

Empathy, Knowledge, and Personal Distress as Correlates of HIV-/AIDS-Related Stigmatization and Discrimination

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This study investigated the influence of empathy, knowledge, and personal distress on HIV-/AIDS-related stigmatization and discrimination in a normal population ($N = 346$). Participants ranging in age from 18 to 69 years responded to a validated questionnaire. The results showed a significant main and joint influence of empathy, knowledge, and personal distress on stigmatization and discrimination. Stigmatization and discrimination are thus identified as great obstacles in the fight against and prevention of HIV/AIDS. Stakeholders in the HIV/AIDS arena should embark on mass education to increase knowledge of HIV/AIDS; also attitudinal change programs should be initiated, while health institutions should be effectively monitored to ensure best practices.

The HIV/AIDS pandemic has become an issue of global concern. As of 2003, UNESCO indicated that the number of people living with the condition was about 40 million across the globe. This excludes those who are indirectly affected, such as caregivers, widows, widowers, orphans, and other categories of dependents and significant others. Presently, there is no scientifically certified cure/drug/vaccine for the AIDS virus and the full-blown disease; however, there are several antiretroviral drugs that are effectively making life worth living for people living with HIV/AIDS (PLWHA). This development has become a ray of hope to PLWHA, and a form of relief to the world at large.

According to Olapegba (2005), developing countries, particularly Sub-Saharan Africa, are the worst hit with the HIV/AIDS scourge. This assertion is consistent with the estimates of UNAIDS (2000), which identified the people in the region who were infected at 23 million (5.5%) out of the global infection of 40 million. The pattern around the world has shown that AIDS is one of the leading causes of death across the continents. Nigeria, the most populous Black nation, is indeed being ravaged by AIDS. The first reported case of AIDS was that of a 13-year-old girl in 1986; the progression after that

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has been at a very alarming rate. By 1999, about 3.5 million cases had been reported, with a national prevalence rate of 5.7% (Federal Ministry of Health, 1999; UNAIDS, 1999).

The rapid spread of HIV in Nigeria and most of Africa was a result of several interwoven factors, including sex work, sexual networking, cultural practices (e.g., polygamy, circumcision), untreated sexually transmitted diseases, poverty, stigmatization, and discrimination (UNAIDS, 2002). Discrimination and stigmatization are said to be implicated in the spread of HIV in Nigeria, based on the observed reactions of PLWHA to stigmatization (Adedokun, Okonkwo, & Ladipo, 2006). HIV-positive individuals may refuse to disclose their status for fear of termination of social relationships, and then may continue their sexual behavior, mindless of the potential effect on their partners. Similarly, the fear of stigmatization and discrimination can hinder people from undertaking voluntary counseling and testing (VCT) to ascertain their HIV status, thereby putting the larger population at risk (Aggleton, 2000; "Standing up to stigma," 2000).

Economic deprivation through job loss as a consequence of stigmatization also discourages disclosure in HIV infection, as the infected individual refuses to disclose infection and to take treatment out of fear that the employer may terminate his or her employment. This failure to disclose may put fellow workers, family members, and associates at risk of infection. As cited in Adedokun et al. (2006), Gasu (1996), and Maduna-Butshe (1997) said that the blame of women and sex workers for the spread of HIV has resulted in considerable discrimination against them. This has tended to cause sex workers to operate secretly; thus, out of reach of intervention efforts. Recently, however, the government of Nigeria and some nongovernmental organizations (NGOs) have tried to put measures in place to stop this situation and to ameliorate the impact on PLWHA and their caregivers.

The projected impact of HIV/AIDS on the world at large, if left unchecked, has shifted the attention of stakeholders to the issue of prevention of HIV, rather than expending efforts only on finding a cure. This focus suggests that if a cure has not yet been found, an attempt should be made to prevent new infections and to care for those who are already infected, while the search for a cure continues.

Meanwhile, the phenomena of stigmatization and discrimination have acted as monsters along the way of preventing HIV/AIDS worldwide. Fredriksson and Kanabus (2005) asserted that ever since scientists first identified HIV and AIDS, the social responses of stigma and discrimination have accompanied the epidemic with unmatched devastation. These social phenomena have spread so rapidly, fueling anxiety and prejudice against PLWHA, that affected individuals have suffered rejection by friends and

family members. In certain instances, the rejection has actually been institutionalized.

Stigma is a powerful discrediting attribute that portrays a person or group in a bad light. Goffman (1963) defined it as an attribute that is deeply discrediting and that reduces a person to one who is in some way tainted and, therefore, can be criticized. Jones, Farina, and Hastorf (1984) viewed it as an attribute that links a person to undesirable characteristics that are contrary to the norm of a social group or unit. This indicates that the stigmatized have a social identity that is devalued in a particular social context. Factors leading to stigmatization in HIV/AIDS can be said to be sociocultural, inadequate knowledge, and government policies at the early stages of discovery of the HIV epidemic.

Socioculturally predisposing factors in HIV/AIDS stigmatization can be said to be premised on the societal concept of good and bad, where misfortune is seen as befalling those who are bad or who have violated particular societal norms. For instance, many societies see HIV/AIDS infection as something associated with minority behaviors (e.g., sex work, homosexuality, other forms of sexual perversion). This may be especially so in Nigeria, where sex is seen as sacred and allowed only in matrimony. Fredriksson and Kanabus (2005) added that some societies see HIV/AIDS as the result of personal irresponsibility, which is believed to bring shame to the family or community. This could have implications for how people will behave toward the infected. In this context, people may see HIV/AIDS as punishment for immoral behavior, crime, war, and so forth. Whichever view people hold will inform their behavior.

According to UNESCO (2003), the stigmatization and discrimination associated with HIV/AIDS prevent many PLWHA around the world from seeking treatment for and information about the disease. This trend is among the main causes for the limited success achieved over the last 20 years. Inadequate knowledge and information are major factors in the perpetration of stigma and discrimination, as people see HIV/AIDS basically as a life-threatening disease resulting from moral fault (e.g., promiscuity, deviant sex, injecting drug use) and as punishment for sin.

