with emotional and ideological needs.**

White lay thinking is more oriented to individual responsibility than black lay thinking is. This parallels such differences in the AIDS campaigns. Black-targeted campaigns are more fear-evoking, while the white-targeted campaigns invoke responsibility. In addition, white lay thinking parallels that of policy-makers in relation to the minimal risk to whites. All 10 white heterosexuals believe that they are at minimal risk of contracting HIV/AIDS. While they recognise that AIDS devastates Africa, this has no bearing on white respondent's feelings of risk. Thus there is a 'fit' between lay and policy thinking in relation to AIDS. South African respondents decode the AIDS campaigns in terms of the 'dominant-hegemonic' position, elucidated by Hall (1980).

The impact of the campaign messages (and of the policy thinking which underpins them) can be illustrated by comparing the sample's reported initial ideas about AIDS, and those issues that they now associate with AIDS (see Figures 6 & 7). The self-report concerning initial ideas, or anchors, for AIDS is obviously subject to distortions of memory. However, the two gauges provide an impression of past and present streams of thinking.

Figure 6. Reported **initial** anchors for AIDS: South Africa

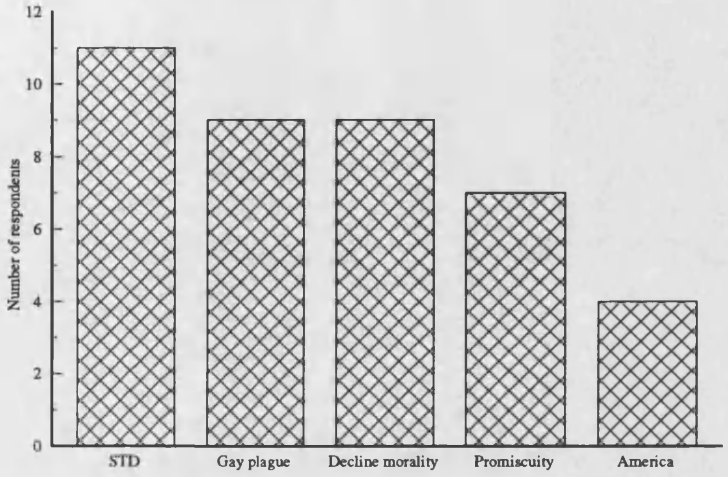
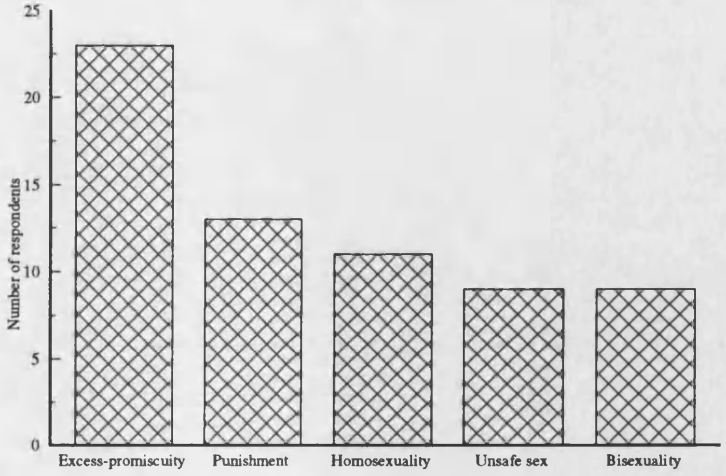



Figure 7. Factors **currently** associated with AIDS: South Africa



The excess theories, so characteristic of the policy-maker responses, become more prominent in lay thinking after the campaign has been set in motion. While people are heavily indoctrinated about the link between promiscuous sex and AIDS, there is little focus on unsafe sex. Like the policy-makers and the campaigns they produce, lay people emphasise promiscuity and punishment categories more than they emphasise specific risk groups. Homosexuality does, however, feature equally prominently in past and present representations of the spread of AIDS.

Black respondents' fantasies concerning the practices which allowed AIDS to escalate do not generally contain a homosexual element. In addition, when black respondents talk about bisexuality as a vector of AIDS, they tend not to imagine that the illness was transmitted from a homosexual source, via bisexual activity, to the heterosexual population. The direction of transmission is often from a heterosexual source to the homosexual population. One may argue that the black social representation actually reflects the different epidemiology which AIDS has in Africa as a whole - where it is predominantly transmitted through heterosexual activity (unlike its epidemiology in the Western world). Statistical realities, which form part of the social context of respondents, will have an influence on the representations. However, the fact that blacks see themselves as worst affected by AIDS at a time when, according to the statistics generated by epidemiologists, they are not, indicates that one cannot assume that lay representation maps onto statistical 'facts'. Blacks filter statistical 'facts' through a prism containing an imbalance of power.

A further prism through which ideas imparted by the mass media are filtered, is that of fantasy. These are the transformations that occur when information moves between media and mind:

| | | |
|---|---|---|
| Ethiopian AID | => | AIDS |
| Green-monkey theory | => | Green-house Effect |
| | => | bestiality with monkeys |
| | => | bestiality with chickens |

Certain elements of the mass media messages are 'negotiated' (Hall, 1980) in terms of respondents' world views. Lay social representations are more punitive than those circulating in the social context. Lay thinkers also emphasise the link between homosexuality and AIDS to a greater extent than occurs in the social context. Of course thinking which circulates in the social context is far more complex than this thesis suggests and includes the influence of religious institutions, which have not been studied in this thesis.

Social representations of AIDS absorb political fears that characterise the final stages of Apartheid. The association of AIDS with the mixed racial suburb of Hillbrow (by one fifth of the sample) is indicative of this. In fact, social representations of in-group pollution view sex across the colour divide as generative of illness. Sex across the colour divide was construed as illegal under the Apartheid laws at the time when these interviews took place. The idiosyncratic response which relates AIDS to the sexual freedom which has come in the final stages of Apartheid is, perhaps, the finest example of the creative use of AIDS as a metaphor concerning one's political fears. Sontag (1979) predicts that the illness which characterises an age absorbs society's

central conflicts. The South African data articulates her vision of illness.

Ideologies, rather than intra-psychic features alone, regulate both the process of blame and the content of the blaming aspersions. Social representations, which continually circulate between social context and individual minds, construe issues in terms of race in South Africa. The Apartheid laws shape the way in which AIDS can be viewed.

While ideology is one of the determinants of lay thinking, it is generally believed that people interact creatively with material transmitted by the mass media (see Chapter Five for fuller discussion). Other than the occasional idiosyncratic line of thinking, there is little creativity in relation to the various AIDS related themes in South Africa. This may be correlated with the fact that, unlike Western democracies in which one expects divergent thinking to be present, due to the breakdown of central doctrines, South Africa still has a stricter core of doctrines. It is less a post-modern society than many countries in the West. My data illustrate that social representations of individual responsibility, of out-group responsibility and of in-group pollution gain wide consensus when a low level of counter-representation and little idiosyncratic thinking are present.

## 7.5 CONCLUSION

This chapter describes the social representations of AIDS, connected to blame, of South African lay thinkers. It is tempting to compare the social representations of AIDS which have arisen with the statistical 'realities' concerning AIDS in South Africa at the time of the interviews. While both black and white respondents tended to

see **black people** as worst affected by AIDS in South Africa, at the time of the interviews blacks constituted only 24% of the PWAs and whites 71%. One needs to add a cautionary note in relation to this issue. While the AIDS figures were dominated by white PWAs, HIV figures were, increasingly, becoming dominated by blacks.

The sin cocktails of blacks do not generally contain homosexual allusions. Blacks are not set upon the idea that AIDS first manifested itself in homosexuals and then transferred to heterosexuals. In fact, I demonstrated that this is often viewed in the reverse order. It is tempting to equate the lack of salience of homosexuality among black respondents with the fact that the blacks with AIDS in South Africa tended to be heterosexual rather than homosexual.

While these considerations need to be kept in mind, they support two opposing positions. The first 'tempting' piece of data supports my contention that representations are not based in current 'realities', but are structured according to ideas which have circulated in the society historically, concerning certain groups. The second 'temptation', however, supports the position that representations map onto realities. I will return to this issue in the final chapter of the thesis. I turn now to describing British social representations of AIDS, related to blame. A comparison between social representations in the two countries appears in Chapter Ten.

## OVERVIEW OF CHAPTER EIGHT

In this chapter I explore the social representations of AIDS, related to blame, which circulate in the British social context. These social representations form the backdrop to lay social representations pertaining to AIDS. British AIDS policy-makers and the British Government's AIDS campaign have been centrally concerned with convincing lay people that AIDS is 'everybody's' problem, rather than the problem of certain groups. The early campaigns, in particular, vacillated between a desire to relate the 'everybody is at risk' message, and the mentioning of 'risk groups'. I discuss the reasoning that underpins both of these positions. I argue that the central role, which epidemiologists have in the AIDS scene, reinforces 'risk group' thinking among lay thinkers. The notion that certain groups are at risk, while others are not, was further reinforced by the widely publicised Kilbracken affair in 1989. Lord Kilbracken's pronouncement that there were very few heterosexuals numbered among the AIDS statistics reinforced the division between 'pure' and 'contaminated' groups, which had been established in early media reporting on AIDS. At the same time, mainstream policy debate has attempted to dissociate itself from this position. Instead, it has attempted to put forward a message which calls on all people to take responsibility for their own actions. This has the consequence of rendering the person who contracts HIV blameworthy.

# CHAPTER EIGHT: THE BRITISH AIDS CAMPAIGN: EXPLICIT AND IMPLICIT AGENDAS

## 8.1 INTRODUCTION

I now investigate the social representations of AIDS which circulate in the British social context. The notion of 'social context' has been fully addressed in Chapter Five. The social context both influences, and is influenced by, lay thinking.

As in Chapter Six, in this chapter I explore two aspects of the 'social context':

1. Relevant **policy-makers'** views of the origin and spread of HIV/AIDS, and of actions to be taken to contain the spread. This is based upon analysis of parliamentary debates, public speeches and interviews with British AIDS policy-makers.
2. Government sponsored **poster campaign** messages relating to the origin and spread of HIV/AIDS, and to actions to be taken to contain the spread. This is based on an analysis of the first British Government sponsored AIDS campaign. This is complemented by an appraisal of subsequent British campaigns.

The two aspects of the social context are treated separately.

While procedural and sampling issues within the British social context are analogous to those in the South African context, a number of factors are clearly different. There has been a proliferation of analyses of the British AIDS scene. This has two implications. Firstly, the work which I do is far more reflexive - I am often commenting on other researchers' commentaries. Secondly, the policy-maker component of this chapter is drawn from secondary sources, rather than the primary sources which are used in Chapter Six.

This is more fully explained in section 8.3 below.

Furthermore, the British interviews occurred later than the South African interviews and the British Government began campaigning against AIDS far earlier than the South African Government. It also invested far more money in this enterprise. Consequently, Britain had produced many more AIDS campaigns than South Africa had, in the time period which I explore. Like the policy-maker interviews, British campaign material is analysed in as analogous a way as possible to the South African material.

## 8.2 BACKGROUND ISSUES: SOCIAL AND MEDICAL REALITIES OF THE BRITISH AIDS EPIDEMIC

I explore the social and medical realities which form a backdrop to British lay thinking. Since the lay interviews began in November 1991, I analyse thinking in the social context up until this time.

### 8.2.1 AIDS STATISTICS AT THE TIME THIS STUDY TOOK PLACE

In November 1991, there were 5065 people known to have AIDS in Britain (CDSC, 1991):

- 79% were homosexual (a small proportion of the people within this category were both homosexual and intravenous drug users).
- 8% were heterosexual (though the statistics state that, save 1%, all of these heterosexuals had either a 'high risk' partner or one from a country in which the major route of HIV transmission was heterosexual).
- 6% were intravenous drug users (a number of the people within this category were both intravenous drug users and homosexual).

- 7% contracted HIV from blood transfusions.
- 1% contracted HIV from mother-to-infant transmission.
- The vast majority of PWAs were white .
- 94% were male; 6% were female.

Certain background issues have been dealt with in Chapter Two. I point out that policy-makers and the campaigns have been centrally concerned with the issue of individual responsibility for AIDS from an early stage. In this chapter I demonstrate this and other strands of thinking empirically, picking up chronologically from where Chapter Two left off (late in 1985).

### 8.2.2 THE EXTENT TO WHICH THE GOVERNMENT SHOULDERED RESPONSIBILITY FOR AIDS

In January of 1985 the Government set up an Expert Advisory Group on AIDS to advise the Chief Medical Officer. In October 1986 the Government established a special All-party Parliamentary Group to expedite official action on the AIDS issue. Its main concern was the use of the mass media to prevent the spread of AIDS. On 21 November 1986 the first House of Commons (HOC) Debate took place concerning the Government's plans to meet the threat of AIDS. 565 people in Britain had contracted the illness. During the House of Commons debate, Norman Fowler, the Secretary of State for Social Services, announced the disbanding of the DHSS' Health Education Council (HEC) in April 1987, and the formation of the Health Education Authority (HEA). Fowler claimed that, due to a need for ongoing public education, a new body was needed to develop and to carry forward health education campaigns. The body was intended to enhance and strengthen the role which the HEC had formerly taken, but, in addition to that role, to provide "a

nationwide centrally conducted campaign" (HOC, p.805) with a clear line of accountability to ministers and to parliament. During the course of the House of Commons debate, 20 million pounds was pledged to public information initiatives, for the coming year (1987).

By 1989, 130 million pounds was granted to various aspects of AIDS ("stemming the spread", "increasing knowledge", "giving help to those who suffer" and "fostering informed opinion"). The Minister of Health, David Mellor (1989), related the generous funding of AIDS to "rectifying an historic neglect" in fields such as the upgrading of genito-urinary medicine, which was formerly "a cinderella service within health". Interestingly, this Government perception of itself is not mirrored by commentators who look at the British AIDS scene from the outside. Mettetal and Verboud (1992) point out that in 1916 the British Government recommended that anonymous, free of charge STD clinics be set up. Since then every Local Health Authority had been required to provide STD services. In addition, the condom has a history of being distributed through scores of channels in Britain.

### 8.2.3 THE ROLE OF MARGINALISED GROUPS IN THE DEVELOPMENT OF AN AIDS STRATEGY

In May 1983 the friends of Terence Higgins (one of the first people to have died of AIDS in Britain), who were involved in the Gay and Lesbian Switchboard, organised the country's first public conference on AIDS. The Greater London Council and what was then the Health Education Council gave financial assistance (Schramm-Evans, 1990). The Terence Higgins Trust (THT), formed in 1983, focused on health education (producing leaflets from 1983) and AIDS care (opening a help-line in 1984), with the explicit aim of

influencing national policy on AIDS. The Gay lobby in Britain is strong because of an unbroken history of creating organisations and institutions (Watney, 1992). Central Government money was first given directly to groups such as the THT in 1985. The government considered voluntary bodies more accessible to minorities such as homosexuals and prostitutes than government bodies could be (Mellor, 1989).

The THT and other NGOs have had a powerful influence on national policy. In 1987 the Minister of Health called together representatives from the THT, Body Positive, CRUSAID, the DHSS, and the Chief Medical Officer to discuss the formation of the National AIDS Trust. It aimed to co-ordinate the many services that were developing and to prepare an effective national plan for dealing with AIDS. Sections of the gay community have sought to undermine the efforts of the Government-NGO alliance. They believe that a hidden agenda underpinned the formation of the National AIDS Trust which related to "getting away with spending as little as possible" (Whitehead, 1989:108). Sections of the gay community also feel that they operate within an intensely moralistic climate, rather than one which accepts homosexuality as a legitimate choice. There is ample evidence to support this argument. It is presented under the 'social representation of in-group pollution' section below.

### 8.2.4 CONFLICTS WITHIN THE AIDS POLICY-MACHINE

While the Government has obviously been committed to AIDS campaigning from 1986 - "we are very committed to funding a public health campaign", "we are wholly committed to a centrally directed campaign" (Mellor, 1989) - the Government has attempted to shirk some of the responsibility for control of the AIDS epidemic. In addition to feelings in the

gay community, that their resources have been exploited so as to minimise government spending, Thatcher vetoed the Kinsey-type 'National Sexual Lifestyles Survey' once it had already begun. The information which this survey aimed to provide was regarded as essential for the control of the epidemic. Yet Thatcher felt that it was a potential invasion of privacy of the electorate which would 'taint' the government.

Acheson, then the Chief Medical Officer at the Department of Health, remarks (Mihill, 1992) that Thatcher was kept out of the AIDS issue because she found it distasteful. She feared that there would be a public backlash against frank advertising. Indeed, in the mid-1980s it was difficult to get ministers to take the threat seriously, according to Acheson. They did not want to be associated in public with AIDS. However, members of Thatcher's government aimed to give knowledge and to change opinions, in the hope of stemming the spread of HIV. They also voiced explicit support for sufferers: "People will get the treatment that they need...no-one will be denied it" (Mellor, 1989).

### 8.2.5 RELATIONSHIP BETWEEN THE MASS MEDIA AS A WHOLE AND GOVERNMENT-SPONSORED AIDS CAMPAIGNS

There has been a proliferation of media analyses of AIDS in Britain (eg. Vass, 1986; Wellings, 1988a; Alcorn, 1989; Beharrell, 1992; Berridge, in press). The early ideas which were portrayed by the media are important since they form the anchors or seeds of social representations of AIDS. Berridge (in press) states that the period from 1981 to 1983 was characterised by notions of 'gay plague' and there were portrayals of homosexual men in America with AIDS, in the British media. Homosexual men were portrayed as a risk group due to their promiscuity and due to their use of 'poppers', a drug which increases one's sexual urge. From 1983 to 1985 a fear arose concerning the heterosexual spread of

the illness. This was related to fear over the safety of the blood supply and observations that AIDS was spreading heterosexually in Africa. Yet the 'gay plague' portrayal of AIDS remained constant. The combination of the notions 'gay plague' and 'heterosexual spread' culminated in reports of the death of Rock Hudson.

Berridge (in press) makes two extremely important points: Firstly, the portrayal of AIDS as a 'gay plague' was almost entirely confined to newspaper reporting, both the quality and the tabloid press. Different forms of media have represented AIDS differently. From the start, television has tended to view AIDS as everyone's issue rather than that of an out-group. Her point is important in that it indicates that the mass media is not monolithic. It conveys, reflects and constructs different angles of a debate.

Her second salient observation is that early media reporting of AIDS was concerned with the statistics of the epidemic. Through the reporting of statistics, the media helped to construct AIDS as a scientific issue. AIDS was anchored not only to the 'gay plague', but to 'the world of science'. This finding has a number of implications which I develop in the following chapters. AIDS statistics are presented in terms of risk groups, as is evident in the CDSC figures above (section 8.2.1). The epidemiology of AIDS, conveyed to lay people via the press, feeds pre-existing ideologies related to groups who are responsible for society's ills. It is interesting to note that 'the world of science', in which the press and lay people anchored AIDS, was the world of epidemiological, rather than of virological science. AIDS tended to be related to the risk group rather than to the virus aspect of scientific discourse on AIDS.

The tabloid press, in particular, has continued to reflect a risk group ideology throughout the 1980s and into the 1990s. An example of this can be drawn from **The Sun**:

> *"Ian [Charleson - the actor] died because he caught AIDS. And it is almost certain that he caught AIDS because he was a homosexual. If his death has done nothing else, surely it must make our gay community face up to the fact that AIDS is a homosexual, drug-related disease. It is not a heterosexual disease. It becomes a heterosexual disease ONLY when gays or drug addicts become either blood donors or switch sides. It is time the homosexuals and drug addicts cleaned up their act. They, and they alone, are responsible for people dying from AIDS (quoted from* ***The Sun*** *12/1/90 in Beharrell, 1992).*

Policy makers have often proposed that the *raison d'être* of the campaign is to redress the misconceptions which the tabloids have instilled. Archie Kirkwood MP remarked on this in the early parliamentary debate on AIDS:

> "The popular press has dealt with this matter [AIDS] in a sensational way and has done itself no credit. It will take us many months to try and redress some of the damage it may have done" (HOC, 1986:849).

In addition, the Chief Medical Officer, Doctor Donald Acheson, informed the nation-wide health departments, between April and November 1986, that the AIDS campaign was an attempt to correct the misconceptions which the lay public held. Certain sections of the mass media fostered the 'misconceptions' to which Acheson and Kirkwood allude, while others fostered a different set of ideas.

## 8.3 A STUDY OF AIDS POLICY-MAKERS: METHOD

### 8.3.1 PROCEDURE AND SAMPLE

I chose not to interview British policy-makers personally. While I initially set out to do so, I encountered a number of obstacles. Among them was the fact that the policy-makers had been subject to a number of similar interviews. There seemed little point in

duplication of such interviews. I was able to draw on interview material, as well as on parliamentary debates and public speeches, in order to ascertain the social representations of AIDS which circulated among British policy-makers up until November 1991. This chapter contains only secondary sources. While I will present this dialogue within the same social representational framework as that used in the previous two chapters, they are not, strictly speaking, analogous.

Berridge and Strong (1992) have pointed out that AIDS was seen as politically important from a fairly early stage, despite Thatcher's sensitivity to it. One explanation of this is in terms of personalities - primarily those of Norman Fowler and Donald Acheson. I deem their voices, as well as those of David Mellor, when he was Minister of Health, and Michael Adler, a prominent medic in the AIDS policy-scenario, central in AIDS policy-making. Unlike the South African policy-makers (see Chapter Six), the 'voices' are mentioned by name in this chapter. I have no ethical constraints and, so, it is unnecessary to eliminate names. However, I hope that the voices will be construed as representatives of hegemonic ideas, rather than as those of specific individuals.

This chapter deals only with ideas concerning AIDS which circulated in the 'social context' up until November 1991. These ideas form the backdrop to the lay sample's social representations of AIDS, which were investigated late in 1991 and early in 1992. These are analysed in the following chapter.

## 8.4 RESULTS: THE TEXTURE OF POLICY-MAKER THINKING

The views expressed in the interview material, the parliamentary debates and the public speeches clustered around three social representations:

A. The social representation of responsibility and punishment.
B. The social representation of out-group responsibility.
C. The social representation of in-group pollution.

### A. THE SOCIAL REPRESENTATION OF RESPONSIBILITY AND PUNISHMENT

DESCRIPTIVE ELEMENTS

**Consensual representations**

In the first House of Commons Debate concerning the Government's plans to meet the threat of AIDS, Norman Fowler states that:

> *"I am in no doubt that the first priority in combating the disease must be public education and that a concerted attempt must be made to inform the public, and particularly the public most at risk....Public education is the first priority"* (HOC, 1986:803).

Fowler prioritises this over previously mentioned issues such as testing blood, and providing haemophiliacs with uncontaminated Factor Eight. This 'public education' involves imploring individuals to take responsibility for their own behaviour:

> *"The key to containing the spread of the infection ultimately rests with the individual's own behaviour"* (HOC, 1986:802).

Fowler then expounds on the nature of these behavioural changes:

> *"Stick to one partner but if you do not, use a condom"*. For drug 'misusers': *"Do not inject drugs; if you cannot stop, do not share equipment"*. This has the aim of effecting a *"change in people's behaviour, everybody taking responsibility for his own actions"* (HOC, 1986:804).

His position remains consistent, a year later, in October 1987:

> *"In the absence of medical defences against AIDS, public education is the main weapon in the fight to limit the spread of infection. Only by*

> *influencing personal behaviour and lifestyles can we hope to minimise the ravages of AIDS throughout our population"* (Fowler quoted in Acheson, 1988:14).

The most salient aspects of Fowler's position are the issues of individual control and responsibility.

A line of argument which appeared in the early parliamentary debate, but which appears to have largely disappeared from later official rhetoric, concerns 'innocent' and 'guilty' groups. Fowler states:

> *"At the moment only a relatively small group of people are infected in this country. In the main they are homosexuals or drug addicts or their partners. In addition, there are the tragic cases of haemophiliacs who have been infected with contaminated blood, and perhaps worst of all, of small babies who have been infected by their mothers"* (HOC, 1986: 802).

Fowler expresses a hierarchy of worth in which non-sexual, non-drug related transmission of HIV - as with haemophiliacs and small babies - is tragic whilst sexual and drug-related transmission is not. In addition, Sir David Price MP and Sir Ian Percival MP state, respectively, that:

> *"Some of us believe that there are strong medical reasons for not entirely liking a society in which sleeping around seems to be the prevailing trend"* (HOC, 1986:820).

> *"Among the guilty [for AIDS] are those who since the early 1960s have actively promoted what they choose to call the 'permissive society'. In this chamber I have even heard it called 'the civilized society'. They have actively promoted every form of deviation from those normal values until the mystery and the beauty of sex have been dragged down to levels of what we have to talk about in this debate"* (HOC, 1986:836).

Responsibility and blame for AIDS is cast onto those who promote and partake in 'permissive' sexuality. AIDS is related to deviations from the norm, to a degraded sexuality. Those who deviate are the guilty parties while others are 'tragic cases', AIDS' innocent victims. Certain people deserve to get AIDS.

There can be no doubt that remarks such as that of Percival, quoted above, contain a punishment theory of AIDS. Those who partake in and promote *"deviation from those normal values"* have denuded sex of its value and have, in some way, *"dragged down"* sexuality to a point where AIDS has to be discussed. A relationship is implied between the appearance of AIDS and the *"permissive society"*, though we are left unsure as to whether God or nature has been the harbinger of AIDS. The final word on this can be left to William Cash MP, speaking within the same debate:

> *"Many of the figures show that AIDS has been generated because of sexual behaviour of one sort"* (1986:820).

This comment explicitly confounds the spread and the 'cause' of AIDS. Talk of a virus does not enter into this morality tale.

**Counter-representations**

In opposition to the individual determinants, Acheson (1988) emphasises situational determinants of the transmission of HIV:

> *"It is necessary to develop a set of policies which, in addition to the correction of social conditions conducive to drug abuse and reduction of the supply of and demand for such drugs..."* (p.16).

In addition, there is a powerful strand of debate which sees moralising as the worst possible way of preventing the spread of HIV. Doctor Pinching, an advisor on AIDS to the Department of Health and Social Services, remarks:

> *"There is a great danger, in public education terms, about moralising. If you tell somebody what he or she has done is unnatural or bad or use any other judgemental term, you immediately alienate them from the community you are trying to protect and it is in everybody's interests to regard everybody in the community as being within the community and to act in the interests of that community"* (HOC, 1987: 161).

PROCESS ELEMENTS

**Anchoring**

Acheson (DHSS, 1986) anchors AIDS to past threats to public health:

> *"While the scourge of smallpox has gone and diphtheria and poliomyelitis are at present under control, other conditions such as legionellosis and AIDS have emerged. The control of the virus infection (HTLV III) which is the causative agent underlying AIDS is undoubtedly the greatest challenge in the field of communicable disease for many decades"* (p.36).

AIDS is anchored to threats which were not imbued with a moral dimension. Consequently, Acheson, in his evidence to the House of Commons Social Services Committee enquiry into AIDS, could cite the historical record as a prime reason for avoiding a punitive response to AIDS (Berridge, 1992) and called for a liberal, consensual response to AIDS (Berridge, in press).

However, fellow policy-makers, such as Fowler, and MPs such as Price, Percival and Cash, quoted above, anchor AIDS to certain lifestyles: homosexual, drug-taking, promiscuous and 'deviant'. Terms such as 'sleeping around' indicate that an issue of morality and punishment is the essence of the anchor.

**Objectification**

AIDS is objectified in terms of war in Fowler's accounts above - *"combating the disease", "education is the main weapon in the fight"*. According to Strong and Berridge (1990), AIDS was construed as an emergency, analogous to war in terms of: its initial unpredictability; the alarm raised around it; its potential for massive escalation; bitter early disputes over the reality of the danger; loss of life. Others (eg. Sontag, 1989) see the use of war imagery in relation to AIDS in terms of construing ill people as the enemy and

thereby justifying their stigmatisation. Obviously worried by this implication, Meacher MP comments, in the House of Commons Debate:

> *"The war against AIDS must not become the war against those who have AIDS"* (HOC, 1986:817).

**Reflexivity**

Fowler's 'innocent' and 'guilty' victims have disappeared from official rhetoric. In addition, Acheson states that he is *"sensitive to the moral and social issues which lie at the root of this epidemic"* (1988:14). Similarly, Mellor (1989) wanted to keep AIDS resources separate from other health issues partly because he did not want to allow the issue of *"deservedness of getting AIDS"* to hamper the development of the field. He stated: *"I find such arguments irrelevant".*

**Self-presentation**

Subsequent to 1986 I can find no record of a key policy-maker juxtaposing the tragic and non-tragic PWA, as one finds in Fowler's early dialogue. This is indicative of both reflexivity and of a politically conscious strategy not to alienate certain voters or, probably more importantly, to violate liberal norms.

**Defensiveness**

Judging from people involved in the AIDS scene, interviewed by Strong and Berridge (1990), AIDS was greeted by reactions of shock:

> *"It's a bit like Kennedy was shot!"* (Unnamed physician).

> *"AIDS really hit us in '85...It just gradually bubbled up...It was a phenomena with which we were totally unfamiliar...Nothing like this had*

*happened in the living memory of anyone. With everything else you knew something of what could and could not be done - cancer and things like that - but here, no one knew anything"* (Unnamed senior civil servant).

Early images of AIDS are likely to have evoked anxiety and, consequently, the need to project outwards or to blame others.

POWER ELEMENTS

Homosexuality and drug use receive little direct attention in the consensual representation, but many indirect allusions. Promiscuity is more likely to be mentioned as the epitome of irresponsibility. This is discussed in terms of the ideology of 'the family' (section 8.5 below).

An individualistic ideology runs throughout policy-maker accounts, although this is coupled with the idea that the government must take responsibility for controlling the spread of AIDS.

## B. THE SOCIAL REPRESENTATION OF OUT-GROUP RESPONSIBILITY

DESCRIPTIVE ELEMENTS

**Consensual representation**

Fowler states that:

*"We can do something about the threat; the position can be contained. We have the opportunity of learning from the experience of other countries where the disease has gained a greater hold...In parts of Africa it is worst of all"* (HOC, 1986:802).

Britain is differentiated from other countries, among which are America and certain European countries, in terms of the size of its epidemic. The epidemic had *"gained a*

*greater hold"* in these countries: *"Only a relatively small group of people are infected in this country"* (HOC, 1986:802).

The British situation is further differentiated from the situation in *"parts of Africa"* where AIDS is *"worst of all"*. While Fowler expressed a desire to learn from the experience of other countries, such as African countries, others doubted whether Africa was capable of offering any guidance to the West, concerning AIDS. At the Social Services Committee of the House of Commons in February of 1987, Mr Powley MP remarked:

> *"I do not want to denigrate any of the African people but do you think they are sufficiently intelligent - some are pretty primitive people - to understand what is happening, how it is being transmitted and what they need to do to stop the spread of the disease"* (HOC, 1987:267).

AIDS is 'other' not only in terms of the fact that other countries have a greater incidence of AIDS than Britain does, but because it is mainly out-groups within Britain who have AIDS. Fowler views AIDS in terms of risk groups throughout the 1986 debate, stating that:

> *"An attempt must be made to inform the public, and particularly the public most at risk, of the dangers"* (HOC, 1986:803).

One alternative to informing risk groups about the illness was the call by Winterton MP, in the Social Services Committee, for homosexuals to refrain from homosexual activity:

> *"The major cause of the spread of AIDS in this country, as you heard from our previous witnesses this afternoon, is from the homosexual community. If we are prepared to take a positive stand on alcohol and a*

*moral stand on nicotine and cigarettes, why should we not take a moral stand on homosexuality and say in a very direct advertisement, 'homosexuality can damage your health'. Because it* ***can.*** *It is unnatural and it can damage your health...If we can do it with cigarette smokers and have a National Non-Smoking Day today, do you not suggest that we should have, 'No Homosexual Activity Day' as well?...Let's be consistent"* (HOC, 1987:187).

**Counter-representations**

The policy debate which has developed around AIDS, subsequent to the early parliamentary debate, tends to emphasise that 'everyone is at risk', rather than that homosexuals or any other 'risk group' are more at risk. This counter-representational stance is well developed in Acheson's response to a question, put forward by Winterton MP, concerning prostitutes as a source of AIDS:

> *"**Winterton MP:** But they [prostitutes] are, surely, one of the main sources of the spread of this plague disease, AIDS?*
> ***Acheson:** They are one of the sources...The way to approach this problem is by encouraging prostitutes to seek assistance in the STD clinics and also to educate potential clients. That is a general education which has to go, obviously, to the whole country"* (HOC, 1987:21).

PROCESS ELEMENTS

**Anchoring**

The African anchor for AIDS is present, as is the homosexual and prostitution anchor. This is discussed under 'objectification' below.

**Objectification**

There are trace elements of the symbolisation of AIDS in terms of various risk groups. Homosexuality symbolises 'the unnatural', and Africa 'the primitive'. However, the policy-makers who are more influential (eg. Acheson and Fowler) tend to de-

emphasise these symbolic aspects.

**Reflexivity**

Government policy-makers, for the most part, have actively constructed the representation that everyone is at risk of contracting HIV. This is surprising in light of the risk group ideology which pervaded the early debates on AIDS. Some have suggested that putting forward the idea that 'everyone is at risk' was an active strategy, on the part of policy-makers, to allay the prejudiced response, reflected in the tabloid press, which had developed in relation to homosexuals:

> "The idea of 'everyone' being at risk was a powerful weapon against anti-gay prejudice in 1986" (Schramm-Evans, 1990:229).

Further explanations of this are discussed in section 8.11.

**Defensiveness**

Not found.

**Self-presentation**

Early policy talk concerning AIDS and out-group responsibility exists. However, as time marches on, language becomes cleansed of such ideas, with the exception of the Kilbracken ideas which are presented under the 'social representation of in-group pollution'. This reflects the high level of reflexivity which operates in policy circles.

POWER ELEMENTS

The influential nature of homosexual men in the policy lobby is captured by Tony Whitehead, a homosexual AIDS activist who later became chairperson of the THT

Steering Committee:

> *"All my links were direct with Sir Donald Acheson. There was no AIDS Department at the DHSS at that time" (Interview with Berridge, July 1989, reported in Berridge, in press).*

Like policy-makers from the central Government, one of the aims of the gay lobby was to convey the idea that everyone, rather than just certain groups, is at risk of contracting HIV. Berridge (in press) finds that the policy aims of organisations such as the THT, were as follows:

> *"To convey the message of dangers of AIDS to gay men; to develop a public role (but without thereby sacrificing credibility among gays) by raising public and political awareness of the dangers of an AIDS epidemic; and to prevent the danger of an anti-gay backlash - by stressing - as the Gay Medical Association had done - the idea of AIDS as potentially and actually, a heterosexual disease".*

Like the government policy-makers, so the gay lobby were using the 'you are all at risk' message to curtail the blaming of homosexuals for AIDS. It would be unfair to construe the message as purely political in its aims. Both lobbies believed, on the basis of the African experience, that HIV/AIDS may well have taken hold in the heterosexual community.

## C. THE SOCIAL REPRESENTATION OF IN-GROUP POLLUTION

### DESCRIPTIVE ELEMENTS

**Consensual representations**

In general the AIDS policy community in Britain has avoided talk of the crossing over of HIV/AIDS from 'them' to 'us'. For a variety of reasons, which appear elsewhere in this chapter, it has tended to emphasise that HIV/AIDS is everybody's problem.

However, one has to remember that parliamentarians devised and ratified Section 28 of the Local Government Act of 1988, at the same time as AIDS was being construed as a non-risk group issue, as everybody's problem. Section 28 states that: (1) A local authority shall not: (a) intentionally promote homosexuality or publish material with the intention of promoting homosexuality; (b) promote the teaching in any maintained school of the acceptability of homosexuality as a pretended family relationship; (2) Nothing in subsection (1) above shall be taken to prohibit the doing of anything for the purpose of treating or preventing the spread of disease.

This law blatantly expresses a fear that homosexuality will invade the boundaries of heterosexuality. The other policy issue which arose around this time supported exactly the opposite viewpoint: Homosexuality and heterosexuality were seen as discrete categories with boundaries that were unlikely to be transgressed.

One member of the All-party Parliamentary Group investigating AIDS, Lord Kilbracken, in 1989, said of AIDS:

> *"The risk for the ordinary straight guy and his girl is very small...If you have a disease where over 95 per cent of those catching it are in a high-risk group you should concentrate on informing them how they can avoid it" (quoted in Snow, 1989:2).*

Kilbracken argues that the heterosexual in-group is pure in relation to AIDS. Only various out-groups are tainted: homosexuals, bisexuals, intravenous drug users, those with high risk partners, those who have had blood transfusions, those who have had sex in Africa, and prostitutes and their clients. Kilbracken's views were widely quoted in the tabloid press.

**Counter-representations**

Since it took its decision to act on AIDS in the mid-1980s, mainstream policy thinking has not given the impression that AIDS is an issue of 'us' versus 'them' . It is therefore debatable whether the mainstream or the Kilbracken view is the 'counter-representation'. I see the mainstream view as the counter-representation because the Kilbracken side of the argument gained such wide mass media coverage, with both right and left-wing publications endorsing his analysis of AIDS.

Fellow members of the All-party Parliamentary Group on AIDS expressed their opposition to Kilbracken in a letter to **The Independent** (1989) entitled 'No HIV boundaries':

> *"At the last count there were 363 reported cases of women who acquired the virus heterosexually. It is quite absurd of Lord Kilbracken to argue that, as many of these were infected either abroad or through a partner in a 'high risk' category, they can be disregarded as a source of infection. It is impossible to 'ringfence' groups and assume that there will be no transmission across group boundaries" (p.18).*

This debate, concerning whether a boundary separates the in-group from the out-group, is an integral part of the social representation of pollution.

PROCESS ELEMENTS

**Anchoring**

Not found.

**Objectification**

The manner in which the official government statistics are laid out (eg. CDSC, 1991) reflects, objectifies and contributes to the formation of boundaries around in-group and

out-group in policy-makers' minds. The category of "transmission between men and women" differentiates between: "'high risk' partner; other partner abroad; other partner UK". Epidemiological thinking, which forms the basis of such statistical categories, draws boundaries around various groups. The doctors who question people with HIV regarding how they may have contracted it, have to slot an individual who may have had multiple exposure to the virus into a category. The doctor's prior social representation of AIDS influences the category which is chosen. The choice of a statistical category relies on both the social representation of the person with HIV as to how HIV might have been contracted, and that of the doctor who must, on the basis of this self-report, slot this individual into a category.

**Reflexivity**

The fact that mainstream policy-makers initially decided to present AIDS as everybody's problem, is a direct reaction to accusations that they and the mass media had initially viewed AIDS as an illness which was confined to homosexuals and to drug-users.

**Defensiveness**

The notion that the world can be split into discrete groups is related to a primary mental process whereby the world is ordered in the face of anxiety. The world of the out-group and in-group appear so distant in Kilbracken's discourse and in the mass media that broadcast it from its front pages, that they do not convey a strong fear of pollution or leakage from the out-group to the in-group. The separation between in-group and out-group was embodied in the headlines of articles in which the Kilbracken

statements appeared, such as **The Sun's** 'Straight sex cannot give you AIDS - official'. This headline also attests to the legitimation which Lord Kilbracken, armed with the scientific endorsement of official statistics, was able to give to an idea.

**Self-presentation**

Not found.

POWER ELEMENTS

The boundary between heterosexual and homosexual, enshrined by way of law, allows certain sections of the policy community to believe that these groups are discrete. However, the fear that the 'other' will invade the 'self' is embodied in laws such as Section 28 of the Local Government Act of 1988, which were explicitly created to allay fears that school children were learning that homosexuality was a legitimate alternative to heterosexuality. Those who devised the law feared that heterosexuality, the children's 'natural' proclivity, might be subverted.

The notion that homosexuality is a 'pretended family relationship', explicitly stated within Section 28, implies that the 'real' family relationship is heterosexual. The heterosexual family is construed as the only institution which validates sexual relationships (Watney, 1989). Section 28 is distinctly ideological.

Conviction under the anti-homosexuality laws, in 1988, was one of the highest this century (Tatchell, 1990). In addition, there has been a drop of approximately 20% of those polled who are in favour of the liberalisation of laws against homosexuality. This

drop had occurred in the latter half of the 1980s (Weeks, 1989). This seems to coincide not only with the growth of the AIDS epidemic but with the growing fear of 'leakage' of the virus into the heterosexual community.

The Kilbracken affair conveyed the message that heterosexuals cannot get AIDS and that it is homosexual propaganda that forces the Government to present AIDS as everybody's problem (Beharrell, 1992). The Kilbracken affair symbolises the belief that boundaries between 'self' and 'other' are impenetrable. This idea has had reverberations on the left as well as on the right. Left-wing magazines such as **Living Marxism** and **Analysis** have talked of the almost non-existent heterosexual AIDS statistics (Gupta, 1991/2; Myers, 1991). Myers (1991) views the fuss made over heterosexual AIDS as a vehicle through which the authorities can bolster family values and proscribe departures from sexual norms. Gupta (1991/2) attributes it to an attempt to impose repressive sexual morality on all. In addition, the Gay community tends to complain that the Government does little to address gay men in its national campaign, despite the fact that these men constitute the vast majority of PWAs (Watney, 1988b).

## 8.5 DISCUSSION OF POLICY-MAKERS' SOCIAL REPRESENTATIONS

The debate concerning whether AIDS is everyone's problem or not is far more accurately addressed by looking at HIV than at the AIDS statistics. Yet it is the AIDS statistics which tend to be used, in the popular press, to convince people that heterosexuals are unlikely to contract HIV. While AIDS figures reflect the pattern of transmission in past years, it is HIV figures which demonstrate who will have AIDS in the years to come.

Certain types of behaviour, such as unprotected anal intercourse, are more likely to allow for the transmission of HIV than others. While anal sex tends to be associated with homosexuals, many men who do not identify with the homosexual group have unprotected anal sex with men. In addition, many heterosexual couples have unprotected anal sex. If one constructs AIDS in terms of 'risk groups', one glosses over the more subtle realities. AIDS is related to one's behaviour, rather than to the group to which one belongs. This behaviour is related to a wide set of social conditions, as well as to individual choices. Of course individual 'choice' is also socially constructed.

All three social representations are partially informed by a certain vision of 'the family', which was a central feature of the Thatcherite philosophy:

> "The family is promoted by its supporters as the natural (and therefore unchanging) order of adult human relations. The family is natural because it is based on the natural instinct to procreate. Healthy sexual desires are therefore heterosexual, and preferably monogamous" (Ray, 1992:11).
>
> "The castigating of homosexuals as diseased, as perverted, or at the very least deviant, confirms family life as the natural, healthy and normal lifestyle" (Ray, 1992:11).
>
> "The defence of the family as a social institution requires the criminalisation of sex that is not compatible with family life. The many laws which discriminate against homosexuals, and a whole political and moral climate of prejudice, stem from this reality" (Ray, 1992:11).

Thatcher stated:

> "There is no such thing as society. There are individual men and women, and there are families. And no government can do anything except through people, and people must look to themselves first...A nation of free people will only continue to be great if family life continues and the structure of that nation is a family one" (quoted in

Watney, 1988b:24).

The Thatcherite section of the government saw the family as a crumbling structure. Figures on divorce and single-parent families were indicative of this decay. The family structure needed to be reconstituted (Elliot & McCrone, 1987). Thatcher's ideology of 'the family' is linked to the ideology of individualism and to the termination of the overarching role of the welfare state.

Michael Adler, a prominent medic in the AIDS policy-scene, is mindful of the re-enactment of history in the present AIDS scenario. He looks back at the findings of the Royal Commission which took evidence, from 1913 to 1916, on venereal disease in Britain. They recommended that:

> "it would be necessary *'to raise moral standards'* and instruct the community in *'self-control'*. So as to leave no doubt as to their moral propriety, the Commissioners concluded that the venereal diseases *'are intimately connected with vicious habits'*" (Adler, 1992: 74).

