

Values under pressure: AIDS and civil liberties

Place and time organize, if not the answers we give to questions, at any rate the questions we ask. Living where and when we do, it was natural, even inevitable, to ask about the impact of AIDS.

Stouffer's (1955) pioneering study on tolerance of communists and nonconformists, conducted at the height of McCarthyism, had documented shockingly low levels of support for civil liberties on the part of the average citizen. To see just how shocking, it is worth citing a concrete example: Asked whether a clerk in a store – an ordinary clerk, in a perfectly ordinary store – should be fired if he is a communist, two-thirds of the public agreed (Stouffer, 1955, p. 43). And Sullivan, Piereson, and Marcus (1979), in the most innovative study of tolerance since Stouffer, concluded that any apparent increase in political tolerance since the 1950s was an illusion.

For all its merits, we had found the Sullivan study unpersuasive, for reasons we detail in Chapter 7. The gut of the issue, as it seemed to us, is to what extent ordinary people were actually capable of supporting the value of tolerance: The burden of Sullivan's argument is that the public supplied little protection to assure toleration of unpopular groups – apart, that is, from disagreeing about which groups should not be tolerated. The outbreak of AIDS afforded a grotesque, but useful, opportunity to assess the reactions of ordinary people when confronted – suddenly, unexpectedly, and undeniably – by a deadly threat.

It is not enough to learn whether a person favors civil liberties in the abstract. It is necessary to know how he reacts in controversial cases – whether he is prepared to stand by basic rights under pressure or whether he yields in the face of threats. So much is plain from previous studies of tolerance, if not from common sense. And yet the study of threats to tolerance has been very largely the study of fantasized threats. Subversives have been a problem from time to time, but the threat of internal subversion was blown out of proportion by McCarthy. It is, accordingly, worth asking how the public will react when they come face to face with a chilling threat that is not fantasized but genuine. AIDS is just such a threat – unexpected, lethal, and associated in the public mind with stigmatized groups.

PREVIOUS RESEARCH

There is a long and distinguished tradition of research on public opinion and civil liberties (e.g., Stouffer, 1955; Prothro and Grigg, 1960; McClosky, 1964; Nunn,

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Crocket, and Williams, 1978; Sullivan, Piereson, and Marcus, 1979, 1982; Gibson and Bingham, 1985). But this body of research has two limitations.

First, the public's reaction to issues of civil liberties is most important in the face of an extraordinary threat, when pressure builds for intolerant reaction. Public opinion studies, however, have concentrated on public attitudes toward the rights of groups in ordinary circumstances, when it is politics-as-usual (e.g., Davis, 1975; Nunn, Crockett, and Williams, 1978; McClosky and Brill, 1983). The point is not that the public's attitudes toward civil liberties are inconsequential in ordinary circumstances. After all, the burden of nearly all previous research is precisely that a large portion of the public fails to respect the rights of a wide array of groups even in the absence of pressure to violate them. All the same, it is important to see what happens when commitments to civil liberties come under pressure. To test a boat's seaworthiness, you must try it in a squall.

Second, to characterize the public's reaction under stress requires knowing the public's opinions before, as well as after, a threat presents itself; quite simply, the fact that people may support the rights of a group in ordinary circumstances is no guarantee they will do so when a controversy blows up. Only studies involving comparisons over time allow conclusions about the steadfastness of values under pressure. Unfortunately, this is precisely what the few studies that focus on public attitudes toward the rights of particular groups during actual controversies typically lack (e.g., Stouffer, 1955; Gibson and Bingham, 1985).

Accordingly, this study has been designed to take advantage of parallel surveys, one conducted before the eruption of AIDS, the other after it. The AIDS epidemic undeniably raises civil liberties issues, most obviously (though by no means exclusively) for homosexuals and for persons suffering from it. This study's design thus provides a rare opportunity to assess the event-sensitivity of attitudes toward civil liberties.

Specifically, this study focuses on two questions. First, to what extent have citizens weakened their commitment to civil liberties for homosexuals under the impact of AIDS? Second, to what extent will ordinary citizens give considerations of civil liberties weight in deciding how to treat persons with AIDS? Both questions matter, to the student of public policy as well as of democratic theory. Given exigencies of AIDS politics, it is of some importance to understand how citizens make up their minds about such issues as mandatory testing for AIDS and protection of the rights of AIDS victims.

DATA AND METHODS

This study is designed around parallel surveys of public attitudes toward homosexuals. Both surveys are cross-sectional samples of the adult population of California, administered by the Field Institute. One was conducted through personal interviews in June 1977 ($n = 1,034$), before the discovery of AIDS as a disease; the other through telephone interviews in December 1985 ($n = 1,005$), after AIDS had become an epidemic.