On the other hand, *discrimination* is said to be a distinction made against a person that results in the person being treated unjustly and unfairly on the basis of his or her belonging to or being perceived as belonging to a particular group. It is also stated that discrimination is composed of actions or treatment based on stigma and directed toward the stigmatized. There is documented evidence of the effect of discrimination on the prevention of HIV/AIDS in some parts of the world. Settle (2006) confirmed that discrimination and fear are serious obstacles to the design and implementation of effective HIV-prevention programs.

According to Settle, information is scarce, and counseling and care are often unavailable.

In line with Settle's (2006) assertions, UNAIDS (2002) reported the outcome of a survey that was conducted in China. It found that 75% of those who were surveyed said that they would avoid people infected with HIV/AIDS, and 45% believed that the disease is a consequence of moral degeneration. Thus, it was concluded that because of the national failure to educate Chinese citizens about HIV/AIDS in the 1980s and 1990s, misunderstanding and ignorance about the disease are common, a situation that exists in other parts of the world.

Forms of discrimination faced by PLWHA are diverse. Reporting from a survey in China's Human Right Watch (2003) quoted a source as saying

Your family won't eat with you, they give you food to eat apart from them, and they won't have contact with you. Your friends ignore you. They are afraid of getting it from casual contact. If you pass them a cigarette, they won't accept.

From the survey, it was also found that families that do not reject their HIV-positive members may suffer stigma themselves. As a result of fear of stigmatization and discrimination, it has been found that it is common for those with HIV to hide their status, even from close family members.

The China report (Human Right Watch, 2003) also indicated that some PLWHA were refused admission to hospitals by healthcare workers because of their HIV-positive status. The situation is not really different in Nigeria. Odimegwu (2002) reported that stigmatization and discrimination of PLWHA are strong contributory factors in the spread of HIV/AIDS. They lead to shame and secrecy, which have silenced open discussions about the causes of HIV/AIDS and the appropriate responses.

Although there seems to be a dearth of literature and official statistics on the occurrence and prevalence of stigmatization and discrimination in Nigeria, informal information lends credence to the prevalence of the phenomena, even in hospitals and other related institutions. Another irony in the Nigerian situation is that many of the measures put in place by government and NGOs to educate people on the dangers of HIV/AIDS with a view to step up prevention actually contain materials that can be considered stigmatizing. A case in point is a radio jingle calling HIV/AIDS *arun to o gbogun*—a disease that has no cure. A phrase like this represents HIV/AIDS as a dreadful disease that kills, rather than a condition that can actually be managed. In a way, this phrase gives the message to PLWHA that they are hopeless cases who are better off dead.

The global nature of the HIV/AIDS pandemic has made it the interest of most all groups and subgroups. The inability of medicine to proffer a cure has caused some major stakeholders to adopt a faith-based approach in combating the epidemic. On the issues of stigmatization and discrimination, even the church at large is not excluded. In December 2003, the World Council of Churches held a special ecumenical meeting in St. Petersburg, Russia, with 24 churches and church-related organizations in attendance to discuss discrimination and stigmatization of PLWHA. In a memorandum released from the meeting, it was affirmed that all human beings are created in the image of God and, therefore, have intrinsic value and dignity. PLWHA are loved and accepted by God and are full and equal members of the human community. "Any form of stigmatization or discrimination perpetrated against human beings, 'including people living with HIV' violates this divine image and is therefore a sin."

Before any appreciable progress can be made in stemming stigmatization and discrimination in HIV/AIDS, there would need to be understanding of psychological factors that could be implicated in initiating and sustaining the phenomena. One factor that research has consistently implicated in human behavior is *knowledge*, which has been defined as the state of acquiring and understanding what has been perceived, experienced, or learned. In other words, the depth or extent of one's knowledge about a particular phenomenon will inform one's behavioral disposition or action.

Concerning HIV/AIDS, there exist myths and misunderstandings about several aspects of the condition, from mode of infection to transmission and origin. Many, if not all, of these myths are quite unfounded, misleading, and dangerous; these might have led to the high levels of stigmatization and discrimination that are now prevalent. For instance, it is believed by some that touching, shaking hands, sharing a bed, or eating with people living with HIV can put someone at risk of contracting it. Consequently, those with this belief may be likely to engage in discriminating behaviors, as compared with people with adequate knowledge.

Another factor that may be likely to be implicated in stigmatization and discrimination is *empathy*, which is a feeling of compassion and tenderness toward other people's plight. Empathy is of particular importance in the African community, as a result of the ingrained value of being one's brother's keeper. Africans are socialized into considering the problems of their kith and kin as their personal problems that must be jointly tackled. In a way, this could inform someone's reaction to PLWHA.

One's feelings toward PLWHA may likely mediate behavior toward them. A person who is highly empathic ordinarily would not be expected to stigmatize or discriminate against PLWHA, in comparison with someone who is low on empathy. Also, feelings of personal distress may be a mediator of

behavior toward PLWHA. In other words, *personal distress*, which is an unpleasant state of arousal in which people are preoccupied with their own emotions of anxiety or helplessness upon viewing another person's plight, may push people to engage in stigmatization and discrimination. Considering the notion that physiological makeup and reactions can account for individual differences in people, it follows that our behavioral manifestations and attitudinal tendencies can be a function of our physiological reactions to situations. People who experience high levels of personal distress tend to view people as deserving of whatever unpleasant experience they are experiencing, and this can be carried over to the HIV/AIDS epidemic.

The literature is replete with theoretical rationales of how personal distress and empathy as personality traits inform behavior in certain situations. Davis (1980) established that people differ in their habitual tendencies to experience empathy and personal distress. He further stated that our actions may be motivated by the desire to increase others' welfare. Batson (1991), Hoffman (1981), and Krebs (1975) largely supported Davis' assertions. Using the framework of the definitions that *empathy* is a feeling of compassion and tenderness upon viewing a victim's plight; and *personal distress* is an unpleasant state of arousal in which people are preoccupied with their own emotions of anxiety, fear, or helplessness upon viewing a victim's plight, these researchers concluded that the two emotional reactions result in very different motivations.