Adler (1992) feels that a return to this moral position is likely in the current British Government AIDS campaign:

> "The government originally took a high profile on explicit education. I sense that they only felt able to do this because AIDS was perceived as a major crisis, but now that things are settling down there is increasing pressure on them to revert to moral messages and the trailing of family values" (p.75).

## 8.6 ANALYSING BRITISH AIDS CAMPAIGNS: METHOD

I will first present a summary of all of the British Government AIDS campaign material produced by November 1991 (excluding material which focuses exclusively on AIDS and drug use). I will then explain the sampling procedure which I have adopted. The campaigns are arranged in terms of five phases:

**PHASE I: 'DON'T AID AIDS'/'DON'T DIE OF IGNORANCE'**

• March 1986: National newspaper campaign (Appendix G).

• May-November 1986: National newspaper campaign (Appendix H).

• November/December 1986: National newspaper campaign (Appendix I).

• December 1986: Poster campaign, involving 1,500 sites. These appear in section 8.7 below.

• November/December 1986: Youth campaign involving radio and magazines (Appendix J).

• December 1986/January 1987: 'Tombstone' campaign screened on television and 'Iceberg' campaign screened in the cinema (Appendix K).

**PHASE II: 'AIDS. YOU KNOW THE RISKS, THE DECISION IS YOURS'.**

• December 1987/January 1988: Poster campaign pointing to the danger, for travellers, of not using a condom in their sexual encounters abroad. (The poster which appeared in June/July 1989 (see Appendix O), also appeared with the slogan 'AIDS. You know the risks the decision is yours'.)

• February/March 1988: Television campaign emphasising the danger to young heterosexuals of not using a condom in casual sexual encounters (Appendix L).

**PHASE III: 'AIDS. YOU'RE AS SAFE AS YOU WANT TO BE'.**

• November 1988-March 1989: National newspaper campaigns attempting to give a wide variety of facts to young heterosexuals (Appendix M).

• June 1989: Campaigns targeted at women in women's magazines (Appendix N).

• June/July 1989: Poster campaigns stating that people should not go too far without

condoms, that for only 15p one could buy life insurance, in the form of a condom, and that one should use a condom if one had sex with old acquaintances (Appendix O).

**PHASE IV: 'CHOOSE SAFER SEX'**

• January 1989: First campaigns targeted at homosexuals and bisexuals in gay magazines (Appendix P).

• June 1989: Further campaigns targeted at homosexuals and bisexuals in gay magazines, reinforcing the need to adopt safer sexual patterns of behaviour (Appendix Q).

**PHASE V: EXPERTS SAY EVERYONE IS AT RISK/'REAL' PEOPLE WHO HAVE CONTRACTED HIV**

• February/March 1990: Television campaigns in which three experts expressed the seriousness of the illness and the steps which could be taken to prevent contracting it. A similar national newspaper campaign appeared simultaneously (Appendix R).

• March 1990: The first magazine campaign targeted at married men who have sex with men (Appendix S).

• January 1991: Television campaign using people with AIDS in a naturalistic setting. One targeted heterosexual women, the other, for the first time on television, gay men.

• July 1991: Television campaign, targeted at travellers, shows the beginnings of a holiday romance and a voice-over relates that they didn't think that condoms were necessary. The print on the screen reads: 'He is 29, heterosexual and got the HIV'.

In selecting an appropriate campaign for content analysis, it was necessary to make the analysis comparable to the South African analysis while remaining true to the British

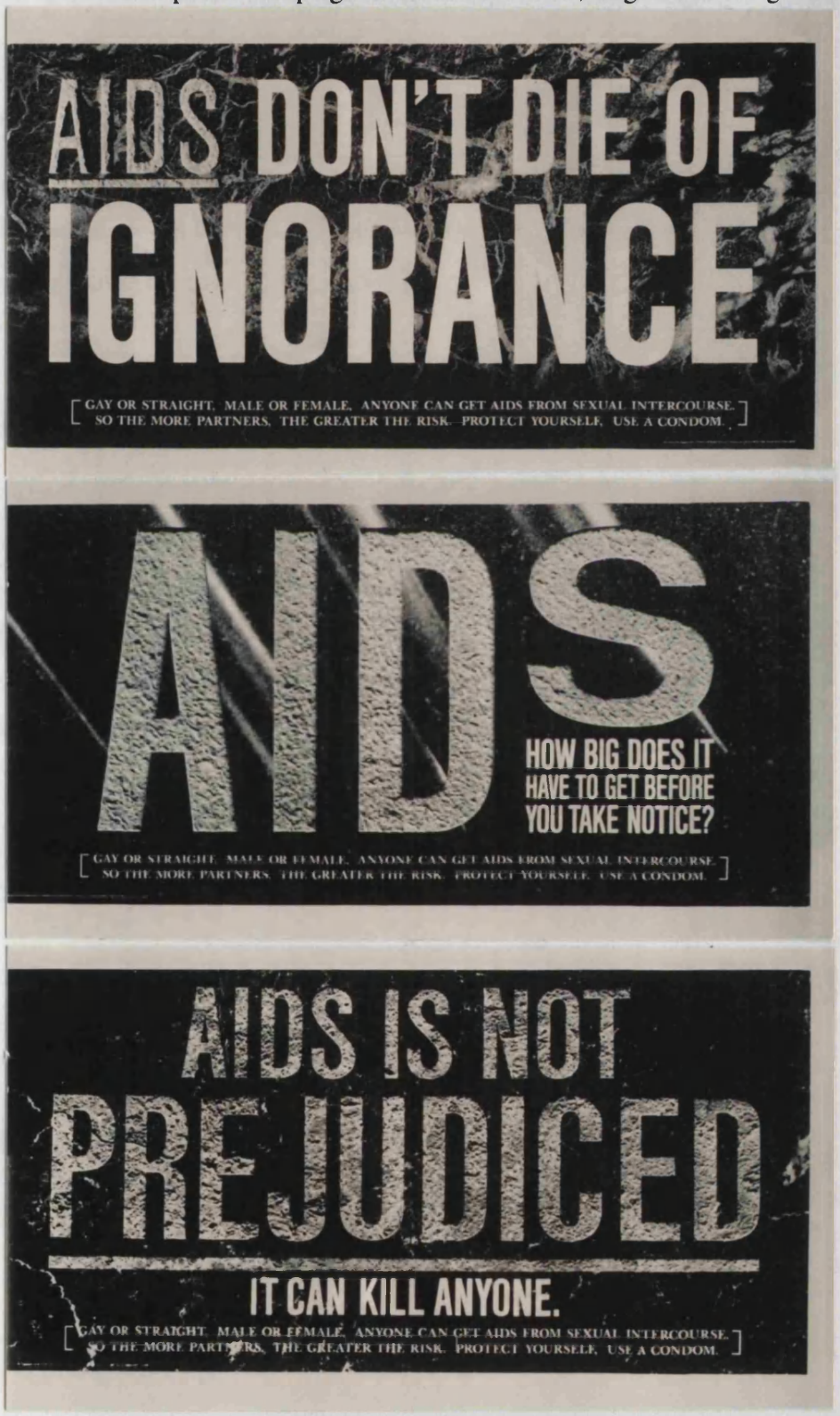
material. I did this by analysing, in comparable terms to the South African campaign analysis, only the poster campaign which characterises the first phase reported above. An additional section examines diachronic changes in the campaign.

This choice requires justification. In the light of the status of the 'anchor' in social representational theory, the first phase of a new campaign is likely to be instrumental in the formation of subsequent social representations. The first phase of the campaign is likely to provide the seeds of many people's social representations of AIDS. Of course this would only be true if the campaign had received wide and appropriate coverage. I turn to certain empirical findings to support this theoretical position. Eighty two percent of an adult British sample, carefully selected to be representative of the entire population, were able to describe the contents of this campaign to a point where interviewers were satisfied that they had seen it, after the campaign had ended (DHSS, 1987). In fact, in the evaluation of the second phase of the campaign, spontaneous recall of the first phase of the campaign was higher than that of the campaign which was under evaluation (Wellings, Orton & Samuels, 1992). None of the subsequent campaigns have had as high a level of recall. One, in the fifth phase, had a 77% level of prompted recall (HEA, 1992). In part, this is because the latter campaigns were more selectively targeted.

As in the South African analysis, I am interested in what the campaigns intended to convey to their target audience, rather than purely in my perception of the campaigns as a social scientist.

## 8.7 RESULTS OF THE ANALYSIS OF THE FIRST PHASE OF THE CAMPAIGN: EXPLICIT MEANING

Figure 8. The first British poster campaign of December 1986, targeted at the general public.



The three posters, which appear in Figure 8, will be analysed in terms of four components: the block of text; the logo; the slogans; and the central visual images.

**a. The block of text**

The first word of the block of text which appears on all three posters is the word 'gay'. The text conveys the facts that gays and straights, males and females can get AIDS. AIDS is exclusively related to sex, in the main, to having lots of partners. Protection is proposed in the form of a condom.

On 19 November 1986 officials of the DHSS including Acheson, BBC executives, and an official of the Cabinet Office met to discuss what message the AIDS campaign intended to convey. It was felt that it should contain three messages:

> "Cut down on partners; Use condoms if you are not sure about your partner; Do not share needles if you must persist in injecting drugs" (quoted in Alcorn, 1989:197).

**b. The logo**

The same logo appears at the bottom of all three posters in tiny writing. It states that the poster is 'issued by the Department of Health and Social Security'.

**c. The slogan**

Three slogans are used in this poster campaign: 'AIDS: Don't die of ignorance'; 'AIDS: How big does it have to get before you take notice'; 'AIDS is not prejudiced: It can kill anyone'. The most striking feature of the three slogans is that they aim to be fearsome in tone: This is a "big" disease from which you can "die". AIDS can "kill".

The slogans also attempt to challenge the idea that AIDS targets homosexuals only by re-iterating that it can kill anyone rather than being "prejudiced" against certain groups.

**d. The image**

The slogans appear as epitaphs carved into tombstones. This represents a direct allusion to the death of an individual from AIDS. Little is left to the inferential powers of the viewer. This is reinforced by the explicit nature of the text (see (a) above). There is no doubt that the image intends to evoke fear.

## 8.8 RESULTS OF THE ANALYSIS OF THE FIRST PHASE OF THE CAMPAIGN: IMPLICIT MEANING

The first phase of the government AIDS campaign perpetuates the idea that group identity is related to AIDS. This is done by using the word "gay" first, in the block of text of the campaign, and then mentioning "straight" people. The posters explicitly mention 'high risk groups' and simultaneously denounce the fact that AIDS is prejudiced against these groups in particular.

At the same time as perpetuating an idea established by the broader mass media concerning 'gay plague', the campaign explicitly identifies 'sexual intercourse' as the causative agent in the spread of AIDS. Certain behaviours, practised by "anyone", transmit AIDS. Each person in the public at large is told: You can "protect yourself" against AIDS. The condom, as well as knowledge (ie. the opposite of "ignorance") are the two forms of protection which are proposed. The risk group ideology and the responsibility ideology co-exist in this poster.

The posters condense the broader set of messages which appear in the newspaper campaigns of this period. The newspaper campaigns are more explicit in terms of their risk group ideology and in terms of the notion of leakage:

> "At the moment the infection is mainly confined to relatively small groups of people in this country. But the virus is spreading" (see Appendix I).

The newspaper campaigns contain two variants of the relationship between partner numbers and the condom. One version states: "Stick to one faithful partner. Or always use a condom". The other states: "The more sexual partners you have, the greater the danger. Use a condom." Talk of 'faithfulness' seems to carry some of the moralising which I have discussed in section 8.5 above.

In addition, in the poster campaign, the slogan 'Don't aid AIDS' which appears in the other media forms, is eliminated. This slogan, like those characterising the subsequent phases of the campaign, gives a message that one is in control of whether one contracts AIDS or not. The person who contracts it is thereby deemed blameworthy. It could be argued that the person who transmits it is blameworthy too.

The level of fear which this campaign was designed to evoke is likely to have had consequences for the anxiety level of its audience. A denial of the extent to which these campaigns are targeted at oneself is probable.

## 8.9 RESULTS OF THE ANALYSIS OF SUBSEQUENT CAMPAIGNS

The second, third and fourth phases of the campaign were characterised by the slogans 'AIDS. You know the risks - the decision is yours', 'AIDS. You're as safe as you

want to be' and 'Choose safer sex' respectively. These slogans express the notion of individual responsibility for AIDS. The HEA logo, which lies at the bottom of all of these campaigns, has become synonymous with this stance.

The texts of the campaigns in the second, third and fourth phases have also tended to emphasise this issue of control. This is especially true of phase three. It contains statements such as "Your chance of getting it doesn't have to be" and "HIV infection may be impossible to recognise, but it is possible to avoid". The following discussion draws heavily on phase three since this campaign has had far greater coverage than phases two and four.

The messages in phases two, three and four have tended to vacillate between imploring people to use a condom, with little or no talk of partner numbers, and a message pertaining to 'faithfulness' and to 'risk groups'. Certain of the campaigns in phase three still state that HIV/AIDS exists "not only among homosexuals and drug misusers". Most campaigns within this phase state that, the more partners one has, the greater one's chance of infection.

Visually, phases two, three and four have tended to use far less fearsome images than the initial phase, although some may argue that these subsequent campaigns continue actively to evoke anxiety. Phase three, in particular, attempts to convey the fact that one cannot distinguish, visually, a person who has HIV from one who does not. This phase presents visual images of highly attractive individuals who 'could have AIDS'. The textual messages also convey some potentially frightening 'facts', such as that

there is no cure for AIDS, that it has the "potential to be the greatest epidemic the world has ever known", that one can have it without knowing it, and that for every one person with AIDS there are 30 with HIV. While this may be construed as a fear tactic, one might also construe it as a form of information provision.

I now turn to the final phase under consideration in this thesis, phase five. Dominic McVey, Senior Research Officer of the HEA states that the HEA had hoped to have a "social engineering, health promotion, condom-pushing approach" to AIDS at the time when the 'expert' campaigns appeared. Yet, he stated, for the Government, pushing condoms implied pushing sex and pushing sex implied that one was inspiring promiscuity (personal communication, 1 June 1990). The 'expert' campaign (see Appendix R) was devised in the light of this censure. Apart from the fact that slogans related to individual responsibility were held in abeyance, the campaign is most noteworthy for its use of a total of nine medics as its AIDS 'experts'. The 'experts' are a mixture of immunologists, epidemiologists, genito-urinary medics and general practitioners. This is indicative of Treichler's (1988; 1992) hypothesis that biomedicine, only one of the many fields which shed light on AIDS, has a privileged status within the current construction of AIDS. It is medics, rather than, for example, educationalists, who are used in this campaign to convey the message that heterosexuals can get AIDS, that one can pass on HIV without knowing that one has it, and that sex and the sharing of syringes transmits it. This reflects a wider issue, that of the credibility of 'science', in the eyes of many lay people.

The majority of the nine 'experts' are epidemiologists. This reinforces the point which

has been made concerning the influence of the epidemiological conception of AIDS on lay thinking. The epidemiological conception of AIDS tends to be concerned with the distribution of AIDS within a population. This, inevitably, tends to be reported, by way of Government statistics, in terms of risk groups. Lay thinkers, who receive reports of such data through the mass media, filter such information through an already existent risk group ideology. This ideology divides the social world into an 'us' and a 'them'. The 'high risk groups' are bundled into the 'them' category. This allows lay thinkers to maintain a sense of immunity to HIV/AIDS. It has negative repercussions for those lay people who identify with the 'high risk groups'.

Phase five of the AIDS campaign was characterised by the giving of 'real life' stories of PWAs, as opposed to previous campaigns in which models, rather than 'real' PWAs, had appeared. These campaigns lay somewhere in between the 'be faithful to one partner' and the equally individualistic, but more morally neutral, condom-pushing approach. There can be no doubt that a modicum of the Thatcherite vision of 'the family', and of the desire to stress blameworthiness, have been evident throughout all phases of the campaign. Acheson construes the following as a difficulty associated with 'practical advice' regarding risk reduction:

> *"It is right to advise people to stick to one faithful partner, but is it right to advise that if they do not they should use a condom?"* (1988, P.19).

Clearly, these thoughts are invested with a certain amount of morality.

Finally, I turn to discussing the campaigns which convey the idea that sexual encounters on holiday may cause one to contract HIV. There are a large number of

such campaigns among the HEA's repertoire. Phases two, three and five contain campaigns with this message. These campaigns appeared in airports, at the time of the Christmas/New Year and the summer holidays. The underlying construction within such campaigns is the notion that sex with foreigners, in foreign lands, may well pollute the pure in-group with AIDS. The HEA's own newspaper remarks, in relation to phase two of the campaign when travel campaigns were introduced:

> "Behaving more responsibly about sex is the only way to stop AIDS spreading further into the general population" ('HEA launches AIDS campaign', 1988:1).
>
> "If we are to avoid the spread of HIV from high risk groups to the public at large, the HEA believes this complacency must be dispelled" ('Comments requested on programme', 1988:8).

The high risk groups are 'other' in terms of sexual orientation or foreign nationality.

## 8.10 SYNOPSIS OF THE BRITISH SOCIAL CONTEXT UP UNTIL NOVEMBER 1991

The notion of 'gay plague' and the link between drug-use, homosexuality and promiscuity characterised early mass media and policy debates on AIDS. Since then, AIDS has tended to be characterised as 'everybody's problem', not least because the gay lobby set out to ensure that this message was adopted. There has been an ongoing debate concerning whether the 'gay plague', versus the 'everybody is at risk' position, is a correct reflection of the statistical reality. The assumption, which underpins both sides of the debate, is that AIDS is linked to individual behaviour and responsibility, rather than to collective action by institutions in the social context. Consequently, those who do not act responsibly, are deserving of the outcomes which befall them. This message parallels the Thatcherite outlook which viewed the family, and the monogamous heterosexual relationships implied by this institution, as the natural order

of adult human relations. By implication, all that is non-monogamous and non-heterosexual threatens the fabric of 'society'. The campaigns themselves have fostered and reflected this position, imploring people to "stick to one faithful partner or always use a condom". This implies, that it is only in 'unfaithful' relationships that HIV can be transmitted. The bottom line of the campaign, up until November 1991, was that you choose whether to contract or not to contract HIV: 'AIDS. You know the risks, the decision is yours'; 'AIDS. You're as safe as you want to be'; 'AIDS. Don't die of ignorance'; 'Don't aid AIDS'.

## 8.11 CONCLUSION

There has been an increasing attempt, on the part of the Government, to address the misconception that AIDS is a homosexually targeted disease. There is an increasing attempt to tell the target audience that AIDS is 'everyone's disease'. There are a number of ways of looking at this trend. Firstly, it may be viewed as the government's way of "taking out political insurance" (Schramm-Evans, 1990:229). If the virus does enter the heterosexual community to a great extent, the government will have warned people of this eventuality. Secondly, as I have mentioned, it may be a genuine attempt on the part of the Government to prevent blame of certain sectors of the society. Thirdly, it may be seen in terms of the ideology of 'the family' promoted by Thatcher. AIDS offers the opportunity of reversing the sexual 'degradation' which arose during the 'permissive' era. Fourthly, it may be pragmatic. Prevention is cheaper than cure. Fifthly, it may be an attempt to correct the social representation of out-group responsibility, that has been created by the mass media and by the early AIDS campaigns themselves. This indicates the high level of reflexivity among policy-

makers (and campaign producers) concerning the influence which they are having on their target audience. This reflexivity is apparent in the disappearance of the notion of 'innocent' versus 'guilty' groups in official discourse. There is also a growing awareness, on the part of the policy-makers, that heterosexuals tend to feel immune from AIDS due to early references to Africa and to homosexuality. Finally, the 'it is everybody's disease' message may reflect a perception that the epidemic itself has changed, and that 'everybody' **is** now at risk, whereas, formerly, they were not.

Campaigns within phases one, two and three, include the 'fact' that the more partners one has, the greater the risk of infection. This bears out moral rather than statistical reasoning. The crucial issue is whether one's sexual behaviour involves an exchange of body fluids (semen, blood or vaginal fluids). Non-penetrative sex, or penetrative sex with the correct use of condoms, with many partners, is more safe than unsafe sex with one partner. One may be in a 'monogamous' relationship with "one faithful partner" but he or she may have had many previous monogamous relationships in which unsafe sex took place. Professor Adler's 'real life' story in the 'experts' campaign challenges, directly, the notion that HIV can only be contracted within an 'unfaithful' relationship:

> *"I have a patient who is an 18 year old student and she became infected through sexual intercourse with her one and only boyfriend".*

The 'pure' and the 'innocent' mix with the 'contaminated' and the 'guilty'. In-group and out-group have sex with one another and Kilbracken and the tabloids' fantasy concerning the firm boundaries which encircle such groups is a defence against the anxiety which this realisation produces.

One final point needs to be made before I turn to the study of the social representations of AIDS, connected to blame, of the British lay sample. The idea that people are responsible for the outcomes which befall them, put forward by AIDS policy-makers, and embedded in the AIDS campaigns, reflects the ideology of individualism which is at the root of Western-based thinking. It may be argued that Thatcher's government emphasised this aspect more than previous British Governments did. However, in Chapter Two I show that individualism was established, in the sphere of health policy, well before her Government's entry into the political arena.

## OVERVIEW OF CHAPTER NINE

In this chapter I explore social representations of AIDS, linked to blame, held by British lay thinkers. The majority of the respondents hold certain people responsible for contracting HIV/AIDS. Individual choice is deemed a central factor in contracting HIV/AIDS. The irresponsible choices which lead to AIDS are associated with various out-groups. The division between in-group and out-group, or 'self' and 'other', tends to occur in terms of sexual orientation. Drug-users and promiscuous people also feature prominently as out-groups. Certain groups in the sample link AIDS to conspiracy and to the excesses of modern living. There is a 'fit' between messages transmitted by mass mediated AIDS campaigns and lay thinking. Responsible choices are linked to the prevention of AIDS in media and lay social representations. However, respondents draw their conspiracy theories from sources beyond the mass mediated campaigns. Unconscious forces work alongside conscious material in the construction of social representations of AIDS.

# CHAPTER NINE: THE TEXTURE OF BRITISH LAY THINKING

## 9.1 STUDYING BRITISH LAY THINKING: METHOD

### 9.1.1 SAMPLE SELECTION

The method used in Britain is extremely similar to that used in South Africa. Several channels were used in selecting the three groups which comprised the sample: heterosexual whites, heterosexual blacks and homosexuals (both black and white; a number with HIV/AIDS). What I term the homosexual 'group' comprised blacks and whites. A basic criteria for all three groups was that they were urban, young adults with a baseline education of 'O-levels'. Heterosexual whites and blacks were approached at two tertiary colleges (Hammersmith & West London and Southwark), a polytechnic (Middlesex) and at a university (London School of Economics and Political Science). Homosexuals were approached through a youth group (London Gay Teenage Group), through a residential church-run youth project (Kennington Project), through a group run for and by people who are HIV positive or have AIDS (Body Positive) and through an association for people with HIV/AIDS (Phoenix). All of these institutions are in London.

### 9.1.2 APPROACHING THE SAMPLE

Interviews were arranged either by approaching individuals directly at the above-mentioned locations, or by asking teachers or leaders within the above-mentioned groups to arrange the interviews.

Interviewees were asked if they were prepared to discuss their ideas about AIDS. They were told that they would be paid £4.00 for a 40 minute interview. Two HIV positive black males refused the invitation to participate.

### 9.1.3 SAMPLE CHARACTERISTICS AND DEMOGRAPHIC DETAILS

Thirty respondents took part in the study:

- 10 heterosexual whites
- 10 heterosexual blacks
- 10 male homosexuals
    - 6 white and four black
    - 3 with HIV/AIDS, all of whom were white.

Half of the heterosexuals were male and half female. The mean age of the sample was 23 with a range of 18 to 39 years old (and a standard deviation of 5). The 'black' respondents in this study were of African or Caribbean origin, rather than of Asian or of mixed racial extraction.

The majority of the sample (25/30) had attained at least one 'A level', with many having recently embarked on some form of higher education. The majority of the respondents (18/30) were college or university students. Twenty seven per cent were in manual jobs or were clerical workers. Others, in more or less equal numbers, were business people, professionals or unemployed. The higher status parent of the vast majority of the respondents was either lower middle class (15/30) or a professional (8/30).

Half of the sample (14/30) had no religion. A further 4 respondents described themselves as either 'pagan' or 'spiritualist'. Only 5 were Catholic and 5 Protestant. Two respondents were Moslem. Two thirds of the sample never attended a place of religion. A third attended occasionally or regularly. All of the regular attenders were black.

The mean number of sexual partners which heterosexuals had ever had was 6.6 (with a standard deviation of 4). The mean number of sexual partners which homosexuals had ever had was 79 (with a standard deviation of 151). It is known that the homosexual definition of a 'sexual partner' differs from that of a heterosexual. Homosexuals do not have to have penetrative sex in an encounter to construe it as sexual.

### 9.1.4 PROCEDURE

The study was carried out between November 1991 and February 1992. All interviews were carried out by the author. Respondents were paid £4.00 for the interview. All of the other procedural details are identical to those carried out in South Africa and appear in section 7.1.4 (Chapter Seven).

### 9.1.5 TECHNIQUES USED

#### 9.1.5.1 The interview

The semi-structured interview was conducted, based on the interview-guide which appears in Appendix T. A full description of the interview, and of the coding of that interview appears in section 7.1.5.1, in Chapter Seven.

#### 9.1.5.2 The questionnaire

A questionnaire, which appears in Appendix U, was used to ascertain the demographic characteristics and sexual activity of the sample. Like the South African questionnaire, the questionnaire was modelled on successful questionnaires previously used in the field by the author (eg. see Dockrell *et al.*, in press). The details gleaned from the questionnaire are reported in section 9.1.3.

### 9.1.6 OFFICIAL AIDS STATISTICS

These statistics are presented in full in section 8.2 of Chapter Eight. In summary, 79% of the PWAs were homosexual, 8% were heterosexual, 6% were intravenous drug users, 5% were haemophiliacs, 1% had contracted HIV through a blood transfusion and 1% through mother-infant transmission. Six per cent were female and 94% male.

## 9.2 RESULTS OF THE ANALYSIS OF LAY THINKING IN BRITAIN

In this chapter I elaborate the social representations which underpin blaming responses in relation to AIDS and blame in Britain. The views expressed in the interviews, pertaining to blame, clustered around four social representations:

A. The social representation of responsibility and punishment
B. The social representation of out-group responsibility
C. The social representation of in-group pollution
D. The social representation of conspiracy

The way in which the interviews are analysed is identical to that reported in Chapter Seven and a full discussion of how this is done appears in section 7.2 of that chapter.

### A. THE SOCIAL REPRESENTATION OF RESPONSIBILITY AND PUNISHMENT

DESCRIPTIVE ELEMENTS

**Consensual representations**

Two thirds (20/30) of the Britons imagine that certain people are responsible for either contracting, spreading or 'causing' HIV/AIDS.

The choice of the human agent is seen to be involved in the contracting of, or the spread of, AIDS. Since the notion of a virus is generally absent from the debate about

the spread of AIDS, the impression given is that human agents cause AIDS rather than that HIV causes AIDS. There are no significant differences in gender, colour, religion or sexual orientation.

A typical example of the link between responsibility and AIDS is:

> *"It's from a lot of unprotected, irresponsible sexual relations with more than one partner...A lot of them (PWAs) are irresponsible in their sex lives, unprotected and I suppose promiscuous"* **(White heterosexual male 5).**

The role of choice or volition is central to many accounts of how people contract HIV/AIDS:

> *"I think there's a lot more people can do to stop it than they really think they can. But I don't know, it seems like they don't really care"* **(White heterosexual female 7).**

> *"Its down to everyone personally. If they went out and have safe sex they won't catch AIDS. If they don't, they will"* **(Black heterosexual male 5).**

There is a powerful division between those who are responsible, 'at fault' and therefore guilty for contracting and spreading the illness and the 'innocent' who contract it through 'no fault of their own'. Many responses are located within the debate between fault and faultlessness. Black respondents, in particular, express this division blatantly:

> *"I reckon a good 20% [of PWAs] are innocent people, what I mean by innocent is: not gay, not drug takers, and not really sexually promiscuous. They just happened to get it from the wrong person"* **(Black heterosexual male 5).**

> *"Well the first impression I get is that they [PWAs] are homosexual. The second impression I get is that they are bisexual, third impression I get is that they are the unlucky ones, they are the ones who were in the wrong place at the wrong time. Homosexuals, to me, I don't, like some*

*people, look at them in sympathy and so on. To me I don't look at them in that way, cos they deserve what they get"* **(Black heterosexual male 3).**

White approaches, though almost identical in content, have a more subtle flavour:

*"It takes different victims as well, it doesn't like, just hit one person, it's, I mean you don't need to have slept around just to get AIDS and I think that's one of the worst things because people who haven't slept around, and they, you know, sleep with the first person and they get AIDS, it's like, I mean, that's not fair"* **(White heterosexual female 7).**

*"You could be the most innocent person in the world who has just had a bad batch of blood in hospital. So I don't think it's specifically, I would say probably the mostly promiscuous young people, not promiscuous necessarily, just not careful"* **(White heterosexual male 9).**

The 'guilty', quite blatantly, are homosexuals, bisexuals, drug-users, and promiscuous people. The 'innocent' are *"small children, not being their own fault"* **(Black heterosexual female 2)** and *"normal people"* [implied to be heterosexual] **(Black heterosexual male 4).**

While the responsibility debate in the heterosexual community hinges around the 'innocence' versus the 'guilt' of the person who contracts HIV/AIDS, in the homosexual community it tends to hinge around the 'unfair' versus 'stupid' dimension involved in contracting HIV/AIDS. Blame of those who contracted AIDS, prior to the great awareness concerning safer sex, is construed as 'unfair' whereas blame for current unsafe sex is justifiable:

*"I think promiscuity is too risky, and anybody who doesn't use a condom is just literally mad, as far as I am concerned. I mean, they don't deserve it, it wouldn't be right to say that, but they are just fools literally"* **(White homosexual male 1).**

*"That's one of the highest risks, definitely: Cruising the scene, whatever. Obviously then you got just the fact that you can catch it anyway if you're unlucky. You know, somebody that had sex for the first time in*

*their life caught it, something like that"* **(White homosexual male 4).**

*"I think the gay men who get infected now are stupid. I mean, there are certain cases, there are a lot of instances where, like Stephan, where it was just very unfair, or myself where, you trust someone, it's terribly stupid to trust someone. I mean, there are lots of cases like that. But people who are having unsafe sex now, on the gay scene are just stupid, there's no excuse for it. But people do it"* **(White homosexual male 5).**

A number of accounts posit a relationship between sexual, and drug or alcohol-related, 'irresponsibility'. A domino effect is linked with the contracting of AIDS:

*"It's all like a ladder or a domino that we flick one and everything else falls down. It can lead to that. Only I know that because I've seen it happen. You know, first the drugs, then the sex, then the this, then the that. I saw it in New York with the crack heads, you know, whereby they couldn't get the money so you'd either kill somebody or sleep with them"* **(Black homosexual male 9).**

*"If you sleep around or if you are drunk one day and you come home with someone and you don't have a condom or anything like that and you just have a one night stand then that is quite careless and you might end up being HIV positive"* **(Black heterosexual female 2).**

A direct link is sometimes made between 'irresponsibility' and moral qualities:

*"A drug user doesn't have to be like a really hard heroine addict or anything like that. I think you know, it [AIDS] just comes from a fairly easy attitude really, a lax attitude, like a lot of my friends who are very morally casual as such. So, I think being, thinking like that then you can put yourself into a higher risk band. It just depends.*
***Interviewer:** What does morally casual mean to you? What are the consequences of that?*
***Respondent:** Well, morally casual I think just means not thinking about things you're doing, you are not taking into account the consequences of actions or events that may crop up within the future which can apply to any number of circumstances"* **(White heterosexual male 8).**

The notion of responsibility is linked, by certain respondents, to punishment.

- 7/30 respondents view AIDS as a punishment meted out by God: 5 of these respondents are black and 2 white.

- 7/30 respondents view AIDS as a punishment meted out by nature: 6 of these respondents are black and 1 white.
- 4/30 respondents, all of whom are black, view AIDS as both a punishment meted out by God and by nature.

There are no significant colour, gender, sexual orientation or religious differences concerning mentioning either God's or nature's punishment. However, it is only blacks who mention both types of punishment.

While God or nature are seen as the agents or cause of AIDS, human behaviour elicits the responses from God or nature:

> *"They [Westerners] always putting God to the test...God says don't test him, right, and for someone to put God to the test it is going to go wrong somewhere along the line. It is nothing to do with God. It is man. It is man's fault that we have got this disease so we shouldn't go and blame it onto God"* **(Black heterosexual male 3).**

The arguments in relation to the punishment of God and of nature are extremely similar. The social representation of God's punishment is linked to two strands of thinking: Western people are punished for the excesses of modern living; Western people and, more specifically, homosexuals are punished for their abuse of sexuality.

The excesses of modern living are vividly sketched by a number of black respondents:

> *"He [God] only gave us [AIDS] now because he sees that man is too materialistic, so he is always finding out new things. So AIDS is like a thing to slow him down"***(Black heterosexual male 3).**

This respondent goes on to express the fact that it is the behaviour of certain races which, in fact, is responsible for God's acts:

*"But is it not God who gave it to us but man himself. And the only man that is doing that is the West because they are moving faster than all the other races. The white man is moving faster than all the other races. That means that he is the leader of the pace, he is the pace-maker"*

*"I believe in some sort of punishment, you know. Somewhere in the bible it says that there is going to be a day when something comes down here and it is going to destroy all of us. And I believe this [AIDS] is it, you know. Because man thinks he's clever but at the end of the day he's going to cause self-destruction to himself"* **(Black heterosexual male 4).**

The idea that certain people are 'abusing sex' is an interesting appropriation of the idea of sexual abuse. This abuse involves failing to use sex for the purpose it was intended - procreation:

*"Lesbians. Well they break all the rules about sex, you see.*
***Interviewer:** And what are the rules that you're thinking of?*
***Respondent:** I think the rules, I think sex is a pleasure thing. And I don't think you should abuse it, you know. I mean once you get started abusing you get things like AIDS, and you can't stop it because it's spreading fast, you know...I believe in some parts of the Bible and some things I don't believe in. Well, that's the way it's meant to be, you know? Have you ever seen two men making a baby?...Once you start to abuse sex its going to backfire on you* **(Black heterosexual male 4).**

This 'abuse' is linked not only to superseding God's rules but also to a form of excess which is often, though not always, associated with homosexuality:

*"Going back to the gays again, not that I think it is a gay disease, just before the AIDS thing came about, if you noticed, lots of gays were coming out and it was very fashionable to be gay, and in the Bible it says it's wrong and everything, so maybe there is something in that as well, I don't know. Not just gays, but everything sexual and that way. Everyone is going a bit mad I think"* **(Black heterosexual female 6).**

The social representation of AIDS as nature's punishment of humans treats AIDS as a 'natural' rectifier of violations of the natural order. It is within these representations that we find excellent examples of statements which confound the idea that

homosexuals spread AIDS with the idea that their acts cause or 'generate' AIDS:

> *"I just think the germs. You know it is not meant for a man and a man to be together so there is probably something there not right. Like as in a woman and a man. It is just something there that doesn't click, so you get this disease [AIDS], these germs...I am thinking more biologically. Biologically there is nothing, there is something in a man that doesn't click with something in another man and that it wasn't meant to be, it was meant to be with a woman...If it is biological, every man is going to be roughly the same. I don't think of it as different [in different parts of the world]. Because I suppose the same, it is going to be the same, it doesn't matter where you are"* **(Black heterosexual female 2).**

Homosexuals are not the only group accused of violating the natural order. Westerners, with their 'fast living', according to black respondents, breach the natural order too:

> *"The West, they got all sorts of sexual activities - talking about America, Europe, Russia and so on. They have got homosexuals, they have got bisexuals, heterosexuals and they have got people who are sick enough to go and like mate with animals and so on. So to me, because they are always experimenting, they are always trying to find out. This and that, this and that, they always trying to find out what it could do to them. So they are always experimenting with each other, other things, other creatures, other objects whatever. So if you do that all the time you are bound to get something wrong at that line. To me that is how it is"* **(Black homosexual male 3).**

AIDS is nature's message to Westerners. It tells them that they should be moral:

> *"Western people, and Western technology has made Western people quite arrogant, they think they can preserve themselves infinitely, that, you know you can have firm breasts when you're sixty, you can have smooth skin when you're sixty as long as you have the money to pay someone to take all of your excess baggage away. It's a law of nature that everything dies. I am not a religious person, but that is a basic pagan, you know that is basic to the human existence, that you die. And to a certain extent, the sooner you accept that the better"* **(Black heterosexual female 9).**

The consequences which befall people tend to be viewed as controllable. Contracting AIDS is related to choice. Responsibility tends to lie with the human 'victims' of AIDS rather than with a virus or with conditions which facilitate the entry of the virus

into people's systems.

**Counter-representations**

While most respondents view homosexuality and 'fast living' as unnatural, one respondent views pre-marital sex as 'unnatural' and links it with AIDS:

> *"To make it acceptable to society for a young girl to, you know, be on the pill...I don't think it's right, I don't think it's meant to be"* **(White heterosexual female 7).**

A small number of respondents (5/30) counter the notion of individual responsibility by alluding to situational determinants of AIDS. Four out of these five are from marginalised groups (2 black homosexuals; 1 white homosexual; 1 black heterosexual):

> *"I thought that it probably was spread from within the gay community faster because there was more promiscuity at the time because of the repression"* **(White heterosexual male 1).**

> *"I do agree that it started in the gay community but that doesn't necessarily mean that it is the fault of the gay and the drug using communities...I think a lot of gay issues relate to that, the fact that because there is so much discrimination against gay people, maybe they are more unlikely to have, because of the shame or the guilt they are more likely to have maybe casual sex, or anonymous sex I don't think you can blame them for spreading it, for causing it, and then just cut them off and turn them away"* **(White homosexual male 2).**

This respondent directly challenges the notion of 'you are to blame for the consequences which befall you':

> *"From my family two have died from AIDS and the other two are HIV positive, and that is 5 out of 15 , and I think like the fact that there is a lot of background things as well, or other things that affect the issues of how people end up in certain situations, or that they do not always have the power themselves to do what allows them to deal with these situations. There are a lot of things that affect your culture, your whole way of life, the kind of class you are born into. All those kind of things will affect how you turn out and how you react to things and how you deal with things"* **(White homosexual male 2).**

Another respondent views situational factors in both Africa and Ireland as responsible for AIDS:

> *"Big problem in Africa, because of their, because of health-care and that type of thing. But it's also like someone was talking to me from Ireland, this guy who I know is gay there, who said that contraception is difficult to get, it's killing a lot of people in Ireland, I mean, different situations, I mean, have added to it"* **(Black homosexual male 8).**

PROCESS ELEMENTS

**Anchoring**

AIDS is anchored to the notion of morality or punishment by 6/30 respondents (3 black and 3 white). A respondent recalls what he first heard about AIDS:

> *"Thinking or hearing that it's this real dirty disease, it like serves the gay people right cos they brought it upon themselves. And that was the first thought I had of it...The term I heard was that they had built their own cesspit and it was sort of God's punishment cos homosexuality is abnormal and shouldn't be, and this is God's way of punishing them. And that was how I heard about it and that was what I associated AIDS with.*
> ***Interviewer:*** *The cesspit idea. What sort of things do you mean more specifically?*
> ***Respondent:*** *Basically they were saying they had built their own destiny. They were saying if you indulge in these things in the end you are going to end up dying of AIDS. This is your punishment in a sense"* **(Black heterosexual female 1).**

**Objectification**

The concept 'safer sex' and, more specifically, the condom, serve as symbols of responsibility. By way of the corollary, 'unsafe sex' and non-condom use serve as symbols of an irresponsible, blameworthy attitude.

The notion of 'promiscuity' forms a distinctive objectification of the fast living, fast

turnover of partners, trespassing of limits, free and easy life, and breaking from traditionalism which leads to God's or to nature's punishment. 15/30 respondents link AIDS to excess, usually to promiscuity, at some point in the interview:

> *"There is an almost religious feeling: Somebody is up there thinking 'you haven't been promiscuous, I'll let you off, you are a nice guy"* **(White homosexual male 4).**

> *"So I think it is sort of to do with God. It's not a punishment. It's just a message...'look people down here, you're going a bit crazy, now slow down'.*
> ***Interviewer:** Going a bit crazy meaning?*
> ***Respondent:** Too promiscuous and you're getting a bit far now"* **(Black heterosexual female 6).**

**Reflexivity**

There is awareness of a tension between the two facets of individualism: the emphasis which it places on 'free choice' as well as the constraints which it places on behaviour, imploring people to take responsibility for their own lives:

> *"We know now that it's body fluids. We know, and we know how those body fluids can exchange, we're aware of the precautions we need to take, but for whatever reasons there are still some people and there are, as long as we're breathing on this planet I am sure there will always be, and I am not being cynical, people who will be prepared to take risks. But that again is an individual choice"* **(White homosexual male 6).**

> *"I'm sure it's like a fairly like controllable disease really, in time, just that it's like got more implications for personal liberty, isn't it really. Because it's like a sexually transmitted disease then you can only like regulate it by regulating people's sexual activity which is something which sort of can fit with liberty really, personal liberty. Or whatever to interfere in that"* **(White heterosexual male 10).**

Homosexuals tend to believe that people who contracted HIV before there was widespread knowledge concerning HIV/AIDS should not be blamed. Those who

contracted it when the community was already 'in the know' are blameworthy. This may be linked to an awareness of the arguments expounded by theorists who have a wide readership within the homosexual community, such as Watney (1988a), whose argument I discussed in Chapter Two.

Certain homosexual respondents were highly attuned to the effects of the representation of AIDS as punishment - especially in terms of early ideas about AIDS:

> *"[AIDS] was gay, was dirty, was disgusting, was punishment, all those things basically, isolation, all the negative things you'd associate with stereotypes and prejudices were attached to this immediately before anybody knew anything really about it"* **(Black homosexual male 9).**

**Defensiveness**

Despite the powerful emphasis upon personal responsibility, it tends to be 'the other' rather than 'the self' who has the possibility of contracting (and, consequently, of spreading or 'causing') HIV/AIDS. Over two thirds of the sample (18/26) (excluding those with HIV/AIDS) believe that their own chances of contracting HIV are below average:

- 8/10 white heterosexuals feel that their chance of contracting HIV is below average. Reasons for minimal risk range from low partner numbers to the 'quality' of one's partners, to non-drug-taking partners, to condom use. The notion of the 'quality' of the partners is most typically expressed:

  *"I think when you meet someone you like you often think they are too nice to have a disease. Maybe it's a mental thing. You can't believe that somebody like that could do"* **(White heterosexual male 3).**

  The 2/10 white heterosexuals who feel that they are of above average risk relate this to the fact that heterosexuals are a high risk group.

• 5/10 of the black heterosexuals believe they are at below average risk. The prime reasons given are low partner numbers and the 'quality' of partners. The notion of the 'quality' of the partners is most typically expressed:

*"Now I am more aware of who I sleep with. I have to find out who they are and who they been sleeping with"* **(Black heterosexual male 3).**

3/10 of the black heterosexuals believe that they are above average in terms of risk because they know that the AIDS statistics contain heterosexuals such as themselves.

• Of the 6 homosexuals without HIV, 5 state that their risk is below average. This is attributed either to condom use or to not having anal sex.

The division between 'good' and 'bad', which is characteristic of the earliest developmental phase of the infant (see Chapter Three), comes to light in the social representations of responsibility and punishment. In order to gain a sense of mastery and of control, the world needs to be split into good and bad individuals or groups. 'Badness' is punishable.