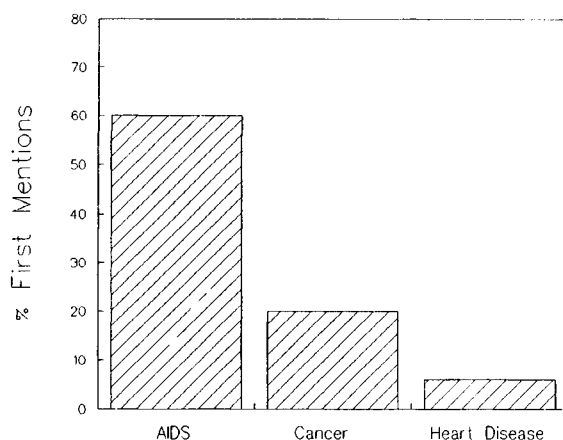


Figure 3.1. Perceptions of the most serious health problems facing California. The question read, "In respect to the serious diseases or medical problems facing California today, which two or three do you think are the most serious?" Only first mentions are displayed.

Both 1985 and 1977 samples were subject to weighting by region, sex, and age, thus ensuring conformity between sample statistics and population parameters for the three attributes. Details of sample construction are presented in Appendix 1. The average completion rate for the two surveys, based on the universe of households contacted, is approximately 50 percent. Interviewing mode effects are discussed in Appendix 2, which shows our findings are not biased by the use of telephones for the second interview.

PUBLIC AWARENESS, APPREHENSION, AND KNOWLEDGE

To appreciate public opinion on AIDS issues, it is necessary to appreciate the extent of public concern about and knowledge of the disease.

Concern

AIDS is a household word. In 1985, we interviewed 1,005 people; 4 of them had not heard or read about AIDS. To put this in context: People are more likely not to know who the president of the United States is than not to have heard of AIDS.

And not only is the general public aware of AIDS. They are also concerned about it. Figure 3.1 presents some evidence on current levels of public apprehension about AIDS. The sample was asked to name the most serious diseases or medical problems facing California today. They had to name a disease themselves, not simply pick one off a list supplied. By concentrating on the first disease that came to their minds, we have a stringent test of the extent to which AIDS, as compared with other serious diseases, is uppermost in people's minds.

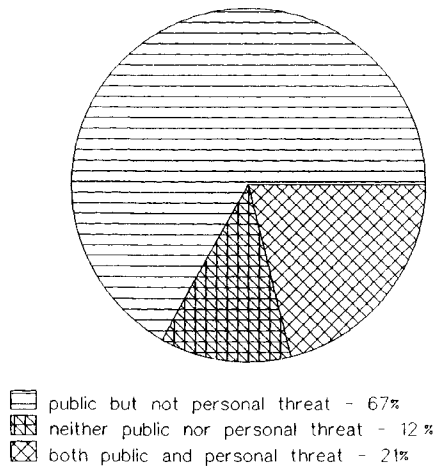


Figure 3.2. AIDS: public or personal threat? Two dichotomous measures of concern were used in Figure 3.2. For “public threat,” the questions were the same as in Figure 3.1, but any mention of AIDS was counted rather than first mentions only. For “personal threat,” the question read, “Now in respect to your own situation, which two or three serious diseases or medical problems are you most concerned about getting?” Again, any mention of AIDS was counted as a personal threat.

As Figure 3.1 shows, AIDS is the health problem most likely to be mentioned first, far surpassing cancer and heart disease, the two next most salient diseases. In fact, though AIDS is responsible for far fewer deaths than either heart disease or cancer, it is almost three times as likely to be mentioned as the former, and eight times as likely to be mentioned as the latter.

And not only does a majority of the public perceive AIDS to be a serious threat. They perceive it to be an immediate one. Indeed, nearly 80 percent believes AIDS is a threat to the general public right now, while an additional 10 percent believes it will be in the next few years.

It is one thing for people to perceive AIDS as a serious public health problem, quite another for them to perceive it as a threat to themselves. Figure 3.2 illustrates, in the form of a pie graph, the proportions of the public who view AIDS as a public threat, as a personal threat, as both a public and a personal threat, and as not a public or personal threat. Plainly, AIDS is seen as a public health problem, not a personal threat. Approximately 20 percent sees it as a threat both to the general public and personally. By contrast, 67 percent sees AIDS as a threat to the public but not personally, while only a minuscule proportion – less than 1 percent – sees it as personal threat but not a public one.

Ignorance

Nearly everyone has heard or read about AIDS. But how well informed are they about the disease? How much do they know about who gets it and how they get it?

Table 3.1. *Knowledge of how AIDS is transmitted*

Do you think a person can get AIDS	Percentage responding			
	Very likely	Somewhat likely	Not very likely	Not at all likely
Through sexual relations with a person who has AIDS	92	6	1	0
By receiving a blood transfusion from a blood donor who has AIDS	94	4	1	1
By using the same hypodermic needle that a person who has AIDS has just used	90	8	1	1
By being exposed to the saliva of a person who has AIDS	37	34	16	8
By kissing a person who has AIDS	26	33	23	15
By working in the same office with someone who has AIDS	2	11	29	56
By using unclean public toilets	11	22	25	38
By shaking hands with a person who has AIDS	7	23	67	1
By drinking from a glass used by a person with AIDS	14	34	24	23
By being nearby when someone who has AIDS has just sneezed	6	18	30	42
By giving blood to a bloodbank or hospital	20	12	16	51
By eating food that has been handled by a person who has AIDS	8	25	29	33

AIDS has been a gay disease in the public mind. When asked who is likely to get it, more than eight in ten said homosexuals. Only a minority understood that AIDS is also a disease of drug addicts and hemophiliacs: Only 33 percent mentioned the former; about 23 percent, the latter. Taken by itself, this might suggest that AIDS was perceived by heterosexuals as a disease that does not endanger them. A feeling of safety, however, tends to be offset by ignorance of how it is spread.