Batson (1991) described personal distress as a negative arousal that we are usually motivated to reduce; the higher the feeling of distress, the higher the motivation to reduce it. In making this point, Batson relied on the arousal/cost-reward model, which sees the reduction of an unpleasant arousal state as the primary motivation underlying personal distress. In this case, the first likely line of action would be to flee the stress-producing situation, but if this line of action is not possible, we will likely render assistance in order to reduce our own unpleasant arousal (Franzoi, 2000). The significance of Batson's proposition to the present study is that personal distress can influence stigmatization and discrimination. When people can escape easily from unpleasant arousal, the tendency to stigmatize is higher than when escape is not likely.

Empathy is also theoretically considered an unpleasant emotion, but it cannot be resolved by flight. Rather, it evokes a strong motivation to offer help. According to Batson's (1991) empathy-altruism hypothesis, the stronger the feelings of compassion for victims, the greater will be our motivation to help. However, readiness to help is motivated more by the desire to improve the victim's welfare than attend to our own. In support of this hypothesis, in a study of gay people, Batson et al. (1997) found that empathy as an emotional response improved people's attitudes toward stigmatized people. This finding was corroborated by the findings of Sibicky, Schroeder,

and Dovidio (1995) and Davis (1996). Unger and Thumhuri (1997) also found that individuals high in empathic concern were more willing to put themselves in situations in which the experience of sympathy for another is likely, but they also were generally more willing to help people in trouble than those low in empathic concern.

Several studies have indicated that there is a prevalence of stigmatization against PLWHA in Africa. Baguma (1992) reported that some medical personnel in Kenya held the notion that PLWHA are morally irresponsible, meaning that medical knowledge of HIV/AIDS does not address moral sanction and stigma in the HIV epidemic. In a related development, in a study carried out among the general population in Oyo State, Nigeria, Adedokun, Ladipo, Odutolu et al. (2004) found that myths about the spread of HIV can fuel considerable stigma. Adedokun et al. reported that many believed that HIV could be transmitted by sharing a public toilet and through mosquito bites. In essence, people who see HIV as a contagion and the infected as morally irresponsible will most likely engage in stigmatization.

In a follow-up study, Adedokun et al. (2006) reported survey results that revealed a high prevalence of stigma in Ibadan and Ogbomosho cities in Oyo State, Nigeria, prior to intervention. It was also reported in the same study that a high percentage of the sampled population attributed HIV infection to divine punishment. However, there was an observed reduction after 1 year of intervention. The purpose of the present paper is to investigate the likely main and joint influences of empathy, knowledge, and personal distress on stigmatization and discrimination with regard to PLWHA in the Western part of Nigeria.

Method

Design

The present research was a cross-sectional survey. The independent variables were empathy, knowledge, and personal distress; while the dependent variables were stigmatization and discrimination.

Participants and Setting

The study took place in Ibadan, the former capital of the old western region of Nigeria; and Lagos, the former capital of Nigeria, and the economic nerve center of the country. The sample consisted of 346 people (190 males, 156 females), who were selected using the accidental sampling technique. Participants ranged in age from 18 to 69 years ($M = 33.3$, $SD = 10.6$). Of the

sample, 206 (59.5%) were single, 123 (35.5%) were married, 8 (1.2%) were divorced, and 9 (2.6%) were widowed. With regard to education, 1.1% had no formal education, 9% had primary school leaving certificate (first 6 years of school completed), 31.2% had a secondary school certificate, 55.8% had a Bachelor's degree, and 2.9% had a graduate degree. Of the sample, 74.6% were Christian, 24.6% were Muslim, and 0.9% practiced African traditional religion.

Instrument

The data for this study were collected through a self-report questionnaire made up of five sections. Section A tapped demographic information of the participants (e.g., age, sex, marital status, occupation, level of education).

Section B of the questionnaire is the Okulate, Lawal, and Owoeye (2002) Knowledge of HIV/AIDS Scale, which measures an individual's level of knowledge of HIV/AIDS infection and transmission. It is a 3-point self-report scale ranging from 0 (*don't know*) to 1 (*no*) to 2 (*yes*). The scale contains three subscales: a seven-item scale measuring knowledge of mode of transmission of HIV/AIDS; a three-item scale measuring belief about HIV/AIDS; and a four-item scale measuring knowledge about the ways of preventing HIV/AIDS. The subscales had overall reliability coefficients of .72, .42, and .71, respectively. The maximum score on the scale is 28, while the minimum is 0. A high score indicates good knowledge of HIV/AIDS, while a low score indicates poor knowledge of HIV/AIDS.

Section C is a seven-item with two subscales (empathy and personal distress) developed by Davis (1996). The scale treats empathy and personal distress as personality traits. The scale is a 5-point Likert-type scale ranging from 0 (*extremely uncharacteristic of me*) to 4 (*extremely characteristic of me*) and has a reliability coefficient of .77. Items 1 through 3 measure empathy, and have a coefficient alpha of .72. A high score is indicative of great empathy. Items 4 through 7 measure personal distress, and had a coefficient alpha of .68. A high score indicates great personal distress.

Section D consists of an adapted version of Herek's (1996) stigmatization scale. The scale is a 12-item, 5-point measure ranging from 1 (*strongly disagree*) to 5 (*strongly agree*). It had a reliability coefficient of .82. A high score indicates a high tendency to stigmatize, while a low score indicates a low tendency to stigmatize.

Section E of the questionnaire is the discrimination scale, developed in the course of this study to measure discriminatory behavior toward PLWHA. The scale was originally made up of 21 items and later was reduced to 18 items after content validity using 10 experts and 80% agreement by the

experts on each item. Item analysis through a pilot study using 50 participants further reduced the items to 13, using .30 as the cutoff point for item-total correlation. The scale yielded a reliability coefficient of .85.

Procedure

In administering the questionnaires, participants were approached in their homes and in their offices. Their consent was sought after explaining to them the purpose of the research and assuring them of confidentiality and anonymity. For those who gave their consent to participate, the questionnaires were given to them, with a promise to pick them up on the third day. In all, about 700 questionnaires were distributed, while 346 were returned and were used for the present analysis. Administration and retrieval took a period of 4 weeks.