**Self-presentation**

Black people seem far less inhibited in terms of differentiating between the 'innocent' and the 'guilty' in the AIDS scene. By contrast, white accounts are more subtle. This is linked to the greater reflexivity of the white respondents.

POWER ELEMENTS

Certain groups are innocent and others guilty, not only in relation to contracting and spreading, but also in 'causing' AIDS. This has consequences for the blamed parties.

While it might cause them to project the problem onto another source, it can result in introjection of the blame. The issue of 'spoiled identity' overlaps with the section on power elements under the 'social representation of out-group responsibility'.

Three homosexual respondents adhere to the notion of 'AIDS as God's punishment'. The quality of their responses indicates an internalisation or introjection of the blame which is cast onto them:

> *"I had a test in January, and I sort of psyched myself, and I had a test and I was negative, thank God, and I put it down to, it's not that God was fair, he just didn't want me basically, just didn't want to know. He like, you know, 'there's no room for this one here'"* **(Black homosexual male 9).**

> *"On some unconscious level the sort of idea of AIDS being punishment for gay people might have permeated my brain"* **(White homosexual male 10).**

Two homosexual respondents adhere to the notion of AIDS as 'nature's punishment' of, in the case of one, anal sex and in the case of the other, homosexuality:

> *"I find it [anal sex] a bit unnatural, I do, and I'm gay, I mean, but I think it's foul. I mean, other people do it and they enjoy it, you know what I mean, I find it painful and for me I just couldn't, I just couldn't enjoy that, I mean, no. It's not for me, I mean, and I'm glad...I mean, it's just not meant to happen... I can't separate myself from the fact that that is why - no, that isn't why any of us, you known what I mean, that is not my fuck piece, no it's not, I don't see it that way, you know what I mean, I don't see that as some part of my genitals where it's like sexually arousing for me"* **(Black homosexual male 8).**

> *"I am gay myself, but gay people are so damned disgusting. Um, you've got, I mean, let's not beat about the bush here... the element is so strong whereby now we are living in an age whereby a man will approach a man in broad daylight. I get approached in broad daylight, you know, and in public places and stuff like that. And it's um, it's just there's a lot of parks and, there's a lot of sort of underground sexual activity going on, clubs, pick-ups, buses, I have been chatted up in the worst of places, you know. I have been in the most unpredictable situations*

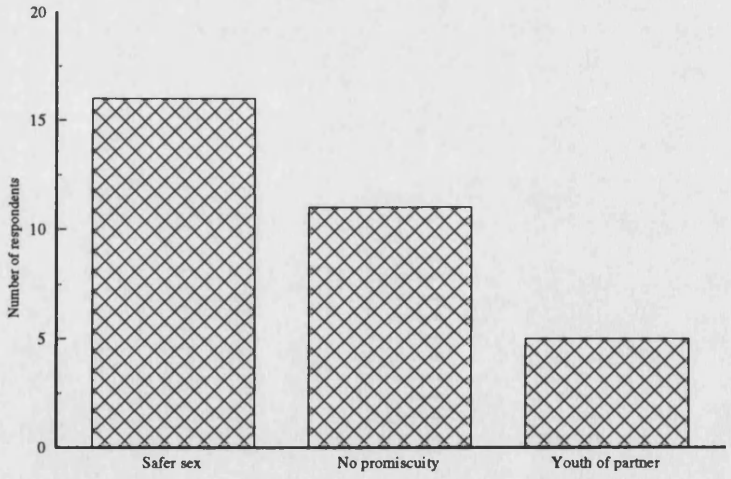
*personally, there's a lot of deviant behaviour going on and that's, I'm not saying it's wrong, but I, it's certainly deviant, you know"* (**Black homosexual male 9**).

The idea that nature rectifies what was not 'meant to be' bears out the ideological function of the social representation of punishment.

## 'FIT' WITH THE SOCIAL CONTEXT

The notion of human agency or choice which manifests itself in the interviews corresponds to the message conveyed by the Government campaigns and by policy-makers. A central message, which runs throughout the five phases of the campaign, is that individuals must take responsibility for their own actions - in terms of partner numbers or of having safer sex. This corresponds to the ways in which lay thinkers feel they can protect themselves against HIV/AIDS, as illustrated in Figure 9.

Figure 9. Protection against HIV/AIDS: Britain.



Once the British Government had decided that the general public needed to be informed about AIDS, substantial funding was set aside to develop the campaign. It has successfully placed issues which it deems important - safer sex and non-promiscuity - onto lay people's agendas. The vast majority (23/30) of the respondents spontaneously mention the campaigns, or material which directly reflects the wording of campaigns, in their interviews. Respondents recall the wording of the campaigns accurately:

> *"Probably started off with the posters or, remember, they had those big posters 'AIDS don't die of ignorance'"* **(White heterosexual female 1).**
>
> *"AIDS don't discriminate. AIDS kills"* **(Black heterosexual male 5).**
>
> *"I go up around Charing Cross and around Tottenham Court Road and lots of places like that all the time. They've got these great big bill sticker things, these great big billboards with this black gravestone on it saying 'AIDS kills'. So wherever you look you're going to see it"* **(White heterosexual female 4).**

It is a testimony to anchoring (as well as to primacy effects) that respondents, in 1991, still report seeing billboards which, in fact, only appeared in 1986.

In talking about the campaigns, certain themes recur: that the campaign targets young people; that there has been a shift from targeting risk groups to the targeting of everyone; that the early campaigns were drug-related; that behaviour rather than group affiliation determines whether one gets HIV/AIDS. A respondent offers an historical account of the campaign:

> *"I suppose it would be early 80's mid 80's when there was a lot of hype and there was the iceberg commercials and stuff, probably just prior to that, just by media coverage.*
> ***Interviewer:** And what sort of things do you remember, you know, the iceberg, what sort of ideas did that put across to you?*
> ***Respondent:** I thought, I got the impression it was very, it was a youth orientated campaign mostly to young people and that there was an*

> *emphasis on homosexuality initially, I felt, I don't think that is so much now, which is fair enough, because I don't think it's a homosexual disease anyway. But it was all about, there was a lot of emphasis on contraception specially, it was all, everything was about condoms more than directed actually at the virus"* **(White heterosexual male 9).**

This account is remarkable in that it maps closely onto the debates which existed in the social context.

Government campaigns may well have brought AIDS onto the agenda of many respondents. When asked how they first heard of AIDS, 23/30 respondents mention the media:

- 9 respondents mention the media as a blanket category.
- A further 9 mention television specifically.
- A further 5 mention newspapers, magazines or posters.

Only 7/30 mention non-media sources (ie. friends, parents and school).

When asked when they first heard of AIDS, the majority of the heterosexuals heard between 1985 and 1987, the years when the Government campaigns began. Homosexual respondents tended to hear before this. One cannot, however, separate out whether events reported in the mass media as a whole, between 1985 and 1987 (eg. Rock Hudson's death), or the campaigns themselves, brought AIDS onto the agenda of the heterosexuals.

While lay ideas tend to correspond with the textual message of the campaign analysed in the previous chapter, lay thinkers also impose their own mind-set on messages conveyed by the campaign:

> *"The one that really got me is the one that um, it's about a girl who caught AIDS from her partner who went on holiday and had sex with someone else who had sex with someone else passed down the line and she's got AIDS and she's innocent. That's why I'm frightened of it. I could catch AIDS for something that wasn't my fault"* **(Black heterosexual male 5).**

It is no coincidence that the respondent recalls that the partner of the "innocent" PWA contracted HIV on holiday. People are suggestible to the fact that illness comes from outside the 'self'. The notion of AIDS as punishment was never conveyed in the campaigns. The respondent quoted above alludes to a campaign which appeared in Phase V. The campaign intended to show that 'real' heterosexual people get AIDS. The respondent interpreted it in terms of "fault". It is in this account that we see that individual responsibility easily translates into punishment and blame. The slogans have consequences for the process of blame: 'Don't aid AIDS'; 'Don't die of ignorance'; 'AIDS. You know the risks, the decision is yours'; 'AIDS. You're as safe as you want to be'; 'Choose safer sex'.

## B. THE SOCIAL REPRESENTATION OF OUT-GROUP RESPONSIBILITY

### DESCRIPTIVE ELEMENTS

**Consensual representations**

The most forceful trend in the data is to view the 'other' or 'out-group' as responsible for the origin, spread and 'cause' of AIDS. The 'other', rather than the 'self', is blameworthy.

## ORIGIN OF HIV/AIDS

The majority of the sample (26/30) view the origin of AIDS in terms of a continent.

- 85% of this group (11/14 whites and 11/12 blacks) imagine that AIDS originated on a continent other than the one with which they identify; 15% of this group (3/14 whites and 1/12 blacks) imagine that AIDS originated on a continent with which they identify.
- The 11 whites imagine that it originated in Africa; 3 imagine that it originated in America.
- The 11 blacks imagine that it originated in America or 'The West'; 1 imagines that it originated in Africa. This data is presented in Table 3.

One gains an impression of which country respondents identify with through their discussion of practices in that country. This can be illustrated by a response of a black respondent:

> *"And when I talk about the Tropics I just want to clarify something: that wasn't in my or other people's mind the main focus. It was America that was dangerous. Even when Africa as a source began to come up, people weren't saying 'we'll avoid Africans', black people. It just never occurred"* **(Black homosexual male 3)**.

I have made the assumption that whites identify with Western countries and the blacks, most of whom are Afro-Caribbean or African, with Africa. There were no direct questions as to which countries respondents identify with. This issue is further discussed in Chapter 10.

Table 3. Where did HIV/AIDS originate? (British responses)

| | AIDS ORIGINATED ON CONTINENT OTHER THAN THE ONE WITH WHICH IDENTIFY * | AIDS ORIGINATED ON CONTINENT WITH WHICH IDENTIFY |
|---|---|---|
| WHITES | 11 (79%) | 3 (21%) |
| BLACKS | 11 (92%) | 1 (8%) |

* This table includes only those respondents who answered the question above in terms of specific CONTINENTS (14 out of the 16 whites in the sample; 12 out of the 14 blacks in the sample).

The tendency to believe that AIDS originated with the 'other' is not significantly different when comparing whites and blacks (Fisher's Exact:p=0.6, two-tailed). Both groups believe that AIDS originated with the 'other' (for both groups, Binomial:$p<0.05$, two-tailed).

The analysis above takes into account only the first response of the respondent to the question above. Four respondents (2 black and 2 white) mention a further continent of origin later in the interview but this was excluded in terms of fulfilling the conditions of the appropriate statistical test. In rhetorical terms this is important. Respondents fluctuate between casting AIDS onto the other and connecting it to continents with which they identify.

## GROUP WORST AFFECTED BY AIDS IN BRITAIN

- Two thirds of the sample (20/30) believe that homosexuals are worst affected by AIDS in Britain (see Table 4).

Heterosexuals are significantly less likely to believe that their own group is worst

affected by AIDS (Fisher exact:$p<0.01$, two-tailed). Both heterosexuals and homosexuals see homosexuals as worst affected by AIDS.

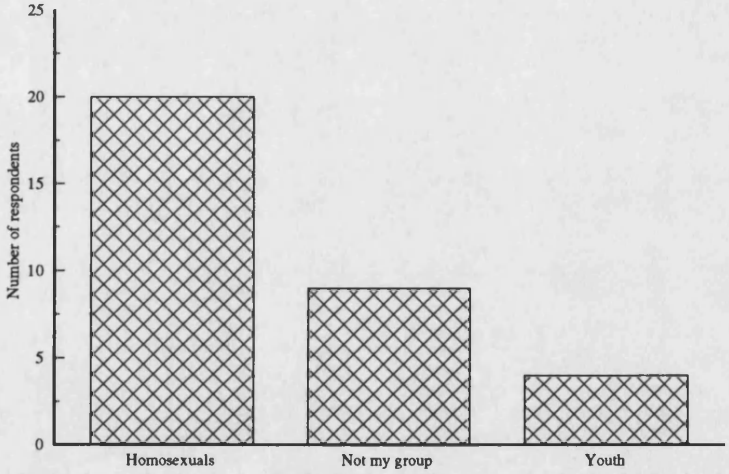
Table 4. Which group is worst affected by AIDS in Britain?

| | OTHER GROUP IS WORST AFFECTED BY AIDS * | OWN GROUP IS WORST AFFECTED BY AIDS |
|---|---|---|
| HETEROSEXUALS | 12 (92%) | 1 (8%) |
| HOMOSEXUALS | 1 (11%) | 8 (89%) |

* This table includes only those respondents who answered the question above in terms of sexual orientation (13 out of the 16 heterosexuals in the sample; 9 out of the 10 homosexuals in the sample).

British respondents tend to answer the question 'Which group is worst affected by AIDS in Britain?' in terms of sexual orientation. They interpret the concept 'group' in terms of sexual orientation. Other responses are illustrated below (Figure 10).

Figure 10. Responses concerning group worst affected by AIDS in Britain.

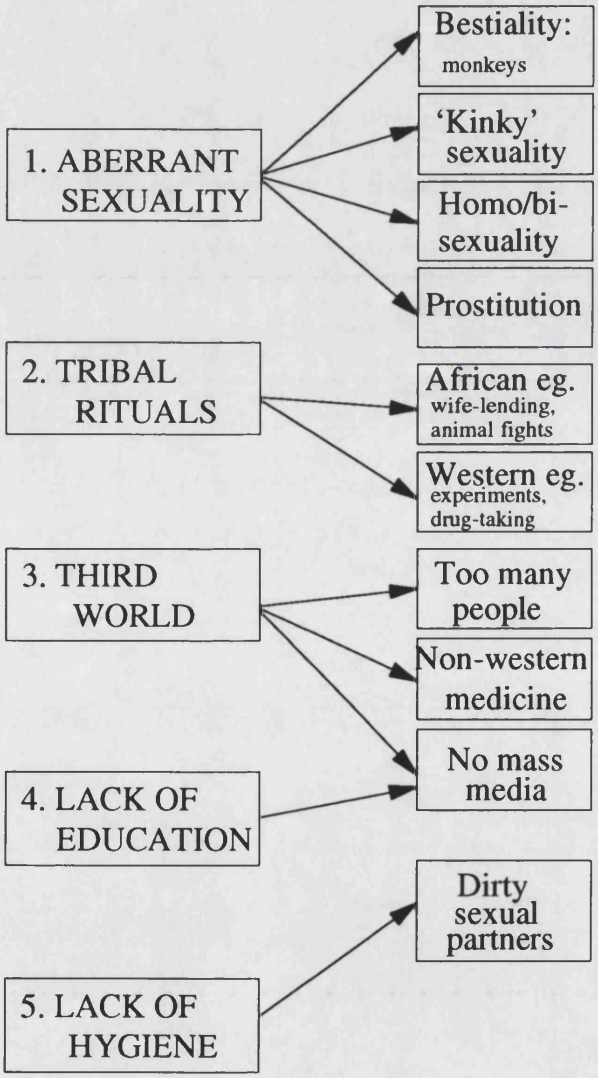


## 'CAUSES' OF HIV/AIDS: SIN COCKTAILS

• Over a third of the sample (11/30) held an intricate set of fantasies concerning the way in which the 'out-group' became infected with HIV/AIDS.

This portion of the sample believe that at least two, of the following five factors, are involved in the origins of AIDS:

Figure 11. British sin cocktails: Fantasies concerning the origin of AIDS



21/30 adhere to at least one of the five factors. White respondents tend to imagine that these practices occur in the under-developed world. They often shift between allusions to different parts of the 'third world', such as 'Africa' and Thailand, as though they are interchangeable. Black respondents, on the other hand, are more likely to associate these practices with Western living. I will present a case study of one white heterosexual's and one black heterosexual's sin cocktail. Each represents a typical line of thinking.

A white respondent (**heterosexual male 3**) says of the origin of AIDS:

> *"Monkeys in Africa. I think that was what I heard and that was passed through god knows what to get through. I've heard some extreme stories about how it reached our shore [much laughter]. Which I care not to utter.*
> ***Interviewer:** I would actually be quite interested to hear because the next question is how it reached our shores. Can you go into it even if it feels difficult.*
> ***Respondent:** It was just meant to be bestiality I suppose.*
> ***Interviewer:** Where? Who?*
> ***Respondent:** I can't imagine, I wouldn't know to tell you the truth. I could probably imagine it would be something like in their tribe in Africa would probably be more prone to that sort of thing".*

This respondent associates the transmission of HIV/AIDS with the interaction of 'Third World tribes' and Westerners:

> *"You could probably catch it through a fight, man had a fight with a monkey that had it in its blood. And then from sex. There is no way of knowing what is what. Not that there is a way of stopping AIDS anyway, if somebody had swopped blood it could easily pass especially in the Third World tribes. If I was to guess that would be it...If a man caught it and he had sex with his wife and someone came along, I don't know how these tribes work so I don't know the moral judgement you place on them. Someone could come along and pay some money and have sex with his wife and then he could take it back to his country and give it to his wife".*

The 'tribes' who are responsible for contracting HIV/AIDS originally, are assumed to

live in close proximity to the animal world: The men in these tribes have physical fights with monkeys. In addition to their greater proximity to the animal kingdom, it is implied that these 'tribes' adhere to a different morality to that of Westerners. Included among these 'tribal peoples' are both Africans and Thais:

> *"I think a lot of people go to Thailand, places like that, specially up until lately. The Thais declared an AIDS free zone, they dismissed it as not even existing in the country. So people caught it a lot that way".*

Finally, there is an inevitability about the destruction which AIDS will effect on these 'tribes'. This is related both to their lack of medical care and their lack of understanding of health issues:

> *"I should imagine it is pretty bad in Africa. If it started there, there is no way of stopping it. No medicine. I can imagine it would be pretty terrible actually. I expect a lot of those countries [Third World] will be wiped out. They just don't understand that sort of thing".*

Thailand, Brazil, Haiti and 'Africa' are designated as 'Third World'. There is often an allusion to prostitution within these places.

Very few respondents talk about transmission of a virus. It is as if the practices involved in the sin cocktail generate or cause AIDS in themselves.

A black respondent's account (**heterosexual male 3**) mirrors that of the white respondent quoted above. While each fantasises in terms of a number of common practices, the place and people who participate in these practices have opposite group identities:

> *"The West, they got all sorts of sexual activities - talking about America, Europe, Russia and so on. They have got homosexuals, they have got bisexuals, heterosexuals and they have got people who are sick enough to go and like mate with animals and so on. So to me, because they are always experimenting, they are always trying to find out. This and that,*

*this and that, they always trying to find out what it could do to them. So they are always experimenting with each other, other things, other creatures, other objects whatever. So if you do that all the time you are bound to get something wrong at that line".*

The origin of AIDS, for this respondent, rests with the sexual experimentation of Westerners. This includes bestiality, homosexuality, bisexuality and heterosexuality. 'Sexual experimentation' is a subset of his 'experimentation' category:

*"It is just like they are always experimenting. That film that I watched, First Born, and they tried to inter-breed a gorilla with a human being and they are always doing them kind of thing and to me that is sick, so along that line, it must have went wrong and that disease appeared, because no-knew about it before that".*

This respondent reiterates the 'sick' or perverse nature of Western society. He is suggestible to ideas conveyed by a Western film, imagining that they map onto rituals within Western society. Finally, his account of the place of origin of AIDS is diametrically opposed to that of many whites:

*"If you read the history of Africa, the slave history, and like how the Europeans used to colonise all the Africans and all the other countries, the poorer countries at this day and age, every time they went to a country they bought a disease with them. Like for instance American Indians, they died out because of the white man, because the white man bought diseases, he slaughtered American Indians, he robbed them from their land, he robbed them from all their belongings and so on and the same time he gave them diseases, all different diseases that they never encountered, that they never came across before. So to me looking at it that way the main problem, there is no way you can get AIDS in Africa because Africa, to me, is the only country, at the moment, who is not Westernised enough to create new problems".*

'Westernised' is equated with an ability to experiment and to be creative. This 'creativity' includes the creation of 'new problems' such as AIDS.

While Figure 11 speaks for itself, one theme requires further elaboration because it is not commonly appreciated in Western thinking. Many black respondents (7/14)

imagine that aberrant sexuality is present in the West but absent from black culture:

> *"You think, well gays are whites. I mean I don't now, I haven't for ages, but I'm saying, when it was brought up, you know, you didn't hear about black gays in those days, in the 70s and all that, so, I don't know, I think it was just the way we all think, or were brought up, but obviously now we know. 'Cos...in the media, over here, most gays and stuff are white, you know, Quentin Crisp and people like that...White people are more kinkier...that's the impression I got, I'm not saying, this isn't me, this is what I hear...(laughing) yeah, it's just what you hear, that they do anything...English people, that they do anything, stuff like that, anal sex...It's just the stereotypes of what you grow up with that I was talking about basically. And like porno films and that stuff you know. Then again, I don't really watch porno films"* **(Black heterosexual female 6).**

> *"More people in the white community would have it [AIDS].*
> ***Interviewer:** Why do you think that? What has made you think in that sort of direction?*
> ***Respondent:** I don't know, it's just the way I've been trained I suppose. Because they tend to do more, I don't know, their sexuality to me seems more like perverse or whatever, they are more likely to do different things...like homosexuality, for example. In the black community I know it exists, but there is a real stigma attached to it, it's really shameful...It's like men are really men and women are really women...You don't try different things like wearing leather or things like that. It's just more natural, just more basic. Let's say the Parfumo affair where you get examples of MPs having loads of different mistresses, etcetera, it just seems, people like Cecil Parkinson having sex with their secretary, the slightly stereotypical versions, people chasing around offices and stuff like that, it just wouldn't happen with us. That's probably because we don't work in offices, we don't have that position of power. It just seems that people with power tend to be sexually a-typical, untypical relationships. Like dirty old men, that sort of picture, like judges or something, making women dress up in school uniforms"* **(Black heterosexual male 8).**

> *"Winston Churchill's father died of syphilis. They might not tell you things like that"* **(Black heterosexual female 9).**

The structure of the black and white sin cocktails are remarkably similar. The sin cocktail tends to occur among those whom one constitutes as 'other'. Principally, the 'other' practises strange rituals (eg. wife lending, fighting with animals, drug taking,

laboratory experimentation) and has an aberrant sexuality (eg. homosexuality, bestiality, 'kinky' sex, prostitution).

**Counter-representations**

This is addressed in the section 'reflexivity' below.

PROCESS ELEMENTS

**Anchoring**

An astounding 25/30 respondents initially anchored AIDS to the notion of a 'gay plague'. This is obviously not only an anchor for the social representation of punishment, but also for the linking of an out-group to this punishment. The notion of plague is likened to leprosy, to a 'gay cancer' and to Karposi Sarcoma. Images of the black death are recalled:

> *"With AIDS at first I thought if you catch AIDS that is it, you deteriorate straight away. You start dying straight away. It would only take you a couple of weeks, a couple of months at the most and you just start getting weaker and weaker. Just like a flower when it withers* **(Black heterosexual male 3)**.

The seed of the social representation which links homosexuality to AIDS reappears in terms of lifestyles which are responsible for the spread of AIDS in the here and now:

- 6/30 respondents posit a link between homosexuality and the spread of AIDS: 5 of these respondents are homosexual.
- These respondents blame homosexual abandonment of safer sex, homosexual promiscuity, 'cottaging' and the club scene for the spread of AIDS.

**Objectification**

- 2/30 respondents see the suburb of Earls Court as a symbol of AIDS.

Earls Court forms an objectification of a combination of unconventional homosexuality and prostitution, for homosexuals:

> *"And there were ideas before AIDS came along of back-room clones sleeping with white Americans in back-rooms in Earls Court and spreading Gonorrhoea around...People said and the anecdotal turned out as truth, that they were hardest hit [by AIDS] because Earls Court was known as London's gay capital and people came from abroad, particularly America, and fun was had by all"* **(Black homosexual male 3).**

While the 'Third World' is the seat of the sin cocktail for the whites, and the West the seat of the sin cocktail for the blacks, there is also a common objectification of AIDS: America. 4/30 respondents link the 'American lifestyle' and AIDS. America stands for: *"A sexual playground...open and free", a "sexual paradise...you could walk into a club and ten men would rip your clothes off", "carefree...a lot more easy-going".*

**Reflexivity**

- 3/30 respondents reject the notion of origin.

They use the word 'blame' in response to the question, 'Where did AIDS originate?':

> *"I find that quite worrying actually because I think it can lead very much to blaming people...the whole idea behind it, the whole idea that it comes from Africa, the gay thing, breeds homophobia, the African thing breeds a lot of nationalism and a lot of racism as well"* **(White heterosexual female 6).**

> *"Most of the source theories seem to be about blame...I suppose like past sexually transmitted diseases, epidemics, until there's a cure there's hysteria...I think it's a panic. Racism and I am afraid all sorts of things come flooding in because people can't cope with it in any other way"* **(Black homosexual male 7).**

*"I think it's irrelevant in many ways where it comes from. I think that one of the reasons why some people look where it comes from is to apportion blame"* **(Black homosexual male 3).**

**Defensiveness**

The notion that 'the other' or out-groups are responsible for AIDS is a powerful indicator of defensive thinking. The fact that the practices of these out-groups are linked to perversity and to the exotic indicates that unconscious fantasy material has been evoked at a time when anxiety concerning AIDS is on the increase.

There are a number of concrete indicators of this tendency to defend the self and the in-group against the consequences of AIDS. Firstly, when asked 'Which group is worst affected by AIDS in Britain', a third (9/30) reply 'My group does not have AIDS'. There are no significant colour, gender or sexual orientation differences concerning this view. The notion of 'group' ranges from national group to racial group to age group to educational group:

*"I don't know why, I feel that if I went to America I would think 'oh he's got AIDS', 'he's got AIDS', 'he's got AIDS'. It's stupid, you know, I just feel that way. Whereas over here I don't think that. I am on a train sitting down and you don't think that"* **(Black heterosexual female 6).**

*"It is like word association, isn't it. I think about AIDS I think of drug use, I think of decadent stars, I think of homosexuals. I very rarely think of heterosexuals when I think about it...when I think about it...usually it belongs more to people in the white community...It is just the way I've been trained I suppose. Because they tend to do more, I don't know. Their sexuality seems more like perverse"* **(Black heterosexual male 8).**

*"I thought the girls I would be going out with would be much too young to have AIDS. Do you know what I mean? They would be the age of, I thought AIDS would only get the like sort of older"* **(Black heterosexual male 4).**

*"Being at college I don't suppose there is all that many high risk people. Most of them are likely to be from fairly upper-middle class backgrounds. Lots of people have travelled over the world and most of them are mature students. They're insulated"* **(White heterosexual female 10).**

A further indication of defensiveness is the tendency either to comment that AIDS is not spoken about with ease or to talk about jokes connected with AIDS. 11/30 respondents do this.

*"And jokes about AIDS it becomes part of your childhood, I suppose, part of your memory that is permanently installed.*
***Interviewer:** Can you remember the flavour of the jokes?*
***Respondent:** It's always a disease attached to homosexuals or Africans or whatever. Not respectable middle-class, working-class people"* **(Black heterosexual male 8).**

According to respondents, serious diseases are very difficult to talk about:

*"Some diseases even become a bit of a joke. And you just don't go into it deeply. It's not something you talk about. I think even illnesses like cancer are the same. People are quite into describing their flu for you but they don't really want to talk about cancer or AIDS"* **(White heterosexual female 2).**

*"I wouldn't like consciously talk about it. It is not a very nice thing to talk about...Any death-related subject is not easy to talk about...I don't talk about things like cancer or meningitis or something like that. You just don't do it"* **(White heterosexual male 3).**

Yet respondents feel that young people are far more likely to be comfortable with topics such as AIDS than older generations:

*"I think people are more conscious of it [AIDS] now. Like I mean we don't joke about it. But sometimes people will say, for example, you will offer someone a drink or whatever and say 'I haven't got AIDS or anything'. I think people are talking about it much more. And I think through that, because like my mum's age group, I don't think they would discuss it with all their friends"* **(White heterosexual female 7).**

Homosexuals found talk about AIDS difficult in the early stages of the epidemic. They

feared that talk about AIDS would bring their own sexuality under the spotlight:

> *"I was ashamed because I wasn't open about my sexuality. I didn't want to bring any, I didn't want to get into a sphere where I was talking about something that was related to people being gay. That they had any concoctions where it might actually come up, where I might actually be challenged and it might trap me...I didn't talk about it, I didn't want to know what it was about because I had a stigma attached to it and I was trying to get away from that stigma, that gay stigma"* (**White homosexual male 2**).

There is a lot of laughing and hilarity in talking about the sin cocktails practised by 'the other'. There is also a tendency to distance oneself from the ideas expressed, by saying that they were ideas which one held earlier in one's life or by saying that these ideas belong to those around one rather than to oneself. There is a considerable overlap between the self-presentational and defensive categories. Is the respondent who laughs and casts what he/she sees as unacceptable onto others, being defensive or merely becoming aware of the presence of an interviewer whom he/she imputes with a judgemental mind set? Is this behaviour linked to unconscious or to conscious processes?

**Self-presentation**

A fair amount of probing is necessary to elicit white responses concerning African bestiality. This is indicated in the account of **White heterosexual male 3** on the origin of AIDS (in the section on consensual elements of this social representation). Those areas of discussion with which respondents have difficulty indicate the taboos of the age. There can be little doubt that talking about African rituals is perceived as racist. This taboo discourages easy expression of such ideas. In addition, the whole de-emphasis of the 'gay plague' notion may be part of a similar process, an attempt not to

appear homophobic.

Respondents often present accounts of the origin and spread of AIDS in a tentative fashion. They are prepared to reveal their thinking but do not seem to want the interviewer to view them in a ridiculous light:

> *"Basically it was the monkeys, stuff like that, the monkeys maybe carried it around in the first place. But I mean I'm more open to any suggestions about where it may have come from. I won't say it definitely came from here and it's definitely there because nobody really knows"* **(White heterosexual female 4).**

> *"There are all sorts of theories and I don't know enough, I'm not scientific enough to really understand the development of particular viruses"* **(White heterosexual female 6).**

> *"Someone said it was, someone suggested that it was a chemical disease that has now escaped and become rampant...physical or mental diseases - it's a very difficult concept, isn't it, you know, germ and that type of things"* **(Black homosexual male 8).**

POWER ELEMENTS

- 7/10 homosexual respondents (3 black and 4 white) introject the blame associated with AIDS. Only one heterosexual did this.

Homosexuals are significantly more likely to introject the blame associated with AIDS than are heterosexuals ($\chi^2$=14.4; p<0.05, two-tailed). Homosexuals connect homosexual identity with guilt in relation to AIDS. This guilt is a direct result of the fact that others equate AIDS and homosexuality:

> *"The best thing the media did was get me and my mother to talk about it - she said I know you are gay, I don't like it but I want you to be careful of this disease. She said 'have you got it yet?'"* **(Black homosexual male 3).**

> *"Actually I read in a magazine, a Sunday magazine when it first came over here. That's when I had my first gay relationship, just after that, so*

> *I really thought I had AIDS...I thought 'I'm going to have an AIDS test. And I did. I was only young. I was fifteen...When they showed me the results and said 'Look, it's negative' I still didn't believe it because I felt ill with stress. I was psychologically believing I had the disease...* ***Interviewer:*** *And had you had any sexual experience at that time...?* ***Respondent:*** *No, I didn't, I didn't have any unsafe sex at all"* **(Black homosexual male 4).**

> *"[AIDS has made me] more anxious to have a really good time, while around, and do useful things, and get things done. Because I haven't much time, not just because of AIDS but for all sorts of things that could pop up"* **(Black homosexual male 7).**

It must be pointed out that none of the respondents quoted above have HIV/AIDS. A number of these respondents actually believe that they will get AIDS because they are homosexual rather than because of their behaviour.

A respondent says in relation to the 'gay plague' anchor:

> *"Until I was actually coming out meeting other gay people, I was still pretty prejudiced against gay people"* **(White homosexual male 1).**

Of course such findings overlap with the notion of reflexivity. Respondents can be both self-reflexive and self-blaming. When asked about the group worst affected by AIDS in Britain a homosexual respondent answers:

> *"In my mind it's going to be the gay thing, you know, which I suppose is where all the blame is attached to. But then they've got the statistics to prove it"* **(Black homosexual male 9).**

'FIT' WITH THE SOCIAL CONTEXT

While 25/30 respondents initially anchored AIDS to 'gay plague', only 6/30 associate it with a homosexual lifestyle in the here and now (see Figures 12 & 13). This parallels the attempt, in the social context, to emphasise that AIDS is 'everybody's' illness. In fact, only 1 out of the 6 who associate it with the homosexual lifestyle, is

heterosexual (as described in the section on 'anchoring' above). The campaigns appear to have lured people away from their initial anchor, although other factors, such as a self-presentational strategy, may also explain this finding. The debate in the social context, represented in various campaigns, has constructed an 'everybody is at risk' way of thinking. It is regarded as 'prejudiced' to think otherwise.

Interestingly, drug users remain a socially acceptable target for blame. Drug users featured most prominently as the out-group whose lifestyle is currently responsible for the spread of AIDS: 14/30 respondents connected a drug-using lifestyle to AIDS with 13/30 citing the more behaviourally oriented theme - people not protecting themselves in sexual relationships - as a lifestyle connected to AIDS (see Figure 13). A tension exists between the power of the campaigns in pointing to the importance of behaviour, and people's projection of blame onto specific out-groups.

## C. THE SOCIAL REPRESENTATION OF IN-GROUP POLLUTION

### PART I: INTER-RACIAL SEXUALITY, BISEXUALITY AND TRAVEL BETWEEN COUNTRIES

#### DESCRIPTIVE ELEMENTS

**Consensual representations**

The concept of the 'leakage' of AIDS between groups tends to centre around the notion of sexual orientation.

- 12/30 respondents view bisexuals as the principal vectors in the spread of AIDS. There are no significant gender, colour or sexual orientation differences concerning the mention of bisexuality.

Those who hold this idea believe that AIDS first manifested itself among homosexuals and then spread to heterosexuals by way of the bisexual conduct of some homosexuals. A typical response runs as follows:

> *"It is not only in the gay community. Many people, bisexuals, spread the heterosexual side of it"* (**White heterosexual female 1**).

In addition, the notion of 'leakage' between groups is indicated by the notion of travel:

- 22/30 respondents link travel between their own and other countries to the spread of AIDS.

It is imagined that cross-national sexual activity transmits HIV/AIDS from country to country. The direction of transmission tends to be from foreigners to members of one's own country.

A small number of respondents (4/30) explicitly connect inter-racial sexuality with the spread of AIDS. All 4 are black. The white out-group pollutes blacks with AIDS. A respondent states:

> *"I do think at the back of my mind that people wanted to blame black people here for spreading it around but it doesn't seem to have happened. What has happened is [that] they [blacks] blame a lot of people who slept with white people [for] bringing it into our community"* (**Black homosexual male 3**).

This respondent continually reiterates the fact that the direction of the pollution or 'leakage' is from Westerners to people from the under-developed world:

> *"Nobody took seriously this 'he must be straight from Brazil, I better avoid him'. And I am one of those who didn't think that way. It was an American or somebody who had slept with an American or somebody who had slept with a white man who had travelled to all these places [who spread HIV]".*

PART II: THE POLLUTING EFFECTS OF MODERNITY

- 10/30 respondents connect a modern, urban lifestyle with AIDS. In a similar vein, AIDS is linked, by 6/30 respondents, to man having tampered with the earth by way of technology.

Colour is significantly associated with the polluting effects of the environment ($\chi^2$=4.7; $p<0.05$, two-tailed). Blacks are more likely than whites to believe in the polluting effects of modernity. They connect AIDS with an urban lifestyle, or with the Westerner's desire to tamper with nature.

Many of these responses are linked to the notion of Western experimentation, which will be elaborated upon under 'the social representation of conspiracy'. Modern living is juxtaposed with traditional lifestyles. Modern Western living lacks the boundaries which traditional lifestyles bestow:

> *"White man...is always coming out with a new thing. Like if you look at India, if you look at Africa, all the countries they got their own cultures and so on, and they follow the tradition for centuries, like they don't change it every century. They don't say 'this century we are going to have this that, next century we are going to have this that' and change it. They always follow the same thing, the same pattern all the time. But if you don't follow the same pattern all of the time, you don't know how to live, if you don't know how to survive... that is what is killing us at the moment"* **(Black heterosexual male 3).**

> *"The Asian community, I don't think there's much AIDS there, they're probably less at risk but we don't know.*
> ***Interviewer:** Why were you thinking that there?*
> ***Respondent:** Because of their social structure, there are types, isn't there? I mean you ought to know about that, but then the man could always go and do something and bring it back home so. I would say, the more socially structured, in a way that minimises it"* **(Black heterosexual male 7).**

This lack of structure is related to the breaking of limits, both in terms of social acceptability and in terms of the speed of living:

*"Like, you've got to the limit now, there is nothing more outrageous you can do, you've done everything, you know what I mean, now sort of calm down now people, and sort of take stock of yourselves and see what you're doing...Slow down people, don't be crazy"* **(Black heterosexual female 6).**

There is a tremendous concern with boundaries: Open boundaries are associated with the permissive Western society and closed boundaries with traditional societies. America, in particular, symbolises free and open boundaries. This is discussed under the section below on 'objectification'.

Their lack of structure and of boundaries allows a variety of ills to enter modern society. In the main, it is toxicity (as described in Chapter Four) which characterises such societies:

*"In Europe, everybody's immune system is compromised because the food isn't very good even if you can get it in its natural state. It's not natural, it's been doctored. Let's just say that when I'm not being paranoid, the Western modern way of living compromises the immune system anyway because the body isn't being fed properly in the way it's supposed to be fed. We are exposed to a hell of a lot of chemicals, radiation, fumes and that is just the man-made stuff...Certain physical situations, lifestyle, food, changes in diet, can actually make us more susceptible to the virus, also you know, in the same way that lifestyle and pollution affects us it also affects microbes and they've had to survive and so they have had to mutate in order to put up with the lead and the petrol fumes and the nuclear radiation levels and all that"* **(Black heterosexual female 9).**

The toxic urban space is characterised by its excess. A number of respondents juxtapose their home towns to London, where they now live. London is riddled with disease, while their home towns are havens of health:

*"Having come from Newcastle I thought 'promiscuous' was probably about two partners a week, but he was talking about five or six a night, and having unsafe penetrative intercourse, so that was the, there was quite a big difference between what went on in London [and] what went*

*on in Newcastle* (**White homosexual male 5**).

> *"I'm originally from Birmingham. I mean, there, I am not saying AIDS isn't as widespread, but I only know of one person, I mean that's probably just from the group that I socialise in, I only know one person in Birmingham who's got AIDS, full blown AIDS. I mean, and he used to live in London, and went back to Birmingham...Birmingham and those kind of towns, they're not so commercial, they're not so competitive, they're not so um, London is very anonymous"* (**Black homosexual male 8**).

In addition, AIDS is associated with industrialised Western nations tampering with their environment. The cutting down of trees in the Amazon, the Green-house Effect and pollution of the atmosphere, are cited as examples of the Western exploitation of the environment:

> *"I reckon the main people that are responsible [for AIDS] are the people that are technologising the world. They are bringing technology and everything into it. And the people that are exploiting the earth the most are the Western, the Europeans and they the one who are more vulnerable to diseases"* (**Black heterosexual male 3**).

**Counter-representations**

Not found.

PROCESS ELEMENTS

**Anchoring**

- 12/30 respondents initially anchored AIDS to America.

AIDS was associated with America because of its multifarious social problems: divorce, homosexuality, early age of beginning sex, the need for 'shrinks', its size - which makes it ungovernable, its drug problem. The symbolic elements of this representation are discussed below.

**Objectification**

In addition to symbolising the sin cocktail (established in the 'objectification' of the 'social representation of the out-group responsibility') America symbolises free and open boundaries:

> *"The Americans I have met, they tend to suggest that America is a lot more free and easy, or was a lot more free and easy than perhaps England...They're a lot more open-minded, so if you're brought up to actually, let's say if you're bisexual there's nothing wrong with it. Then you're much more likely to go out and be bisexual"* **(White Homosexual male 1).**

America symbolises overturned boundaries and limits.

In addition, the entertainment figures Rock Hudson and Freddy Mercury, symbolise the leakage between homosexuality and heterosexuality:

- 5/30 respondents mention either one of them or both when talking about AIDS.

They are used as symbols of the concept 'all is not what it seems'. The boundaries between heterosexuality and homosexuality are not as secure as respondents would like them to be.

A further objectification of the issue of the polluting effects of modernity is the Amazon.

- 3/30 respondents allude to the Amazon as a symbol of the West's exploitation of 'nature'. Within these accounts the West is equated with modernity and with pollution, and the Amazon is associated with purity and innocence:

*"They [the West] have tried to blame the environmental problem at the*

*moment, the Green-house Effect, for example South America, the rain forests, the trees. They [the West] are saying that all, that the Brazilians, or whatever, Argentineans, they are cutting down the trees and all that. But what are they cutting it down for? To survive. They are cutting it down for bread and water...They owe the West billions of dollars and the only way they can owe them back is to do those kind of things. So the main problems is the Western people...It is for MacDonalds"* **(Black heterosexual male 3).**

*"Man thinks he's clever, but at the end of the day he's going to cause self-destruction to himself...Environmental issues, things like that, things we do to destroy, you know, the Amazon, you know, Third World. I mean, I mean I swear the Europeans do exploit... and they don't give a shit because it's not theirs"* **(Black heterosexual male 4).**

**Reflexivity**

Not found.

**Defensiveness**

A desire to maintain the purity of 'the self' and of the in-group is evident in statements pertaining to the fact that one's own group does not have AIDS (illustrated in 'the social representations of responsibility and punishment' and of 'out-group responsibility').

**Self-presentation**

Interestingly, a respondent quoted in the section on consensual representations of modernity makes what he sees as an anthropological allusion to the structured nature of the Asian community. One can gauge this by his aside concerning the fact that these issues are a part of the social scientist interviewer's knowledge:

*"I mean you ought to know about that..."* **(Black heterosexual male 7).**

This allusion indicates that the interviewer is always present in the mind of the respondent. The data which are collected reflect this presence.

### POWER ELEMENTS

In a certain way this representation contains less imbalance of power than the other representations which have been described. There is a certain symmetry in terms of groups not wanting other groups to transgress their boundaries.

The vision of modernity as polluting manifests itself predominantly among black respondents. Environmental issues have had tremendous media exposure in past years. Yet blacks are significantly more suggestible to the link between these ideas and AIDS than are whites. The media exposure has tended to suggest that modern, industrialised societies have tampered with their environments. Capitalism has been perceived as a system which pursues consumptive needs at the expense of a respect for the 'natural' world. Black people, with their history of oppression by Western peoples, appear to represent the West as a greedy, exploitative force.

### 'FIT' WITH THE SOCIAL CONTEXT

Section 28 of the Local Government Act of 1988 (described in the previous chapter), legislated in the midst of the AIDS epidemic in Britain, is related to a fear that homosexuality will invade heterosexuality. At the same time, the Kilbracken affair (described in the previous chapter) asserted that there were firm boundaries separating the heterosexual in-group from the AIDS infested out-groups. Both these streams of thought are present in the lay thinkers' social representation of in-group pollution.

## D. THE SOCIAL REPRESENTATION OF CONSPIRACY

### DESCRIPTIVE ELEMENTS

**Consensual representations**

- 14/30 respondents link AIDS to a conspiracy.
- 9 of the 14 are black; 5 of the 14 are whites.
- 1 of the 9 blacks is homosexual; 4 of the 5 whites are homosexual.

Being from a marginalised group (being either black or homosexual) is significantly associated with holding a conspiracy theory of the origin of AIDS ($\chi^2$=4.7; p<.05, two-tailed). Gender and colour are not significantly associated with holding a conspiracy theory of the origin of AIDS.