To assess ignorance, respondents were read "a list of ways that some people say you can get AIDS." These included both ways that genuinely put a person at risk (e.g., receiving a blood transfusion from a blood donor who has AIDS) and ways that do not (e.g., giving blood to a blood bank or a hospital). After each, respondents were asked whether it is very likely, somewhat likely, not too likely, or not at all likely that a person can get AIDS in this way.

The problem, as Table 3.1 shows, is not that people are unaware of how AIDS is spread but rather that they are ignorant about how it is *not* spread. Look, for example, at opinions about whether AIDS can be transmitted by having intimate sexual relations with a person with AIDS: 92 percent estimates that this is very likely; another 6 percent somewhat likely. Corresponding numbers appear for

sharing hypodermic needles with a person with AIDS and receiving blood from a person with AIDS: 90 percent regards the former, and 94 percent the latter, as quite likely to be ways to get AIDS. In short, nearly everyone knows how AIDS is, in fact, spread.

But many do not know how it is *not* spread. Look, for example, at opinions about giving blood: One in three believes that the chances of getting AIDS by giving blood to a bloodbank or hospital are good – a staggering number considering the question plainly is about giving, not getting, blood. Moreover, a third believes the chances are good of getting it by eating food that has been handled by a person with AIDS – or merely by shaking hands. Nearly 50 percent thinks that drinking from a glass used by a person with AIDS puts you at risk; 33 percent, that using unclean public toilets does so; 13 percent, that working in the same office as someone with AIDS does so. Or consider fears about public toilets: One in three believes it is either very or somewhat likely that unclean public toilets can be a source of AIDS. In short, substantial numbers of the public are ignorant of how AIDS is *not* spread.

This ignorance testifies not to the absence of a correct theory of how AIDS is transmitted but to the presence of a false one. The person who believes that AIDS can be spread merely by being in the presence of a person with it believes a *fortiori* that it can be spread by casual contact.

Establishing how many people have a badly mistaken idea of how AIDS is not transmitted is plainly of some importance. It would be one thing if most people got most things right about how AIDS is transmitted – after all, anybody can make a mistake – but quite another if a great many got a great many things wrong. Accordingly, two measures of the numbers of mistakes were calculated. To measure false negatives, respondents were given a point each time they failed to recognize that an actual cause of AIDS is, in fact, a cause. An unequivocal answer was required. Thus, a respondent had to say that it is “very likely” that sharing a hypodermic needle with a person with AIDS is a way the disease is spread in order to be counted as knowledgeable. To measure false positives, respondents were given a point each time that they said AIDS is transmissible in ways it, in fact, is not transmitted. Only items with a clearly right or clearly wrong answer were included. Accordingly, the “saliva” and “kissing” items were not included in either index because of some element of genuine uncertainty attaching to them. Again, answers had to be unequivocal: Respondents had to say, for example, that it is “not at all likely” that AIDS is spread through sneezing.

As Figure 3.3 shows, nearly everyone knows most of the ways that AIDS is transmitted. Specifically, eight out of every ten get it entirely correct, identifying sex, needle sharing, and receiving blood transfusions as sources of AIDS. On the other hand, as Figure 3.3 (lower panel) also shows, roughly equal numbers make many mistakes as make a few. The rectilinearity of the distribution suggests that knowledge about AIDS is not cumulative: Realizing that the disease is not spread by one form of casual contact does not bring with it an appreciation that it is not spread by other forms of casual contact. As a consequence, only a small propor-