Statistical Analysis

The obtained data were analyzed using multiple regression analysis. In two separate analyses, stigmatization and discrimination were regressed against knowledge, empathy, and personal distress.

Results

From Table 1, it is evident that there was a significant joint influence of knowledge, empathy, and personal distress on stigmatization, $F(3, 281) = 31.82, p < .05$, with a 25% joint contribution. The results also reveal

Table 1

Multiple Regression Analysis Showing Main and Joint Influence of Knowledge, Empathy, and Personal Distress on Stigmatization of PLWHA

Variable	B	t	R	R ²	F	p
Knowledge	-.204	-3.89*	.504	.246	31.82	<.05
Empathy	-.334	-6.36*				
Personal distress	.328	6.19*				

Note. PLWHA = people living with HIV/AIDS.

* $p < .01$.

Table 2

Multiple Regression Analysis Showing the Main and Joint Influence of Knowledge, Empathy, and Personal Distress on Discrimination Against PLWHA

Variable	<i>B</i>	<i>t</i>	<i>R</i>	<i>R</i> ²	<i>F</i>	<i>p</i>
Knowledge	-.219	-3.94*	.402	.16	18.02	<.05
Empathy	-.261	-4.68*				
Personal distress	.204	3.64*				

Note. PLWHA = people living with HIV/AIDS.

that knowledge ($B = -.204$), $t(281) = -3.89$, $p < .01$; empathy ($B = -.334$), $t(281) = -6.36$, $p < .01$; and personal distress ($B = 3.33$), $t(281) = 6.19$, $p < .01$, had a significant influence on stigmatization.

Table 2 shows a significant joint influence of knowledge, empathy, and personal distress on discrimination, $F(3, 281) = 18.02$, $p < .05$, with a 16% joint contribution. The results also reveal that knowledge ($B = -.219$), $t(281) = -3.94$, $p < .01$; empathy ($B = -.261$), $t(281) = -4.68$, $p < .01$; and personal distress ($B = .204$), $t(281) = 3.64$, $p < .01$, had a significant influence on stigmatization.

Discussion

In line with the literature, the present study confirmed the existence of stigma and discrimination in HIV/AIDS. According to UNESCO (2003), the phenomena have become major stumbling blocks in the fight against the epidemic. Specifically, this study examined the influences of empathy, knowledge, and personal distress on HIV/AIDS-related stigmatization and discrimination in some parts of Nigeria.

The results show that knowledge, empathy, and personal distress are significantly related to people's individual and collective attitudes and behaviors regarding HIV/AIDS stigmatization. The depth of an individual's knowledge of HIV/AIDS informs whether he or she will stigmatize; findings from the present study indicate that the higher the knowledge of HIV/AIDS, the lower will be the stigmatization expressed. This confirms the findings of Herek and Capitanio (1993) and Patel, Mazumder, and Kotecha (2004), who reported that knowledge significantly influences stigmatization. In this regard, it may become quite obvious that when people do not have adequate knowledge of a particular issue, whether attitudinal or behavioral, the tendency is to fall back on stereotypical beliefs and implicit personality theory.

Also, inadequate knowledge attribution about PLWHA may occur based on what Kelley (1972) called the *discounting principle*, once one factor is known to be present, other likely factors are discounted. In the context of HIV/AIDS stigmatization, once someone with inadequate knowledge making an attribution knows that sexual intercourse is a major route to HIV infection, he or she concludes that the condition is brought about by promiscuity, thereby discounting other likely routes of infection that have nothing to do with promiscuity.

This finding also corroborated the findings of Adedokun et al. (2006), who found in studies conducted in Nigeria that knowledge of HIV reduces stigmatization and discriminatory behaviors. Specifically, the researchers took a measure of HIV knowledge prior to intervention among the general populace in Ogbomosho and Ibadan, South West, Nigeria. This was followed by intervention in the form of educating the populace on HIV over a period of 1 year. Post-intervention measures of stigmatization indicate a reduction in stigmatization and discrimination, thereby confirming the efficacy of knowledge in stigma reduction and attitudinal change in general.

It was also found that high empathic concern leads to lower levels of stigmatization, meaning that people who empathize greatly with PLWHA will have more favorable attitudes toward them. This is in line with the research of Unger and Thumhuri (1997), who found that people with high empathic concern are more sympathetic toward the plight of others than are those with low empathic concern.

Personal distress was also found to have a significant relationship with stigmatization. An intercorrelation revealed that the higher the personal distress experienced, the higher was the empathic concern and, as a consequence, the lower the stigmatization. This, however, did not support the findings of Unger and Thumhuri, who reported that people who experience personal distress are not willing to help or support people in distress.

This obvious difference may be a result of the cultural orientation of the populations of interest in the two studies. For the present study, carried out in Nigeria, one fundamental issue of the cultural orientation is the holistic nature of relationships and the high value attached to social support. Everyone is his or her brother's keeper, and it does not matter one's level of discomfort or distress: Society still demands that one must support and show concern for others, especially those in need.

However, this study found support in the work of Batson (1991). Using the empathy-altruism hypothesis, Batson concluded that the stronger the feeling of compassion for victims, the greater would be the motivation to help. This was further corroborated by the findings of others (Batson et al., 1997; Davis, 1996; Sibicky et al., 1995).

The results on the influence of empathy, knowledge, and personal distress on discrimination actually followed the same pattern found in stigmatization. This is suggestive of a high correlation between stigmatization and discrimination. Specifically, it was found that there was a negative relationship between knowledge and discrimination against PLWHA. The higher the knowledge, the lower was the discriminatory behavior. This supports the findings of Lau and Tsui (2000), who reported that there is a relationship between level of knowledge about HIV/AIDS and discriminatory attitudes toward PLWHA.

In the present study, we also found that empathy and personal distress have a significant influence on discrimination against PLWHA. Following the pattern of stigmatization as previously explained, this is a confirmation of the findings of Batson, O'Quinn, Fultz, Vanderplas, and Isen (1983). However, it should be noted that stigmatization may not always lead to discrimination. In some instances, societal and other forms of environmental factors may pressure an individual to conform to the popular norm and to exhibit discriminatory behaviors.