I have defined, as a conspiracy theory, the idea that an agent intentionally conspired to bring AIDS about. A dominant line of reasoning is that AIDS is connected to Western experimentation:

> *"The West they are always experimenting, they are always finding out new, they are always coming up with theories - if you do this what happens. They are always experimenting. So to me, along that line, they must experiment with something that can develop into AIDS that created the disease AIDS, because AIDS didn't come out of nowhere. Where was it one, two hundred years ago, people weren't dying, it must have come now. It is not more than fifty, sixty years old. It is a very new disease. It is not like the old diseases. So the only way, so the only way it could have come is for someone to make a mistake along the line and create a disease like that"* **(Black heterosexual male 3)**

The intentionality of the act is sometimes a point of debate. As in the account above, certain respondents show doubt in relation to whether the creation of AIDS was a mistake or not. There is also a debate concerning whether its creation was connected to

scientific experimentation or to biological warfare:

> *"There's good chance of it being an experiment...It could be used as a weapon I suppose, it could be used as a weapon, I don't know. The Americans get up to a lot of things, you know? People think they're the most innocent people but they're not, there's a lot of things that goes on behind shut doors. I reckon they could have sort of formed it as a weapon or just a daily experiment, one of the experiments they do there, in laboratories... Yeah, there are the chances that it could have been an experiment of like maybe an animal had this unknown disease or whatever, and they probably took samples of its blood or whatever, could have been a monkey, a chimpanzee, anything you know, and it could have leaked out, it's one of those possibilities, and you know, bit like Chernobyl type of thing"* **(Black heterosexual male 4).**

The notion of experimentation includes certain medical experiments on black people, as well as population control:

> *"I reckon America has got a lot to do with it, a lot more to do with it than we think. I've read about it... in the 1940s where a group of black GI prisoners of war were contaminated with hepatitis or syphilis or what's the name. They were let back into the community just to see. So they gave it to their wives and their children and it seems they used them like guinea pigs really, they didn't tell them that they had it, you see. Now if something like that could of happened, it doesn't surprise me that something like that could of happened as well"***(Black heterosexual male 7).**

> *"I actually think the AIDS virus was sort of invented in a laboratory. I think it was invented years ago probably in the 60s or something, and so now it's got out. I don't know why they did it, they needed it to control the population or something. I think there's antidote as well, but they waiting for a right time to release it"* **(Black heterosexual female 6).**

> *"1960s, they [the Americans] had...these ideas to forcibly put something in water of Third World countries to stop....against the Governments' wishes, to stop them from having babies...they don't want to be swamped. I mean, America is, I mean Europe is getting together - they're tightening up, aren't they? They're saying how they want to keep immigration people out, immigration out...I think we should try to get to the bottom of how it got about, but I just feel about it being manufactured as a population control"* **(Black heterosexual male 7).**

The notion of biological or chemical warfare, often linked to population control, is also spelled out by various respondents:

> *"My own reasoning and history of, you know, America and the way they think. It's to do with....have you heard of ethno-biological...there's these bombs, bombs that only attacked non-Europeans.*
> ***Interviewer:** How did they do that?*
> ***Respondent:** Because of the pigment in non-Europeans...if you phone up the American Embassy now they will tell you it exists, it's no secret"* **(Black heterosexual male 7).**

> *"We occupy one of the richest continents in the world. We don't do much with it in white terms and they would love to get their little grand claws on them...America has a race problem and America is definitely set up for white people so they have a race problem with blacks, hispanics, you know we don't die quite as easily as the indigenous Americans did. We are pretty hard to get rid of. AIDS seems to be doing a good job"* **(Black Heterosexual female 9).**

The notion that AIDS exists in order to rid society of certain groups - usually marginalised groups - is prominent within the conspiracy theories. While black respondents believe that it is targeted at black people, homosexual respondents believe that it is targeted at marginalised groups in general. Such groups range from homeless people to drug users to homosexuals:

> *"The programme said that AIDS was biologically man-made, a man-made disease ordered by the American Senate to rid society of proportions of certain classes and that was very wrong. I thought it was a good theory and explained a lot...Homeless people or people in hostels and things like that or people that are taken into hospital, it could be injected that way and it could be started that way...I think they actually wanted to solve something, they wanted to make both them communities look bad, kind of strike them again, try and completely hammer them back down when they were starting to rise especially I don't think the drug community but the gay community"* **(White homosexual male 2).**

The idea of experimentation and of biological warfare is confounded by fantasies concerning the practices of 'the other', in the laboratory setting:

> *"I think it was a scientific development by the Americans in the Vietnam War. They were trying to make a killer disease to kill all the Vietnamese people and it went wrong, and they was testing it on monkeys, this is what I've been told, they was testing it on monkeys and some like nasty people must have buggered the monkeys and caught it from them"* **(Black heterosexual male 5).**

There is a powerful tendency, throughout all of these accounts, to imagine that someone was in control of AIDS at its inception. 'America' features most prominently as the inventor of AIDS, but its Senate and the CIA also feature.

### Counter-representations

Not found.

## PROCESS ELEMENTS

### Anchoring

Black people have experienced a history of exploitation in terms of slavery and other forms of oppression. I discuss further events under the section on ''fit' with the social context'. In the assimilation of new events, such anchors may be influential.

### Objectification

The notion of 'experimentation' may be seen as a symbol of the Western attempt to tamper with nature, in accordance with self-interest.

### Reflexivity

Many of the conspiracy theories cited above appear paranoid. A number of respondents are aware of this:

> *"I actually went through, in one very paranoid phase, I actually thought it was manufactured in some sort of American laboratory and tested on African people...A sort of retribution that Americans were dying"* (**Black heterosexual female 9**).

This respondent, and others, are not only aware of the fact that their ideas may seem paranoid, they are conscious of the fact that they may appear fantastical:

> *"Although I realise that it is in the realms of my own fantasy, I wouldn't be surprised if there were a ring of truth. It wouldn't shock or horrify me but I do know it's in the realms of fantasy".*

**Defensiveness**

Paranoid thinking is associated with the first stage of the infant's development - the paranoid-schizoid position. This stage is characterised by splitting the objects in the world around one into good and bad, introjecting the good and projecting the bad. America - its Senate and the CIA - may serve as objects onto which the bad may be projected. This allays a sense of anxiety in the person who is projecting, leaving the person with the sense of control for which he/she struggles.

**Self-presentation**

Many respondents begin talking about conspiracy in a rather tentative manner:

> *"I haven't really heard of any other explanations as to where it has come from. So I'm not too sure of what to make of that. That statement wasn't actually backed by any proof as such"* (**Black heterosexual female 1**).

Their accounts then tend to gain momentum, as if the judgemental gaze of the interviewer had disappeared. When they become aware of the interviewer once more, they sometimes become self-conscious, indicating that they know that the ideas which they propose are not fully acceptable. Respondents then reflect that the interviewer

must find their ideas *"bizarre", "mad"* or *"absurd"*.

### POWER ELEMENTS

I have indicated that being from a marginalised group (being black or homosexual) is significantly associated with holding a conspiracy theory in this sample. Groups who feel blamed for AIDS attempt to empower themselves by way of counter-blaming strategies: conspiracy theories.

### 'FIT' WITH THE SOCIAL CONTEXT

There was no allusion to a conspiracy theory of AIDS, either in British policy-debate or in the AIDS campaigns. The appearance of this social representation cautions one against viewing policy decisions and campaigns as the only shapers of lay thinking. The 'social context' in which lay thinkers operate is, in fact, far wider than the two elements which I have chosen for analysis (in the previous chapter). The mass media as a whole, and specifically the mass media which is targeted at homosexual and at black audiences, has considered the possibility of the conspiracy theory of AIDS. The mass media are often drawn on in order to lend credence to the respondents' conspiracy theories. Unfortunately, none of the 14 respondents who linked AIDS to conspiracy could provide me with a direct reference. Respondents mention that the source of their conspiracy theory is the mass media and go on to discuss why it appealed to them:

> *"I have read wee snippets in publications where the CIA have been linked, and let's be realistic here. You know, it could well be, you know, if you want to, if you want to eradicate a species from the world or, or, a minority, or a category from the world, whether it be insects or whatever, you go for the reproductive system, don't you"* **(White homosexual male 6).**

This example illustrates how respondents use the media to give weight to ideas which appeal to them.

It is tempting to think of the conspiracy as an interesting delusion of marginalised people, to reduce it to a fixation at an early stage of development, as I have done in the section on defensiveness (above). Yet when respondents cite examples of past conspiracies, they draw on events which actually occurred. The respondent (black heterosexual 7, in the section on 'consensual representations') who talks about medical experimentation involving blacks in the 1940s, for example, appears to be drawing on the Tuskegee studies which I have discussed in Chapter Four. Conspiracy theories may reflect ideas which circulate in the family and cultural life of black respondents:

> *"In black America, it's big in black gay America, it's a big thing that it [AIDS] was manufactured, sort of um, clinically manufactured and that just sounds so relevant. Because I mean, how does something just pop up all of a sudden? I am not saying listen we didn't do it, okay, but it's not about, it's not sort of allocating blame, it's about come on let's sit down and be rational here, let's forget all the hype and the crap and you know, it's like, I think there is a lot of truth in that"* **(Black homosexual male 9).**

## 9.3 'FIT' BETWEEN THE SOCIAL REPRESENTATIONS IN BRITAIN

There is a considerable overlap between all four of the British social representations (mapped out in section 9.2 above). Among the groups who are construed to be 'at fault', in terms of contracting HIV, are homosexuals, bisexuals, promiscuous people and drug-users. The 'faultless' are small children and heterosexuals who contract HIV. An in-group/out-group mentality is at the heart of all four social representations. In addition, the representations of punishment and of pollution overlap. Westerners are perceived to abuse nature, by way of environmental pollution, as well as by way of

technology. AIDS is nature's or God's punishment of humans for these abuses. This constellation of forces overlaps, further, with the social representation of conspiracy. In tampering with their environment, Westerners create illnesses such as AIDS. They then use such illnesses for controlling populations which are a nuisance to them.

The symbol 'America' absorbs all four representations. It is represented as a place of immorality and excess, a place in which sin cocktails occur, a place with open boundaries, and a place which has a history of conspiring against certain groups. However America, like other places mentioned (eg. Earls Court), is not held responsible. It is Americans, human agents, who are held responsible for AIDS. Paradoxically, within all four representations, the behaviours of certain individuals, as well as group identities, are held responsible for AIDS.

## 9.4 DISCUSSION OF BRITISH LAY THINKING

The findings will be discussed in terms of the hypotheses (emphasised here in bold type) delineated in section 4.11 (Chapter Four):

> **Responsibility for the origin and spread of HIV/AIDS is placed with the 'other' rather than with the 'self'.**

There is a symmetry in the British process of inter-group blame. AIDS, in certain respects, is a 'not-me' illness. In terms of the origin of AIDS, whites tend to hold Africa responsible while blacks tend to hold 'the West' responsible. This finding demonstrates the function of a study which gives equal attention to the representations of 'the blamed' and those of 'the blamers'. Kitzinger and Miller (1991) found that the

most popular belief about the origin of AIDS in Britain was that it came from Africa. My study corroborates this finding in terms of the white British majority. However, it shows that black British citizens are as likely as whites, to hold responsible for AIDS, a continent with which they do not identify. Groups imagine that out-groups are responsible for AIDS. 'Not-me' representations are also evident in the fact that the majority of the sample (excluding those with HIV/AIDS), spanning all demographic groups, view themselves to be below the average in terms of risk of contracting HIV. Finally, a substantial proportion of the British sample, upon being asked which groups have AIDS in Britain, state that their own group does not have AIDS. This finding is also consistent across the demographic groups.

**The 'other' is imagined to be involved in the practice of sin cocktails.**

Again, both black and white groups view the practices which occur in 'the West' or Africa, respectively, in a similar way. Black respondents' fantasies about the activities of the 'other' (which I term sin cocktails) are striking. There is a pervasive tendency to confound a representation of Western experimentation in laboratories, with Western sexual experimentation. The 'unnatural' quality of genetic engineering and similar rituals is equated with the aberrant sexuality which takes place in the West. Representations of aberrant sexuality and of culture-specific rituals, held by black respondents, mirror those held by white respondents. The difference is that white respondents imagine that such practices occur in the under-developed world, with its lack of hygiene and education. Interestingly, while white respondents articulate these thoughts with hesitancy, black respondents vocalise their sin cocktails with conviction.

White experimentation rituals are not only perverse, they are often sinister. Western technology allows for AIDS to be unleashed among unwanted minorities. Reflexivity is clearly evident in the white sample. There is a strong anti-racism, anti-homophobia line of thinking among whites. Blacks, however, are reflexive only in terms of the prejudice to which Africa has been subjected as a consequence of AIDS. My finding contradicts that of Kitzinger and Miller (1991) who found that it was mainly blacks who believed that the association of AIDS with certain groups was tantamount to blame. Blacks in my sample were significantly more likely than whites to be aware of the blame inherent in attributing origin or spread ($\chi_2$=9.9; p<.05, two-tailed) to a specific group. Yet their awareness tended to concern only their in-group.

There is a high degree of reflexivity in the sample as a whole. This is evident not only in stating an awareness of blame, but in the careful and hesitant manner in which origin theories are express. Those respondents who express a lot of reflexivity in terms of one issue, often blame an out-group for another. This corroborates Boyle *et al.*'s (1989) finding that illiberal language and liberal claims coexist in talk about AIDS, in Britain.

**The 'other's' behaviour is perceived as potentially polluting of the 'self'.**

One idea, shared by all demographic groups, is that bisexual behaviour allows for AIDS to leak from homosexuals to heterosexuals. Foreigners are also liable to transmit HIV/AIDS to the British in-group. In addition, a small number of black respondents fear that miscegenation allows for AIDS to spread from whites to the otherwise pure,

black in-group. AIDS is also linked to the polluting effects of modernity by significantly more blacks than whites. Black respondents appear more concerned with contamination (by the white/Western out-group) than white respondents are. This contamination is linked directly with the wide range of aberrant Western behaviours which the mass media report on a daily basis.

**Certain groups, who have been marginalised in their society historically, and who have been linked to AIDS in the hegemonic ideology, cast responsibility inward rather than outward.**

While the racial dimension is prevalent in social representations of AIDS, no British black respondents mention that they experience AIDS-related stigma because they are black. Sexual orientation appears to be a far more salient factor in the formation of British thinking about AIDS. Both heterosexual and homosexual respondents imagine that it is homosexuals who are worst affected by AIDS in Britain. Not all groups experience 'not-me' feelings in relation to AIDS. There is an asymmetrical component to the blame process. Homosexuals identify closely with AIDS. Many feel that they will contract HIV/AIDS because they are homosexual, irrespective of their behaviour. One homosexual expresses that AIDS has made him feel "prejudiced against myself". Inter-group blame is not always self-protective. When certain groups are viewed as diseased within the dominant ideology self-protection is constrained and self-blame occurs.

**The behaviour of individual humans, rather than situational determinants, collective sin, luck or a virus, is deemed responsible for the spread/cause of AIDS.**

Two thirds of the sample, with no significant demographic differences, place responsibility for AIDS on individual behaviour. The issue of choice is central to British lay accounts of how people contract HIV/AIDS. Blacks' responses are notable for their powerful and uninhibited division between those who are at fault, and those who are blameless, in the AIDS domain. In addition, only black respondents combine the 'AIDS is God's punishment' and 'AIDS is nature's punishment' representations. A number of black respondents believe in a 'natural' order, whereas this belief is seldom expressed by white respondents. Homosexuality and anal sex are not 'meant to be'. The black respondents' thinking appears to correspond to the Thatcherite vision of the family, as the natural order of adult human relations.

The majority of those who oppose the individualist outlook on AIDS are from marginalised groups. Situational determinants of AIDS tend to be mentioned by homosexual respondents. While British thinking about AIDS draws on an individualist ideology, voices of the more collectivist welfare state are also present.

**There will be a 'fit' or overlap between messages contained in the AIDS campaigns and lay thinking. However, people are active in terms of the messages which they receive. They transform aspects of such messages in accordance with emotional and ideological needs.**

AIDS was initially conceptualised as an issue of leakage, from contaminated

homosexuals, to pure heterosexuals (see Chapter Two). The policy debate, and resulting AIDS campaigns, over the years, have attempted to alter the representation of AIDS as an illness linked to contaminated risk groups. While Clift *et al.* (1990) found that AIDS was linked to drug-users and to homosexuals, my data indicate that homosexuals did not feature as prominently as they might have done. Many respondents mentioned that they linked AIDS to homosexuality and to drugs initially (see Figure 12). However, homosexuality did not feature as a lifestyle currently associated with AIDS (see Figure 13). This transformation must be linked to the campaigns of the late 1980s and early 1990s, in which a strenuous effort was made to inform all sexually active people that they were equally likely to contract HIV.

Figure 12. Reported **initial** anchors for AIDS: Britain

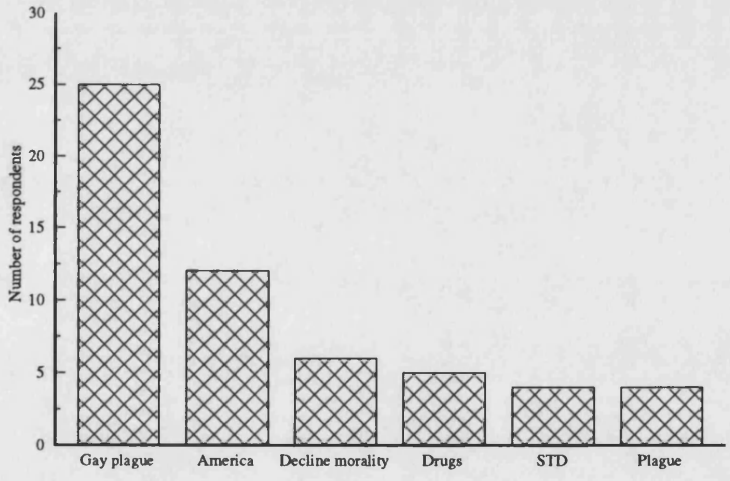
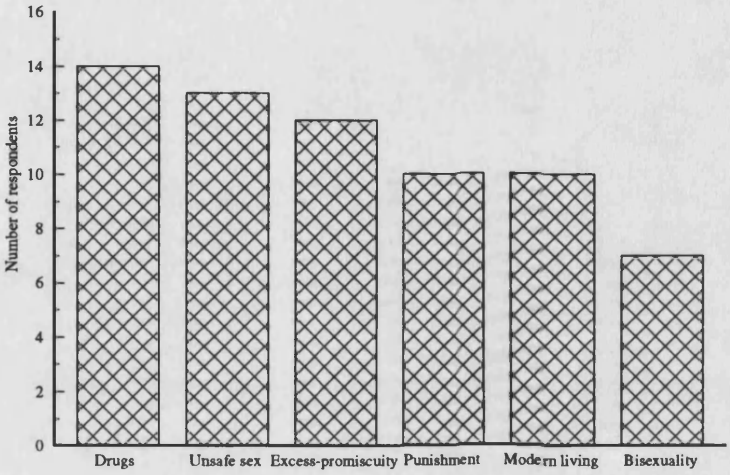


Figure 13. Factors **currently** associated with AIDS: Britain




The fact that many heterosexuals believe that 'young people' are the group most at risk of contracting HIV in Britain (see Figure 10, above), also indicates that the campaigns have had an impact. The British campaign intentionally targeted young people. Young people seem to realise this. The influence of the campaigns is further evident in the fact that almost half of the respondents link AIDS to unsafe sex (see Figure 13). The campaigns have also acted as agenda-setters. The fact that the campaign has had such a wide audience is used, by homosexuals in particular, as an excuse to attribute responsibility. Now that people are in the 'know' concerning facts about AIDS, they have no excuse for contracting it. Contracting it, in fact, can now be construed as an act of choice.

The parallel between thinking in the social context and lay thinking is striking. This is indicative of the 'dominant-hegemonic' position elucidated by Hall (1980). Lay people

decode media messages in terms of the ideologies with which the messages have been encoded. However not all representations of AIDS 'fit' with those intended by policy-makers. In keeping with the Hall (1980) continuum (see section 5.4.1, Chapter Five) certain representations are 'negotiated' or 'opposed'.

Old anchors still pervade social representations of AIDS. Kitzinger (1990) states that (what I term) 'anchors', dominate AIDS discourse, because exposure to these images is wider than exposure to the media itself. It stretches into the playground and into daily conversation. There is a strong belief in the link between a 'domino effect' and AIDS. Respondents talk of a link between drugs, promiscuity and AIDS. This maps closely onto early media ideas in which homosexuality, promiscuity and 'poppers' were regarded as determinants of AIDS, rather than HIV being regarded as the cause.

A certain ideological set is used, especially by black respondents, in understanding the AIDS messages. AIDS is regarded as a force which might rectify moral fortitude, rather than as an illness which results from contracting a certain virus. A fearsome campaign, a fearsome illness and a law (Section 28) which reflects and imposes certain ways of thinking about AIDS, contribute to this tendency to moralise.

Social representations thrive on meanings which circulate in society in a semi-conscious or an unconscious form - the less people are aware of social representations the greater their effect (Markova, 1989; Moscovici, 1984). The messages transmitted in campaigns may have little impact on non-conscious ideas. However, the conscious level of dialogue is highly important in terms of changing certain practices. The overt

attempt, on the part of the gay lobby, to undermine the 'gay plague' anchor, has made it socially unacceptable to associate AIDS with homosexuality, in conversation with an interviewer.

## 9.5 CONCLUSION

In this chapter I describe and discuss the social representations of AIDS, connected to blame, of British lay thinkers. The following chapter compares the British material to that of the South Africans. It attempts to lend some theoretical coherence to the empirical findings which have been described.

## OVERVIEW OF CHAPTER TEN

In this chapter I provide a cross-cultural comparison of the South African and the British social representations of AIDS. This comparison indicates that, while the process of inter-group blame is similar in both countries, the content of the blaming aspersions differs. The content of the blaming aspersions, which are attached to AIDS, are related to the specific ideological forces which operate in each of the cultures. I emphasise that the thesis benefits not only from its cross-cultural approach, but from the combination of complementary theories which underpin it. I illustrate the advantages of this approach in relation to the KAP study, which has hegemony in social scientific AIDS research. Areas of future work are highlighted.

# CHAPTER TEN: CROSS-CULTURAL COMPARISON AND CONCEPTUAL REFLECTION

> "It is no longer possible...to overlook the influence of the unconscious on the conscious, the role of the preconceptual and the non-conceptual on the conscious, the presence of the irrational - the economy of desire, the will to power - at the very core of the rational. Nor is it possible to ignore the intrinsically social character of structures of consciousness, the historical and cultural variability of categories of thought and principles of action" (Introduction to Habermas, 1990:IX).

## 10.1 INTRODUCTION

Having explored the texture of the South African and British data, I am in a position to provide a cross-cultural comparison of the representations of AIDS in South Africa and in Britain. This comparison highlights the influence of history, of culture and of the unconscious on social representations of AIDS. In the light of this empirical work, I am able to reflect upon the strengths of the theory of inter-group blame which has been forged in the course of this thesis. In addition, I am able to reflect upon the utility of the methodology I have used for the study of social representations. Finally, I address those issues which future work on inter-group blame should resolve.

## 10.2 DIFFERENCES AND SIMILARITIES: SOUTH AFRICA AND BRITAIN

### 10.2.1 THE TWO SAMPLES: A DEMOGRAPHIC COMPARISON

The South African and British lay samples were 'matched' on as many demographic variables as possible. Equal numbers of heterosexual and homosexual white and black respondents are present in the two samples. In addition, the samples are very similar in terms of mean age, mean education level, socio-economic status and urban background. However, South African respondents are significantly more likely to attend a religious

institution than are British respondents ($\chi^2$=9.3; p<0.05, two-tailed). This difference is not surprising in the light of the fact that while 16/30 British respondents claim to have no religion, or to be 'pagans', only 1/30 South Africans claim to have no religion. A further demographic distinction between the two samples lies in partner numbers. While South African heterosexuals report a mean of 3.5 partners, their British counterparts report a mean of 6.6 partners. Clearly, then, I am comparing two samples which are similar to one another in certain respects, but diverge in respect of religion and sexual history.

Both samples are small. While they provide a basis for cross-cultural comparison, I am not claiming that either sample is representative. The use of a small sample is discussed in full in section 5.7 of Chapter Five.

### 10.2.2 THE TWO SAMPLES: CULTURE, HISTORY AND THE UNCONSCIOUS

#### 10.2.2.1 AIDS as a 'not me' illness - the workings of individualist and other unconscious forces

In both South Africa and Britain the vast majority of the respondents feel:

- Origin AIDS => 'other' continent to the one with which they identify
- Own risk of contracting AIDS => below average

> *"I didn't believe I would ever get AIDS even up to just prior to being diagnosed. It is something that you thought would happen to someone else, but not to you...you just feel protected, it is something that happens to somebody else. You drive on the road. You never think constantly that you could make an accident right at that specific point in time. Accidents happen to other people, not to you, until it happens to you"* **(South African white homosexual male 2: he has AIDS).**

> *"I felt I wasn't at risk. I thought: I'll never get it.*
> ***Interviewer:** Why?*
> ***Respondent:** Because I don't sleep around and I always thought it happens*

*to others...When someone gave you a pamphlet, you thought: 'It will never happen', so I didn't bother"* **(South African black homosexual male 5: he has AIDS).**

Why does this 'not me' feeling arise? Farr (1987) believes that this is related to protection of a positive self-esteem. He relates this need to the ideology of individualism which pervades modern Western societies. Within this ideological climate, individuals are deemed responsible for the outcomes which befall them. The individual is praised for success, and blamed for failure. Contracting an illness represents failure and, so, the individual is held blameworthy, in accordance with this ideology, for failure.

My findings, in both South Africa and Britain, illustrate the importance of the representation of responsibility in blaming people who contract HIV. Two thirds of both samples imply that irresponsibility is related to contracting HIV. The focus upon individuals and their behaviour is a consequence of the Protestant and capitalist forces present in South African and British social institutions (eg. laws) and ideologies. The fact that the black South African group use the individual responsibility discourse significantly less than other South Africans, indicates that there may well be a relationship between individualism and blame for individual behaviour. Indigenous South African culture is a more collectivist one. Ngubane (1977) states that in Zulu culture, for example, people are not made to feel responsible for conditions such as physical and mental illness. They are made to feel that they are the victims of external forces - intruding alien spirits - which need to be removed, rather than the victims of their own behavioural choices.

Yet, even in cultures in which individuals are not held responsible for their actions, or for

the outcome of these actions, 'not me' feelings in relation to AIDS are present. These feelings are present in the black South African group in my sample, as they have been, internationally, in many thinkers not influenced by Western culture (see Sabatier, 1988; Apeagyei *et al.*, 1991; de Bruyn, 1992). In addition, 'not me' feelings, in relation to epidemics, have been present in world history way before the ideology of individualism became pervasive. I have indicated that the black death, for example, evoked blame of certain groups. Thus the ideology of individualism is only one of a number of factors which determines the form which blame takes in my sample. The presence of blame-based responses to crises internationally, and throughout history, must be explained in terms of a more universalist theory.

Psychoanalytic theories are not popular within mainstream social psychology. However, in line with the quotation with which this chapter begins, I propose that social psychology needs a theory of the unconscious. The fear of trespassing into the non-conscious world is a hangover from the history and current traditions in which that which is not easily amenable to experimentation is ignored. Social psychology has to forgo its fears of the unknown if it is to come to grips with the full range of material which people present in interviews.

The material of which I speak, in relation to my own study, is the presence of sin cocktails, jokes, defensiveness, and denial in social representations of the origin and spread of AIDS. The sin cocktails map onto Cohn's (1976) notion that, since Roman times, in times of crisis, it has been imagined that the out-groups practise aberrant forms of sexuality and strange rituals. By way of explanation, Gilman (1988) states that we

project onto groups who represent 'otherness', at a specific point in our history, aspects of ourselves from which we wish to distance ourselves. 'Perversity' is projected onto the 'other'. At the same time as distancing themselves from the acts of 'the other', the respondents in my study were eager to theorise and to depict such acts. The quality of such theorisation, whilst often expressed in terms of a revulsion, is illustrative of desire. Desire co-exists with the dehumanisation of the practices of the 'other'.

Earlier British work on AIDS found that women were less blaming than men, or had different patterns of blame. (Clift *et al.*, 1990; Connors & Heaven, 1990; McDevitt *et al.*, 1990). Women, in my total sample, are significantly less likely than men (homosexual and heterosexual) to express the sentiment: 'My group does not have AIDS' ($\chi^2$=3.9; $p<0.05$, two-tailed). This seems to indicate that women are less likely to deny that AIDS might affect them. When the statement 'My group does not have AIDS' is made, predominantly by men, defensive thinking is manifest. It is men, primarily those who have sex with other men, who dominate the South African and British AIDS statistics at the time of this study. While this finding indicates that woman may be less blaming, there are no other significant gender differences in the total sample or in the South African or the British samples analysed separately. This may be related to the fact that AIDS has increasingly been construed as everybody's problem and, so, both men and women, rather than just men, begin to feel defensive about it.

In Chapter Three (see Section 3.3) I showed that unconscious thought processes, such as the denial indicated above, may result from early mental development in which the infant protects itself from anxiety by way of invoking defensive mechanisms. If one believes that

AIDS exists, but that the 'self' or 'in-group' is not affected by it, one must imagine that it is 'others' who are infected. From the earliest stage of development, the infant equates bad with the 'not self', and good with the 'self'. This results from a process in which objects, in the world surrounding the infant, are divided or 'split' into good and bad. In order to maintain a sense of equanimity at times of raised anxiety and helplessness, the infant draws a strong boundary between good/loving and bad/persecutory objects and experiences. The infant imagines that the good emanates from inside itself, and that the bad lies outside of this boundary. The distinction between a good 'self' and a bad 'other' manifests itself most powerfully when anxiety is raised.

Douglas's (1966) notion of pollution takes the division between a pure self and a contaminated other as its starting point. One distances oneself from feelings of vulnerability by way of delusions of purity. Her theory explains why a central fear in relation to AIDS, relates to 'leakage' from a bad 'other' to a good 'self'. Her theory demonstrates why national panic arose when it was realised that heterosexuality could be tainted by AIDS, whereas the earlier phase, that of the 'gay plague', incited more voyeurism and fascination than it did national panic. People construct symbolic systems of purity to put into order the chaos which they experience at times of crisis. That which cannot be placed within this order threatens the system. It, therefore, becomes dangerous and powerful, a potential polluter of the purity which has been forged. Anomalous groups, or those who cannot be placed within a 'pure' category, those who transcend the boundaries between symbolic systems of purity, often become the targets of blame for a crisis. My finding, that almost a third of South Africans give inter-racial explanations for the spread of AIDS to the in-group, corroborates the Jochelson *et al.* (1991) findings in

relation to South African black women. The fear of miscegenation - from the white out-group to the in-group, is also present among British black people. Other anomalous, potentially infecting persons, in both South Africa and in Britain, are bisexuals and foreigners. Certain figures and places form powerful objectifications of the notion of pollution. In South Africa the mixed-racial suburb of Hillbrow forms a pervasive symbol of pollution, as do migrant labourers. The spectre of Rock Hudson performs a similar function in the British group: An apparently heterosexual film star who flirted with homosexuality.

The positions of both Douglas and the psychoanalysts emphasise people's need to maintain the 'purity' of the 'self' or 'in-group', at times of crisis. This is done by imagining that there is a boundary which separates the space of the self from the 'other' who is, by way of contrast to the self, impure and, therefore, potentially polluting. This position is highly complementary to that of Herzlich (1973), who found, among her French respondents, that illness is seen to emanate from the environment and health from the self. Thus the contaminating 'other' need not even be human. In my interviews with the respondents, the polluting effects of modern living form a dominant motif. Urban living is connected to AIDS in that it engenders freedom of expression, experimentation with both the natural world and the human body, and a fast pace of living. This, again, is consistent with Herzlich's data. Black British respondents, in particular, juxtapose the polluting effects of modern Western living with the idealised, rural, non-Western existence with which they identify:

| The West | The non-West |
| --- | --- |
| • Experimentation | • Traditionalism |
| • Guilt - Colonisers | • Innocence - Colonised |
| • Test God | • Respect God |
| • Active tampering with the body and with sexuality | • Passive acceptance of the natural order |

In both the South African and British samples, America forms a dominant symbol of the excessive nature of modern living - excessive sex, excessively fast pace, excessive over-use of environmental resources. America is implicated in generating or spreading AIDS because it has transgressed the boundaries of the 'natural'.

This corroborates Sontag's (1979, 1989) notion that the illness which dominates the particular society's conceptualisation of illness acts as a social commentary on the dominant thoughts and conflicts of that epoch. The fear of global destruction, due to the environmental damage which has occurred, becomes linked to illness. In South Africa, AIDS absorbs the fears surrounding the final stages of Apartheid - fear that interracial sexuality generates AIDS, fear that freedom from the tight constraints of the old social order will allow for the permissive society, which will cause the AIDS epidemic to escalate. In both South Africa and Britain, sexual pollution by 'the other' is equated with environmental pollution.

The link between illness and excess, skilfully explicated by Kleinman (1980), may well be related to the Protestant ethic of moderation, common to many segments of both cultures. The link between AIDS and excess derives from the world of science. Early on, medics associated AIDS with homosexuals overloading their immune systems through

excessive sexual encounters and excessive drug-use. A similar theory gained momentum in 1992 when a number of doctors challenged the notion that AIDS is caused by HIV. They felt that the immune overload theories had dropped by the wayside, despite the fact that they had not been disproved. Medics and lay people alike are vulnerable to believing in theories which claim that illness is caused by excess. The Protestant ethic of moderation forms one of the pillars of excess theories.

Douglas's (1966) theory of purity and danger, in a similar vein to Tajfel's (1981) position on prejudice, is expressed in terms of a universal tendency to categorise. My data shows that ideological forces shape the categories which people use. There does appear to be a pervasive tendency to say 'not me' when faced with an anxiety-provoking event. Yet, the categorisation process, which allows people to place themselves within the 'pure' in-group, and to distance themselves from the 'dangerous' out-group, is distinctly ideological in character. Apartheid and colonial thinking amongst South Africans, and vestiges of colonialism among British whites, accord Africa the status of a polluting 'other'. The corollary of this is that politicised blacks (as are the British black respondents) see colonial and imperialist forces as pollutants. This is indicated by way of conspiracy theories and suppositions regarding the polluting effects of modernity. While Douglas's and Tajfel's positions allow one to explain the process of inter-group blame, they do little to explain the dynamics of its content.

A further ideological force which colours the content of blaming aspersions, in both South Africa and Britain, is the ideology of the family - and, consequently, of monogamy and faithfulness - as the natural order of adult relations. Overall, the texture of the South

African data is far more moralistic than the texture of the British data. It is interesting that low partner numbers, and a greater adherence to religion, parallel this high level of morality. Despite far lower numbers who adhere to a religion in Britain, the numbers who believe that AIDS is deserved punishment are similar in both samples. Black respondents make up the majority of those in the British group who believe in a punishment theory. South Africans, and British black respondents, tend to invoke the bible to lend weight to their beliefs. In both South Africa and Britain, God or nature punishes perverse people (usually interpreted as members of groups with which the respondent does not identify) for contravention of what was 'meant to be'. In Britain, punishment theories have also found expression in the tabloid press, which has talked of 'Virus victims swirling in a cesspit of their own making', and of the fact that 'Good Christian people who wouldn't dream of misbehaving will not catch AIDS' (quoted in Markova & Wilkie, 1987). In addition, the anchor for AIDS, 'plague', suggests punishment.

The unnatural 'other', who is deserving of punishment, is always just one step more 'perverse' than oneself. An HIV positive man in the sample states:

> *"If you want to have anal sex with a man, go ahead and do it. But if you are doing it with a variety of toys and various parts of the body, it is bestial and immoral, immoral almost, as well"* (**British homosexual male 6**).

Like perversity, people define as 'promiscuous' those who have had more partners than they themselves have had. The construction of a promiscuous out-group is functional. No-one identifies with the 'promiscuous' group. This group can be infused with a host of projections, and none of its members will take offence.

The ideological level is at the core of AIDS-related thinking. This level, which lurks

below the surface, colours all. So, while humans attempt to uphold the boundaries between pure and contaminated systems, by splitting between self and other and by projecting bad out onto other, ideological forces determine which groups become the objects of the projection. Ideology underpins social representations of a phenomenon. Social representations may be available to consciousness, whilst the underlying ideologies are not. Social representations concerning the practises of certain groups, and of AIDS as a 'not me' illness, are the outward manifestations of unconscious forces.

**10.2.2.2 AIDS as a 'me' illness for marginalised groups - the workings of power**

In South Africa, the vast majority of respondents think that:

- Group worst affected by AIDS => blacks

In Britain, the vast majority of respondents think that:

- Group worst affected by AIDS => homosexuals

AIDS is a 'me', rather than a 'not me' illness for black South African respondents. AIDS is a 'me' rather than a 'not me' illness for homosexual British respondents. In addition to the feeling that their own groups are worst affected by AIDS, certain marginalised groups (homosexuals in Britain, and blacks and homosexuals in South Africa) are also significantly more likely, than non-marginalised groups, to practise self-blame in relation to AIDS. Cross-culturally, homosexuals, as a particular marginalised group, are more likely to introject blame than the other groups are ($\chi^2$=13.6; $p<0.05$, two-tailed). It is noteworthy that in Britain, but not in South Africa, the homosexual group alone, is also significantly more likely to practise self-blame than the rest of the British sample. This indicates that, since South African homosexuals coexist as a marginalised group with

black heterosexuals, they experience less direct blame than they otherwise might do.

South Africans use race and Britons use sexual orientation to differentiate 'self' from 'other'. In each case, the group with less power is seen, even by those group members themselves, to be the group worst affected by AIDS. For black South Africans, the feeling of being worst affected by AIDS did not reflect the epidemiological statistical reality of the time, as it did with homosexual British respondents. Not everyone is saying 'not me' in relation to being affected by AIDS.

What of the respondents with HIV/AIDS in the sample? What happens when you can no longer say 'not me' in relation to AIDS? Since the number in the sample with HIV/AIDS is small, it is difficult to draw out trends which differentiate them from other respondents. There are few obvious differences, save one. A major point of divergence between those with HIV/AIDS and those without it is that the former are significantly more likely to represent AIDS in a positive light, often viewing it as a blessing ($\chi^2$=23.1; $p<0.05$, two-tailed). A South African and a British response demonstrate this:

> *"People used to say to Paul 'Do you think this is a punishment from God?' He said 'Definitely not a punishment, it's a gift from god'. If we have to take it in a religious aspect, yes, maybe it is a gift from God, because it brings you back to more reality, more, not sober, [but] more natural person. It brings you back to earth"* **(South African white homosexual 3, with AIDS).**

> *"Being told I was [HIV positive] has changed my life for the better, and it has been a, I know I can honestly say categorically, it has been a wonderful gift for me. I am not saying that's right for everybody because I am very aware that there's lots of people out there that might be aghast at someone coming out with a statement like that, but all I am saying, for me it has been a gift, and I have made it a wonderful gift, and it has enhanced my...I am not into any orthodox form of religion, but what has, what it has really got me in touch with is the power of love and being loved and being connected to love and just life and spirit really"* **(British**

**white homosexual 6, with HIV).**

Interestingly, not only do the respondents with HIV/AIDS view their AIDS as positive, they subvert the representation of 'AIDS as punishment' to one in which 'AIDS is a gift from God'. Again, this phenomenon can only be understood in terms of the workings of the unconscious. In the face of an extremely serious illness, which is accompanied by immense social stigma, many (5/7) respondents with HIV/AIDS feel positive about their condition. This, clearly, is a defence termed idealisation. This is the attempt to hold onto a good, perfect world at a time when, unconsciously, one's world feels unhinged.

The British respondent, quoted above, tells the interviewer that he is aware that there are *"lots of people out there that might be aghast"* if they heard his positive view of AIDS. This demonstrates that the respondent is aware of mainstream thinking on AIDS, but is opposed to it. This high level of awareness, and the need to alert the interviewer to self-awareness, is common in the British sample as a whole, but far less so in the South African counterpart. A highly significant difference between the South African and the British respondents is that the latter are significantly more aware or reflexive in relation to AIDS-related blame ($\chi^2$=15.9; $p<0.05$, two-tailed). Reflexive respondents think that connecting a group with the origin or spread of AIDS is tantamount to blame. Typically, a respondent states:

> *"I think the reason why people try and originate it [AIDS] is in some way to say: This is what these people have done to us"* (**White British female 6**).

The greater reflexivity of the British sample appears to be related to two forces. Firstly, South Africa has a history of massive state restrictions on press reporting and of censorship of ideas which can be expressed. The more centralised nature of doctrines and

of institutional thinking, with less creativity allowed, has left South Africans with less of an ability than British people to critically evaluate the ideas which circulate around them. Secondly, related to the more open nature of British institutions and ideologies, is the fact that the British gay voice forces those in contact with this voice to reflect upon the AIDS-related thinking in British society. The THT, formed in 1983, had the explicit aim of influencing national policy on AIDS. The gay lobby in Britain has challenged its status as a risk group. It has, undoubtedly, influenced the dominant message emitted from the social context, that 'AIDS is everybody's illness'. This has diminished the media's focus on the homosexual domination of the AIDS and the HIV statistics. Gay political empowerment, or the "means by which human beings regulate, attempt to regulate and challenge, with a view to changing, unequal power relationships" (Bhavnani, in press), has had an immense impact on AIDS-related thinking. Having laws made against you (eg. Section 28 of the Local Government Act of 1988) (see Chapter Eight) recognises the power that you have.

Despite the equation made between AIDS and Africa in Britain, and newspaper articles which state that blacks dominate the heterosexual AIDS statistics in Britain, no British black respondents expressed a feeling of being stigmatised for AIDS. For whatever reason, the British Government has attempted to keep inter-group blame - levelled at homosexual or black people - at a minimum. This challenges the Moerkerk and Aggleton (1990) finding that the British response to AIDS has been 'political', rather than concerned with AIDS-related discrimination.

Despite higher levels of reflexivity in Britain than in South Africa, there is no significant

difference in terms of holding situational factors or, indeed, a virus 'responsible' for AIDS. The process of blame is similar in the two countries, yet British respondents are more aware of the fact that they blame. What I term 'reflexivity' can be recast as self-presentation. Perhaps the British respondents mention that connecting a group to the origin and spread of AIDS is tantamount to blame, merely because they are aware that 'prejudice' is not approved of by the interviewer. Van Dijk (1984) holds this stance, believing that the most characteristic aspect of contemporary prejudice is its denial. Whilst difficult to separate from self-presentation, the notion of reflexivity is infused with greater optimism. This is the optimism offered by a non-determinist theory: It offers the hope of change.

Conspiracy theories are noteworthy by their absence in the South African sample. This is best explained by looking at Falmer's (1992) analysis of Haitian conspiracy theories. Most importantly, in Haiti, conspiracy theories of AIDS were started by organised, political forces. Blamed groups in South Africa, especially blacks, had no recourse to political organisation at the time that my interviews were conducted. The presence of conspiracy theories in marginalised Britons, but not in South Africans, is strong evidence of the importance of power, rather than of psycho-dynamic forces, in terms of which theories become socially acceptable. Interestingly, South Africans began to voice conspiracy theories later, once the beginnings of a political voice had been established (as shown in Chapter Four). The empowered black British voice also dwells on the fact that colonial forces have a history of bringing illness to the under-developed world and on the 'kinky' nature of white sexuality. One wonders whether such theories will gain credence among black South Africans, now that a political voice has been gained.