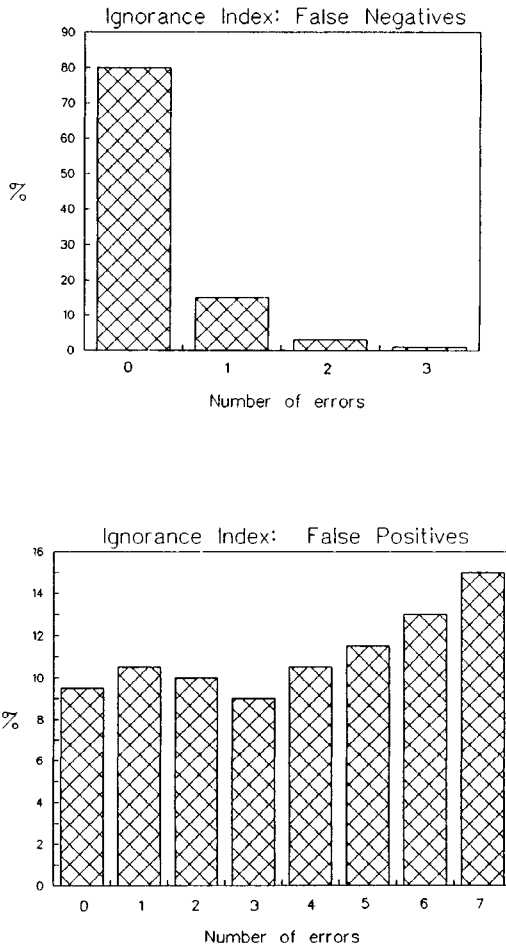


Figure 3.3. The distribution of ignorance. The ignorance index of false negatives consisted of questions 1, 2, and 3 from Table 3.1. Zero points were given for each correct “very likely” answer. One point was given for each “somewhat likely,” “not too likely,” or “not at all likely” answer. The ignorance index of false positives consisted of questions 6, 7, 8, 9, 10, 11, and 12 as described in Table 3.1. Zero points were given for each “not at all likely” answer and one point for each “very likely,” “somewhat likely,” or “not too likely” answer.

tion of the population has an understanding of the principles of AIDS transmission; in fact, fully 60 percent believes that AIDS is spread in a majority of the ways it is not spread.

There are, then, two kinds of ignorance: being unaware of how AIDS is spread and of how it is not spread. The two are correlated, but negatively rather than positively ($r = -.14$). Both also are related to education, not surprisingly. What

is surprising is that one is correlated positively with it, the other negatively. Thus, the more schooling people have had, the more likely they are to be aware of how AIDS is *not* spread, but the less likely they are to be aware of how it *is* spread.

Education seemingly reduces one kind of ignorance but increases the other. This apparent paradox exposes a response bias in risk estimation. The less schooling a person has had, the harder it is for her to have confidence in discriminating between a true source of AIDS and a false one. Hence, the more likely she is to suspect that something – anything – may be a cause of AIDS. This aspect underlies the pseudoparadox of education seeming both to increase and to decrease knowledge. Apprehensive guessing promotes the likelihood that any conceivable source of AIDS will be perceived as an actual source of it, with contradictory consequences: increasing the likelihood of a correct answer when people are asked about a true source of AIDS; decreasing the likelihood of it when they are asked about a false source of it.

CHANGES IN ATTITUDES TOWARD HOMOSEXUALS' RIGHTS

Students of public opinion are accustomed to observing that the general public pays little attention to many issues of public policy, even issues that dominate their very chances of survival (e.g., nuclear war). AIDS is a powerful exception to this rule of indifference. Moreover, there is much ignorance about it, typically taking the form of a belief that AIDS can be spread by casual contact. Add apprehension to ignorance and you would seem to have a potentially explosive combination.

One of our aims in undertaking this study was to determine if the public has become more intolerant of homosexuals under the impact of AIDS. Figure 3.4 displays, in graphic form, public attitudes toward the civil liberties of homosexuals as they were in 1977, on the left side, and as they are now, on the right side.

Although we feared a backlash, support for the rights of homosexuals has gone up, not down. Consider opinion on whether gay fathers should be disqualified from having custody of their children in the event of divorce. In 1977, only around 50 percent of the public approved of a gay father getting custody – “even if the court (found) him fit in all other ways to take care of the children”; very nearly 40 percent disapproved. By 1985, however, 61 percent approved and only 31 percent disapproved. This is not an isolated result. Take the parallel question, whether a lesbian mother should be allowed custody. In 1977, only around one-half of the public approved and one-third disapproved. By 1985, though, two-thirds approved and only one-quarter disapproved.

A liberal trend on antidiscrimination laws is also evident. In 1977, less than a majority of Californians (45 percent, to be exact) approved of a “law that would make it illegal to discriminate against homosexual persons by anyone selling or renting housing in California.” By 1985, such a law had the backing of a solid majority (55 percent) of the public. Or consider opposition to homosexual teach-