Taking into account the abundance of evidence in the literature that stigmatization and discrimination are great obstacles in the design and implementation of effective HIV-prevention programs (Human Right Watch, 2003; Odimegwu, 2002; Settle, 2006; UNAIDS, 2002) and having identified the important roles of empathy, knowledge, and personal distress in promoting and sustaining stigmatization and discrimination, efforts should be geared toward a drastic reduction and prevention of the phenomena. Attempts should be made by government, NGOs, and other stakeholders to mount mass-education programs to give people adequate knowledge about HIV/AIDS. Attitudinal change programs should be given priority, while monitoring mechanisms should be built to ensure that medical and paramedical institutions do not practice or promote discriminatory behaviors.

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The HIV/AIDS pandemic has become an issue of global concern. As of 2003, UNESCO indicated that the number of people living with the condition was about 40 million across the globe. This excludes those who are indirectly affected, such as caregivers, widows, widowers, orphans, and other categories of dependents and significant others. Presently, there is no scientifically certified cure/drug/vaccine for the AIDS virus and the full-blown disease; however, there are several antiretroviral drugs that are effectively making life worth living for people living with HIV/AIDS (PLWHA). This development has become a ray of hope to PLWHA, and a form of relief to the world at large.

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has been at a very alarming rate. By 1999, about 3.5 million cases had been reported, with a national prevalence rate of 5.7% (Federal Ministry of Health, 1999; UNAIDS, 1999).

The rapid spread of HIV in Nigeria and most of Africa was a result of several interwoven factors, including sex work, sexual networking, cultural practices (e.g., polygamy, circumcision), untreated sexually transmitted diseases, poverty, stigmatization, and discrimination (UNAIDS, 2002). Discrimination and stigmatization are said to be implicated in the spread of HIV in Nigeria, based on the observed reactions of PLWHA to stigmatization (Adedokun, Okonkwo, & Ladipo, 2006). HIV-positive individuals may refuse to disclose their status for fear of termination of social relationships, and then may continue their sexual behavior, mindless of the potential effect on their partners. Similarly, the fear of stigmatization and discrimination can hinder people from undertaking voluntary counseling and testing (VCT) to ascertain their HIV status, thereby putting the larger population at risk (Aggleton, 2000; "Standing up to stigma," 2000).

Economic deprivation through job loss as a consequence of stigmatization also discourages disclosure in HIV infection, as the infected individual refuses to disclose infection and to take treatment out of fear that the employer may terminate his or her employment. This failure to disclose may put fellow workers, family members, and associates at risk of infection. As cited in Adedokun et al. (2006), Gasu (1996), and Maduna-Butshe (1997) said that the blame of women and sex workers for the spread of HIV has resulted in considerable discrimination against them. This has tended to cause sex workers to operate secretly; thus, out of reach of intervention efforts. Recently, however, the government of Nigeria and some nongovernmental organizations (NGOs) have tried to put measures in place to stop this situation and to ameliorate the impact on PLWHA and their caregivers.

The projected impact of HIV/AIDS on the world at large, if left unchecked, has shifted the attention of stakeholders to the issue of prevention of HIV, rather than expending efforts only on finding a cure. This focus suggests that if a cure has not yet been found, an attempt should be made to prevent new infections and to care for those who are already infected, while the search for a cure continues.

Meanwhile, the phenomena of stigmatization and discrimination have acted as monsters along the way of preventing HIV/AIDS worldwide. Fredriksson and Kanabus (2005) asserted that ever since scientists first identified HIV and AIDS, the social responses of stigma and discrimination have accompanied the epidemic with unmatched devastation. These social phenomena have spread so rapidly, fueling anxiety and prejudice against PLWHA, that affected individuals have suffered rejection by friends and

family members. In certain instances, the rejection has actually been institutionalized.

Stigma is a powerful discrediting attribute that portrays a person or group in a bad light. Goffman (1963) defined it as an attribute that is deeply discrediting and that reduces a person to one who is in some way tainted and, therefore, can be criticized. Jones, Farina, and Hastorf (1984) viewed it as an attribute that links a person to undesirable characteristics that are contrary to the norm of a social group or unit. This indicates that the stigmatized have a social identity that is devalued in a particular social context. Factors leading to stigmatization in HIV/AIDS can be said to be sociocultural, inadequate knowledge, and government policies at the early stages of discovery of the HIV epidemic.

Socioculturally predisposing factors in HIV/AIDS stigmatization can be said to be premised on the societal concept of good and bad, where misfortune is seen as befalling those who are bad or who have violated particular societal norms. For instance, many societies see HIV/AIDS infection as something associated with minority behaviors (e.g., sex work, homosexuality, other forms of sexual perversion). This may be especially so in Nigeria, where sex is seen as sacred and allowed only in matrimony. Fredriksson and Kanabus (2005) added that some societies see HIV/AIDS as the result of personal irresponsibility, which is believed to bring shame to the family or community. This could have implications for how people will behave toward the infected. In this context, people may see HIV/AIDS as punishment for immoral behavior, crime, war, and so forth. Whichever view people hold will inform their behavior.

According to UNESCO (2003), the stigmatization and discrimination associated with HIV/AIDS prevent many PLWHA around the world from seeking treatment for and information about the disease. This trend is among the main causes for the limited success achieved over the last 20 years. Inadequate knowledge and information are major factors in the perpetration of stigma and discrimination, as people see HIV/AIDS basically as a life-threatening disease resulting from moral fault (e.g., promiscuity, deviant sex, injecting drug use) and as punishment for sin.

On the other hand, *discrimination* is said to be a distinction made against a person that results in the person being treated unjustly and unfairly on the basis of his or her belonging to or being perceived as belonging to a particular group. It is also stated that discrimination is composed of actions or treatment based on stigma and directed toward the stigmatized. There is documented evidence of the effect of discrimination on the prevention of HIV/AIDS in some parts of the world. Settle (2006) confirmed that discrimination and fear are serious obstacles to the design and implementation of effective HIV-prevention programs.

According to Settle, information is scarce, and counseling and care are often unavailable.