**10.2.2.3 The 'fit' between lay thinking and thinking in the social context**

- The 'fit' between South African lay thinking and messages emitted by the social context in South Africa lies along the continuum between what Hall (1980) terms the 'dominant-hegemonic' and 'negotiated' positions.
- The 'fit' between British lay thinking and messages emitted by the British social context lies on the continuum between what Hall (1980) terms the 'dominant-hegemonic' and the 'oppositional' positions.

I have fully described Hall's (1980) continuum in Chapter Five (see section 5.4.1). The continuum runs from the 'dominant- hegemonic', to the 'negotiated', to the 'oppositional' positions. At the one end ('dominant-hegemonic'), messages emitted by the media are encoded in the manner intended by those who transmit them. At the other end ('oppositional'), those who receive the messages view them in a different way to that intended by those who transmit them. The British respondents' responses to the messages emitted in their social context have been more challenging than those of the South African sample. The high level of reflexivity present in the thinking of the British respondents (and largely absent in that of the South Africans) has allowed for a more challenging response to messages emitted by the mass media. However, while multiple readings of messages exist, readings which parallel the hegemonic ideologies dominate in both countries.

Both the South African and the British Governments have been concerned with emitting

two central AIDS-related messages: Partner numbers must be kept to a minimum and people should practise safer sex. In addition, the British campaigns have been centrally concerned with relaying the idea that 'everyone is at risk'. I have shown, in Chapters Seven and Nine, that lay thinkers have absorbed the 'dominant-hegemonic' messages.

One unintended consequence of the South African and British Government campaigns was that people were more likely to blame after the screening of the first campaigns than before the campaign (DHSS, 1987; The McCann Group, 1988). The proportion of British people who saw AIDS as a reflection of low moral standards also increased after the screening of the first AIDS campaign (Clift & Stears, 1988). The early campaigns functioned to increase blame-related lay thinking. How did this occur? The campaigns' target audience used the fact that people had been told to act responsibly, by the campaigns, to blame them for their irresponsibility. People who became infected were defying Government orders to act responsibly. In my data, having information is equated with having choice. People use the AIDS campaigns as a point from which they can judge the irresponsibility of others. In addition, the campaigns set up a cycle of denial, due to their fearsome overtones. The anxiety which results from viewing fear-evoking material causes one to protect oneself, by imagining AIDS as a 'not me' and, consequently, a 'them' illness.

The messages in both countries were filtered through ideological and emotional prisms. Fantasies concerning the sin cocktails practised by 'the other' refract and obscure the messages transmitted by the campaigns. The ideological and defensive prisms blind respondents to their own unsafe sexual behaviour. Sin cocktails, for example, were not

suggested in the campaigns and, despite certain tabloid reporting, may be construed, predominantly, as lay peoples' 'negotiation' of the meanings emitted to them from the social context. Fantasies concerning the practices of the AIDS-riddled 'other' blind people to the unsafe nature of their everyday activities.

Whilst both the South African and the British samples adopt and negotiate the dominant AIDS messages, a number of British respondents move one step further along Hall's (1980) continuum, to 'opposing' the dominant messages. Black British respondents, with their conviction that the West has inaccurately blamed Africa for AIDS, set up a counter-blaming theory, in which AIDS is related to a conspiracy, rather than to unhealthy individual behavioural choices. Similarly, the homosexual group believe that AIDS is an intentional ploy to rid the world of marginalised groups. In addition, rather than accepting the 'AIDS kills' message, many homosexuals, especially those with HIV/AIDS, valorise AIDS, regarding it as a gift from God, rather than as a death knell.

Science, the mass media and lay thinking interact to create social representations of AIDS. Ideas of 'opinion-leaders' or in the case of AIDS, AIDS policy-makers, are effective in forging hegemonic thinking by setting the agenda, or setting up the framework of the AIDS-related debates in which lay thinkers situate themselves. However, creative thinking, especially in Britain, allows for negotiated and oppositional readings of hegemonic thinking to arise. Flux and change result.

### 10.2.3 SUMMARY OF THE CROSS-CULTURAL COMPARISON

In both societies, the majority of respondents hold 'not me' beliefs in relation to the

continent on which AIDS originated. In addition, the majority in both societies believe that they are below average in AIDS-related risk. There is also a common fear that out-groups infect the in-group with HIV/AIDS. In addition, certain marginalised groups in both societies have a greater tendency to absorb the blame for AIDS. Overall, it may be said that the process of blame is remarkably similar in the two societies.

The content of the blame diverges. Whilst the Western model of blame, in which individuals are blamed for their choice of behaviours, is present in both cultures, it is far less prominent among South African blacks. In addition, while the ideology of the family as the natural order of adult relations is present in both cultures, biblically-based words such as "adultery", "sodomy" and "temptation" pervade South African, but not British, discourse. While the notion that certain groups can be 'ringfenced' in the hope of stopping AIDS from seeping into the in-group is present in both cultures, the groups tend to be defined by way of sexual orientation in Britain and by race in South Africa.

While responsibility and choice tend to be associated with blame in Western social science and philosophy, blame, more universally, is associated with self-protection. This involves finding an 'other' who can plausibly be linked with the fear-evoking crisis which one faces. The finding of a legitimate enemy gives a sense of control, order and community to the in-group whose support one needs in coping with the crisis.

Similarities in the process and form of AIDS in South Africa and in Britain relate to the similarity of the ideologies and of the unconscious forces which operate in the two societies. Though blaming responses have their roots in early development of the infant,

these responses must be activated by ideological forces. Blame is not a 'natural' function of human thinking.

## 10.3 STRENGTHS OF THE THESIS

### 10.3.1 THE CROSS-CULTURAL ANGLE

The cross-cultural component of the thesis allows me to demonstrate that the patterns of thinking which result from the entry of a single virus into two societies is more related to history, culture and the unconscious than it is to the virus itself. However, the shape of the epidemic itself does have an influence upon the representations which arise: In South Africa the epidemic is, increasingly, affecting black people, as the social representations suggest. In Britain, the epidemic is, increasingly, affecting heterosexuals, as the representation there suggests.

Cross-cultural work allows one to code the 'lacks' or absences which structuralist and psychoanalytic theories have deemed so important. The presence of a conspiracy theory in Britain and its absence in South Africa directs one to thinking about the relationship between power and counter-blaming strategies. The presence of high levels of reflexivity in Britain, and of low levels in South Africa, allows one to think about the merits of free speech and of public fora in which counter-ideological ideas can be expressed.

### 10.3.2 PROVIDING WHAT KAP STUDIES LACK

The strengths of this thesis can be highlighted by comparing it with the KAP study, which currently dominates the AIDS field. The KAP study, largely a psychological invention, contains many of the problematic assumptions inherent in dominant forms of psychology.

The social context, in which people's knowledge, attitudes and practices are forged, are not explored by such studies. By placing AIDS-related thinking within the minds of individuals, KAP studies fail to tap into the dynamic interaction between social context and lay thinking. It is within such a dynamic exchange that lay thinking evolves. If one views thinking as something which evolves over time, it cannot be fixed at any point in time. People's thinking is socially constructed and, in order both to understand it and to change it, research has to examine aspects of the social structure.

A second problem with the KAP model is that it underestimates the role of emotion. By examining lay thinking and the social context, in parallel, we become aware of the emotive content of people's first exposure to AIDS. Certain people's thinking about AIDS derives from the early fear-evoking AIDS campaigns. Others were exposed to media or non-media representations of AIDS earlier than the initial campaigns. Their first exposure to AIDS was also in terms of fear-evoking metaphors of plague and war. I have established that there is a considerable amount of overlap between lay thinking and ideas which are communicated by the social context. It is more difficult to establish a link between social context and lay <u>feelings</u>. This link has to be established theoretically. One infers, on the basis of psychodynamic theory, that defensiveness indicates that people are protecting themselves from their fears. The taboos, jokes and, 'not me' feelings which are scattered throughout dialogue concerning AIDS point to underlying fears. A model, such as the KAP model, which does not put the emotional dimension of health-related beliefs at centre stage, underestimates this central dimension of human thought and action. It refuses to take seriously levels of anxiety and concern that lurk beneath the surface of what people are able, rationally, to tell one.

No AIDS researcher can be oblivious to the fantasy level at which respondents operate. Bestiality, for example, is commonly mentioned in relation to the origin of AIDS. When the researcher enters the interview with a structured interview-schedule and/or a questionnaire, as most AIDS researchers do (Clift *et al.*, 1990), with no theoretical framework in which to code non-conscious material, this information is easily excluded from the reported research. I have established that fantasy material reflects what people do not like about themselves. In line with Gilman's (1988) and Cohn's (1976) ideas, analysis of such projections demonstrates that there is both an abhorrence for the perversity and strangeness of the other, and a lusty fascination with it. Like the Austrians, Hungarians and Germans who put 'tribal' peoples in their zoos, so the black respondents in my study were suggestible to the idea that Churchill's father died of syphilis, and that judges make women dress up in school uniforms. Similarly, the white respondents were suggestible to the idea that certain 'tribes' tie the legs of women together, and that cannibalism and incest are commonplace in Africa. KAP studies do not tap into this level of fantasy. The level of fantasy is of interest to the KAP studies because in constructing disease-generating sin cocktails, people justify as 'pure' their own set of practices. This reinforces their sense of immunity to HIV/AIDS. In the light of this knowledge, it is no coincidence that the vast majority of the total sample feel that their chances of contracting HIV are minimal. Whatever one's own practices, those of the 'other' can be construed, on the level of fantasy, as more perverse, unnatural and disease-generating.

The KAP study also ignores issues of power, culture and history. This is the other level which lurks beneath the surface of AIDS-related thinking. At the same time as ignoring that which cannot be easily measured, KAP study findings are often framed in terms of

an inconsistency between knowledge, and the 'resulting' attitudes and practices. Generally, surprise is expressed concerning the fact that high levels of knowledge do not lead to changes in attitudes and behaviour. My theoretical framework demonstrates that there is no reason why the three should be connected to each other. KAP studies make a massive assumption that conscious forces are predictive of behaviour. Psychology, a major influence on the KAP study, has tended to be defined as the science of the conscious mind (Moscovici, 1982; Markova & Wilkie, 1987).

Like dominant forms of psychology, KAP studies do not do justice to the social, cultural, historical and unconscious forces, for two reasons. Firstly, they subscribe to a division between stimulus and response. Secondly, they shy away from measurement of that which cannot be reliably tested and validated by another researcher. This brings to light a variety of epistemological issues. The aim of science is to search for better and better explanations of the issue under investigation. In satisfying external criteria concerning what 'good science' is, AIDS research is happy to sacrifice faithfulness to the object of study. The KAP study, based on rationalist tenets, finds itself faced with a phenomenon whose processes are anything but rational: AIDS-related knowledge, attitudes and practices.

### 10.3.3 ADVANTAGES OF A SOCIAL REPRESENTATIONAL APPROACH

#### 10.3.3.1 A concept infused with the historical and the socio-cultural

The theory and concept of social representation embodies many of the aspects which the KAP model lacks. It is concerned with the historical (anchors) and social (objectification) facets of a phenomenon, is not caught in a stimulus-response dualism or in the belief that

social psychology is a science of the rational mind. The concept of anchoring, specifically, seems to be seminal in work on AIDS. The way in which an issue is initially presented to lay people lies at the root of their social representation of the issue. In my South African sample, one finds that the anchors for AIDS, around which there is most consensus, map onto the factors which are presently perceived to be linked with AIDS (see Figures 6 & 7, Chapter Seven):

| Anchor | | Current Factors |
|---|---|---|
| Gay plague | => | Homosexuality |
| Promiscuity | => | Excess-promiscuity |
| Decline morality | => | Punishment |
| Sexually transmitted disease | => | Unsafe sex |

In Britain, 'Gay plague', which was a major anchor for AIDS, is not among the top six factors currently associated with AIDS (see Figures 12 & 13, Chapter Nine). This is indicative of the power of the gay lobby, in transforming the social representations of AIDS. Anchors, in interaction with current thinking, set up the debates in which AIDS-related thinking is situated.

Social representational theory focuses upon the social context in which a representation is formed. It predicts that the mass media mediates between science and lay thinking. I have highlighted, throughout the empirical study, that the epidemiological perspective of medical science has dominated the mass mediated accounts of AIDS - from the press reporting of AIDS, to the AIDS campaigns themselves. Lay thinkers often conceptualise AIDS in terms of categories of groups at risk, which were originally set up by epidemiologists. Whilst epidemiologists may utilise this system of classification towards a variety of ends, they seem to be used, by lay people and the tabloid press, in terms of

naming groups who can be blamed for carrying and for transmitting HIV. The transformations which occur, between the intentions of the epidemiologist, and lay thinking, cannot be explored in the KAP approach.

Social representations are not static entities. Since they are linked to historical and to cultural forces, they are continually in the process of evolution. The transformations that occur within social representations can partially be explained by looking at a phenomenon from multiple perspectives, such as those of the epidemiologist and of lay thinkers or, in my study, the blamed and the blamers. The thinking of those who are blamed for AIDS is rarely given equal status to the thinking of the blamers. In comparing these two perspectives, we become aware of the importance of empowerment in the formation of counter-blaming strategies amongst members of blamed groups.

#### 10.3.3.2 Complementarity with a number of social psychological approaches

The social representation, as it is traditionally defined (eg. Moscovici, 1984), does not encompass the emotional and ideological levels which I deem important. I see no reason not to 'import' these components into the nucleus of the representation. Allansdottir, Jovchelovitch and Stathopoulou (in press) state that one cannot 'glue' social representational theory together with any other theory: The underlying assumptions of theories must have compatibility. Psychoanalysis and structuralist forms of social psychology have compatibility with a traditional social representational approach. The theory of inter-group blame, which I have attempted to forge (summarised in Section 10.3.3), incorporates aspects of these theories. The strength of the thesis lies not only in using these vital theories in tandem, but in conceptualising a framework in which they can

be explored empirically (see Chapter Five). In Table 5, below, I indicate the relationship between the theories which I draw on and my conceptual framework.

Table 5. The relationship between my theory of inter-group blame and the conceptual framework within which my empirical data is analysed.

| **Theory of inter-group blame** | **Conceptual framework** |
|---|---|
| Social representations | • Consensual representations<br>• Anchoring<br>• Objectification |
| Psychoanalysis | • Defensiveness |
| Structuralist-inspired forms of social psychology (eg. Billig, van Dijk, Giddens (micro-sociology in the case of Giddens)) | • Counter-representations<br>• Self-presentation<br>• Reflexivity<br>• Power elements<br>• 'Fit' with social context<br>• 'Fit' with other social representations |

This synthesis has allowed me to do more justice to the object of my study than any of the individual theories would have done. My attempt to synthesise various compatible strands of thinking into a workable framework for the analysis of semi-structured data could be of use in the field of discourse analysis too. Sampling the social context as well as lay thinking makes for a very complex and time-consuming study, but allows one to view the transformations that occur between ideas that are to be found in the social context, and lay thinking. This is especially important if one hopes to draw out implications for the social context itself - in this case, for AIDS campaigns.

Overall, the strength of the thesis lies in its movement towards a complex, but useful, explanatory base for blame. Its utility stretches beyond that of attribution theory and of the theory of ethnocentric bias. At the level of process, my theory concurs with

attributional and ethnocentric theories. They postulate a tendency towards out-group blame, but that certain groups blame themselves rather than others, for certain events. In addition, my theory is consistent with these others in terms of the functions of inter-group blame: control, order and self-protection. However, my theory differs from the attributional and ethnocentric theories in two ways. Firstly, it is centrally concerned with the content of lay 'attributions', not purely in classifying whether, for example, characterological or behavioural blame has taken place. Secondly, it attempts to explain rather than to model the process of blame. The central dynamic of blame - a desire to protect the self at a time when one's sense of order is threatened - can be explained in terms of individualist and psycho-dynamic forces. It is these forces which lie at the root of blame.

### 10.3.4 THE THEORY OF INTER-GROUP BLAME

I set myself the rather ambitious task of devising a theory of inter-group blame. Let me try to summarise the theory which has evolved. The fundamental question which the theory tries to address is: Why do people always feel 'It won't happen to me' when a crisis occurs?

When a crisis such as AIDS occurs, lay people's representations of it are determined by the filtering of scientific ideas, by way of the mass media, to them and to the people around them. A crisis is constructed by the way in which these institutions view the phenomenon. This aspect remains central to the process which then takes place.

The fundamental dynamic, when faced with a crisis, is to protect the self. A partial

explanation for the need to protect the self is that, within a culture shaped by the ideology of individualism, 'self' needs to see itself in a positive, successful light. Yet the need to heap blame for crises onto the 'other' precedes the rise of the individualist ideology historically. In addition, this need is present in cultures which are not influenced by individualism. A more fundamental explanation for protection of the self lies in the psycho-dynamic notion that, in the face of anxiety-provoking crises, early feelings of helplessness are evoked. Defences that were formed in the early stage of the infant's development are evoked. The most primary of the defences against anxiety is that of 'splitting' good from bad objects, introjecting only the good and drawing a boundary around the good self, by projecting the bad onto others.

The level of representation is particularly important in terms of who is chosen as the representative of the bad 'other'. The groups to which science and the mass media initially anchored AIDS linger in people's choice of a group to blame. The initial choice of groups, made by science and by the mass media, is linked to hegemonic ideology. The choice relates to those who appear to be responsible for the crisis, at its inception. Members of blamed groups internalise the blame, but also have a tendency to cast blame outwards. If such groups are empowered, as the gay community in Britain is, they tend to devise counter-blaming theories to those put forward by the hegemonic structures. In the sphere of AIDS, the conspiracy theory is a counter-blaming strategy. As Farmer (1992) suggests, it is merely the rhetoric of a powerless group. It does not have the same consequences for various groups that blame has. However, like the 'rhetoric' of the gay lobby, it too will transform social representations of AIDS. Knowledge is the outgrowth of a chain of transformations (Moscovici, 1987).

The desire to protect the immunity of the self appears to be more fundamental than the particular choice of 'others' whom one can hold responsible. The urban, over-technologised space is linked to AIDS in much the same manner as various risk groups are. Yet, my theory differs from that of Herzlich (1973) in that I believe that it is the actions of the people who inhabit and who create these spaces that is implicated, rather than the space itself.

## 10.4 AREAS OF FUTURE WORK

• This thesis focuses purely on social representations which connect AIDS and blame. It casts no light on the extent to which blame-related thinking pervades people's social representations of AIDS. While certain theorists have touched upon this area (eg. see Clift *et al.*, 1990), additional work is required.

• I have made the assumption that whites, in both South Africa and Britain, identify with Western countries and with other whites and that blacks, in both South Africa and Britain, identify with Africa and with other blacks. This assumption was central to my coding of responses to the questions: 'Where does AIDS originate?' and 'Who is worst affected by AIDS in your country?' in terms of 'self' or 'other'. I realise that this assumption is problematic in the light of allusions to America among South African and British whites. America was categorised as 'self' when it was provided as an answer to the above-mentioned question 'Where does AIDS originate?'. However, a number of South African and British whites also view America as 'other' in terms of its excess and its permissiveness. Of course a theoretical problem arises: Respondents have a myriad of identities and different identifications are evoked by way of different subject areas,

interviewers and interactions. Future research on inter-group blame would have to explore the identity to which each individual respondent adhered, before categorising blaming responses in terms of 'self' or 'other'.

• Social representational theory, pioneered in France, has undergone a number of transformations in its translation from French. English translations, and British social representational work, have stressed that the function of the social representation is to make the unfamiliar familiar so as to enhance communication by establishing shared codes of understanding. French work stresses that the social representation confers identity. Future work on AIDS and blame should incorporate the French conceptualisation of the social representation.

• I take for granted the fact that power relationships affect the material which is evoked in an interview between a white woman, and white and black women and (homosexual and heterosexual) men. Bhavnani (in press) points out that certain research situations contain ambiguity in terms of power relationships. The white female interviewer may be seen as both a figure of authority by black men, in terms of the race/class dimensions, and a figure of subordination in terms of a gender hierarchy. Different social representations are elicited by the reactivity between any two individuals. Interview material is different from material from secondary sources, for this very reason. Methodologically, then, my British policy-maker data is very different from the South African data. It is sensitivity to such issues, rather than elimination of such biases, which is optimal. Dockrell and I argue that:

> "Traditionally, psychologists have attempted to eliminate or to reduce reactivity in research contexts...the desire for objectivity and for the

> avoidance of social interpretation is counter-productive. By cleansing research of reactivity we would fail to gain knowledge about those areas which carry a social stigma in particular cultures, at particular times" (Dockrell & Joffe, 1992:514).

Black South African respondents were definitely aware of a colour difference in relation to the white interviewer. This was best illustrated by the black South African respondent who differentiated between "your place" and "our place" in an attempt to locate the place in which AIDS is found. Of course one has to consider that the data given by black respondents might have been very different if they had been interviewed by a black interviewer. However, interviewer and respondent can never be matched in terms of the variety of social identities which constitute each individual's identity. In addition, one cannot control for the (unconscious) transference and counter-transference processes which the interview situation evokes.

• The level of reflexivity, especially amongst British respondents, was far higher than expected. It is difficult to separate reflexivity from self-presentation. Despite reservations expressed in terms of the group interview (see Section 5.6.1, Chapter Five), it may have yielded less reflexive social representations because self-awareness tends to dwindle in the group situation.

• I consider the early experience of each respondent as one of the factors which shapes their pattern of blame in adulthood. The Adorno *et al.* (1950) study concluded that what they termed 'prejudiced attitudes' are rooted in early experience, in hierarchical child-rearing practices. On an individual level, blaming reactions, following a crisis, may well be related to early experience. However, I have attempted to capture the social nature of blame: That it circulates in the culture as well as in cognition, and that it exists on the

inter-group level, rather than as a disposition or tendency of certain individuals. Future research may attempt to explore, with greater precision, the relationship between the individual's tendency to blame, and the way in which this might be constrained or activated by ideological forces.

• I would like the theory of inter-group blame which has evolved in this thesis, to be extended to cover other crisis events. I realise that much of the **content** of blaming aspersions would be different for AIDS, as opposed to, for example, an earthquake. But many of the **processes** may well be the same: The tendency to defend the self by casting responsibility out, at a time of crisis; anchoring the event and groups connected with the event to previous similar events in the history of one's society; the influence of the relative status or power of various groups on the processes of blame, self-blame and counter-blame; the ideological 'fit' between lay reactions and those expressed by opinion leaders.

## 10.5 CONCLUSION

Self-protection colours the way in which everyone relates to AIDS. Demographic differences become irrelevant in the face of this pervasive force. However, the ability to protect the self is sometimes undermined by repeated attacks upon one's identity by forces outside of the self. For those who are blamed for AIDS the self-protective 'not me' feelings co-exist with the 'me' feelings.

## OVERVIEW OF CHAPTER ELEVEN

Inter-group blame has deleterious consequences both for the 'blamers' and for the 'blamed'. In this chapter I explore the possibilities for diminishing inter-group blame. I investigate the potential for change at the level of mass mediated AIDS campaigns. A discussion of the positions of Sontag and of Treichler in relation to illness points to the fact that change must be enacted at the level of representation. Changes to the current social representations are considered in terms of the theoretical position which I have established in the thesis. These possibilities lie in finding less fear-evoking, and less individual responsibility-based social representations with which to represent AIDS. The politically empowered gay lobby has been instrumental in using different social representations, from those of the Government, in its AIDS campaigns. This lobby has influenced the form which the British Government's AIDS campaign has taken. This illustrates that changes in social representations of AIDS can be engineered.

# CHAPTER ELEVEN: CHANGING SOCIAL REPRESENTATIONS OF AIDS

> "[Confusion about transmission and stereotypes concerning homosexuals are] part of the necessary work people do in attempting to understand - however imperfectly - the complex, puzzling, and quite terrifying phenomenon of AIDS" (Treichler, 1988:34).
>
> "We cannot effectively analyse AIDS or develop intelligent social policy if we dismiss such conceptions as irrational myths and homophobic fantasies that deliberately ignore the 'real scientific facts'" (Treichler, 1988:34).

## 11.1 INTRODUCTION

Inter-group blame has a number of consequences, both for the 'blamers' and for the 'blamed'. Having established that these consequences are harmful, I look at the possibilities for change. While change may take place at a number of different levels, I will look at changes which can be brought about in mass mediated AIDS campaigns.

I look at possibilities for change in the social representations of AIDS, transmitted by mass mediated AIDS campaigns, from the vantage point of the theoretical framework which I have established. This involves the interplay of conscious and unconscious factors. Ideas about AIDS were originally transmitted from the world of epidemiology, via the mass media, to lay thinkers. I have shown that it is the epidemiological branch of medicine which has shaped the public face of AIDS. It has done this through the mass media's use of AIDS statistics, classified by way of risk groups; and through the use of epidemiologists as policy-makers and as public figures associated with AIDS. The representation of AIDS in terms of 'risk groups', then, is related to the influence of

epidemiology on social representations of AIDS. In addition, certain anchors for AIDS arose on the basis of epidemiological thinking. The idea of AIDS as a 'gay plague' is a particularly powerful anchor in societies influenced by Western media. It has its roots in the fact that Gay Related Immune Deficiency (GRID) or (what was later termed) AIDS was first identified in homosexual men. The development of this syndrome was correlated with the homosexual lifestyle both in the world of medical science and in the journalism which conveyed these findings to lay thinkers.

Lay thinkers filter the ideas which are transmitted to them through ideological and emotional prisms. This act of 'filtering' occurs at the level of the unconscious. The ideological and emotional prisms function in tandem. Defensiveness is a consequence of the fact that ideas transmitted to lay people are filtered through the emotional prism. Subsequently, people represent AIDS as an affliction suffered by 'the other', rather than by 'the self'. The ideological prism determines which groups constitute 'otherness'. Apartheid and colonial ideologies lead to the association of AIDS with the under-developed world. The family-centred ideology leads to the association of AIDS with homosexuality and with promiscuity. In addition, the ideology of individualism, in particular, fosters a strong sense of individual responsibility in members of Western influenced societies. In such societies the burden of responsibility for illnesses, such as AIDS, becomes all too great. Comfort is sought by projecting this responsibility away from the self. In viewing AIDS as an affliction of 'the other', the space of 'the self' remains pure and unthreatened.

The conscious and unconscious levels of AIDS-related thinking contain complementary

ideas. Certain epidemiologically determined 'risk groups', whom people view as different from themselves, as 'not me', are linked with AIDS. This has a number of consequences.

## 11.2 THE CONSEQUENCES OF INTER-GROUP BLAME

### 11.2.1 CONSEQUENCES FOR THE 'BLAMERS'

Almost all of the respondents in my sample attempted to blame others for AIDS, as a strategy of self-protection. While this defence protects the respondent from feeling out of control, it does nothing to protect the respondent from contracting HIV. In fact, the feelings of invulnerability and of immunity, that arise as a consequence of self-protection, are likely to render safer sex unnecessary. Blame leaves the 'blamer' more, rather than less, vulnerable to potential infection.

> "[There is] strong evidence to support the hypothesis that anti-gay, and also probably racist, attitudes tend to encourage the denial of heterosexual transmission among prejudiced individuals" (Watney, 1990:24).

As a consequence of inter-group blame, people not only deny the possibility that they will contract HIV, they stigmatise those groups whom they associate with AIDS. The stigma which surrounds AIDS can be explained in terms of the multiplicity of tabooed activities with which it is associated. It is connected to STD, a symbol of pollution (Douglas, 1966; Conrad, 1986; Sontag, 1989). It is linked to death. It is coupled with stigmatised groups, stigmatised in terms of the criminal and/or biblical censure of activities such as drug-use, anal sex, and excessive sexuality:

> "Stigmatised illnesses are usually diseases that in some fashion are connected to deviant behaviour: either they are deemed to have produced it as with epilepsy or are produced by it as in the case of VD" (Conrad, 1986:52).

It is 'high risk groups' who have been the targets of AIDS-related stigma. The meaning

of 'high risk group', within epidemiology, is a group of people who are, themselves, statistically at special risk of contracting HIV (Scott, 1992). Yet, within lay social representations of AIDS:

> "The term has been misappropriated to mean exactly the opposite: people who are a special risk to others and therefore blameworthy" (Scott, 1992: 79).

Friedland (1988) adds:

> "Although useful for epidemiologic surveillance purposes, this designation creates the illusion that non-membership in a 'group' conveys protection" (p.2898).

Like feelings of invulnerability, stigma fosters feelings of resistance to AIDS-related information:

> "One of the most striking aspects of the social reaction to AIDS is how fear and stigma have lead to resistance to information about AIDS" (Conrad, 1986:55).

So stigma has the consequence that those who stigmatise others distance themselves from the illness.

Dominant thinking in relation to HIV/AIDS:

> "joins a morass of unthinkability in which homosexuality is already (for many people) placed, a Gothic territory where fears are flung out into a sort of mental wasteland beyond the castle walls of the ego" (Williamson, 1989:70).

The construction of a 'Gothic territory' is functional: It allows for the maintenance of the purity of one's own territory. Those who operate outside of this system of purity, are deemed aliens. Aliens have a role in society. They demonstrate which behaviours members of the society should avoid. Aliens play an important part in the cohesion and identity of the in-group, defining what is normal behaviour. The 'other' is needed to define the 'self'. Through defining what is 'unnatural behaviour', members of a group

denote what is 'natural'. It is the fear of the fall into the 'unnatural' which determines blamers' need to position homosexuals and promiscuous people as so different to themselves. People construct deviance to distance themselves from the chaos which is feared. This chaos is often represented, in Western culture, as disease (Gilman, 1988). The drawing of boundaries around the normal and the abnormal is an important part of a society's maintenance of its sense of order. Outsiders are not merely functional in terms of defining acceptable and unacceptable behaviour. They have an intrinsic fascination: They represent facets of the blamers which the blamers most fear. In looking at 'deviant' people, they see aspects that haunt their unconscious, aspects which they seek to deny (Gilman, 1988; Ussher, 1991).

Whilst functional in individualistic psychological terms, blame is counter-productive in physical terms. The risk of the 'projector' or 'blamer' is increased when such a territory is constructed.

### 11.2.2 CONSEQUENCES FOR THE 'BLAMED'

> "The victims of this plague remind us of our fragile mortality and we shun them for this unwelcome message" (Friedland, 1988:2899).

While many individuals project blame for AIDS away from the self and the in-group, certain groups are at the receiving end of blame for the origin and spread of AIDS. People with HIV/AIDS and those identified with groups who are associated with AIDS experience blame in a variety of guises.

AIDS has tended to affect those already marginalised and so reactions to AIDS are reactions to those marginalised groups (Herek & Glunt, 1988). The social worth of

individuals affects our sense of compassion towards them (Friedland, 1988). The social representation exists that individuals, who tend to be from marginalised groups, have brought AIDS upon themselves. They have contracted AIDS knowingly and wilfully. Blame of the PWAs, for contracting their illness, results in a lack of compassion for them. A lack of compassion can be manifest at various levels. Compassion is a broad concept of collective will. It includes political acts which bring about resources, structures, institutions, behaviours and norms directed at promotion of health (Friedland, 1988). Compassion, expressed at the level of political activity, has often been absent in countries' reactions to PWAs and to groups associated with AIDS. Within the two countries sampled in this study, the expulsion of migrant mine workers with HIV/AIDS from South Africa is the most profound example of diminished compassion. Certain theorists (eg. Stoddard, 1992) argue that Britain's Section 28 is also indicative of a lack of respect for human rights. In addition, diminished compassion is evident in the failure of the British Government to make a strenuous attempt to control the spread of HIV until it was feared that AIDS might affect the heterosexual community. A documentation of the violation of the rights of PWAs throughout the world (eg. see Sabatier, 1990) provides further evidence of the lack of compassion which has characterised reactions to AIDS. In possibly the most extreme measure which has been documented, the entire population of Cuba is tested for HIV, and those who are positive live in special sanatoria (Stoddard, 1992).

Stigma has both functional and harmful consequences for both the 'blamers' and the blamed. I have mentioned that it leaves 'blamers' feeling immune from AIDS, thereby increasing their chances of actually acquiring HIV. Stigma has a host of deleterious consequences for the 'blamed'. The psychological consequence of stigma which has come

to light in this study, (and was evident in the Isaacs and McKendrick (1992) study of South African homosexuals), is that of spoiled identity. People who identify with groups who carry the stigma for AIDS are more likely to blame themselves for AIDS. They absorb the projection of 'unnaturalness' and of chaos, from hegemonic thinking.

Perhaps counter-intuitively, stigma has a function for certain groups. Stigma increases solidarity among the stigmatised community by demarcating its boundaries (Herek & Glunt, 1988). In-group identification occurs. This makes the stigmatised group's ability to transform social representations of AIDS stronger, if the societal norms around it are not too admonishing or repressive.

AIDS-related stigma has the potential to unify the stigmatised groups, and to allow them to fight the representations which oppress them. However, this potential is often curtailed by feelings of powerlessness within the stigmatised groups. The national counterpart of feelings of spoiled identity are feelings, on the part of citizens of a country, that they are helpless in relation to their AIDS epidemic. Doctor Banda, a Zambian AIDS policy-maker, states that this has been the effect of blaming Africa for AIDS, on his own country (personal communication, 8 October 1991). The World Health Organisation has documented feelings of helplessness and of passivity within a number of countries which are badly affected by AIDS (Meyer, 1988). Africans and homosexual Westerners may experience themselves to be powerless and to be at the mercy of AIDS, because of their (stigmatised) identities rather than because of their behaviours.

## 11.3 CHANGING THE REPRESENTATIONS OF ILLNESS: THE SONTAG/TREICHLER DEBATE

Sontag (1979) views illness as a medical phenomenon, which becomes imbued, by lay thinkers, with a number of extraneous metaphors. Lay thinkers impute the dominant illness of each age (AIDS currently has this status, according to Sontag (1989)), with the other central conflicts of the age. I have demonstrated that AIDS absorbs the fears invoked by the fall of Apartheid in South Africa, as well as a host of fears concerning the collapse of the eco-system. In addition, the dominant illness of each age tends to be couched in the metaphors of foreignness and war. Sontag (1979) calls for a change in this practice of characterising illnesses by certain metaphors which do not belong to them. Illness is just illness. If the harmful social consequences of illness are to end, illness must be stripped of its metaphors. While she does not say so explicitly, Sontag's (1979) thesis implies that a virological vision of AIDS should dominate. If AIDS were viewed purely as a set of symptoms which resulted from a tiny virus, it would carry less social baggage.

The Sontag (1979) position is well expressed in Judith Williamson's (1989) stance on AIDS:

> "Nothing could be more meaningless than a virus. It has no point, no purpose, no plan; it is part of no scheme, carries no inherent significance. And yet nothing is harder for us to confront than the complete absence of meaning" (p.69).

A virus becomes endowed with a purpose it lacks.

Treichler's (1988, 1992) position stands in direct contrast to the idea that HIV is a 'meaningless virus'. Disease is only knowable through its metaphors because it is only knowable through language and imagery (Treichler, 1992). Knowledge of natural

phenomena such as AIDS is mediated through our symbolic constructions of them. Virology, immunology and molecular biology permeate the way in which we think about AIDS. They are discourses or symbolic constructions in the same way that 'cultural' or 'social' constructions are discourses. Because of the privileged position of science at this point in history, in Western-influenced cultures, such discourses are seen as the (metaphor-free) lens through which other aspects of the world are compared. Medical ideas about AIDS, from the virological to the epidemiological, can only be assimilated by lay thinkers with the help of symbolic systems, such as the system of metaphor or of social representation.

The Treichler (1988, 1992) argument is convincing. My own data illustrates the fact that viruses are not perceived as 'meaningless' little things. Many of the British respondents in my sample are aware of the fact that a virus causes AIDS. Yet the 'virus' is not always perceived as a microbe lying at the bottom of a microscope. Virologists may well perceive a virus in terms of its chemical properties and the like. Respondents, in my sample, and in that of Aggleton *et al.* (1989), link viruses to germ-warfare, to biological warfare, to cloning, and to laboratory experimentation. Clearly, then, we cannot assume that the deleterious consequences of inter-group blame can be curtailed by campaigns adopting a virological rather than the current epidemiological model of AIDS.

In fact, Sontag modifies her thesis on illness of the 1970s, when she writes about AIDS in the late 1980s. This revision obviously occurs in the light of criticism of her work, by theorists such as Treichler. Sontag's (1989) position comes to resemble that of Treichler (1988, 1992). Sontag (1989) argues that one cannot think without metaphors: All thinking

is interpretative. Yet there are certain metaphors from which we should abstain. In particular, she talks of a need to 'retire' the military metaphor. The use of this metaphor shows how dreaded a disease is. There is a need to make this dreaded disease foreign, to distance oneself from it. As we distance ourselves from the disease, so we distance ourselves from, and demonise, those whom it infects. Sontag (1989) proposes that certain metaphors should be 'retired' if AIDS related thinking is to change. Is the 'retiring' of certain metaphors all that can be done to change social representations of AIDS?

## 11.4 ARE LAY AND SCIENTIFIC THINKING SIMILAR?

The Sontag/Treichler debate brings to light the controversy concerning the similarities and differences between thinking in the lay and in the natural scientific worlds. While Sontag's (1979) position implies that the two worlds are separate, Treichler (1988, 1990) characterises both worlds in a similar way:

> "There is a continuum, then, not a dichotomy between popular and biomedical discourses and these play out in languages" (Treichler, 1988:35).

> "No clear line can be drawn between the facticity of scientific and non-scientific (mis)conceptions. Ambiguity, homophobia, stereotyping, confusion, doublethink, them-versus-us, blame the victim, wishful thinking: none of these popular forms of semantic legerdemain about AIDS is absent from biomedical communication" (Treichler, 1988:37).

I mentioned, in Chapter One, that the social representation fulfils two functions. Firstly, in making the unfamiliar familiar, the social representation gives people a way of understanding and, therefore, of feeling in control in relation to their worlds. Secondly, it facilitates communication, by setting up a shared code of understanding the world. To what extent does thinking in the natural scientific world share these two functions? In

discussing this I will need to talk about 'science' as a single entity. (I do not include the social sciences in this discussion). This rather abstract and idealised vision of science allows me to sketch the differences which are salient in terms of my argument.

Science is an attempt, by humans, to understand the workings of the world, so that they can experience control of it. Beyond the experience of control, certain scientific advances allow for a degree of actual control of phenomena, such as illness. There is ample evidence to prove that medics responded to AIDS in line with the social representational tenet of attempting to make the unfamiliar familiar. AIDS was initially termed Gay Related Immune Deficiency. An unfamiliar illness, which affected a group who were familiar to medics in terms of other medical issues such as a high level of STDs, was understood in terms of the behaviours of its victims. Furthermore, in an attempt to gain an understanding and sense of control of what was later termed AIDS, medics explored the possibility of the origin of AIDS being in Haiti or in Africa. An unfamiliar illness, which appeared to be related to sexuality, was imagined to originate in the under-developed world. Medics had explored the under-developed world in the hope of finding the origin of syphilis, in earlier centuries. A final example which illustrates that medics, like lay thinkers, look to the familiar to assimilate new knowledge, is in the classification of risk groups. The classification system is self-perpetuating. Medics slot people with HIV/AIDS into known risk groups. New ideas concerning risk are not easily added to the system of classification (Bloor *et al.*, 1991). The unfamiliar is assimilated in terms of the familiar. In addition, like lay thinkers, medics set up a shared set of codes, such as a classification system, to facilitate communication.

Lay and scientific thinkers respond to new phenomena in a similar fashion. The difference between the two modes of thinking lies in what is subsequently done with the information. Ideally, a theory only has the status of belonging to an empirical science if it is falsifiable (Popper, 1983). Thus scientists conduct their work so that other scientists, through use of the same methods, may falsify it. Like social representational thinking, a shared code of understanding is set up in order to communicate. Yet, the scientific finding is far more open to criticism and modification than is the social representation. Scientific thinking aims to be fully reflexive, whereas the reflexive process is more obtuse, slower and less pronounced in lay thinking.

In their quest to make phenomena understandable, scientists often use statements of correlation, before arriving at a probability concerning whether an effect is or is not related to a given cause. The social representational world is quick to move from the level of classification to description and explanation. Lay thinking, and the journalism that informs it, over-estimate certainty and consistency. Certainty and consistency are non-existent in the scientific world - scientists talk in terms of probability. One of the differences, then, between representations which arise from lay thinking and those that arise from the empirical sciences is that the latter are more reflexive, more sensitive to information which challenges earlier findings.

One of the lessons which can be drawn from scientific thinking is that change comes about through reflexivity. Consequently, if social representations of AIDS are to be changed, people need to gain awareness of the deleterious consequences of existing social representations. Findings from the plethora of academic studies concerning social

representations of AIDS need to be popularised.

According to Treichler (1988; 1992) and Sontag (1989) people will continue to interpret AIDS metaphorically. Metaphors which do not perpetuate the cycle of blame need to be injected into current social representations of AIDS. New social representations can then be fed into mass mediated AIDS campaigns.

Along what pathways should one go to seek out new metaphors? Neither Treichler (1988, 1989, 1992) nor Sontag (1989) provide answers to this question, other than suggesting that the military metaphor be 'retired'. I respond to this challenge in terms of the theoretical framework which I have forged. I also draw on examples of AIDS campaigns which appear to be in the process of transforming social representations of AIDS.

## 11.5 CHANGING SOCIAL REPRESENTATIONS OF AIDS: LESSONS FROM OBSERVATION OF THE ROLE OF ANXIETY

My study illustrates that defence mechanisms are one of the factors involved in the process of inter-group blame. Defence mechanisms are activated when individuals experience anxiety in relation to an event. This anxiety is the result of an interaction between the way in which the event is represented in the world beyond the individual, and the inner feelings which this representation evokes. Initial anxiety in relation to AIDS, in Britain and in South Africa, was roused by the anchors of plague, punishment and war in the mass media. Later on, mass mediated AIDS campaigns rekindled anxiety by way of their fear-evoking strategies.

Anxiety-evoking campaigns appear to result in defensive thinking. Defensive thinking can

be diminished by infusing campaigns with social representations of AIDS which do not provoke anxiety. I have discussed, in Chapter Two (Section 2.3.2), that commercial advertisers realised, a long time ago, that fear was of no use in attempting to persuade people to buy a product. The evidence in the health promotion sphere is equivocal (eg. see Soames Job, 1988). Certain researchers conclude that there is a positive relationship between the intensity of fear arousal and behavioural change (eg. McGuire, 1969; Kirscht & Haefner, 1973). Yet recent research supports the negative relationship between the intensity of fear arousal and change (eg. Brooker, 1981; Tripp & Davenport, 1988/9). Systematic research into the effects of AIDS campaigns, more specifically, has shown that light humour is more positively received than mild fear is, by viewers practising high risk behaviours in relation to contracting HIV (Baggaley, 1988).

Instances of both humorous and erotic AIDS campaigns are present in Britain. In fact, the HEA has now used both methods, but the erotic method was pioneered by the THT. Recent HEA television and cinema campaigns have used humorous messages in order to diminish the taboo surrounding AIDS. In the place of the early fear-evoking campaigns, an elderly woman, working on a rather humorous looking condom production line, talks about the 'changed face' of the condom, over the years. A similar campaign depicts an elderly man talking about the days in which he used to use old-fashioned condoms behind his father's tool-shed. Clearly, the HEA has realised that 'not me' feelings need to be tackled and that certain non-stigmatised identities - such as those of older people - need to be associated with AIDS. Members of the HEA, and the market research and advertising agencies involved with their AIDS campaign, have assimilated critiques of themselves. In response to the critique concerning the blaming social representations

elicited by fear-evoking campaigns, the HEA produced a humorous campaign.

The finding, that fear-evoking campaigns produce undesirable unconscious effects, in terms of prevention of the spread of HIV, is counter-intuitive. It is often claimed that homosexuals adopted safer sex because they knew people who had died of AIDS. Those who want to use fear as a tool of AIDS prevention often draw on this assumption (Scott, 1992). In fact, data from London, Amsterdam, Sydney and San Francisco indicate that, when the homosexual HIV incidence began to decline in the early 1980s, there were very few people known to have HIV, and HIV anti-body tests had not yet been introduced. Fear alone cannot explain the changes. Fear is not a necessary condition for motivating people to change their behaviour.