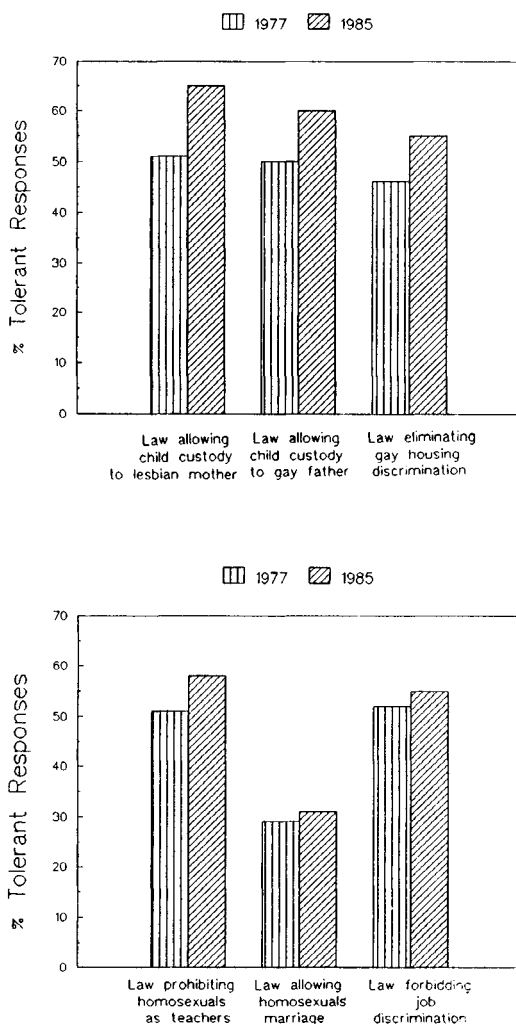


Figure 3.4. Increases in support for civil liberties of homosexuals. Wording of questions appears in Appendix C.

ers. In 1977, a bare majority opposed “a law against allowing persons who are homosexuals to teach school in California.” By 1985, a solid majority (59 per cent) had formed against it.

On a number of fronts, the public has become more supportive in its attitudes toward the civil liberties of homosexuals, AIDS notwithstanding. True, there is no more support for legalized gay marriages now than earlier, and only slightly more support for antidiscrimination laws now than eight years before. Moreover, the amount of change is not enormous; substantial opposition to civil liberties and

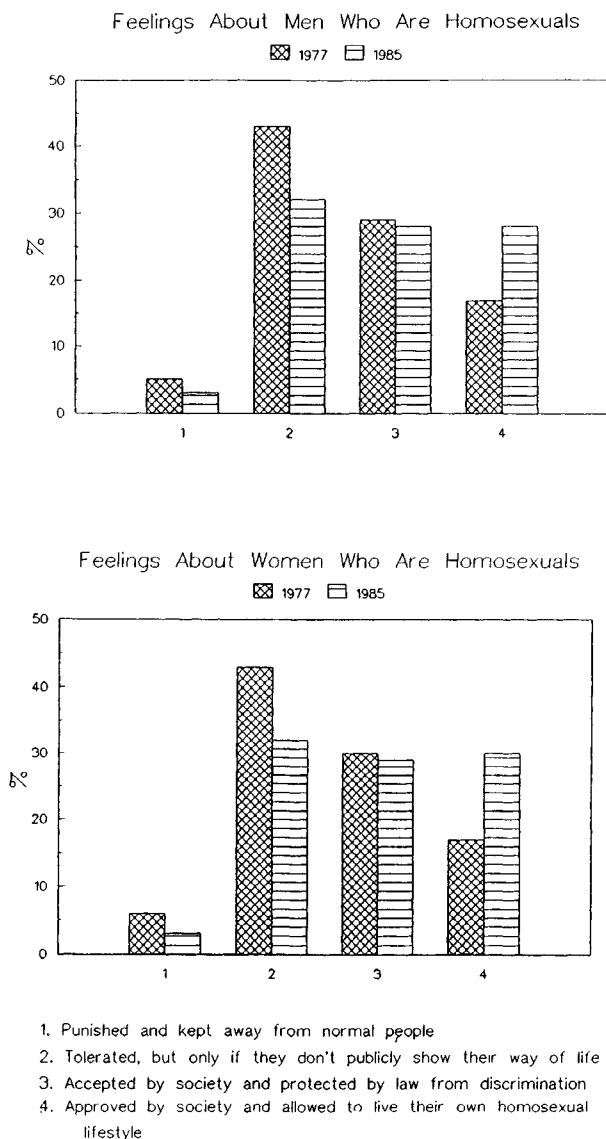


Figure 3.5. Positive and negative feelings about male and female homosexuals. The question read, "Which of the following statements best describes how you personally feel about men/women who are homosexuals?"

civil rights for homosexuals remains. Yet such caveats miss the point. There was every reason to fear a public backlash against homosexuals under the pressure of AIDS. But none has occurred. In fact, just the opposite: Supporters of gay rights were in the minority only ten years ago and now they constitute a majority.

Table 3.2. *National trends in attitudes toward homosexuals' civil liberties, 1977–85*

	1977	1980	1982	1984	1985
<i>Favors free speech for homosexuals</i>					
Yes, %	62	66	65	68	67
No, %	35	31	31	28	30
Don't know, %	4	3	4	4	3
<i>Accepts homosexuals as college teachers</i>					
Yes, %	49	55	55	59	58
No, %	46	41	41	37	39
Don't know, %	4	4	4	4	3

It is not just attitudes toward abstract, or political rights that have changed. Figure 3.5 depicts trends in public feelings toward homosexuals. Respondents were asked "Which of the following statements best describes how you personally feel about men who are homosexuals?" Four alternatives were read: Homosexuals should be (1) "punished and kept away from normal people"; (2) "tolerated, but only if they don't publicly show their way of life"; (3) "accepted by society and protected by law from unfair discrimination against them because of their homosexual lifestyle"; and (4) "approved by society and allowed to live their own homosexual lifestyle." Respondents were asked which best described their feelings toward men who are homosexuals and toward women who are homosexuals. As Figure 3.5 shows, fewer citizens are negative or grudging in their attitudes toward homosexuals; more are positive, even approving; and both the decrease in negative feelings and the increase in positive ones apply across the board, that is, as much to lesbians as to gays.