In line with Settle's (2006) assertions, UNAIDS (2002) reported the outcome of a survey that was conducted in China. It found that 75% of those who were surveyed said that they would avoid people infected with HIV/AIDS, and 45% believed that the disease is a consequence of moral degeneration. Thus, it was concluded that because of the national failure to educate Chinese citizens about HIV/AIDS in the 1980s and 1990s, misunderstanding and ignorance about the disease are common, a situation that exists in other parts of the world.

Forms of discrimination faced by PLWHA are diverse. Reporting from a survey in China's Human Right Watch (2003) quoted a source as saying

Your family won't eat with you, they give you food to eat apart from them, and they won't have contact with you. Your friends ignore you. They are afraid of getting it from casual contact. If you pass them a cigarette, they won't accept.

From the survey, it was also found that families that do not reject their HIV-positive members may suffer stigma themselves. As a result of fear of stigmatization and discrimination, it has been found that it is common for those with HIV to hide their status, even from close family members.

The China report (Human Right Watch, 2003) also indicated that some PLWHA were refused admission to hospitals by healthcare workers because of their HIV-positive status. The situation is not really different in Nigeria. Odimegwu (2002) reported that stigmatization and discrimination of PLWHA are strong contributory factors in the spread of HIV/AIDS. They lead to shame and secrecy, which have silenced open discussions about the causes of HIV/AIDS and the appropriate responses.

Although there seems to be a dearth of literature and official statistics on the occurrence and prevalence of stigmatization and discrimination in Nigeria, informal information lends credence to the prevalence of the phenomena, even in hospitals and other related institutions. Another irony in the Nigerian situation is that many of the measures put in place by government and NGOs to educate people on the dangers of HIV/AIDS with a view to step up prevention actually contain materials that can be considered stigmatizing. A case in point is a radio jingle calling HIV/AIDS *arun to o gbogun*—a disease that has no cure. A phrase like this represents HIV/AIDS as a dreadful disease that kills, rather than a condition that can actually be managed. In a way, this phrase gives the message to PLWHA that they are hopeless cases who are better off dead.

The global nature of the HIV/AIDS pandemic has made it the interest of most all groups and subgroups. The inability of medicine to proffer a cure has caused some major stakeholders to adopt a faith-based approach in combating the epidemic. On the issues of stigmatization and discrimination, even the church at large is not excluded. In December 2003, the World Council of Churches held a special ecumenical meeting in St. Petersburg, Russia, with 24 churches and church-related organizations in attendance to discuss discrimination and stigmatization of PLWHA. In a memorandum released from the meeting, it was affirmed that all human beings are created in the image of God and, therefore, have intrinsic value and dignity. PLWHA are loved and accepted by God and are full and equal members of the human community. "Any form of stigmatization or discrimination perpetrated against human beings, 'including people living with HIV' violates this divine image and is therefore a sin."

Before any appreciable progress can be made in stemming stigmatization and discrimination in HIV/AIDS, there would need to be understanding of psychological factors that could be implicated in initiating and sustaining the phenomena. One factor that research has consistently implicated in human behavior is *knowledge*, which has been defined as the state of acquiring and understanding what has been perceived, experienced, or learned. In other words, the depth or extent of one's knowledge about a particular phenomenon will inform one's behavioral disposition or action.

Concerning HIV/AIDS, there exist myths and misunderstandings about several aspects of the condition, from mode of infection to transmission and origin. Many, if not all, of these myths are quite unfounded, misleading, and dangerous; these might have led to the high levels of stigmatization and discrimination that are now prevalent. For instance, it is believed by some that touching, shaking hands, sharing a bed, or eating with people living with HIV can put someone at risk of contracting it. Consequently, those with this belief may be likely to engage in discriminating behaviors, as compared with people with adequate knowledge.

Another factor that may be likely to be implicated in stigmatization and discrimination is *empathy*, which is a feeling of compassion and tenderness toward other people's plight. Empathy is of particular importance in the African community, as a result of the ingrained value of being one's brother's keeper. Africans are socialized into considering the problems of their kith and kin as their personal problems that must be jointly tackled. In a way, this could inform someone's reaction to PLWHA.

One's feelings toward PLWHA may likely mediate behavior toward them. A person who is highly empathic ordinarily would not be expected to stigmatize or discriminate against PLWHA, in comparison with someone who is low on empathy. Also, feelings of personal distress may be a mediator of

behavior toward PLWHA. In other words, *personal distress*, which is an unpleasant state of arousal in which people are preoccupied with their own emotions of anxiety or helplessness upon viewing another person's plight, may push people to engage in stigmatization and discrimination. Considering the notion that physiological makeup and reactions can account for individual differences in people, it follows that our behavioral manifestations and attitudinal tendencies can be a function of our physiological reactions to situations. People who experience high levels of personal distress tend to view people as deserving of whatever unpleasant experience they are experiencing, and this can be carried over to the HIV/AIDS epidemic.

The literature is replete with theoretical rationales of how personal distress and empathy as personality traits inform behavior in certain situations. Davis (1980) established that people differ in their habitual tendencies to experience empathy and personal distress. He further stated that our actions may be motivated by the desire to increase others' welfare. Batson (1991), Hoffman (1981), and Krebs (1975) largely supported Davis' assertions. Using the framework of the definitions that *empathy* is a feeling of compassion and tenderness upon viewing a victim's plight; and *personal distress* is an unpleasant state of arousal in which people are preoccupied with their own emotions of anxiety, fear, or helplessness upon viewing a victim's plight, these researchers concluded that the two emotional reactions result in very different motivations.

Batson (1991) described personal distress as a negative arousal that we are usually motivated to reduce; the higher the feeling of distress, the higher the motivation to reduce it. In making this point, Batson relied on the arousal/cost-reward model, which sees the reduction of an unpleasant arousal state as the primary motivation underlying personal distress. In this case, the first likely line of action would be to flee the stress-producing situation, but if this line of action is not possible, we will likely render assistance in order to reduce our own unpleasant arousal (Franzoi, 2000). The significance of Batson's proposition to the present study is that personal distress can influence stigmatization and discrimination. When people can escape easily from unpleasant arousal, the tendency to stigmatize is higher than when escape is not likely.