Even with the cessation of fear-evoking campaigns, fear is likely to be attached to AIDS for some time to come. This is related to the plague anchor in social representations of AIDS. Yet, with the reduction of fear levels in AIDS campaigns, the need for unconscious defensiveness should also diminish. AIDS can be 'de-plagued' or normalised so that its image no longer evokes the fear that the plague once did. Berridge (1991) has pointed out that the British Government adopted a strategy of normalisation of AIDS from 1988. However, my empirical work points to the fact that respondents often refer to recent citing of 'iceberg' and 'volcano' Government AIDS campaign posters, on specific billboards, where these could only have been seen five years earlier. Anchors are not easily challenged.

In line with the psychodynamic model, if one wants to lessen people's defensiveness one

needs to make their fears conscious - to bring id material to the ego. It is necessary to expose the underlying structures that inform social representations. Only by making unconscious structures accessible, can we hope to forge new social representations of AIDS. Journalists and social commentators who 'de-construct' ideas surrounding AIDS, feed this process of change. Sontag (1979) points out that the metaphors which link certain illnesses with foreignness often arise when the illness is not well understood and when no cure is possible. The fear-evoking disease is flung out onto the territory of 'the other'. Once the illness is understood and a cure is discovered, the social representations of AIDS will undergo radical transformation.

## 11.6 CHANGING SOCIAL REPRESENTATIONS OF AIDS: LESSONS FROM OBSERVATION OF THE ROLE OF IDEOLOGY

According to the tenets of the sociology of knowledge, thought and representation are socially constructed. Changes in social structures, therefore, can lead to changed social representations. I have shown, by way of the influence of the British gay lobby on British social representations of AIDS, that change occurs, at the level of ideology, when new and creative counter-ideologies confront hegemonic ideologies. I will demonstrate this process in terms of two aspects of the HEA's AIDS campaign.

From its inception the THT's AIDS campaign has drawn on a very different ideological base to that of the HEA. A family-centred, 'one partner relationships are safe' message has been absent from their wide-reaching campaign. Instead, erotic black and white photography has been used to promote safer sex (see Appendix V). 'Safer sex', within THT discourse, has been associated, primarily, with erotic, non-penetrative practices (for example, mutual masturbation), and, secondly, with the use of condoms for penetrative

sex. Assisted by Government funding, the THT issued a heterosexually targeted campaign (January 1990) with slogans such as 'it's that condom moment' and 'wet your appetite for safer sex' accompanying erotic imagery (see Appendix W). The HEA's campaign in the gay press has followed this lead. A campaign proclaims: 'They used to say masturbation was bad for you. Now it could save your life' (see Appendix P).

In Chapter One (Section 1.8) I show that the language used by gay organisations influenced Government AIDS language from the early phases of the campaign. British Government AIDS language has not only become much more explicit as a result of the gay influence, it has also become less rooted in the family-centred ideology. However, it must be pointed out that erotic, HEA-funded imagery appears in homosexually-targeted campaigns, but not in heterosexually-targeted campaigns in the mass media. Hegemonic ideology demands that mass mediated messages for heterosexuals do not stray too far from the family-centred base.

From its inception, the HEA has aimed to construct AIDS as an illness which is not related to people of marginalised identity. It has done so by increasingly focusing on behaviour, rather than on identities related to the transmission of AIDS. Despite their hope that this would prevent the target audience from feeling 'not me', I have shown that people have continued to associate AIDS with behaviour which is just that bit more excessive or deviant than their own. As a reflexive institution, the HEA has shown an increasing awareness of this tendency. A recent campaign, distributed in universities and other institutions on World AIDS Day, in 1992, depicts people of many nationalities and of all walks of life. The message reads: 'AIDS can affect anyone'. The slogan reads:

'AIDS: Everyone needs to know the facts'.

Interestingly, this campaign relates to identity rather than to behaviour. The HEA has vacillated between the identity-related and behavioural strategies throughout. In fact, one of its most unusual campaigns was the AIDS charter, which appeared in national newspapers on World AIDS Day in December 1988 (see Appendix X). Although over-dense in terms of writing, the AIDS charter is the government campaign which stands out in terms of its difference from the pure 'you are responsible' message which characterised all of the campaigns during the period which I examined. The charter expresses solidarity with PWAs. This campaign relates to compassion for PWAs together with imploring healthy people to recognise that "AIDS is everybody's business". I have indicated, throughout the thesis, that a focus on 'lifestyle' leads to blame. Over recent years there has been an increasing emphasis on the effect of lifestyle on health. Lifestyle is an area over which people are deemed to have full control. Lifestyles can be altered with the use of common-sense and willpower. People who find difficulty with changing their lifestyle are blamed for their own health. The AIDS charter not only moves away from the lifestyle-based approach, it also 'normalises' the illness, attempting to demonstrate that AIDS is not associated with deviants, which Conrad (1986) suggests as a strategy for stigma reduction. Expressing compassion for PWAs not only has potential to reduce the stigma experienced by the 'blamed', it may also make for less blaming. If a disease is normalised, it evokes far less fear than if it is constructed as threatening.

While the AIDS charter challenges some of the consequences of an individualistic ideology, it draws on other aspects of the ideology of individualism, such as the

'individual right to dignity'. Changed social representations can be brought about without overturning the central ideologies which inform reactions to AIDS in Western-influenced societies. Different aspects of a single ideology may have distinctive influences on social representations of AIDS.

The fact that AIDS is often associated with stigmatised identities rather than with certain activities is evident in findings that lay thinkers imagine that lesbians are at special risk of contracting HIV (Kitzinger, 1990). Lesbians are implicated in relation to the spread of AIDS in my study. Two South Africans (one black and one white) and two British respondents (one black and one white) correlate lesbianism positively with AIDS. All of these respondents are heterosexual. They mention it when asked who is worst affected by AIDS in their own country. A typical response would be:

> *"50% are gay - 25% gay men and 25% gay women"* **(South African white heterosexual 2).**

In fact, the activities of lesbians tend to put them at lower risk of contracting HIV than the activities of heterosexuals or of homosexual men.

This type of response should not be construed as a 'misconception'. It relates to the level of fantasy, to a social representation which links disease and deviant identities. Such social representations are changed when 'the other' finds a forum for its voice, and is able to feed counter-ideological material into the existing AIDS language and imagery.

All meaning is socially constructed and, therefore, can be deconstructed and then, if found to be damaging, changed. The British gay lobby has been empowered to fight the implications of the 'gay plague' anchor, because researchers, many of them gay (eg.

Watney, 1987; Weeks, 1989), have deconstructed the ramifications of this and other metaphors at an early stage in the epidemic. This illuminates the role of reflexivity, often instigated by popularisation of ideas arising in academia, in changing social representations of AIDS.

I have stated that the British gay lobby, because of its politically organised nature at the time that AIDS entered British society, was able to challenge the social representation of AIDS as a 'gay plague'. This group was, and has remained, extremely powerful in terms of shaping reactions to AIDS in Britain. By way of contrast, the 'blamed' in South Africa, black people and homosexuals, were not politically organised at the time when AIDS began to affect them. What influence will the release of Mandela, and the total shift in South African politics, including the repealing of the Apartheid laws, have on social representations of AIDS in South Africa?

There has been a mushrooming of health organisations which are concerned with broad health inequalities in South Africa since the release of Mandela and the unbanning of the ANC. One unifying philosophical shift, within these health organisations, has been the focus on situational determinants, rather than on individual determinants, in the social representation of illness. Responsibility for illnesses is seen to rest with social structures rather than with individual lifestyle. This counter-ideological current is likely to have an impact on the way in which AIDS is represented in the mass media and in social representations in the coming years.

## 11.7 CHANGES WHICH CAN BE EFFECTED AT THE CONSCIOUS LEVEL

Unconscious forces are only partially determinant of the social representations of AIDS. I have demonstrated that lay representations of AIDS are also related to the way in which the mass media and other institutions have represented the epidemic. It is at the level of groups, black and white groups, heterosexual, bisexual and homosexual groups, young and old groups, that mass mediated AID campaigns have been actively targeted.

This is partly a function of the epidemiological model which views a population in terms of the relative risks of various groups, for contracting an illness. In addition, market-research, whose findings have a major influence on AIDS campaigns, also operates in terms of 'target groups'. Market research agencies must advise their clients where to place campaigns, on the basis of the composition of the audience of a particular channel of the mass media.

The very notion of 'target groups', for whom campaigns are intended, unwittingly feeds the process of inter-group blame. This may be related to the fact that certain groups are obviously the target of a campaign, or that certain groups are depicted or mentioned in the campaign. This associates these groups with AIDS. I have pointed out that reflexivity enables social representations of AIDS to be transformed. When epidemiologists, for example, are made aware of the way in which their 'risk groups' are interpreted, this may result in changed practices.

Certain strands of social psychological theorising (eg. symbolic interaction) would propose that 'not me' and 'risk group' feelings merely result from the failure of self-insight. This

could be tackled by reflecting the danger inherent in unsafe sex back to individuals. This is essentially what phase five of the British campaign has done. It has taken 'ordinary people' 'like you and me' and shown that they have contracted AIDS. Both heterosexual and homosexual 'ordinary people' are represented. Interestingly, some are shown in rural environments, presumably to challenge the notion that AIDS is related to urban pollution.

Does this assist in challenging 'not me'/'risk group' feelings? It is difficult to gauge. Certain factors militate against any change in such feelings. Firstly, debates such as that which arose around the Kilbracken statements (see Chapter Eight) compete with the message that 'ordinary people' 'like you and me' could get AIDS. In market research terminology, the campaigns do not have the media 'monopoly' concerning which ideas get transmitted. Other sections of the mass media link AIDS to 'risk groups'. In addition, the 'hold a mirror up to the person' approach is not able to challenge the impact of emotion (eg. anxiety) and of ideology (eg. colonialism) on people's perception of AIDS.

I have demonstrated, in Chapter Ten, that the KAP model is not a good one for effecting changes in behaviour. If one perceives the media as an agenda setter, rather than as knowledge and attitude changer, one gains a more useful way of conceptualising the role of the campaign. The mass media mediate messages to the masses. Worldwide research has shown that campaigns which have focused exclusively on making safer sex normative have been more effective than campaigns with multiple messages (and multiple ideologies), such as those of Britain and of South Africa:

> "Both long-term cohort studies and other epidemiological data have demonstrated, again worldwide, that campaigns advocating safer sex can be correlated with very significant reductions in HIV incidence. These campaigns have addressed neither partner choice nor the number of

partners" (Scott, 1992:79).

This indicates both that campaigns can have an impact on AIDS-related behaviour, and that campaigns which focus purely on condom use are more effective than those which advocate the 'do not sleep around' type messages prevalent in both South Africa and Britain. It is the call to take responsibility, evident in British and in South African campaigns, which elicits 'not me' reactions.

## 11.8 CHANGING COUNTER-BLAMING SOCIAL REPRESENTATIONS

My findings corroborate the hypothesis that groups which are politically marginalised place blame for disease at the feet of governments and of public officials:

> "For non-elite groups disease is a symbol of their resentment of power" (Nelkin & Gilman, 1988:375).

Non-elite or marginalised groups often use the conspiracy theory as a form of counter-blame for AIDS. If conspiracy theories are viewed as counter-blaming mechanisms, used by marginalised groups, as they are in my sample, then a reduction in blame would reduce counter-blame. To a certain extent, counter-blaming theories have fewer consequences than do strategies of blame. Unlike theories of blame, perpetuated by elite or hegemonic groups, the conspiracy theory is only a rhetorical device (Falmer, 1992). Consequently, it is unlikely to have consequences for those who are blamed. However, counter-blaming strategies may have deleterious consequences for the 'blamers', in much the same way as the 'not-me' response has. Feelings of vulnerability may be diminished by projecting AIDS onto 'the other'. This issue is obviously open to debate because if one feels that an elite group is conspiring against one's own group, one may well feel that, ultimately, it will be successful in its endeavour.

## 11.9 A CHANGED WAY OF THEORISING 'PREJUDICE' AND 'HOMOPHOBIA'

Prejudice against homosexuals has tended to be construed, in both the gay and mainstream press, as 'homophobia'. This construction, like acrophobia or claustrophobia, implies that certain individuals, as a result of certain cognitive/emotional problems, fear a certain category of object. This negates the social construction of blame. Ray (1992) asks:

> "In Britain, **Gay Times** columnist Simon Watney has characterised both Europe and America as homophobic societies. What can this mean? That everyone in Europe and the US suffers from the same irrational dread?" (p.11).

The notions 'prejudice' and 'homophobia' construe blame as intra-personally motivated. Yet we know that individual inner causes are less related to the making of atrocities, such as the holocaust, than are dehumanising ideologies (Cohn, 1966; Dicks, 1972; Poliakov, 1974). Societies are as blaming as their hegemonic ideologies are, rather than the tendency to blame being a personality trait, or an intra-psychic fixation (but see Section 10.4 concerning areas of future work). By construing the response to AIDS in terms of an inter-group process, the focus is shifted from the intra-individual level. It is at the level of relationships between groups of people that change must, then, be initiated.

There is an inter-individual beginning to patterns of blame in terms of early infant-parent interaction. One outcome of the early developmental phases is the tendency to associate bad outcomes with others and good outcomes with oneself. This tendency has an inter-group counterpart, in the form of ethnocentricism. Yet, ideologies activate or constrain the tendency to associate anxiety-evoking events with others.

When certain ideologies are enforced by institutions in the society, they gain hegemony. Ideologies can give cultural licence for dehumanising certain selected 'others' in a society,

but they can also be channelled into respect for fellow humans (Sherwood, 1980). Sherwood (1980) cites the Race Relations Acts (1968, 1976) in Britain as vehicles with which to instill tolerance in a society. Such acts co-exist with debates concerning the undesirability of coloured immigrants. Within an ideological climate which contains anti-'prejudice' laws, although people might be 'prejudiced', they will not be able to rationalise their own judgements as respectable. This is highly important if one considers the salience of self-presentational strategies when people communicate (and thereby forge) their social representations of the world.

The blaming responses which I have documented in this thesis are invoked by laws, as well as by policy-maker opinions, formal religious doctrine, the mass media and a collective history which views homosexuals and black people in a negative light. If inter-group blame is viewed as a phenomenon which arises in the interaction between social context and individual mind (rather than as a problem of certain individuals), change can be effected by changing representations of AIDS in the mass media.

## 11.10 CONCLUSION

My theory of inter-group blame deems as central the forces of history, culture and the unconscious in the formation of human thought processes. History, culture and the unconscious are constantly in flux. It follows, then, that the process of inter-group blame and the content of the social representations which relate AIDS and blame, are also in constant flux. Changes in social representations can only be brought about by assessing which social representations are currently used, their implications, and the alternative social representations available.

This process of assessment needs to be theoretically driven. At the same time, theory needs to be supportable by empirical findings. Empirical work must focus on both the contents of the mass media and on lay thinking. While the content of the messages emitted by the mass media must be analysed, one cannot deduce audience understanding of the mass media from content analysing the messages which it emits. My thesis has shown that people filter the mass media through defensive and ideological prisms. An analysis of the content of the mass media does not indicate exactly how messages will be 'read'. Audience understandings must be gauged empirically, too.

Social representations of AIDS can have damaging implications. They result in feelings of invulnerability among 'blamers', and feelings of spoiled identity among the 'blamed'. In Britain, a group threatened with a spoiled identity has unified. This unity has allowed the gay group to challenge the damaging social representations of AIDS. It has injected into the discourse on AIDS, social representations which are not based on a family-centred ideology. Practices which take place outside of the nuclear family are deemed erotic and acceptable. The voice of the marginalised can have a massive impact on mainstream policy-making. My data show that the voice of the marginalised makes for reflexivity in relation to blame, in policy and lay domains. Social representations can be changed by way of political activism and by the sheer force of historical flux. A black British respondent provides an optimistic view of how her own blame of the 'other' has potential for change. Having linked AIDS to the sexual perversion of white people, she states:

> *"In moments of anger the racist side of me comes out, yes, but I don't cultivate it. I mean, I accept it, it's a part of me, I think it's a basic human fault. But then, you know, infanticide used to be a basic human fault, but people managed to overcome it"* **(British heterosexual black female, 9).**

## APPENDIX A: RESULTS OF BRITISH PILOT WORK

## PART I: SEMI-STRUCTURED INDIVIDUAL PILOT INTERVIEWS OF 10 BRITISH HOMOSEXUAL RESPONDENTS

### METHOD

#### Sample

Nine self-identified homosexuals and one self-identified bisexual between the ages of 17 and 21 were interviewed. Eight were white, and two were black. All respondents were British. One half of the respondents saw themselves as middle-class, the other as working class. The majority of the respondents were either Protestants or Catholics. Four respondents had no religion.

#### Procedure

The individuals were interviewed during November 1989 at London Gay Teenage Group (LGTG), a youth group for homosexuals and lesbians under the age of 22. The interviews took place in an office adjoining the Group's common-room. The interviews were audio-recorded with the respondents' permission.

PROBES USED IN THE INDIVIDUAL INTERVIEWS:

**1. How did you first hear about AIDS?**

**2. When did you first hear about AIDS?**

**3. What did you first hear about AIDS?**

**4. Feelings when first heard about AIDS.**

**5. Where did AIDS first come about?**

**6. How did AIDS first come about?**

**7. Why did AIDS come about?**

**8. How does AIDS continue to spread?**

**9. Who is worst affected by AIDS in Britain?**

RESULTS

Responses of the respondents (n=10) to the probes (listed above) are represented in the histograms which follow. Some respondents gave multiple responses:

Figure A.1. How first heard of AIDS

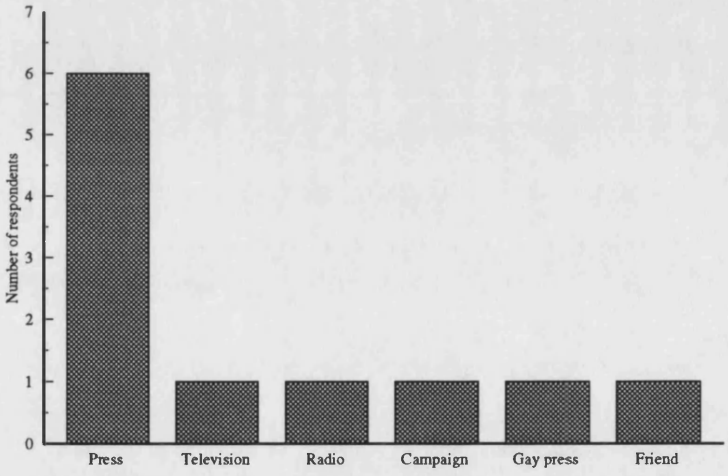


Figure A.2. When first heard of AIDS

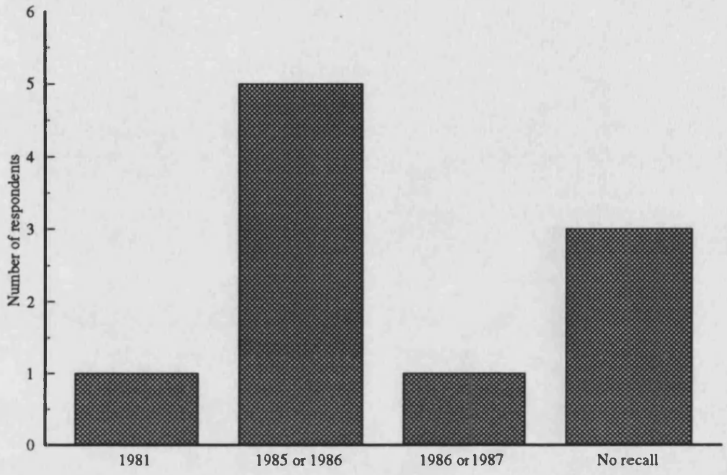



Figure A.3. Initial ideas about AIDS

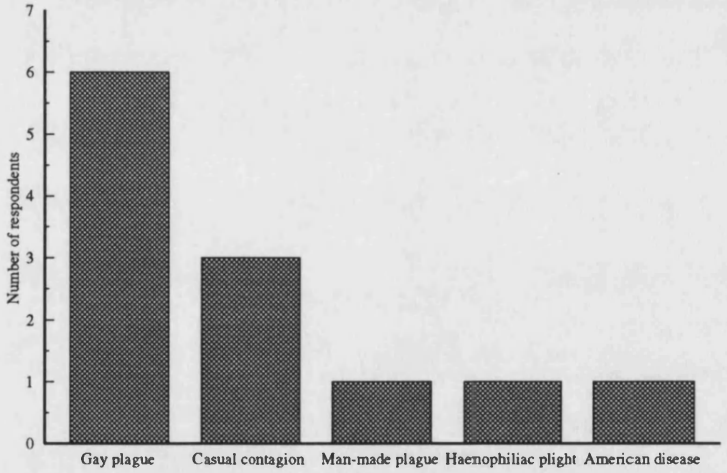


Figure A.4. Feelings evoked when first heard about AIDS

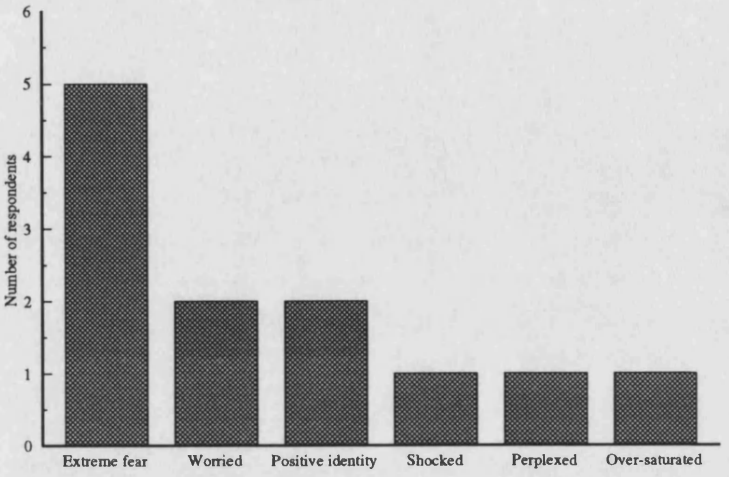



Figure A.5. Where AIDS began

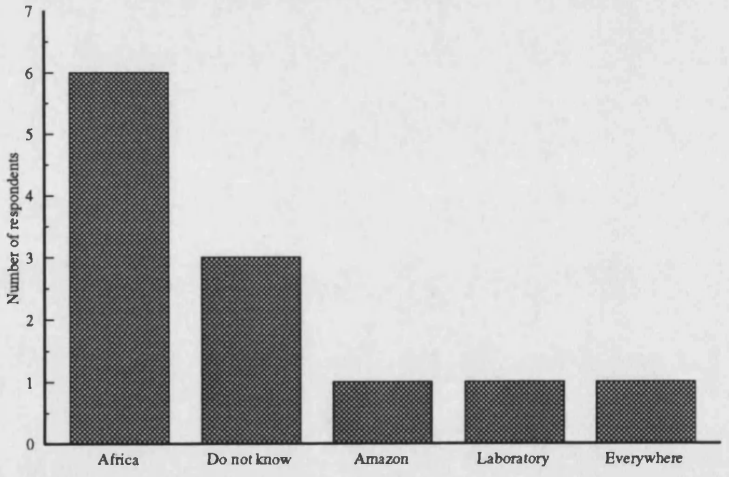


Figure A.6. How AIDS began

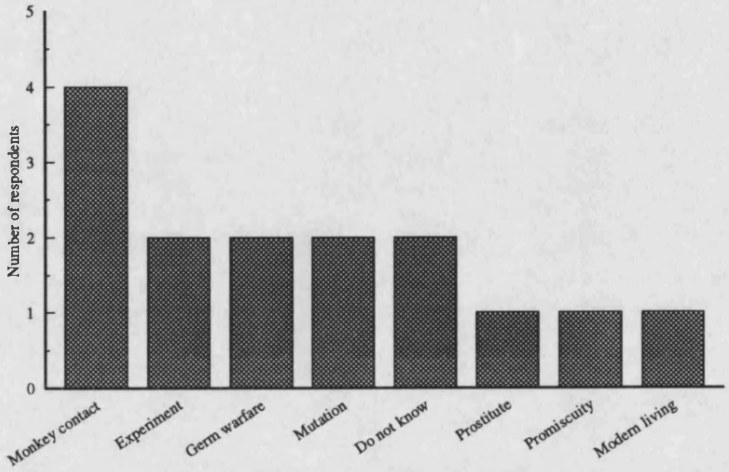



Figure A.7. Why AIDS began

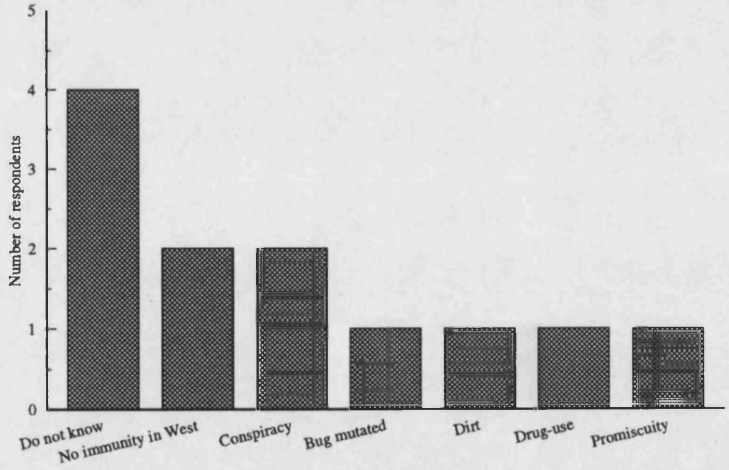


Figure A.8. Ways in which AIDS currently spreads

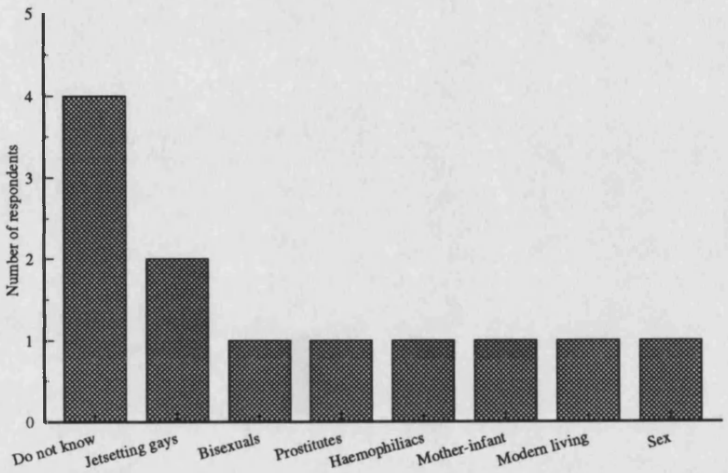
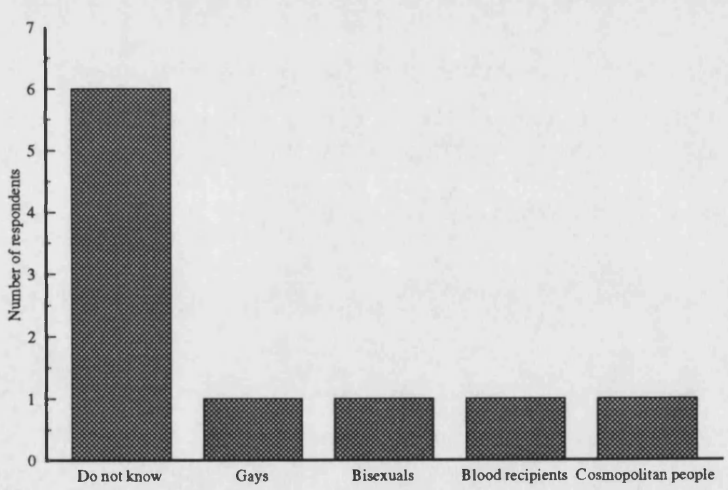



Figure A.9. Group worst affected by AIDS in Britain



QUALITATIVE ANALYSIS: DENOTATIVE LEVEL

An overwhelming majority of the respondents stated that they had heard about AIDS through the media "in 1985 or 1986" (they could not recall an exact date), despite the fact that many references to it appeared in the English media from 1981. While few respondents explicitly mentioned Government AIDS campaigns as an initial source of information, 1985/6 was when the first British Government AIDS campaigns appeared in the mass media. Rock Hudson's death also occurred at this time (1985). Half of the respondents heard about a 'gay plague' initially. While they were probably alerted to AIDS via Government campaigns, they also recalled issues presented in other mass media. These issues included: Conspiracy theories about the creation of the virus; the ease of casual transmission of AIDS; the link between AIDS and Kaposi Sarcoma (a form of cancer), bowel dysfunction, haemophilia, and sex.

These issues were touched upon in the Government campaigns of 1985/6, which emphasised the existence of certain 'high-risk groups' (gay men, haemophiliacs, prostitutes, drug users and the sexual partners of these group members), described the symptoms of AIDS (such as Kaposi Sarcoma), and attempted to dispel myths concerning the casual contagion of the virus. Campaigns tend to be mentioned less often than more alarmist-type articles, but their impact is evident in the choice of both the year of first hearing about AIDS, and in the content of what was heard.

Most of the respondents felt extremely fearful, shocked and chilled, when they first heard about AIDS. An interesting reaction is the feelings of identification experienced by these gay and bisexual men when they heard the news "*I quite enjoyed it because it was about*

*gay people*". A minority felt either perplexed by the issue, or able to ward off the threat which it presented.

AIDS was imagined to have originated in "*the darker states of Africa*", a long time ago. The specific location of the origin ranged from Zaire to Nigeria to South Africa. The "*dark*" African "*sub-continent*" is seen to be inter-changeable with "*the Amazon*", by one respondent. Six of the eight white respondents mentioned the African origins of AIDS. More than one respondent confounded the notion of a laboratory origin and an African origin - the virus was perceived to have originated in a laboratory in Africa. Both black respondents deemed the theory of an African origin racist and untrue. A theory which was equally prevalent was that no-one knows where AIDS originated, and that this is, in fact, not an important issue anyway.

The "*Green monkey theory*" was the most prevalent theory of how AIDS began, although most respondents held a few theories of how AIDS first came about. Respondents tended to be unclear about the origin of AIDS. However, the two black respondents felt fairly sure that many others believe in the African origins, but that no scientific evidence for this exists. One of the black respondents felt "*disgusted by the suggestion of an African origin*". The media were seen to propose homosexuality as the origin of AIDS.

The theories of why AIDS came about were far more varied than expected, but it must be noted that none of the respondents mentioned the wrath of god, or nature punishing humans for unnatural acts. Rather, AIDS was seen as Africa's punishment for its over-population, or the Western world's punishment for 'modern living', for modern Western

lifestyles.

Various forms of sexual contact were deemed responsible for the spread of AIDS. Respondents tended to link this with the modern habit of travelling between countries. Bisexuals, prostitutes, San Francisco and modernity were associated with AIDS. None of the respondents connected their own sexual acts with AIDS.

Only two respondents were aware of the fact that the vast majority (82%) of people who had AIDS at this time, according to Government statistics, were homosexual or bisexual. The majority did not hazard a guess concerning which groups in Britain were worst affected by AIDS.

QUALITATIVE ANALYSIS: CONNOTATIVE LEVEL

Myths about Africa - the symbol of the unknown, the unhygienic, the bestial, and the ancient, permeate the respondents' accounts. The idea that modern living undermines resistance to illness ties in remarkably closely with Herzlich's (1973) findings. Sontag's (1979) notion of disease as a metaphor for foreignness is borne out in the allusions to travel ("*jet-setting*"), beliefs that one should not sleep with an American, and allusions to AIDS as a disease of the **other/out-group**.

Theories concerning active conspiracy by way of "*germ-warfare*", and "*evil scientists*" are also of interest. There is a strand of paranoid thinking amongst these respondents. In addition, respondents resent the media for their portrayal of the origin and spread of AIDS. The media has also conspired against gay people. There appear to be differences

between the black and white respondents' constructions of AIDS. White respondents tend to blame Africa or the under-developed world for AIDS. The black respondents blame modern living for AIDS. They resent the fact that whites blame Africa for AIDS. However, the number of blacks was, of course, far too small to indicate whether this is a trend.

## DISCUSSION

The responsibility for the origin and spread of AIDS is quite clearly placed outside of the particular respondent and his social group, despite the fact that the media has told him that the plague began within his in-group. He tends to have felt extremely threatened by the new disease, and this may explain his defensive need to place it outside of himself. While some defensiveness, in the form of blame, is obviously present, it is interesting to note that a number of respondents do not know about the origin or spread of AIDS and will not hazard a guess. The gay media has constantly reiterated that the seeking of answers to these questions is society's way of finding a party to blame for AIDS. A number of homosexual men appear to have taken this message on board.

## PART II: GROUP PILOT INTERVIEWS WITH BRITISH HOMOSEXUAL RESPONDENTS

## METHOD

### Sample

Two groups, each consisting of six people from LGTG, were interviewed. Four out of the six people in each group had been interviewed on an individual basis (as part of the individual pilot sample) prior to the group interview. The demographic characteristics of those who had not formerly been interviewed are unknown.

**Procedure**

The two groups were interviewed consecutively on 26 November 1989 in LGTG's common room. The group interviews were audio-recorded on an unobtrusive recorder which lay in the middle of the circle of respondents. Group members were aware that they were being recorded. The nine areas covered in the individual interviews were raised by the interviewer in the group context. The group members were invited to speak freely about any issues which arose in the course of the group discussion.

RESULTS:
QUALITATIVE DESCRIPTION OF THE DATA

**Where did AIDS begin?**

GROUP 1:

- Initial emphasis on the fact that it "*doesn't matter*", "*no-one knows*", it's "*irrelevant*", it's "*like blaming the common cold on where it started*", "*people dying, that is the problem*".
- Possible theories:
  -> in homosexuals
  -> in Green monkeys in Africa
  -> in pigs on the Mexican border

GROUP 2:

- Initial emphasis:
  -> Africa, because there is a higher incidence there.
  -> New York, because there are more cases in America than in Africa or, alternatively, the sophistication of American medicine allowed the Americans to identify the illness first.
  -> Great Britain, because of imperialism.
- One suggestion: "*no-one knows*".

**How did it start?**

GROUP 1:

- The tabloids initiated the 'gay plague' rumour.
- It has been here for ages, but became recognised as an epidemic because it was

blown out of proportion by the newspapers.

GROUP 2:

- It is a 'designer disease': An old disease wrapped in designer packaging.
- It started due to the **Sun** newspaper's desire to attack homosexuals.
- Bestiality.
- When monkeys were killed for food in Africa their blood was digested by one African and he spread it through his many and indiscriminate homosexual and heterosexual liaisons.
- A virus mutated.

**To which illness is AIDS analogous?**

GROUP 1:

- It is like cancer - cancer is everywhere.
- It is like M.E. in that "*it is a condition of the nervous system*" and results from "*the way we live our life*".
- It is unlike M.E.: It is not just YUPPIES who get it.

GROUP 2:

- Kaposi Sarcoma.

**Why does AIDS exist?**

GROUP 1:

- This question is offensive because:
  1. There has been a history of blaming illnesses on people. Jews were scapegoated for their creation of the Bubonic plague.
  2. The search for why a disease exists has never done much to eradicate the disease. Rejoinder to this: It could help with an immunisation program.
  3. Illnesses just happen, you cannot blame - "*It is just the body*".
- AIDS is a reaction to modern living, it is the "*Eighties Effect*".
- Illness is related to your attitude to your body - if you say you feel ill, you become ill: A healthy lifestyle leads to creation of a healthy mind which leads to creation of a healthy body.
- AIDS was just waiting to happen - nothing just comes from nowhere.
- It exists due to people's lack of immunity to foreign diseases: In the same way that the colonised died from a lack of immunity to the diseases which were endemic to the colonisers, Westerners are dying from lack of immunity to this African illness

  -> AIDS is Africa's revenge.

GROUP 2:

- Africa is a promiscuous society rife with polygamy, sexual orgies, and freedom from the constraints of Christianity.
- A lack of bodily defence - due to modern living- allows cancer to enter the body.
- Germ warfare - AIDS was made in a laboratory *"I don't rule out the possibility with governments the way they are now"*.
- It is an STD with a new *"designer packaging"*.
- The issue is how to deal with it now rather than why it exists.
- Personal hygiene.
- It is a gay disease because gay sex is quite risky.

**Who is worst affected by AIDS in Britain?**

GROUP 1:

- Mainly drug users.
- Mainly gays (maximum proportion of gays within the total number of people with AIDS in Britain: 40%)
- It is equally divided between gays and drug users.
- AIDS in women is on the increase - they will be the next group affected by AIDS.
- This issue is a political one in which the right-wing are persuading themselves that AIDS is not a problem for heterosexuals.
- There might be more AIDS in the straight community than people think - it appears as if more gays have got AIDS because they go forward for tests.

GROUP 2:

- Drug users.
- Heterosexuals.
- Gays (Maximum proportion of gays within the total number of people with AIDS in Britain: 60%).
- There might be more AIDS in the straight community than people think - they do not go for tests.

**Do you see yourself to be at risk of contracting HIV?**

GROUP 2:

- Very high because of what might do in the future, because started having sex young and because sex is so central in the gay scene.
- With the right attitude one can act safely - using a condom. Rejoinder: But condoms can split.
- London is a risky place.
- One can be unlucky.

- Everyone tries the bad things in life.

**Remarks on the various groups connected with AIDS**

GROUP 1:

- Straights feel 'I am not at risk, I do not need to use a condom'.
- Haemophiliacs are getting compensation because it is the Government's fault that they got it - but it is nobody's fault for getting it, so all PWAs should get compensation. Rejoinder: But haemophiliacs are a 'vote-winner' "*whereas faggots and junkies are not*".
- The gay community is very divided - different factions prevent a unified fight against AIDS.

**Describe a person with AIDS**

GROUP 2:

- Unlucky.
- Looks like someone with cancer - gaunt and skinny.

**Who gets AIDS?**

GROUP 2:

- Stupid people - those who are not using safer sex .
- Ignorant people - those who are not aware of safer sex.
- Compulsive men - men are over-sexed.
- Sluts.
- If you trust someone you generally do not get AIDS.

DISCUSSION

There are a multiplicity of ideas surrounding the origins of AIDS. Those pertaining to Africa are particularly interesting because they reflect ideas about colonialism, imperialism, and Christianity. The analysis of the cultural and historical context in which these social representations are steeped would be very interesting.

There is a lot of resistance to 'blaming others', especially among members of Group 1. However, they do radically underestimate the proportion of homosexuals within the group who have AIDS in England: It stood at 82% (Government statistic) at the time that these interviews took place. Group 1 placed it at 40% and Group 2 at 60%. In addition, both groups had a tendency to overemphasise the extent to which the drug-using and female populations had been affected by AIDS. This appears to be evidence of the defensive tendency to protect the in-group.

## COMPARISON OF THE QUALITY OF THE DATA GLEANED IN THE INDIVIDUAL VERSUS THE GROUP INTERVIEWS

The range of social representations which arose during individual interviews was similar to that which was put forward in the group situation. Social representations which emerged from the group interviews were richer in fantasy, symbolic and superstitious material. However, 'opinion leaders' tended to dominate the discussion at many critical points in these groups. They prevented others from expressing certain lines of thought. In addition, the data which were gleaned in the group interviews were difficult to analyse systematically in terms of both their denotative and connotative levels. These issues are discussed in the text of Chapter Five.

APPENDIX B: SOUTH AFRICAN AIDS MISINFORMATION LEAFLET, NOVEMBER 1989

# AIDS INFORMATION DISTRIBUTING SOCIETY

OF SOUTH AFRICA

# FACTS ON AIDS:

## PRESS WON'T PRINT !!

## AIDS --- HUSHED --- WHY ???

An article published by Dr Maurice Shapiro, medical director of the S.A. Blood Transfusion Services corresponds with reports from the rest of Africa confirming the estimation that diagnosed AIDS cases in Blacks are doubling every 5 months!

If there is 1 in every 100 S.A. Blacks at present, infected by the AIDS virus, as reported by the Citizen of 29 September 1989, simple arithmatic shows that at present we have 270,000 Black AIDS sufferers in S.A.. Thus calculated at the present rate of increase ALL the South African blacks will be infected by 1992!!!! I.e. we have an AIDS PANDEMIC that is being hushed by the present day press.

| | | |
|---|---|---|
| 270 000 | - | September 1989 |
| 540 000 | - | February 1990 |
| 1 080 000 | - | July 1990 |
| 2 160 000 | - | December 1990 |
| 4 320 000 | - | May 1991 |
| 8 640 000 | - | October 1991 |
| 17 280 000 | - | March 1992 |
| 34 560 000 | - | August 1992 |

Of 12 202 white women tested for the virus, NOT ONE was found to be AIDS positive. (The Citizen 29/9/1989). This proves that AIDS is rife amongst the blacks but, for all practical reasons, absent in whites except in the homo-sexuals and mainly because of their lifestyle.

1

# THE ORIGIN OF AIDS

## MAN MADE DISEASE

The AIDS virus is in all likelihood man-made because it started simultaneously in more than one country, as opposed to, a "spontaneous" virus which first appears in one area only. While it could have come from a biological warfare laboratory in the Soviet Union (which has 8 biological weapons production facilities - a product of genetic engineering experiments), it is more likely that it came from mass vaccinations with contaminated vaccines by the WORLD HEALTH ORGANISATION IN AFRICA in the 1960's.

The vaccines are made by taking a virus of a disease and injecting it into an animal or tissue culture of an animal part. Once the disease is fully developed in the animal tissue culture, the serum is taken from the animal and they then generate the vaccine, but if the animals or their parts which were injected with smallpox or hepatitis-B vaccine were already infected with other viruses, those viruses could have crossed with the injected viruses to create a third virus (i.e. AIDS).

# WHAT ARE THE METHODS OF TRANSMISSION OF AIDS

## GOVERNMENT STORY - TRUTH OR TALE

The official government line is that AIDS can only be spread by sexual intercourse with an infected person, by a contaminated blood transfusion or by using a contaminated i.v. needle, the government dogmatically maintain that the AIDS virus cannot be transmitted casually and hence they claim that the virus can be contained if "safe sex" (i.e. the use of condoms) is employed, if clean needles are used by drug users and if the Blood Banks are cleaned up (and they claim that they have been). These explanations are over simplistic, defy logic and defy the facts!!!

## AIDS THE COMMON COLD

AIDS is a virus like the common cold virus or the myriad of flu viruses we have seen in recent years, those viruses are spread by sneezing, coughing kissing and other forms of close contact.

## AIDS WITH TEARS

The AIDS virus has been found by researchers in every form of body fluid: semen, blood, tears, perspiration, urine, saliva, etc. If the virus is in those fluids, why wouldn't it be transmitted in those fluids as it is widely understood to be in blood and semen ?

## AIDS KISSES

Elderly couples and parents and children whose only form of contact has been kissing, are known to have infected one another with the AIDS virus.

# FLYING AIDS

The authorities dogmatically maintain that AIDS cannot be transmitted by insects (i.e. mosquitos, flies, cockroaches, tics and fleas) to both humans and animals (i.e. the bubonic plague via fleas, malaria via mosquitos, polio virus via flies, tic fever via tics etc) which proves that insects do not have a mysterious chemical in their make-up that destroys "germs" as was told to us on T.V. by a so-called fundi on AIDS!!!

They surely don't think much of our intelligence ! What is the difference between a mosquito (a live flying needle) and a metal needle? Only the size of the needle, and the virus is sub-atomic in size and thus, quite capable of passing through a mosquito beak.