Granted this positive trend, what interpretation should be placed on it? Is the increase in support for homosexuals perhaps a sympathetic reaction to AIDS? Alternatively, would there have been a still larger increase if not for AIDS?

Table 3.2 presents national trend data bearing on these questions from the General Social Survey (NORC) on two issues: free speech for homosexuals and homosexual college teachers. The time series begins in 1977 and runs, in annual or biannual increments, through 1985 – the same interval covered by the two California samples, but with intermediate years included.

The trends for both items in the national samples parallel those from the California samples: Support for gay rights increases over the same period, and by about the same margin. The national data extend as well as corroborate the California data, by allowing us to see whether the overall trend in this period was in any way altered with the emergence of AIDS. The pattern is plain: The rate of increase in support for gay rights is approximately the same (taking account of sampling tolerances) after the identification of AIDS as before it. Thus, in 1977, 62 percent supported free speech for homosexuals; that went up to 65 percent in 1982; and up again to 67 percent in 1985. Similarly, in 1977, 49 percent said that a homosexual should be allowed to teach in a college; that rose to 55 percent in

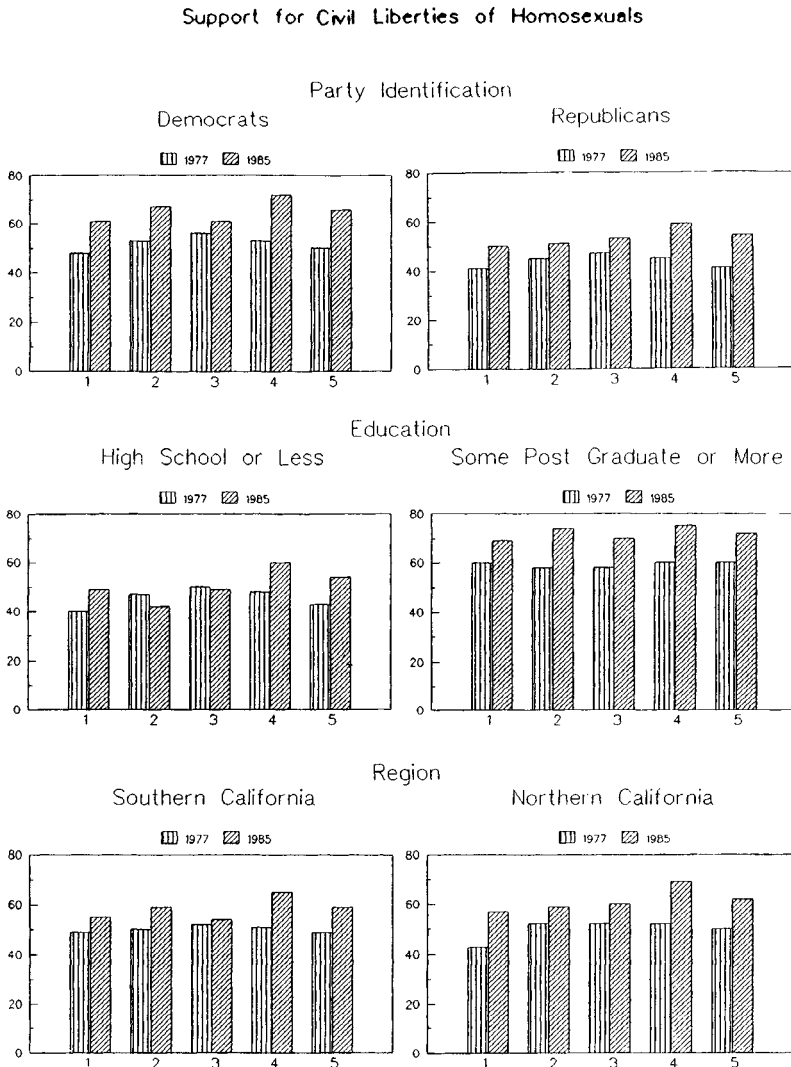


Figure 3.6. The generality of changes in attitudes toward homosexuals. Same question wording as described in Figure 3.5.

1982; and rose again to 58 percent in 1985. To be sure, the public did not change its view of the desirability of homosexuality over this period: An unwavering majority – three in every four – continued to regard homosexuality as “almost always wrong.” All the same, the public has become steadily, if slowly, more supportive of the rights of homosexuals and seems to have done so not because of but regardless of AIDS.