Empathy is also theoretically considered an unpleasant emotion, but it cannot be resolved by flight. Rather, it evokes a strong motivation to offer help. According to Batson's (1991) empathy-altruism hypothesis, the stronger the feelings of compassion for victims, the greater will be our motivation to help. However, readiness to help is motivated more by the desire to improve the victim's welfare than attend to our own. In support of this hypothesis, in a study of gay people, Batson et al. (1997) found that empathy as an emotional response improved people's attitudes toward stigmatized people. This finding was corroborated by the findings of Sibicky, Schroeder,

and Dovidio (1995) and Davis (1996). Unger and Thumhuri (1997) also found that individuals high in empathic concern were more willing to put themselves in situations in which the experience of sympathy for another is likely, but they also were generally more willing to help people in trouble than those low in empathic concern.

Several studies have indicated that there is a prevalence of stigmatization against PLWHA in Africa. Baguma (1992) reported that some medical personnel in Kenya held the notion that PLWHA are morally irresponsible, meaning that medical knowledge of HIV/AIDS does not address moral sanction and stigma in the HIV epidemic. In a related development, in a study carried out among the general population in Oyo State, Nigeria, Adedokun, Ladipo, Odutolu et al. (2004) found that myths about the spread of HIV can fuel considerable stigma. Adedokun et al. reported that many believed that HIV could be transmitted by sharing a public toilet and through mosquito bites. In essence, people who see HIV as a contagion and the infected as morally irresponsible will most likely engage in stigmatization.

In a follow-up study, Adedokun et al. (2006) reported survey results that revealed a high prevalence of stigma in Ibadan and Ogbomosho cities in Oyo State, Nigeria, prior to intervention. It was also reported in the same study that a high percentage of the sampled population attributed HIV infection to divine punishment. However, there was an observed reduction after 1 year of intervention. The purpose of the present paper is to investigate the likely main and joint influences of empathy, knowledge, and personal distress on stigmatization and discrimination with regard to PLWHA in the Western part of Nigeria.

Method

Design

The present research was a cross-sectional survey. The independent variables were empathy, knowledge, and personal distress; while the dependent variables were stigmatization and discrimination.

Participants and Setting

The study took place in Ibadan, the former capital of the old western region of Nigeria; and Lagos, the former capital of Nigeria, and the economic nerve center of the country. The sample consisted of 346 people (190 males, 156 females), who were selected using the accidental sampling technique. Participants ranged in age from 18 to 69 years ($M = 33.3$, $SD = 10.6$). Of the

sample, 206 (59.5%) were single, 123 (35.5%) were married, 8 (1.2%) were divorced, and 9 (2.6%) were widowed. With regard to education, 1.1% had no formal education, 9% had primary school leaving certificate (first 6 years of school completed), 31.2% had a secondary school certificate, 55.8% had a Bachelor's degree, and 2.9% had a graduate degree. Of the sample, 74.6% were Christian, 24.6% were Muslim, and 0.9% practiced African traditional religion.

Instrument

The data for this study were collected through a self-report questionnaire made up of five sections. Section A tapped demographic information of the participants (e.g., age, sex, marital status, occupation, level of education).

Section B of the questionnaire is the Okulate, Lawal, and Owoeye (2002) Knowledge of HIV/AIDS Scale, which measures an individual's level of knowledge of HIV/AIDS infection and transmission. It is a 3-point self-report scale ranging from 0 (*don't know*) to 1 (*no*) to 2 (*yes*). The scale contains three subscales: a seven-item scale measuring knowledge of mode of transmission of HIV/AIDS; a three-item scale measuring belief about HIV/AIDS; and a four-item scale measuring knowledge about the ways of preventing HIV/AIDS. The subscales had overall reliability coefficients of .72, .42, and .71, respectively. The maximum score on the scale is 28, while the minimum is 0. A high score indicates good knowledge of HIV/AIDS, while a low score indicates poor knowledge of HIV/AIDS.

Section C is a seven-item with two subscales (empathy and personal distress) developed by Davis (1996). The scale treats empathy and personal distress as personality traits. The scale is a 5-point Likert-type scale ranging from 0 (*extremely uncharacteristic of me*) to 4 (*extremely characteristic of me*) and has a reliability coefficient of .77. Items 1 through 3 measure empathy, and have a coefficient alpha of .72. A high score is indicative of great empathy. Items 4 through 7 measure personal distress, and had a coefficient alpha of .68. A high score indicates great personal distress.

Section D consists of an adapted version of Herek's (1996) stigmatization scale. The scale is a 12-item, 5-point measure ranging from 1 (*strongly disagree*) to 5 (*strongly agree*). It had a reliability coefficient of .82. A high score indicates a high tendency to stigmatize, while a low score indicates a low tendency to stigmatize.

Section E of the questionnaire is the discrimination scale, developed in the course of this study to measure discriminatory behavior toward PLWHA. The scale was originally made up of 21 items and later was reduced to 18 items after content validity using 10 experts and 80% agreement by the

experts on each item. Item analysis through a pilot study using 50 participants further reduced the items to 13, using .30 as the cutoff point for item-total correlation. The scale yielded a reliability coefficient of .85.

Procedure

In administering the questionnaires, participants were approached in their homes and in their offices. Their consent was sought after explaining to them the purpose of the research and assuring them of confidentiality and anonymity. For those who gave their consent to participate, the questionnaires were given to them, with a promise to pick them up on the third day. In all, about 700 questionnaires were distributed, while 346 were returned and were used for the present analysis. Administration and retrieval took a period of 4 weeks.

Statistical Analysis

The obtained data were analyzed using multiple regression analysis. In two separate analyses, stigmatization and discrimination were regressed against knowledge, empathy, and personal distress.

Results

From Table 1, it is evident that there was a significant joint influence of knowledge, empathy, and personal distress on stigmatization, $F(3, 281) = 31.82, p < .05$, with a 25% joint contribution. The results also reveal

Table 1

Multiple Regression Analysis Showing Main and Joint Influence of Knowledge, Empathy, and Personal Distress on Stigmatization of PLWHA

Variable	B	t	R	R ²	F	p
Knowledge	-.204	-3.89*	.504	.246	31.82	<.05
Empathy	-.334	-6.36*				
Personal distress	.328	6.19*				

Note. PLWHA = people living with HIV/AIDS.