# NO CURE

Numerous AIDS researchers have concluded that the virus can exist on a dry surface for two weeks (this has been widely reported) and in liquid indefinitely. No known chemical substance (i.e. chlorine, antibiotics, chemotherapy, radiation) will kill the AIDS virus - only a temperature above 169 degrees F will destroy it. Another falacy is that AIDS is sexually transmitted only by homo-sexuals (this may have been primarily true 5 - 7 years ago BUT NOT TODAY.

# CASUAL DEATH

Recent studies show that there are now many more hetero-sexuals infected with the virus than homo-sexuals. Additional evidence that AIDS can be transmitted casually is the fact that over 67% of the reported cases in America were not homo-sexuals, i.v. drug users, recipients of blood transfusions, promiscuous or associated with any "high risk" group or behaviour. The origin of the infection is a total mystery.

# MEASURES TO TAKE TO AVOID AIDS

If, indeed, the AIDS virus can be transmitted casually, as a growing body of evidence seems to suggest, there are a number of areas where a person has a growing risk of exposure which should be avoided:

A. UNCOVERED TOILET SEATS. (VERY HIGH RISK)
B. SWIMMING POOLS (VERY HIGH RISK)
C. BEACHES
D. PUBLIC TOILETS (HIGH RISK)
E. BASIN TAPS (VERY HIGH RISK)
F. MULTI-RACIAL HOTELS (VERY HIGH RISK)
G. MULTI-RACIAL RESTAURANTS (HIGH RISK)
H. MULTI-RACIAL CHURCHES
I. COMMON COMMUNION CUPS (VERY HIGH RISK)
J. COMMUNION WAFERS HANDED OUT BY HAND
K. DISCOS AND PUBLIC BARS
L. JACCUZZIS
M. SALAD BARS
N. BLACK SERVANTS (BEING A HIGH RISK SECTION OF THE POPULATION, MONTHLY BLOOD TESTS SHOULD BE TAKEN FROM THEM TO SAFEGUARD YOUR FAMILY)
O. EXTRA/OR PRE-MARITAL SEX (HETERO OR HOMO-SEXUAL)
P. KISSING STRANGERS

**IF YOU HAVE ANY LOVE FOR YOUR FAMILY, CHILDREN AND FRIENDS PLEASE MAKE A PHOTOSTAT AND HAND TO EVERYONE YOU COME IN CONTACT WITH, TO SAVE THE WHITE RACE FROM EXTINCTION**

APPENDIX C: SOUTH AFRICAN AIDS CAMPAIGN (NATIONAL NEWSPAPERS), SEPTEMBER 1989

The real tragedy about AIDS is the number of people who ignore it.

What Behaviour Puts You At Risk?

The Problem of Drugs And AIDS

Is There A Cure For AIDS?

What Is All This Talk About Condoms?

You Won't Get AIDS Through Casual Contact

What About Dating?

Talking With Children About AIDS

You Can Make A Difference!

Could You Become Infected with HIV?

How Do You Get AIDS From Sex?

What Does Someone With AIDS Look Like?

How Do You Get AIDS?

What AIDS Means To You

AIDS The more you know, the safer you'll be.

## APPENDIX D: INTERVIEW-GUIDE FOR FINAL SOUTH AFRICAN RESPONDENTS

This interview-guide is based on findings from the pilot work, on certain theoretical considerations, and on the concerns raised by Forster and Furley (1989) and by Pierce and van de Veer (1989).

The central questions in the interview-guide are those which are numbered and appear in capital letters. The prompts appear beneath these main questions. These **prompts were used only when an issue had already been raised by a respondent.**

# SOUTH AFRICAN INTERVIEW-GUIDE

INTRODUCTION

I am carrying out a study on people's ideas about AIDS. I am very interested to hear all of your ideas about a few issues. There are no correct or incorrect answers. After the discussion, I would like you to complete a short questionnaire. Please remember that your responses are anonymous and confidential. You will receive R10.00 at the end of the session.

QUESTIONS

1. DO YOU RECALL **HOW YOU FIRST HEARD** ABOUT AIDS?
   - If yes, how did you first hear about AIDS?
   - Word of mouth, someone suffering from it, newspaper, television, billboard, church, school.

2. **WHEN** WAS THIS?

3. WHAT DID YOU **FEEL WHEN YOU FIRST HEARD** ABOUT IT?
   - Degree to which felt threatened by it.
   - What did you think it was all about?
   - Do you still feel this way about it?

4. MANY PEOPLE HAVE DIFFERENT IDEAS ABOUT **WHERE IT MAY HAVE BEGUN.** COULD YOU DISCUSS YOUR IDEAS.
   - Probe for extent to which people are sure/unsure of their assertions.
   - Probe for social rules as to which explanations are acceptable.
   - Probe for what have anchored it to.

5. MANY PEOPLE HAVE DIFFERENT IDEAS ABOUT **WHERE IT SPREAD TO.** COULD YOU DISCUSS YOUR IDEAS.
   - Geographical spread.

6. PEOPLE HAVE DIFFERENT IDEAS AS TO **HOW IT SPREAD.** COULD YOU DISCUSS YOUR IDEAS.
   - If involvement of monkeys, how did it get from monkey to human?
   - If sexual interaction is suspected, what sort of sexual interaction - between whom?
   - If other theories: Specific mechanisms accounting for initial spread.

7. HOW DOES IT **CONTINUE TO SPREAD,** FROM PERSON TO PERSON, HERE IN SOUTH AFRICA?
   - Specific methods of transmission.
   - Who spreads it? What acts spread it?
   - If terms arise, define promiscuity, homosexual acts, unnatural acts.
   - Do heterosexuals never do these things?
   - Define the sorts of lifestyles which spread it; define whether giving/receiving

blood is equally likely to spread it.
- Do they mention 'virus'?
- Did the spreaders know what the consequences of their actions would be?

8. IF YOU HAD TO **DESCRIBE A PERSON WITH AIDS**, HOW WOULD YOU DESCRIBE THIS PERSON.
- Possible aspects: Age, gender, colour, occupation, sexual preference, rich/poor.
- What do you think are the symptoms of AIDS?
- Do they mention plight? Unlucky?

9. THERE ARE APPROXIMATELY 326 PEOPLE KNOWN TO HAVE AIDS IN SOUTH AFRICA. **TO WHICH GROUPS** DO YOU THINK THAT THEY BELONG?

10. TO WHAT EXTENT DO YOU SEE YOURSELF TO **BE AT RISK** OF GETTING AIDS?

APPENDIX E: CODING FRAME

**CODING OF SOUTH AFRICAN AND BRITISH INTERVIEW DATA**

SOURCE OF AIDS INFORMATION:

SR = RADIO
SN = NEWSPAPER/MAGAZINE/POSTER
ST = TELEVISION
SM = MEDIA AS BLANKET CATEGORY
SF = FRIENDS
SL = LOVER
SS = SCHOOL/UNIVERSITY
SC = COMMUNITY/YOUTH GROUP/CHURCH/PARENT

YEAR IN WHICH HEARD ABOUT AIDS:

Y1 = PRE-1985
Y2 = 1985-7
Y4 = 1988 onward

INITIAL FEELINGS ABOUT AIDS:

FS = SHAME (WOULD HAVE A 'G' TOO)
FC = MYSTIFIED/CONFUSED/SURPRISED
FF = FEAR
FM = PREVENTION POSSIBLE/MASTERY
FD=LOSS OF TRUST IN POTENTIAL SEXUAL PARTNERS/DISTRUSTING
FR=DUE/GOOD PUNISHMENT FOR BAD PEOPLE/RETRIBUTIVE FEELINGS (BUT MAY INCLUDE SELF AS A POTENTIAL BAD PERSON) (link to LP)
FN = NOT RELEVANT TO SELF

ARE THEY CURRENTLY LESS WORRIED OR MORE WORRIED:

TL = LESS WORRIED
TM = MORE WORRIED
TS = SAME & REASON FOR NO CHANGE

REASONS FOR FEELING LESS WORRIED:

EL = NON-MEDIA EDUCATION
EM = MEDIA EDUCATION
EP = THERE ARE PRECAUTIONS ONE CAN TAKE (from condom to not sleeping around)

REASONS FOR FEELING MORE WORRIED:

HN = INFORMATION: LACK OR SURFEIT
HS = DISEASE SPREADING - WITH IMPLICATION INTER-GROUP SPREAD OCCURS

HI = 'INNOCENTS' BECOMING ILL

AIDS IS ANCHORED TO: (THOSE ISSUES WITH WHICH AIDS WAS INITIALLY LINKED, ACCORDING TO RESPONDENTS)

AM = GENERAL DECLINE IN MORALITY/BACKLASH FROM THE SEXUAL REVOLUTION OF THE 1960S/SCOURGE OF GOD
AR = INTER-RACIAL MIX
AV = DISEASED INDIVIDUALS, FOR EXAMPLE, ROCK HUDSON
AP = BEING MULTI-PARTNERED/PROMISCUITY IMPLICATIONS
AS = SEXUALLY TRANSMITTED DISEASE
AI = INCURABLE ILLNESSES
AH = GAY PLAGUE TYPE IDEAS
AA = AMERICANNESS
AF = AFRICANNESS
AG = DRUGS - INTRAVENOUS AND ALSO 'POPPERS'

GEOGRAPHICAL ORIGIN AIDS:

OP = REJECT NOTION ORIGIN
OU = AMERICA
OM = THE MIXING OF THE RACES/NATIONS
OW = THE WEST
ON = AFRICA
OS = RESPONDENT'S OWN COUNTRY
OO = RESPONDENT SAYS 'NOT MY COUNTRY - INEXPLICIT OTHER PLACE'
OH = ALL OVER THE WORLD
OE = ENGLAND

WHY DID IT ORIGINATE IN THIS PLACE?

WH = HOMOSEXUALITY
WN = NAVY/SOLDIERS
WP = PROSTITUTION
WC = PROMISCUITY
WR = UNDER-DEVELOPMENT
LZ = LACK OF EDUCATION
WD = ANIMAL BITES A PERSON
WB = BEWITCHMENT/TRIBAL RITUALS
WU = UNSAVOURY PARTNERS - ALLUSIONS TO DIRT
WL = BESTIALITY
WK = KINKY WESTERN SEXUALITY
WF = COLONIALS HAVE A HISTORY OF BRINGING WESTERN DISEASES TO UNDERDEVELOPED COUNTRIES/COLONISING THE MEDICAL SYSTEM
WE = EXPERIMENTATION

LU = MODERN, URBAN LIVING/A TRADITION-FREE LIFESTYLE/THE PERMISSIVE SOCIETY
WG = LINK AIDS TO 'GREEN' PHENOMENA, LIKE GREEN-HOUSE EFFECT
WW = IT HAS BEEN IN THE WORLD FOR A VERY LONG TIME - NO EXPLANATION EXISTS

HOW AIDS SPREADS TO RESPONDENT'S OWN COUNTRY:

WT=INFECTED TOURISTS COMING INTO RESPONDENT'S OWN COUNTRY
WA = INFECTED AMERICANS/EUROPEANS BRINGING IT INTO RESPONDENT'S OWN COUNTRY
WZ = MIGRATION TO RESPONDENT'S OWN COUNTRY
WS = CITIZENS OF RESPONDENT'S OWN COUNTRY WHO BRING IT BACK TO RESPONDENTS OWN COUNTRY AFTER TRAVELLING TO FOREIGN LANDS
[MANY OF THE CODES FROM OTHER SECTIONS OVERLAP WITH THIS SECTION]

LIFESTYLES CONNECTED WITH AIDS IN THE RESPONDENT'S OWN COUNTRY:

LG = HOMOSEXUAL
LS = HETEROSEXUAL
LX = INTERLINKING OF HOMOSEXUALS AND HETEROSEXUALS: BISEXUAL ACTIVITY
LEL = THOSE WHO HAVE A LOT OF PARTNERS - EXCESS - OVERDOING IT UNNECESSARILY
LH = PROSTITUTION
LL = BRITISH LIFESTYLES, FOR EXAMPLE, SOCCER, PUNK
LA = AMERICAN LIFESTYLES, FOR EXAMPLE, FAST CARS, HOLLYWOOD DECADENCE
LO = A NIGHT LIFESTYLE, FOR EXAMPLE, GOING TO CLUBS
LI = ANTI-LIFESTYLISM - SOME HAVE WEAKER/STRONGER IMMUNITY TO IT - BEHAVIOUR IS NOT THE CENTRAL FACTOR
LR = A HIGH RISK GROUP LIFESTYLE
LD = INJECTING DRUGS
LC = UNSAFE SEX
LN = A LIFESTYLE OUT OF TUNE WITH NATURE/NATURE HAS ITS WAYS/NATURAL BALANCE IS THREATENED
LP = ABUSING SEX/GOING AGAINST THE WILL OF GOD/GOD PUNISHES YOU FOR THIS

DO THOSE WHO SPREAD HIV ACT INTENTIONALLY?

IY = INTENTIONALITY IS INVOLVED - WORDS SUCH AS 'RESPONSIBILITY', 'OWN DOING', 'WRONG', 'TO BLAME', 'FAULT', 'NORMAL' ARE USED
IS = CERTAIN GROUPS (EG. PROSTITUTES) DO IT INTENTIONALLY, OTHERS (EG. 'THE GENERAL PUBLIC') DO NOT
II = NOT INTENTIONAL - THEY ARE IGNORANT
IR = NOT INTENTIONAL - THE SPREAD IS RANDOM
IU = NOT INTENTIONAL - FATE TAKES ITS COURSE

THE MEDIA AND AIDS:

DA = CAMPAIGNS ARE MENTIONED OR WORDS OF CAMPAIGNS ARE REPRODUCED IN TALKING ABOUT AN ISSUE
DO = MEDIA SOURCES OTHER THAN CAMPAIGNS ARE MENTIONED AS THE SOURCE OF AIDS IDEAS
DC = MEDIA IS MENTIONED IN CONNECTION WITH CERTAIN GROUPS AND AIDS
DY = MEDIA FEELS SALIENT IN GENERAL
DN = MEDIA DOES NOT FEATURE SIGNIFICANTLY

STEREOTYPES OF A PERSON WITH AIDS:

VT = DEPENDS ON WHAT STAGE THE PERSON IS AT
VR = MOUSTACHED/GAY LOOKING MEN
VV = VISIBILITY OF AIDS - BLISTERS, SORES
VW = WEIGHT RELATED
VE = WEAK/TIRED
VF = FEAR-INSPIRING
VI = ISOLATED
VC = LOOKS LIKE A PERSON OUT OF CONTROL - LIKE A DRUNK PERSON, LIKE A HELPLESS PERSON
VM = SAD/MISERABLE/DEPRESSED
VG = ACHING/ITCHING GENITALS
VN = A NORMAL PERSON - ANYONE CAN GET AIDS
VP = A BLESSED PERSON - AIDS IS A BLESSING

GROUP WORST AFFECTED BY AIDS IN RESPONDENT'S OWN COUNTRY:

GG = REFUSAL TO NAME GROUPS - IT IS A GENERAL RATHER THAN A GROUP-TARGETED ILLNESS
GZ = HETEROSEXUALS
GF = HETEROSEXUAL BLACK WOMEN
GW = WHITE PEOPLE
GK = BLACK PEOPLE
GEL = BLACK MEN
GH = HOMOSEXUALS (INCLUDING BISEXUALS)

GD = RICH/DECADENT PEOPLE
GP = DISCO/PARTY PEOPLE
GY = YOUTH
GS = SINGLE PEOPLE, WITH MANY PARTNERS
GA = DRUG USERS
GB = HAEMOPHILIACS
GU = THOSE WHO HAVE UNPROTECTED SEX (THIS IS NOT REALLY A GROUP, BUT A BEHAVIOUR-BASED RESPONSE)
GN = STATEMENT IMPLYING THAT PEOPLE OF RESPONDENT'S OWN COUNTRY ARE NOT INFECTED
GM = STATEMENT IMPLYING THAT RESPONDENT'S OWN GROUP IS NOT INFECTED

PERSONAL PROTECTION AGAINST GETTING AIDS:

PL = FEEL PROTECTED BY CERTAIN LIFESTYLES: HAVING A STABLE RELATIONSHIP, NOT BEING PROMISCUOUS, BEING CHOOSY ABOUT ONE'S PARTNERS
PA = FEEL PROTECTED BY YOUTH OF ONE'S PARTNERS
PM = FEEL PROTECTED BY ONE'S OWN PRINCIPLES
PS = FEEL PROTECTED BY THE MORALITY OF ONE'S OWN COUNTRY
PF = FEEL PROTECTED BECAUSE THERE ARE FEW PEOPLE WITH AIDS IN ONE'S OWN COUNTRY
PP = FEEL PROTECTED BY THE FACT THAT ONE'S REFERENCE GROUP HAS PRINCIPLES
PC = FEEL PROTECTED BY USE OF PRECAUTIONS: CONDOMS, ABSTENTION, ASKING SEXUAL PARTNER ABOUT HIV STATUS, GOING FOR A TEST, NON-INTRAVENOUS DRUG USE
PE = FEEL PROTECTED BY ONE'S KNOWLEDGE ABOUT AIDS
PN = THERE IS NO PROTECTION: FATALISM

PERCEPTION OF OWN RISK:

RP = ABOVE AVERAGE RISK
RM = BELOW AVERAGE RISK

'MISCONCEPTIONS' CONCERNING AIDS: (THESE ARE ISSUES WHICH ARE TRADITIONALLY VIEWED AS MISCONCEPTIONS IN MANY STUDIES ON AIDS)

BM = AIDS CAN BE CASUALLY TRANSMITTED
BC = THERE IS A CURE FOR AIDS

MISCELLANEOUS:

P = PERSONAL ACQUAINTANCE WITH A PERSON WITH AIDS

THE FOLLOWING CODES DERIVE FROM CONCEPTUAL IDEAS WHICH AROSE IN THE FINAL ANALYSIS OF THE DATA. MANY OF THE CODES LISTED ABOVE WERE RE-CODED IN TERMS OF A SINGLE CONCEPT AND APPEAR IN THIS SECTION:

B = BELIEF THAT ATTRIBUTING THE ORIGIN OR SPREAD OF AIDS TO A COUNTRY OR GROUP IS TANTAMOUNT TO BLAMING THAT COUNTRY OR GROUP FOR AIDS - REFLEXIVITY CONCERNING THE BLAME/PREJUDICE DEBATE

K = BELIEF IN SITUATIONAL RATHER THAN INDIVIDUAL DETERMINANTS OF AIDS

S = RECOGNITION THAT CERTAIN GROUPS ARE STIGMATISED FOR AIDS

G = INTERNALISATION OF BLAME - FEELING RESPONSIBLE FOR AIDS BECAUSE OF ONE'S GROUP IDENTITY/SPOILED IDENTITY/GUILT

M = SHOWING DOUBT IN RELATION TO ONE'S OWN IDEAS - RECOGNISING THAT THEY MAY BE SEEN BY THE INTERVIEWER AS FAR FETCHED OR PARANOID

D = JOKES, TABOOS IN TALK ABOUT AIDS

W = SIN COCKTAILS - COMBINING TWO OR MORE FANTASTICAL IDEAS CONCERNING HOW AIDS ORIGINATED, FOR EXAMPLE, BESTIALITY AND THE TRIBAL RITUAL OF WIFE-LENDING

C = HOLDING A CONSPIRACY THEORY OF AIDS

R = ALLUSION TO ROCK HUDSON OR TO FREDDY MERCURY

I = STATEMENT THAT PEOPLE SHOULD TAKE RESPONSIBILITY FOR THEIR OWN BEHAVIOUR

A = MISCEGENATION ALLUSIONS

Z = BISEXUALITY ALLUSIONS

L = LESBIAN ALLUSIONS

H = MENTION OF HILLBROW (SUBURB OF JOHANNESBURG) IN RELATION TO THE SPREAD OF AIDS

E = MENTION OF EARLS COURT (SUBURB OF LONDON) IN RELATION TO THE SPREAD OF AIDS

APPENDIX F: QUESTIONNAIRE FOR FINAL SOUTH AFRICAN RESPONDENTS

# QUESTIONNAIRE: SOUTH AFRICAN

## THIS IS A CONFIDENTIAL QUESTIONNAIRE AND CANNOT BE TRACED BACK TO YOU IN ANY WAY

**Please answer the following questions about yourself.**

**How old are you? _____**

**Are you male or female? _____**

**What is your marital status?**
**Single__**
**Married__**
**Living with a partner__**
**Other (please state)_____**

**What is your nationality?**
**South African__**
**Other (please state)_____**

**In which city/town do you live?_____**

**What is your religion?**
**Protestant__**
**Catholic__**
**Moslem__**
**Hindu__**
**Jewish__**
**Other (please state)_____**
**None__**

**Do you ever go to a place of religion (eg. Church, Mosque, Synagogue)?__**

**If yes, how often do you go?_____**

**What is the highest level of education which you have reached?**

**Standard eight leaving certificate__**
**Matric__**
**Further education (please specify)_____**

**Please describe your current occupation:**

_____

_____

**What is/was your father's occupation?_____**

**What is/was your mother's occupation?_____**

**PLEASE ANSWER THE FOLLOWING QUESTIONS ABOUT YOUR SEXUAL BEHAVIOUR.**

**Do you choose sexual partners who are:**

**Male_____**
**Female_____**
**Either male or female_____**
**Other (please state)_____**

**About how many sexual partners have you had in the last month?**

**0 ___**
**1 ___**
**2-5 ___**
**6-10 ___**
**11-20 ___**
**more than 20 ___**

**About how many sexual partners have you had in the last 6 months?**

**0 ___**
**1 ___**
**2-5 ___**
**6-10 ___**
**11-20 ___**
**more than 20 ___**

**How many sexual partners would you say you have ever had? _____**

**Have you ever had a sexually transmitted disease?__**

**If yes, what disease was it?_____**

**THANK YOU VERY MUCH.**

APPENDIX G: BRITISH AIDS CAMPAIGN (NATIONAL NEWSPAPERS), MARCH 1986

# ARE YOU AT RISK FROM AIDS?

*AIDS is a serious disease. Not all the information available has been entirely accurate, so many people are confused about who is at risk, how the disease is spread and how dangerous it is.*

*To explain the facts entirely it is necessary to describe certain sexual practices. There may shock but should not offend you as we are talking about an urgent medical problem.*

*Please read this carefully. It is up-to-date and authoritative. It is only by knowing the true facts about AIDS that we can hope to control the spread of this disease. This requires an effort by all of us.*

Donald Acheson — Chief Medical Officer of the Department of Health and Social Security

A. J. Wilkes — Chief Medical Officer for the Health Departments of the United Kingdom

## WHAT IS AIDS?

AIDS stands for Acquired Immune Deficiency Syndrome.

It is caused by a virus that attacks the body's natural defence system.

This is why some people who have the virus can fall prey to infections and other illnesses which rarely trouble healthy people.

Not everyone who carries the virus develops AIDS. But, anyone who has the virus can pass it on.

At present there is neither a vaccine to prevent people catching the virus nor a cure for those who develop AIDS.

## IS AIDS SPREAD THROUGH NORMAL CONTACT WITH OTHER PEOPLE?

AIDS is caused by a virus which is spread by having sex with an infected person or by injection of contaminated blood.

So normal social contact with a person who carries the virus such as shaking hands, hugging and social kissing carries no risk. Nor does being at school or at work with infected people.

## DOES AIDS ONLY AFFECT HOMOSEXUALS?

NO.

## IS AIDS SPREAD BY OBJECTS TOUCHED BY INFECTED PEOPLE?

No-one has ever become infected from toilet seats, door knobs, clothes, towels, swimming pools, food, cups, cutlery or glasses.

## ARE BLOOD TRANSFUSIONS SAFE?

Before the virus was discovered, there was a very small risk from blood transfusions. Now all blood donations are screened for the infection. Any blood found to be infected is rejected.

The process of giving blood is not and never has been risky. All the equipment at blood donation centres is sterile and used once only.

## HOW IS AIDS SPREAD?

In two ways.

☐The virus spreads mostly through sexual intercourse with an infected person.

☐It is also spread if an infected person's blood gets into someone else's blood. The major risk of this happening is to drug users who share needles or other equipment.

☐Babies of infected mothers are also at risk, in the womb, during birth, or from breast milk.

## HOW DO YOU KNOW IF YOU ARE AT RISK?

Injecting drug users are at risk if they share needles or other equipment. By far the best solution is not to inject at all. Those who persist, should not share equipment.

However, the major risk of infection is through sex.

The more sexual partners someone has the more likely they are to have sex with an infected person.

Cutting down on casual relationships cuts down the risk.

The next line of defence is to know what is safe sexual practice and what is not.

## WHAT IS SAFE SEX?

☐Any sex between two people who are uninfected is completely safe.

☐Hugging, squeezing and feeling are all safe with anyone.

## WHAT IS RISKY SEX?

☐Sexual intercourse with an infected person is risky.

☐Using a sheath reduces the risk of AIDS and other diseases.

☐Rectal sex involves the highest risk and should be avoided.

☐Any act that damages the penis, vagina, anus or mouth is dangerous, particularly if it causes bleeding.

☐Intimate kissing with an infected person may be risky.

## WHAT OF THE FUTURE?

Doctors and scientists around the world are searching urgently for a vaccine or cure.

No-one can predict when this might be found, but it is almost certain it will take some time yet.

But AIDS can be controlled by reducing the spread of infection.

These facts show how it can be done.

## MORE INFORMATION

For the booklet on AIDS, containing more detailed information and advice, write to Dept A, P.O. Box 100, Milton Keynes MK1 1TX.

Or call in strict confidence.

THE HEALTHLINE TELEPHONE SERVICE:
01-981 2717,
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0345 581151.

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DON'T AID AIDS

# AIDS. HOW TO KEEP YOURSELF SAFE.

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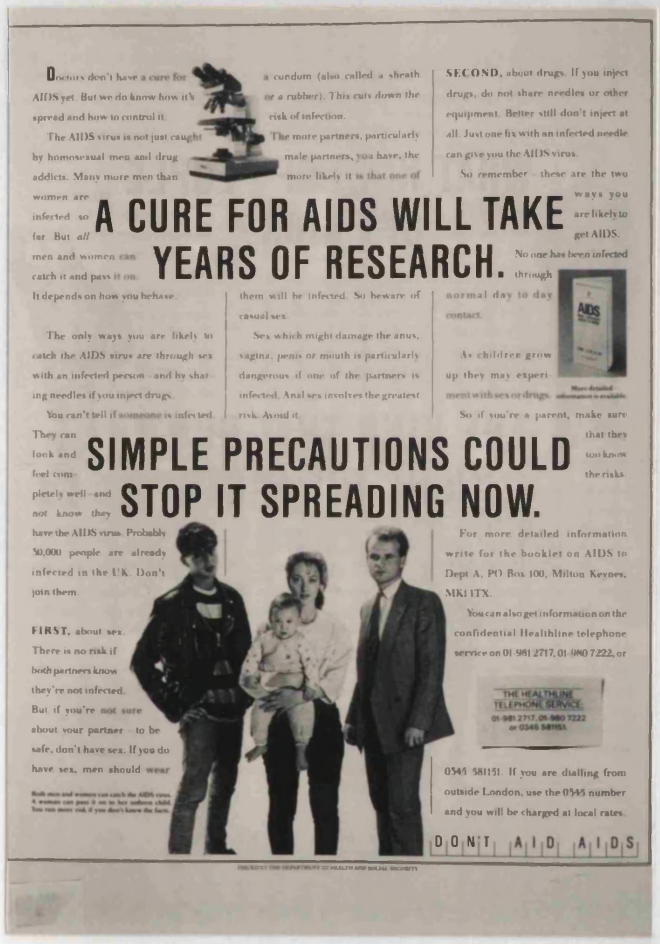
If you are calling from outside London, use the 0345 number and you will be charged at local rates.

DON'T AID AIDS

## APPENDIX H: BRITISH AIDS CAMPAIGN (NATIONAL NEWSPAPERS), MAY-NOVEMBER 1986



Doctors don't have a cure for AIDS yet. But we do know how it's spread and how to control it.

The AIDS virus is not just caught by homosexual men and drug addicts. Many more men than women are infected so far. But *all* men and women can catch it and pass it on. It depends on how you behave.

The only ways you are likely to catch the AIDS virus are through sex with an infected person – and by sharing needles if you inject drugs.

You can't tell if someone is infected. They can look and feel completely well – and not know they have the AIDS virus. Probably 30,000 people are already infected in the UK. Don't join them.

**FIRST**, about sex. There is no risk if both partners know they're not infected. But if you're not sure about your partner – to be safe, don't have sex. If you do have sex, men should wear a condom (also called a sheath or a rubber). This cuts down the risk of infection.

The more partners, particularly male partners, you have, the more likely it is that one of them will be infected. So beware of casual sex.

Sex which might damage the anus, vagina, penis or mouth is particularly dangerous if one of the partners is infected. Anal sex involves the greatest risk. Avoid it.

**SECOND**, about drugs. If you inject drugs, do not share needles or other equipment. Better still don't inject at all. Just one fix with an infected needle can give you the AIDS virus.

So remember – these are the two ways you are likely to get AIDS. No one has been infected through normal day to day contact.

As children grow up they may experiment with sex or drugs. So if you are a parent, make sure that they too know the risks.

For more detailed information write for the booklet on AIDS to Dept A, PO Box 100, Milton Keynes, MK1 1TX.

You can also get information on the confidential Healthline telephone service on 01-981 2717, 01-980 7222, or 0345 581151. If you are dialling from outside London, use the 0345 number and you will be charged at local rates.

# A CURE FOR AIDS WILL TAKE YEARS OF RESEARCH.

# SIMPLE PRECAUTIONS COULD STOP IT SPREADING NOW.

THE HEALTHLINE TELEPHONE SERVICE 01-981 2717, 01-980 7222 or 0345 581151.

DON'T AID AIDS

These are the facts.

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You can also get information on the confidential Healthline telephone service on either 01-981 2717, *01-980 7222*, or 0345 581151.

If you are dialling from outside London, use the 0345 number and you'll be charged at local rates.

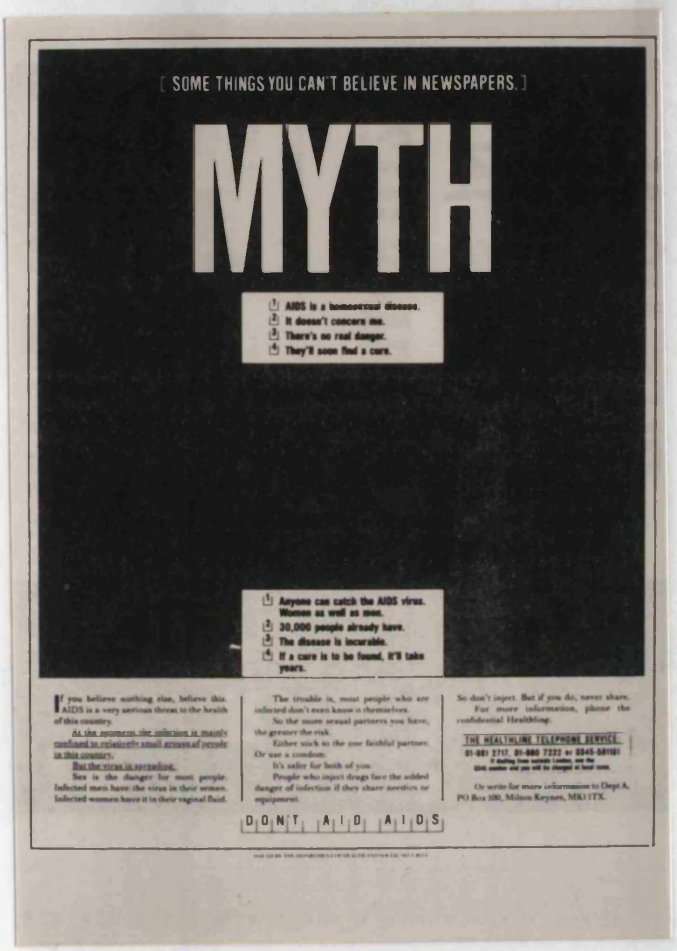
# WHAT KIND OF PEOPLE GET AIDS?

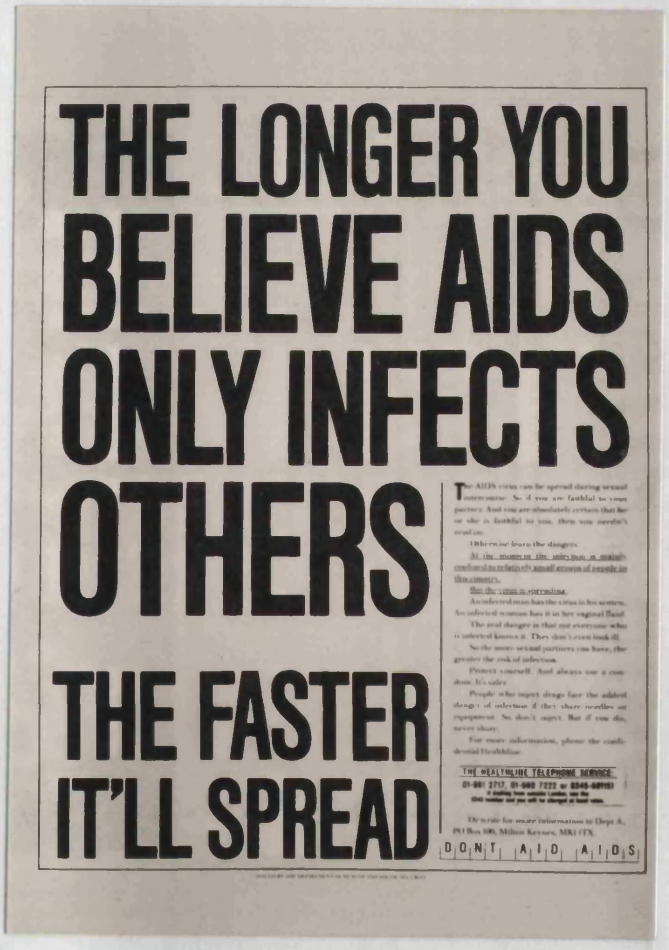
# THE KIND THAT DON'T KNOW THE FACTS.

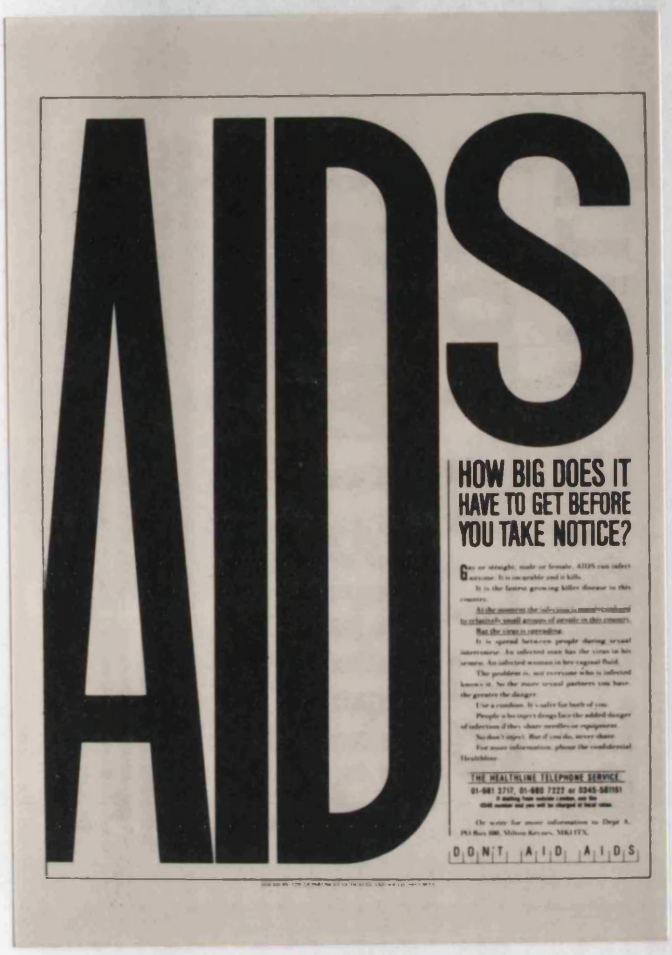
THE HEALTHLINE TELEPHONE SERVICE 01-981 2717, 01-980 7222 or 0345 581151.

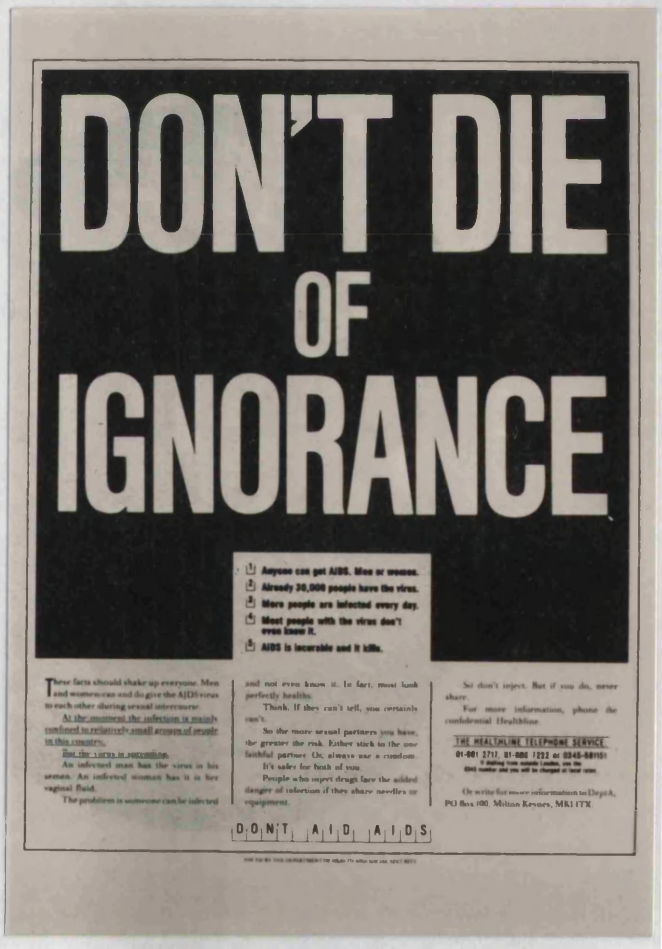
DON'T AID AIDS

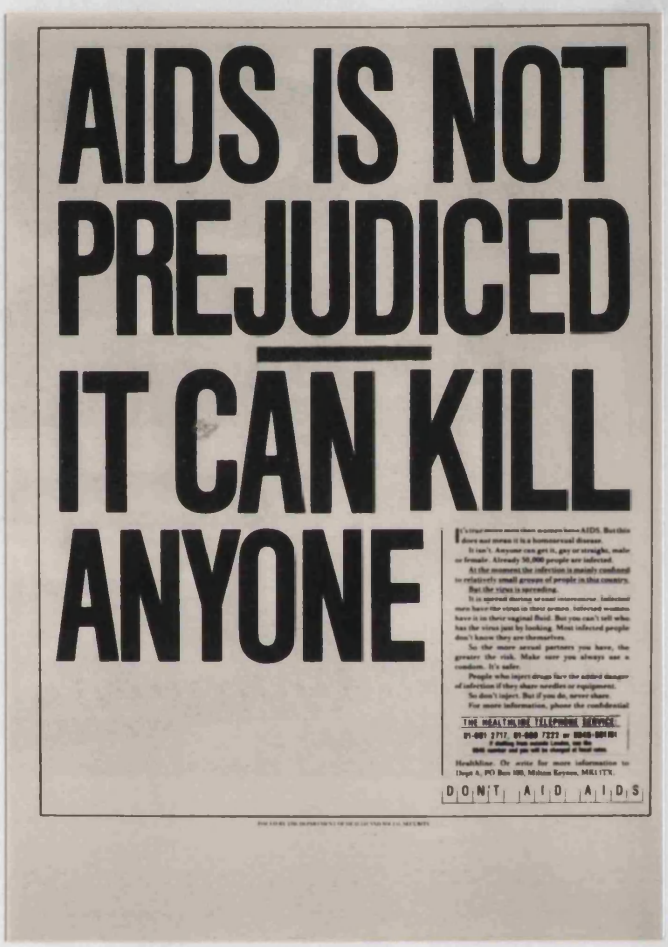
APPENDIX I: BRITISH AIDS CAMPAIGN (NATIONAL NEWSPAPERS), NOVEMBER/DECEMBER 1986




AIDS
HOW BIG DOES IT HAVE TO GET BEFORE YOU TAKE NOTICE?
THE HEALTHLINE TELEPHONE SERVICE
DON'T AID AIDS


DON'T DIE OF IGNORANCE
Anyone can get AIDS. Men or women.
Already 30,000 people have the virus.
More people are infected every day.
Most people with the virus don't even know it.
AIDS is incurable and it kills.
THE HEALTHLINE TELEPHONE SERVICE
DON'T AID AIDS


AIDS IS NOT PREJUDICED
IT CAN KILL ANYONE
DON'T AID AIDS

APPENDIX J: BRITISH YOUTH-TARGETED AIDS CAMPAIGN (RADIO AND MAGAZINES), NOVEMBER/DECEMBER 1986

**Script of the radio AIDS campaign:**

- YOU HEAR THE SOUND OF A GUN BEING LOADED.

"The AIDS virus is invisible - you can't tell if someone has got it..."

YOU HEAR THE GUN CLICKING. AND A LOUD BANG.

- YOU HEAR THE SOUND OF A GUN BEING LOADED.

"If you're taking drugs, remember that you are taking a big risk..."

- YOU HEAR THE GUN CLICKING, AND A LOUD BANG.

"This is Paul Gambuccini, and I'm not here to play records..."

"Hello, Ian Drury here. A few years ago I made a record called 'Sex and Drugs and Rock and Roll'..."

**Magazine AIDS campaign:**

# DON'T INJECT AIDS

Imagine somebody who knows a bit about drugs. Somebody who's smoked, swallowed and snorted most things.

But so far, they've never used a needle. If they do, though, the first needle they use will probably be somebody else's.

At that moment, they'll be in serious danger of catching AIDS. Because sharing a needle or equipment with someone who carries the AIDS virus is the easiest way to get infected.

Now does this somebody sound a little like you? If it does, don't inject. And never share.

For more information and advice, please phone 01-981 7140 or 0345 581858. (If dialling from outside London, use the 0345 number and you will be charged at local rates.)

DONT AID AIDS

# HOW TO STOP YOURSELF DYING FOR SEX.

AIDS is incurable and it kills.

Up until now, the virus has been confined mainly to small groups of people, but it's spreading all the time.

The virus can definitely be passed on during sex between a man and a woman, if one of them is infected.

A woman can catch it from a man's sperm.

A man can catch it from a woman's vaginal fluid.

So in the future, the more sexual partners you have, the more you're at risk.

To reduce the risk, have as few partners as possible.

And when you do have sex remember that only one thing can protect you from infection. A condom.

If you ever have sex with anyone you're not completely sure about, always use one.

Because these days, sex can be a matter of life and death.

For more information and advice, please phone 01-981 7140 or 0345 581858. (If dialling from outside London, use the 0345 number and you will be charged at local rates.)

DONT AID AIDS


# HOW MANY PEOPLE WILL GET IT FOR CHRISTMAS?

Every day, more and more people are catching the AIDS virus.

Up until now, it's been confined mainly to small groups of people. But it's spreading all the time.

Men and women can give the virus to each other during ordinary sex if one of them is infected.

If a man carries the virus, it's in his sperm. If a woman carries it, it's in her vaginal fluid.

When you meet someone you fancy at a party or in the pub, just remember this - you can't tell whether someone has the virus just by looking at them.

Many people who have it can walk around for years before they start looking ill. And during all this time, they can still pass the virus on to you.

So in the future, sleeping around is quite simply risking your life. It's best to have sex with as few people as possible. But if you do have sex with someone you're not completely sure about, always use a condom. (Or make your partner use one). It's safer for both of you.