It is, all the same, important to see if these newly positive attitudes toward homosexuals are widely diffused through the society. After all, the aggregate

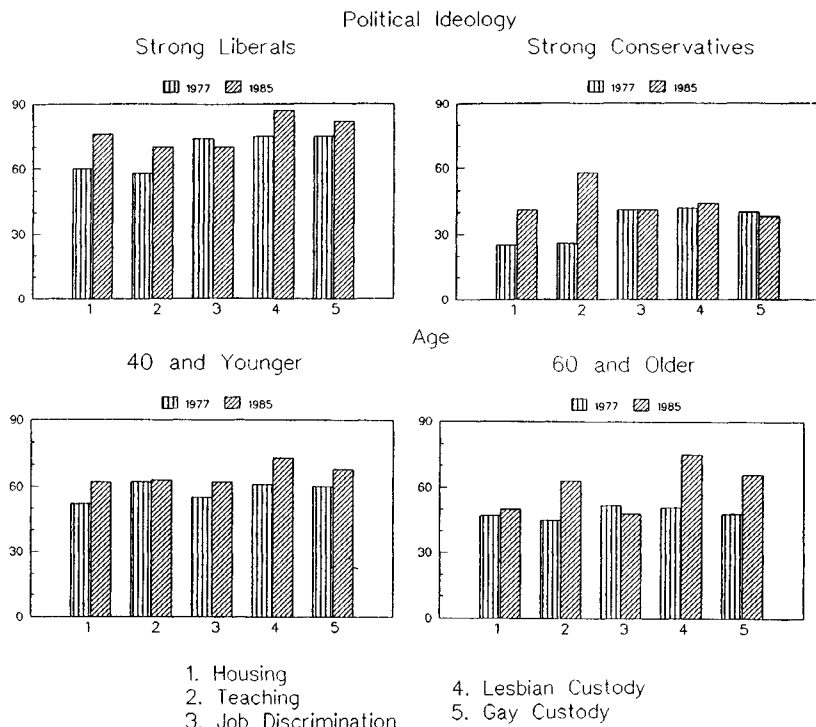


Figure 3.6. (cont.)

trend may obscure off-setting movements: a backlash in some parts of society masked by an increase in support in other parts. Accordingly, Figure 3.6 compares attitudes of different social and political strata, in 1977 and 1985.

Take partisanship. Notice, first, that Democrats are more likely to support civil liberties of homosexuals than Republicans, both in 1977 and in 1985. But – and this is the point to emphasize – both Democrats and Republicans are more likely to support gay rights in 1985 than in 1977. Moreover, the increase in support among Republicans tends to be sizable – indeed, sufficiently so as to make them as supportive of gay rights in 1985 as Democrats were in 1977. Similarly, there is more support for gay rights, not only among the most educated, those with postgraduate training, but also among the least, those with a high school degree or less. For that matter, the trend is positive, not only in northern California but in southern California as well. The trend toward tolerance is an across-the-board affair. Not that it is equally strong in all parts of the society: Some from particular backgrounds or outlooks have resisted it, conservatives being in this respect especially notable. Nor has the trend to tolerance shown itself on all issues with equal strength. Attitudes on such issues as anti-job discrimination laws have been resistant to change. Still, the main point is that public support for homosexuals has increased, not in one narrow stratum of society but in many of its principal parts as defined by education, age, geography, and politics.

This is welcome news to anyone who values a tolerant society. But scapegoating of homosexuals is not the only risk. As pressing a concern are the rights of persons suffering from AIDS, homosexual or not. To what extent does the public support their rights? To what extent is it prepared to override them?

RIGHTS OF PERSONS WITH AIDS

AIDS has raised a cloud of civil rights issues. Should health departments be required to disclose to school boards the names of children and employees with AIDS? Should the names of people exposed to the AIDS virus be listed on the public record? Should victims of the disease be quarantined? Or tattooed? Or evicted from their apartments? Or fired?

Figure 3.7 displays public attitudes toward the rights of persons with AIDS in a variety of situations. A glance at it suggests the public takes a mixed position – indeed, seems of two minds about the civil rights of persons with AIDS. Sometimes, a clear majority supports the rights of those with AIDS, sometimes not.

Consider the issue of eviction. When asked if landlords have the right to evict renters with AIDS, very nearly 80 percent says no, while only about one in seven, or 15 percent, replies yes. The picture is much the same with respect to job security. Sixty percent of the sample says no, employers should not have the right to fire an employee because that person has AIDS. Conversely, only 25 percent says yes, the employer should have a right to dismiss someone with the disease. In short, commanding majorities in the public wish to protect persons with AIDS from arbitrary eviction or firing.

To guard against any inclination to dismiss this as superficial or inconsequential, it is worth recalling that similarly sizable majorities, only a generation ago, took the position that ordinary store clerks who were communists – hardly a national security risk – should be fired (Stouffer, 1963, p. 43). In contrast, consider opinion on whether children with AIDS should be allowed to go to school. Children's safety taps deep psychological roots, yet over 50 percent of the general public is in favor of letting children with AIDS attend school and less than 30 percent is opposed to it.