* $p < .01$.

Table 2

Multiple Regression Analysis Showing the Main and Joint Influence of Knowledge, Empathy, and Personal Distress on Discrimination Against PLWHA

Variable	<i>B</i>	<i>t</i>	<i>R</i>	<i>R</i> ²	<i>F</i>	<i>p</i>
Knowledge	-.219	-3.94*	.402	.16	18.02	<.05
Empathy	-.261	-4.68*				
Personal distress	.204	3.64*				

Note. PLWHA = people living with HIV/AIDS.

that knowledge ($B = -.204$), $t(281) = -3.89$, $p < .01$; empathy ($B = -.334$), $t(281) = -6.36$, $p < .01$; and personal distress ($B = 3.33$), $t(281) = 6.19$, $p < .01$, had a significant influence on stigmatization.

Table 2 shows a significant joint influence of knowledge, empathy, and personal distress on discrimination, $F(3, 281) = 18.02$, $p < .05$, with a 16% joint contribution. The results also reveal that knowledge ($B = -.219$), $t(281) = -3.94$, $p < .01$; empathy ($B = -.261$), $t(281) = -4.68$, $p < .01$; and personal distress ($B = .204$), $t(281) = 3.64$, $p < .01$, had a significant influence on stigmatization.

Discussion

In line with the literature, the present study confirmed the existence of stigma and discrimination in HIV/AIDS. According to UNESCO (2003), the phenomena have become major stumbling blocks in the fight against the epidemic. Specifically, this study examined the influences of empathy, knowledge, and personal distress on HIV/AIDS-related stigmatization and discrimination in some parts of Nigeria.

The results show that knowledge, empathy, and personal distress are significantly related to people's individual and collective attitudes and behaviors regarding HIV/AIDS stigmatization. The depth of an individual's knowledge of HIV/AIDS informs whether he or she will stigmatize; findings from the present study indicate that the higher the knowledge of HIV/AIDS, the lower will be the stigmatization expressed. This confirms the findings of Herek and Capitanio (1993) and Patel, Mazumder, and Kotecha (2004), who reported that knowledge significantly influences stigmatization. In this regard, it may become quite obvious that when people do not have adequate knowledge of a particular issue, whether attitudinal or behavioral, the tendency is to fall back on stereotypical beliefs and implicit personality theory.

Also, inadequate knowledge attribution about PLWHA may occur based on what Kelley (1972) called the *discounting principle*, once one factor is known to be present, other likely factors are discounted. In the context of HIV/AIDS stigmatization, once someone with inadequate knowledge making an attribution knows that sexual intercourse is a major route to HIV infection, he or she concludes that the condition is brought about by promiscuity, thereby discounting other likely routes of infection that have nothing to do with promiscuity.

This finding also corroborated the findings of Adedokun et al. (2006), who found in studies conducted in Nigeria that knowledge of HIV reduces stigmatization and discriminatory behaviors. Specifically, the researchers took a measure of HIV knowledge prior to intervention among the general populace in Ogbomosho and Ibadan, South West, Nigeria. This was followed by intervention in the form of educating the populace on HIV over a period of 1 year. Post-intervention measures of stigmatization indicate a reduction in stigmatization and discrimination, thereby confirming the efficacy of knowledge in stigma reduction and attitudinal change in general.

It was also found that high empathic concern leads to lower levels of stigmatization, meaning that people who empathize greatly with PLWHA will have more favorable attitudes toward them. This is in line with the research of Unger and Thumhuri (1997), who found that people with high empathic concern are more sympathetic toward the plight of others than are those with low empathic concern.

Personal distress was also found to have a significant relationship with stigmatization. An intercorrelation revealed that the higher the personal distress experienced, the higher was the empathic concern and, as a consequence, the lower the stigmatization. This, however, did not support the findings of Unger and Thumhuri, who reported that people who experience personal distress are not willing to help or support people in distress.

This obvious difference may be a result of the cultural orientation of the populations of interest in the two studies. For the present study, carried out in Nigeria, one fundamental issue of the cultural orientation is the holistic nature of relationships and the high value attached to social support. Everyone is his or her brother's keeper, and it does not matter one's level of discomfort or distress: Society still demands that one must support and show concern for others, especially those in need.

However, this study found support in the work of Batson (1991). Using the empathy-altruism hypothesis, Batson concluded that the stronger the feeling of compassion for victims, the greater would be the motivation to help. This was further corroborated by the findings of others (Batson et al., 1997; Davis, 1996; Sibicky et al., 1995).

The results on the influence of empathy, knowledge, and personal distress on discrimination actually followed the same pattern found in stigmatization. This is suggestive of a high correlation between stigmatization and discrimination. Specifically, it was found that there was a negative relationship between knowledge and discrimination against PLWHA. The higher the knowledge, the lower was the discriminatory behavior. This supports the findings of Lau and Tsui (2000), who reported that there is a relationship between level of knowledge about HIV/AIDS and discriminatory attitudes toward PLWHA.

In the present study, we also found that empathy and personal distress have a significant influence on discrimination against PLWHA. Following the pattern of stigmatization as previously explained, this is a confirmation of the findings of Batson, O'Quinn, Fultz, Vanderplas, and Isen (1983). However, it should be noted that stigmatization may not always lead to discrimination. In some instances, societal and other forms of environmental factors may pressure an individual to conform to the popular norm and to exhibit discriminatory behaviors.

Taking into account the abundance of evidence in the literature that stigmatization and discrimination are great obstacles in the design and implementation of effective HIV-prevention programs (Human Right Watch, 2003; Odimegwu, 2002; Settle, 2006; UNAIDS, 2002) and having identified the important roles of empathy, knowledge, and personal distress in promoting and sustaining stigmatization and discrimination, efforts should be geared toward a drastic reduction and prevention of the phenomena. Attempts should be made by government, NGOs, and other stakeholders to mount mass-education programs to give people adequate knowledge about HIV/AIDS. Attitudinal change programs should be given priority, while monitoring mechanisms should be built to ensure that medical and paramedical institutions do not practice or promote discriminatory behaviors.

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