Christmas is a time for giving. But don't let anyone give you AIDS.

For more information and advice, please phone 01-981 7140 or 0345 581858. (If dialling from outside London, use the 0345 number and you will be charged at local rates.)

DON'T AID AIDS

# YOU KNOW WHAT'S IN HIS MIND.

# BUT HOW CAN YOU TELL WHAT'S IN HIS BLOOD?

Anybody, whether they're male or female, can catch the AIDS virus from ordinary sex. The disease is incurable and eventually it kills.

Up until now, the virus has been confined mainly to small groups of people, but it's spreading all the time.

If a man carries the virus, it's in his sperm. If a woman carries the virus, it's in her vaginal fluid. The problem is, signs of illness can take years to develop.

So, even though over 30,000 people in the UK carry the virus, most of them will look perfectly normal. But they can still pass the virus on to other people.

With this in mind, suppose a boy shows all the usual signs of fancying you?

Just remember, the more people you have sex with in the future the greater your chances of catching the virus.

And apply that rule to this boy as well. If he's had lots of other partners, how can you be sure he's free from infection?

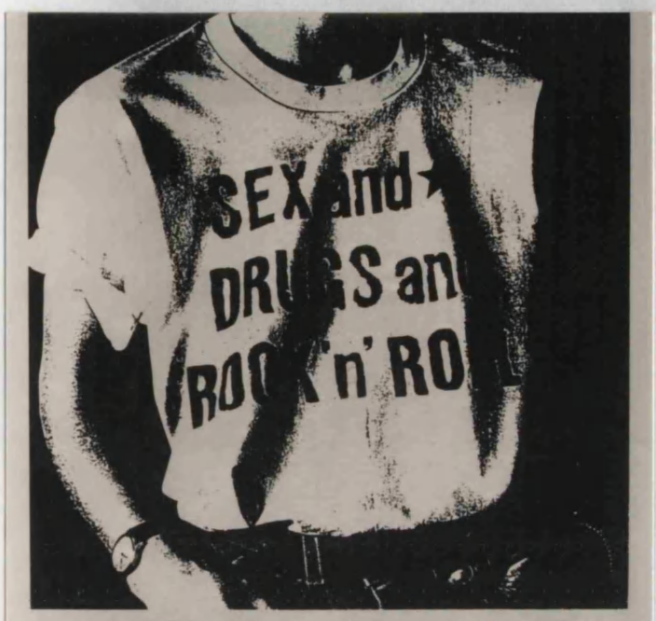
If you're not completely sure about him and you do decide to have sex, insist that he wears a condom.

(By preventing his sperm from entering your body, it can help you to avoid infection.)

He may complain that condoms aren't very romantic. But what's so romantic about AIDS?

For more information and advice please phone 01-981 7140 or 0345 581858. (If dialling from outside London, use the 0345 number and you will be charged at local rates.)

DON'T AID AIDS




## AT LEAST ROCK 'N' ROLL CAN'T GIVE YOU AIDS.

AIDS could have you on its hit list. And that doesn't just mean gays.

Here it is, once and for all – men and women can and do give the AIDS virus to each other during sex.

A man can carry the virus in his sperm, a woman in her vaginal fluid. They may not know they are infected. And you can't tell.

So don't sleep around. From now on, you need to be very sure about someone you have sex with. If in doubt always use a condom. It's safer for both of you.

Also on the list is anyone who injects drugs. Using an infected needle is the easiest way to put the virus into your bloodstream.

So don't inject.

But if you can't stop, never share a needle or equipment.

For more information and advice please telephone 01-981 7140 or 0345 581858. (If dialling from outside London, use the 0345 number and you will be charged at local rates.)

DON'T AID AIDS


## THE ONE THAT GIVES YOU AIDS.

"Your next sexual partner" needn't be the latest in a long line.

He could just as easily be your very first. Even though the AIDS virus has up until now been confined mainly to small groups of people, it's spreading all the time.

Any infected man can pass the AIDS virus to you in his sperm, during ordinary sex.

(And likewise, any infected woman can pass the virus to a man in her vaginal fluid.)

So please don't say "It can't happen to me," because it happens to people like you every day.

This doesn't have to mean the death of romance, but it does mean that in the future you've got to be very careful. The more people you sleep with, the more chance you will have of getting infected.

To reduce the risk to yourself, have as few partners as possible.

And if you do have sex with anyone you're not completely sure about, make sure he wears a condom.

If he won't, then don't. It could be the death of you.

For more advice and information, please phone 01-981 7140 or 0345 581858. (If dialling from outside London, use the 0345 number and you will be charged at local rates.)

DON'T AID AIDS

# NOW IT CAN CAUSE DEATH AS WELL AS LIFE.

Next time you have sex, think what you could be starting.

AIDS is incurable and it kills.

Up until now, the virus has been confined mainly to small groups of people.

But it's spreading all the time. The virus can be passed on between a man and a woman during ordinary sex, if one of them is infected.

In an infected man, it's in his sperm. In an infected woman, it's in her vaginal fluid.

So in the future, the more people you have sex with, the greater your chances of catching the virus.

To reduce the risk, sleep with as few people as possible.

And if you do have sex with someone you're not completely sure about, always use a condom. (Or make your partner use one.)

Any contraceptive can prevent a new life from starting. But only a condom can prevent your death.

For more advice and information please phone 01-981 7140 or 0345 581858. (If dialling from outside London, use the 0345 number and you will be charged at local rates.)

D O N'T A I D A I D S

# HOW GAY DO YOU HAVE TO BE TO CATCH AIDS?

You don't have to be gay at all.

In fact, the higher you rate your pulling power with women, the more danger you could be in.

Up until now, AIDS has been confined mainly to small groups of people, but it's spreading all the time.

If a woman is infected with the AIDS virus, she can pass it to you in her vaginal fluid. (Likewise, if a man carries the virus, he can pass it on to a woman in his sperm.)

And the more women you have sex with in the future, the more chance you'll come into contact with one who is infected.

If you're into keeping a score, forget it. Reduce the risk to yourself by having as few partners as possible.

And unless you're completely sure about your partner, always wear a condom.

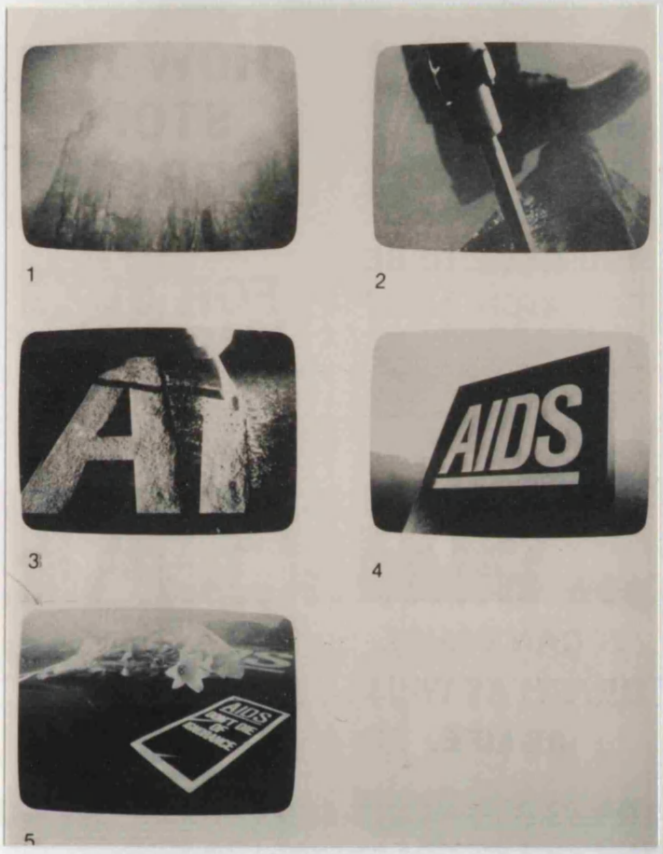
That's how careful you have to be to stay alive.

For more information and advice, please phone 01-981 7140 or 0345 581858. (If dialling from outside London, use the 0345 number and you will be charged at local rates.)

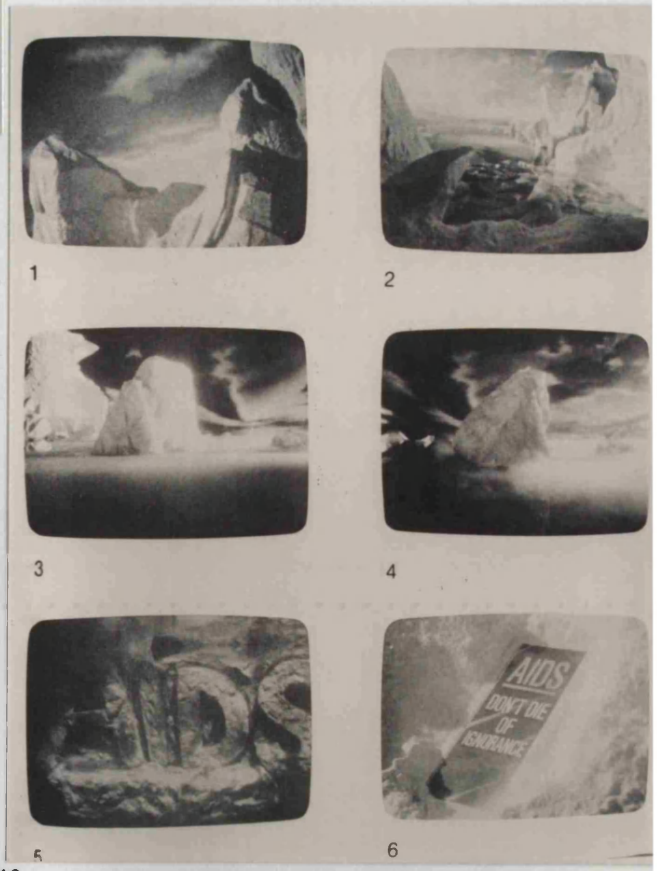
D O N'T A I D A I D S

APPENDIX K: BRITISH 'TOMBSTONE' (TELEVISION) AND 'ICEBERG' (CINEMA) AIDS CAMPAIGN, DECEMBER 1986/JANUARY 1987

**'Tombstone' AIDS campaign:**



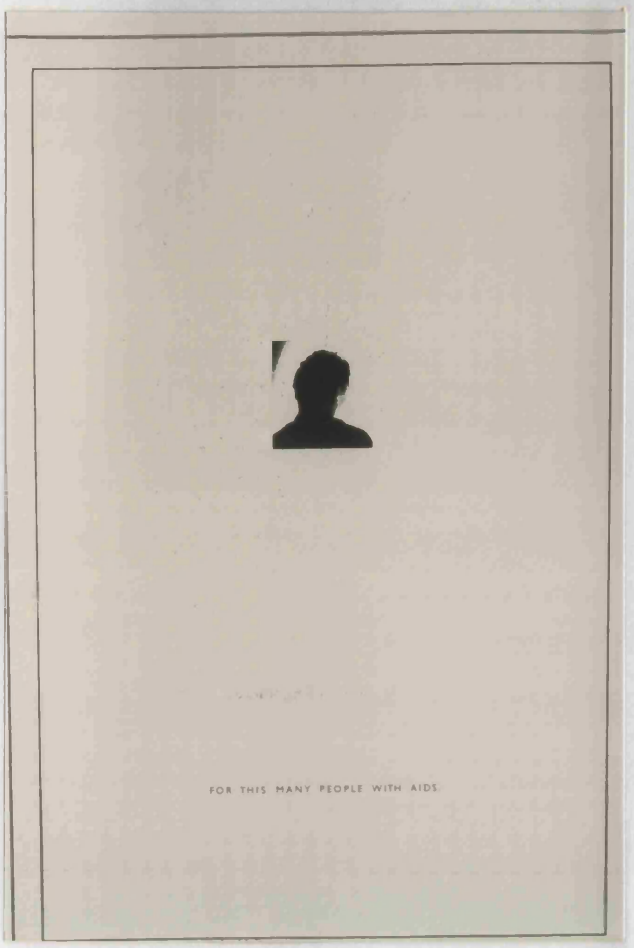

**'Iceberg AIDS campaign:**

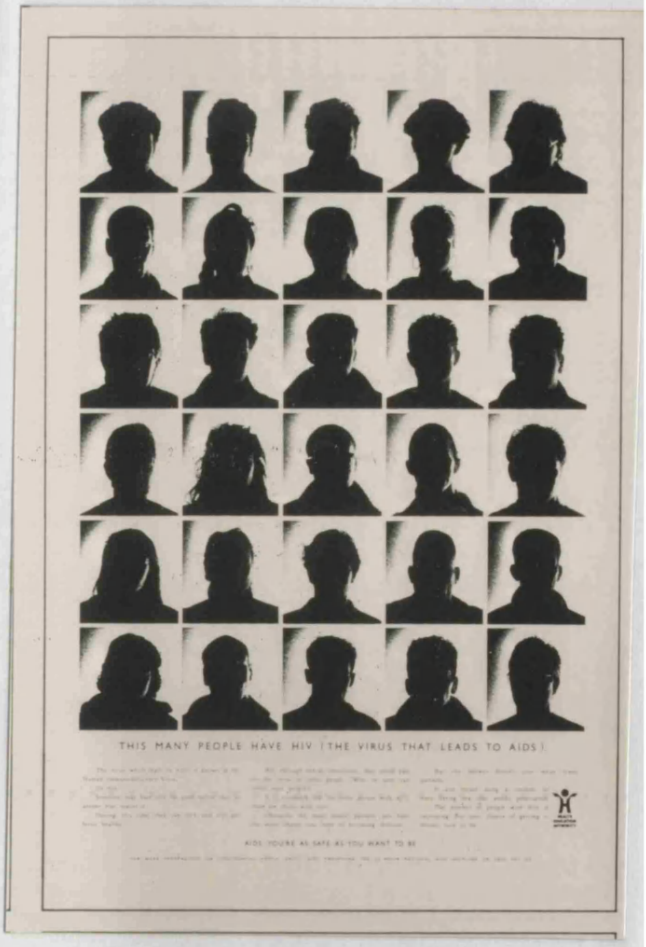


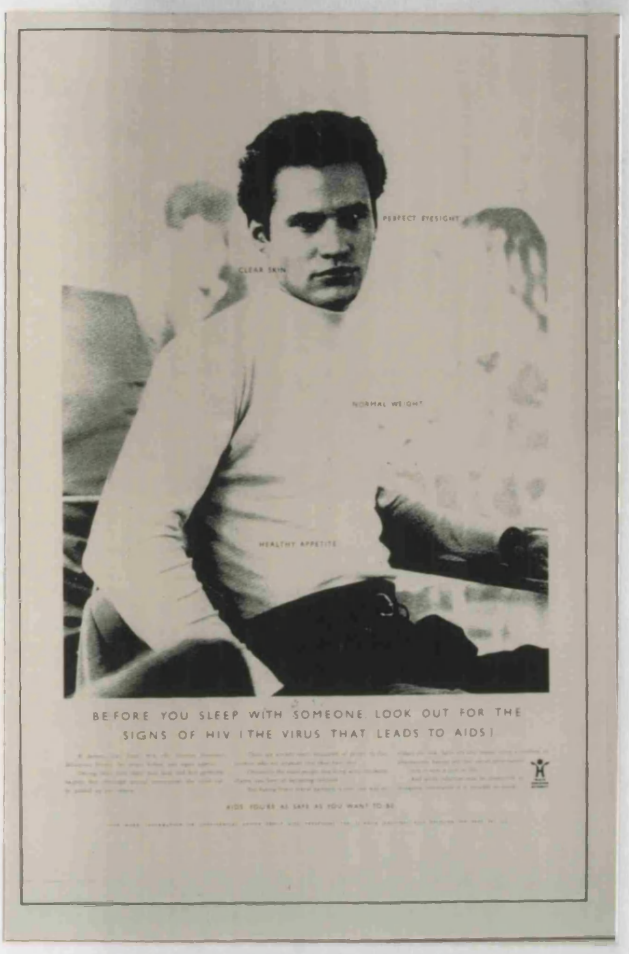
APPENDIX L: BRITISH AIDS CAMPAIGN (TELEVISION), FEBRUARY/MARCH 1988

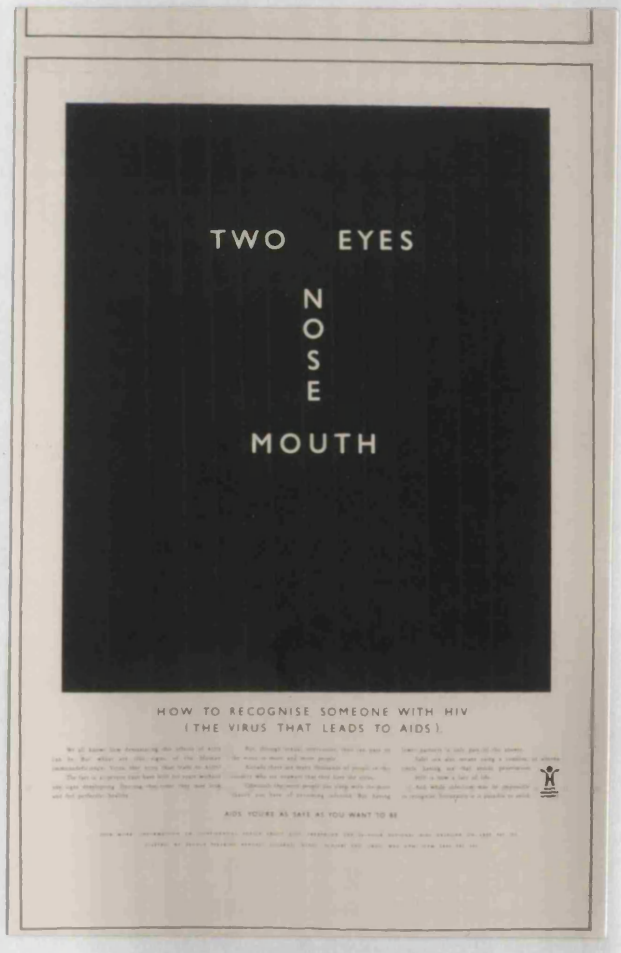

THE MORE PARTNERS
YOU HAVE,
THE GREATER THE RISK.
AIDS.
YOU KNOW THE RISKS.
THE DECISION IS YOURS.

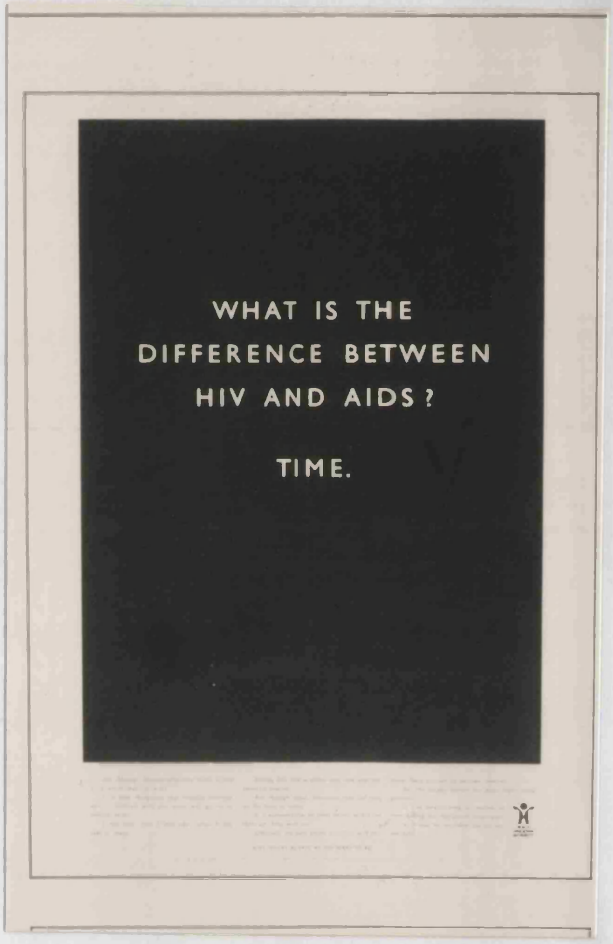
APPENDIX M: BRITISH AIDS CAMPAIGN (NATIONAL NEWSPAPERS), NOVEMBER 1988-MARCH 1989



FOR THIS MANY PEOPLE WITH AIDS

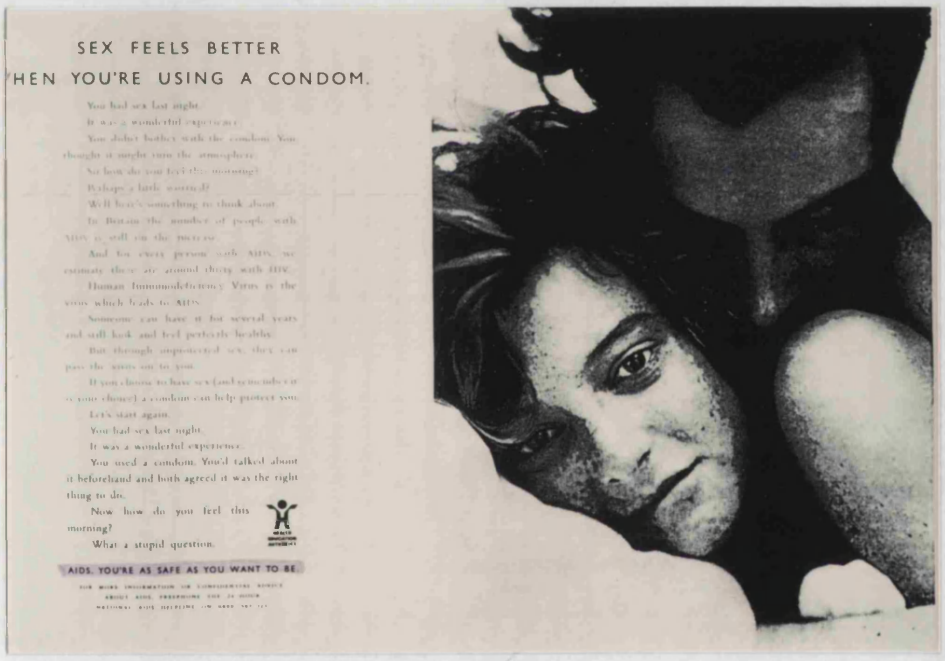

THIS MANY PEOPLE HAVE HIV (THE VIRUS THAT LEADS TO AIDS)


PERFECT EYESIGHT
CLEAR SKIN
NORMAL WEIGHT
HEALTHY APPETITE
BEFORE YOU SLEEP WITH SOMEONE LOOK OUT FOR THE
SIGNS OF HIV (THE VIRUS THAT LEADS TO AIDS).
AIDS. YOU'RE AS SAFE AS YOU WANT TO BE.

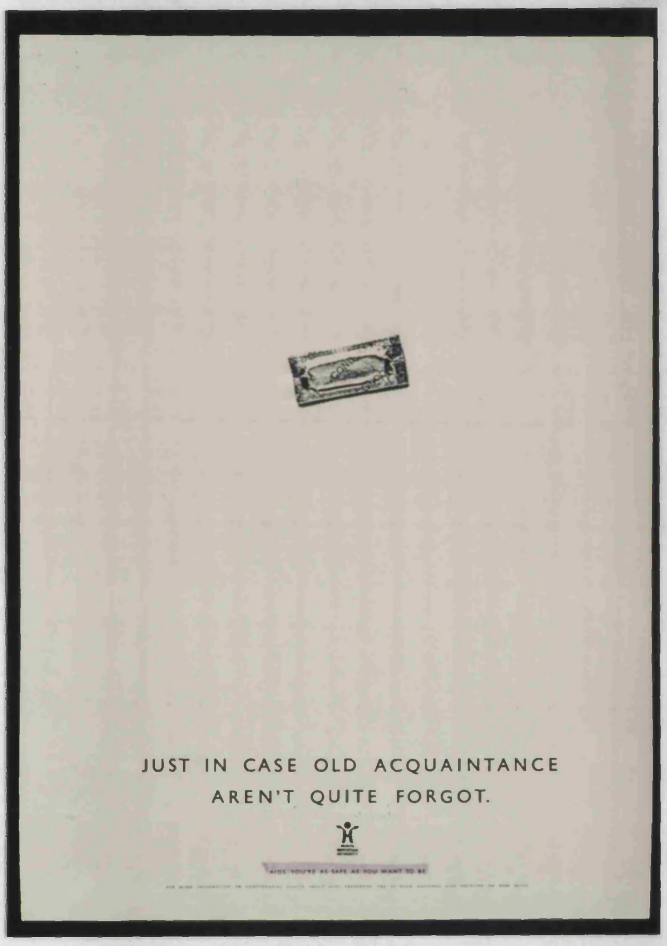

TWO EYES
NOSE
MOUTH
HOW TO RECOGNISE SOMEONE WITH HIV
(THE VIRUS THAT LEADS TO AIDS).
AIDS. YOURS AS SAFE AS YOU WANT TO BE.


WHAT IS THE
DIFFERENCE BETWEEN
HIV AND AIDS?
TIME.

APPENDIX N: BRITISH WOMEN'S AIDS CAMPAIGNS (WOMEN'S MAGAZINES), JUNE 1989



## APPENDIX O: BRITISH AIDS CAMPAIGN (POSTERS), JUNE/JULY 1989



## APPENDIX P: BRITISH HOMOSEXUAL AND BISEXUAL AIDS CAMPAIGN (GAY MAGAZINES), JANUARY 1989

THEY USED TO SAY MASTURBATION WAS BAD FOR YOU. NOW IT COULD SAVE YOUR LIFE.

[threat of AIDS has not gone away.
not all doom and gloom though.
e's one way you can avoid ever coming into
with HIV?
r Sex.

exciting. But don't let the name put you off.

Safer sex simply means any activity where infected blood or semen (or vaginal fluid) can't enter your body.

Like bodyrubbing, fingering, mutual masturbation or massage.

has cuts or sores in their mouth, and possibly if infected semen is swallowed.

Unprotected anal intercourse, however, still carries the highest risk of any sexual activity.

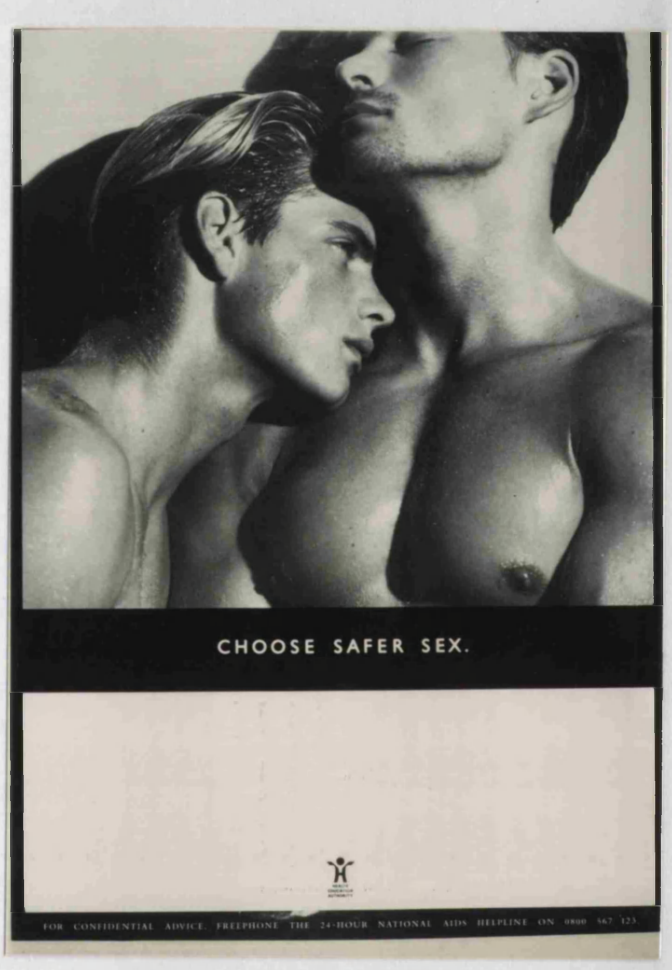
Even if you do use a condom it won't make it

If you'd like more information or advice, a local helpline.

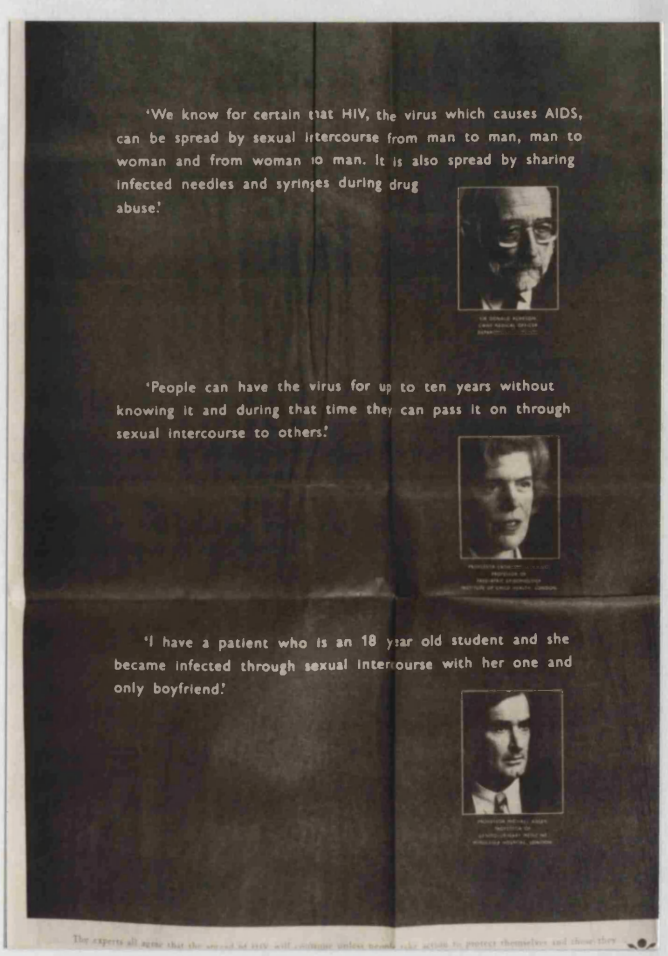
Or call the National AIDS Helpline free on 0800 567123.

It's open 24 hours a day and it's

APPENDIX Q: BRITISH HOMOSEXUAL AND BISEXUAL AIDS CAMPAIGN (GAY MAGAZINES), JUNE 1989



## APPENDIX R: BRITISH 'THREE EXPERTS' AIDS CAMPAIGN (NATIONAL NEWSPAPERS AND TELEVISION), FEBRUARY/MARCH 1990



## APPENDIX S: BRITISH AIDS CAMPAIGN FOR MEN WHO HAVE SEX WITH MEN (GENERAL INTEREST MAGAZINES), MARCH 1990

APPENDIX T: INTERVIEW-GUIDE FOR FINAL BRITISH RESPONDENTS

The interview-guide is based on findings from the pilot work, on certain theoretical considerations, and on the concerns raised by Forster and Furley (1989) and by Pierce and van de Veer (1989).

The central questions in the interview-guide are those which are numbered and appear in capital letters. The prompts appear beneath these main questions. These **prompts were used only when an issue had already been raised by a respondent.**

# BRITISH INTERVIEW-GUIDE

INTRODUCTION

I am carrying out a study on people's ideas about AIDS. I am very interested to hear all of your ideas about a few issues. There are no correct or incorrect answers. After the discussion, I would like you to complete a short questionnaire. Please remember that your responses are anonymous and confidential. You will receive £4.00 at the end of the session.

QUESTIONS

1. DO YOU RECALL **HOW YOU FIRST HEARD** ABOUT AIDS?
   - If yes, how did you first hear about AIDS?
   - Word of mouth, someone suffering from it, newspaper, television, billboard, church, school.

2. **WHEN** WAS THIS?

3. WHAT DID YOU **FEEL WHEN YOU FIRST HEARD** ABOUT IT?
   - Degree to which felt threatened by it.
   - What did you think it was all about?
   - Do you still feel this way about it?

4. MANY PEOPLE HAVE DIFFERENT IDEAS ABOUT **WHERE IT MAY HAVE BEGUN**. COULD YOU DISCUSS YOUR IDEAS.
   - Probe for extent to which people are sure/unsure of their assertions.
   - Probe for social rules as to which explanations are acceptable.
   - Probe for what have anchored it to.

5. MANY PEOPLE HAVE DIFFERENT IDEAS ABOUT **WHERE IT SPREAD TO.** COULD YOU DISCUSS YOUR IDEAS.
   - Geographical spread.

6. PEOPLE HAVE DIFFERENT IDEAS AS TO **HOW IT SPREAD.** COULD YOU DISCUSS YOUR IDEAS.
   - If involvement of monkeys, how did it get from monkey to human?
   - If sexual interaction is suspected, what sort of sexual interaction - between whom?
   - If other theories: specific mechanisms accounting for initial spread.

7. HOW DOES IT **CONTINUE TO SPREAD,** FROM PERSON TO PERSON, HERE IN BRITAIN?
   - Specific methods of transmission.
   - Who spreads it? What acts spread it?
   - If terms arise, define promiscuity, homosexual acts, unnatural acts.
   - Do heterosexuals never do these things?
   - Define the sorts of lifestyles which spread it; define whether giving/receiving blood is equally likely to spread it.

- Do they mention 'virus'?
- Did the spreaders know what the consequences of their actions would be?

8. IF YOU HAD TO **DESCRIBE A PERSON WITH AIDS**, HOW WOULD YOU DESCRIBE THIS PERSON?
- Possible aspects: Age, gender, colour, occupation, sexual preference, rich/poor.
- What do you think are the symptoms of AIDS?
- Do they mention plight? Unlucky?

9. THERE ARE APPROXIMATELY 5065 PEOPLE KNOWN TO HAVE AIDS IN BRITAIN. **TO WHICH GROUPS** DO YOU THINK THAT THEY BELONG?

10. TO WHAT EXTENT DO YOU SEE YOURSELF TO **BE AT RISK** OF GETTING AIDS?

APPENDIX U: QUESTIONNAIRE FOR FINAL BRITISH RESPONDENTS

# QUESTIONNAIRE: BRITISH

## THIS IS A CONFIDENTIAL QUESTIONNAIRE AND CANNOT BE TRACED BACK TO YOU IN ANY WAY

**Please answer the following questions about yourself.**

**How old are you? _____**

**Are you male or female? _____**

**What is your marital status?**

**Single_____**
**Married_____**
**Living with a partner_____**
**Other (please state)_____**

**What is your nationality?**

**British _____**
**Other (please state)_____**

**In which city/town do you live? _____**

**In which borough do you live? _____**

**For how long have you lived in Britain? _____**

**What is your religion?**

**Protestant ____**
**Catholic _____**
**Moslem _____**
**Hindu _____**
**Jewish _____**
**Other (please state)_____**
**None _____**

**Do you ever go to a place of religion (eg. Church, Mosque, Synagogue)?**

**Yes ____**
**No _____**

**If yes, how often do you go? _____**

**What is the highest level of education which you have reached?**

**CSE (Grades 2-5 or ungraded) _____**
**CSE Grade 1 _____**
**GCE 'O' level/GCSE/School Certificate/Matric _____**
**GCE 'A' level/Higher School Certificate _____**

**Please describe your current occupation:**

_____
_____
_____

**If you are a student, for how many years have you been studying?**

_____

**What is/was your father's occupation?**

_____

**What is/was your mother's occupation?**

_____

**Please answer the following questions about your sexual behaviour. Answers are completely confidential. You do not have to answer a question if you do not want to.**

**Do you choose sexual partners who are:**
**Male** _____
**Female** _____
**Either male or female** _____
**Other** _____

**About how many sexual partners have you had in the last month?**

**0** ____
**1** ____
**2-5** ____
**6-10** ____
**11-20** ____
**more than 20** _____

**About how many sexual partners have you had in the last 6 months?**

**0** ____
**1** ____
**2-5** ____
**6-10** ____
**11-20** ____
**more than 20** ____

**How many sexual partners would you say you have ever had?**

_____

**Have you ever had a sexually transmitted disease (eg. syphilis)?**

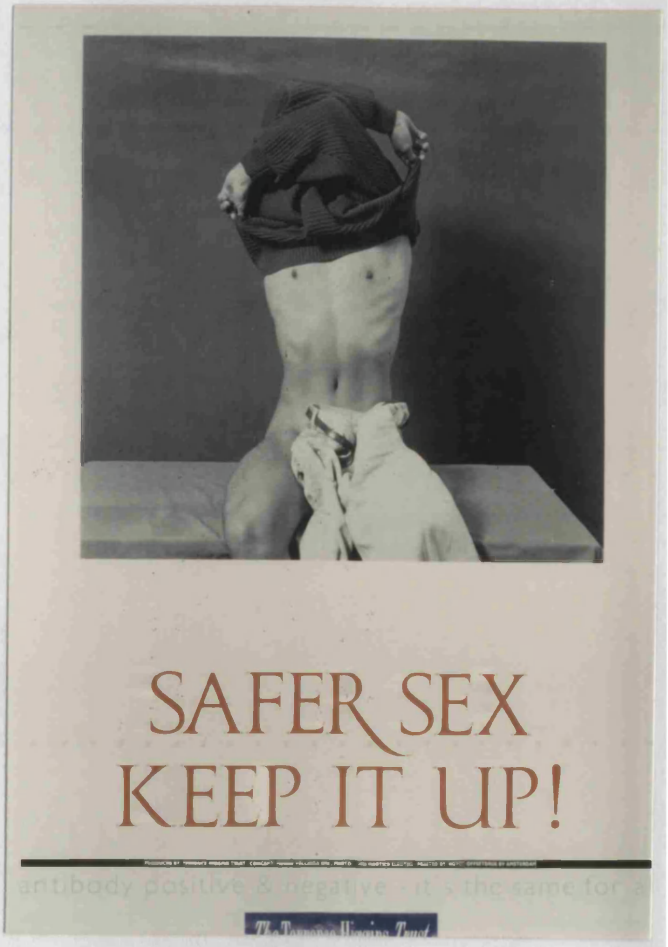
**Yes** ____
**No** ____

**If yes, what disease was it?** _____

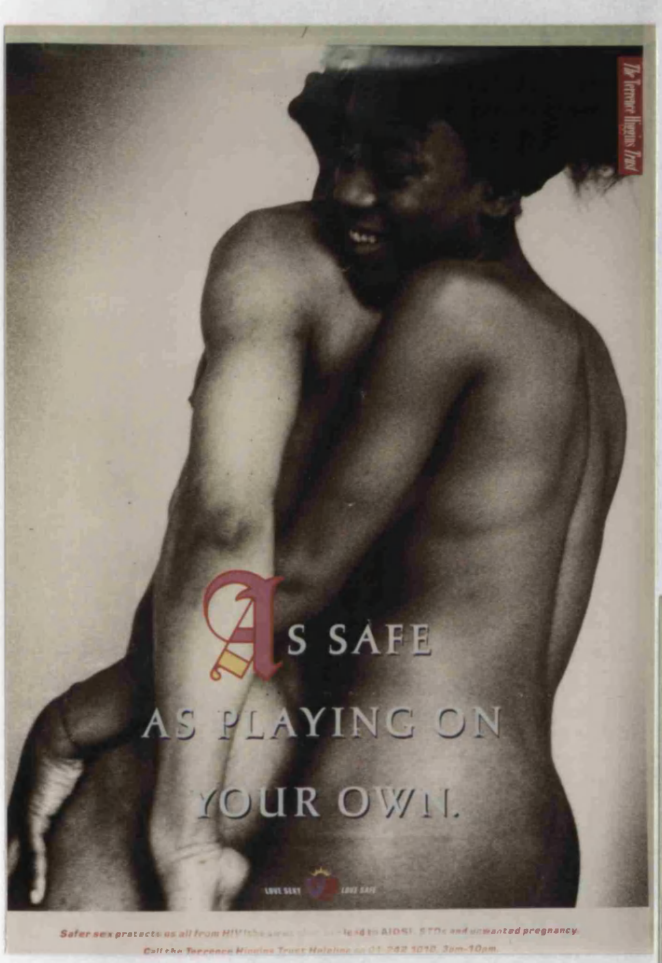
**Is there anything else which you would like to say?**

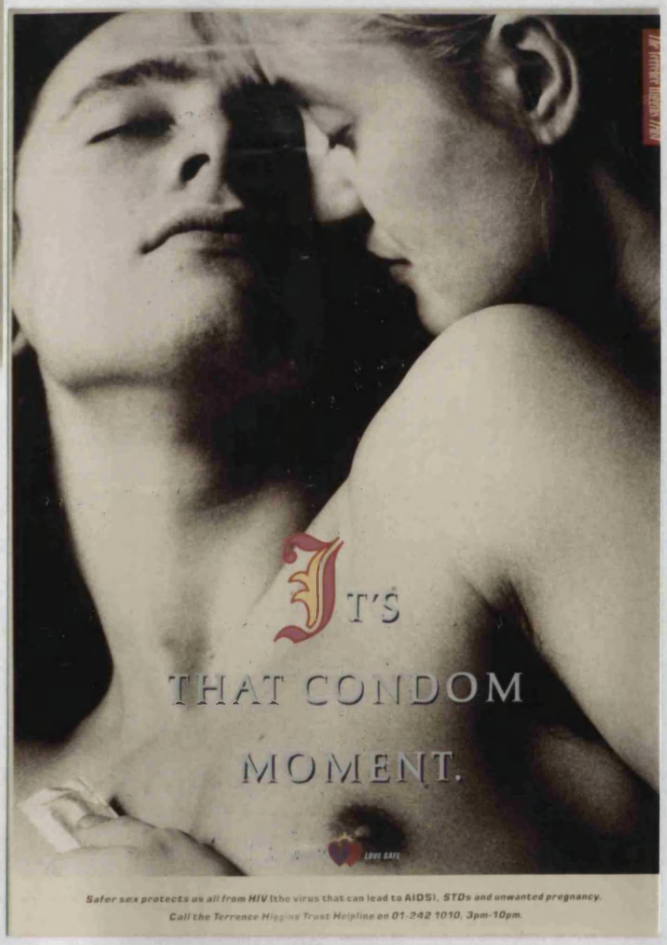
_____ **THANK YOU FOR PARTICIPATING.**

APPENDIX V: TERENCE HIGGINS TRUST HOMOSEXUAL AIDS CAMPAIGN (POSTERS), 1987

APPENDIX W: TERENCE HIGGINS TRUST HETEROSEXUAL AIDS CAMPAIGN (POSTERS), JANUARY 1990



## APPENDIX X: WORLD AIDS DAY CAMPAIGN (NATIONAL NEWSPAPERS), DECEMBER 1988

### The text reads as follows:

AIDS will be one of the biggest health challenges facing the country for the rest of this century and beyond. We already know that thousands of people will die because they are already infected with the Human Immunodeficiency Virus and this virus can lead to AIDS.

Unless we act now many thousands more will become infected, and lives that could have been saved will be lost.

We believe that many have not yet recognised the potential scale of the AIDS epidemic. Instead, those with AIDS, particularly homosexual men have been stigmatised and AIDS has been portrayed as an illness associated with 'undesirable minorities'.

The reality is that AIDS is everybody's business. Men, women and children. In a few years time most people will know of somebody infected with HIV, and realise the tragic consequences of a disease for which there is no cure and no vaccine in sight.

The human tragedy of acquiring a fatal condition, and the loss of hundreds of lives, already means that AIDS is exacting a terrifying human and economic toll.

Only by acting now to ensure that everybody knows the risk of HIV and acts sensibly to reduce the risk of becoming infected can countless lives be saved. A sustained and long-term program of education is essential.

We commit ourselves to doing all in our power to prevent the spread of HIV and AIDS, encourage a greater understanding of the nature of the disease and establish a climate of opinion in which people with HIV and AIDS are treated with care, sympathy and dignity. Please join us in recognising AIDS as everybody's problem.

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