A quite different impression of the public's position, however, is suggested by attitudes about testing. Respondents were asked if "people who cook for restaurants or schools be required to take a test to verify that they have not been exposed to AIDS?" There is no mistaking the dominant view on this issue. Fully two-thirds of the public believes that people who cook for restaurants or schools should be required to take a test to verify that they have not been exposed to AIDS. Conversely, less than a third opposes mandatory testing for food handlers. Clearly, mandatory testing and disclosure raise fundamental civil liberties concerns. But this does not deter a commanding majority from supporting mandatory testing.

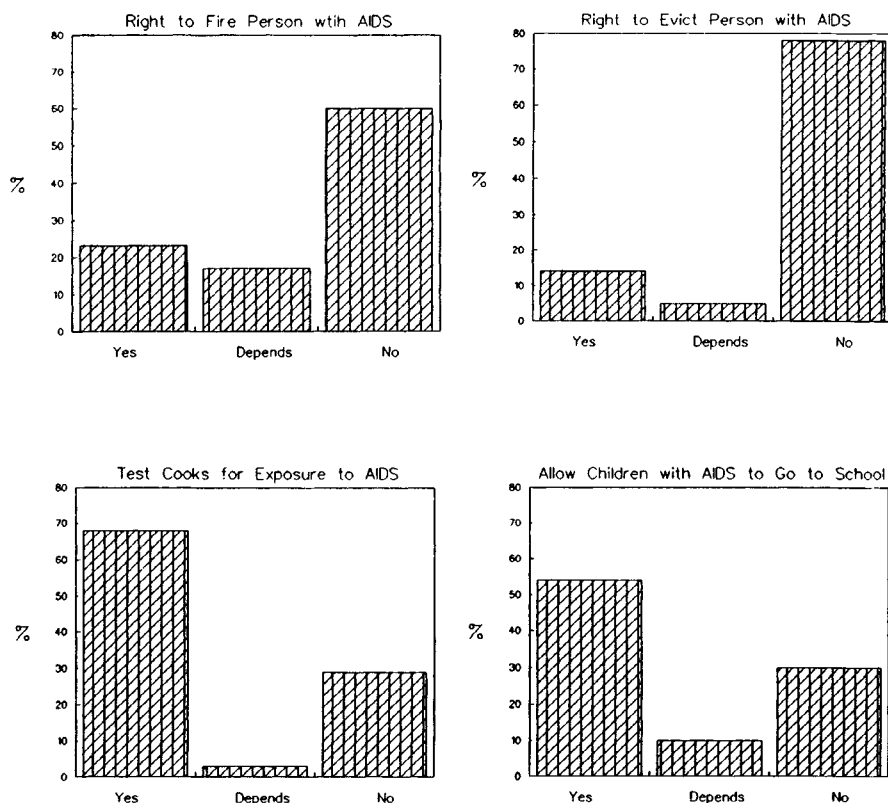


Figure 3.7. Attitudes toward AIDS policy issues. For *Right to fire person with AIDS*, the question read, "Should employers have the right to fire an employee specifically because that person has AIDS?" For *Right to evict person with AIDS*, "Should landlords have the right to evict renters who have AIDS from their buildings?" For *Test cooks for exposure to AIDS*, "Should people who cook for restaurants or schools be required to take a test to verify that they have not been exposed to AIDS?" For *Allow children with AIDS to go to school*, "Should children with AIDS be allowed to go to school or not?"

Policy reasoning: principal considerations

The average citizen's decision about whether to support the rights of persons with AIDS is likely to rest on two kinds of considerations. One of these is itself a family of considerations – ignorance and its brothers and cousins, fear and intolerance. Fairly obviously, the less people know about how AIDS is transmitted, the more likely they are to believe that it can be spread through casual contact; and the more likely they are to believe this, the more likely they are to favor measures to identify, report, isolate, or control people infected with AIDS in ways that deprive them of rights they would ordinarily enjoy. Moreover,

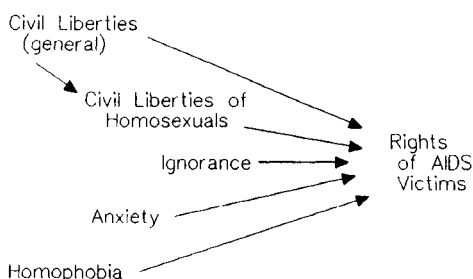


Figure 3.8. Simplified causal model of attitudes toward persons with AIDS.

people who are ignorant of AIDS are also likely to be especially fearful of it; and it cannot be supposed that their fear of AIDS will increase their solicitude for the rights of persons suffering from it. Nor should it be forgotten that AIDS is associated in the public mind with homosexuals, a controversial and unpopular group in any case. Homophobia, it must be supposed, will also play a role in shaping public attitudes toward the rights of persons with AIDS.

But here are also considerations on the other side, promoting rather than undercutting support for the rights of persons with AIDS. Most obvious of these is support for gay rights. The more committed a person is to gay rights, the more likely he or she is to support the civil liberties of persons with AIDS. A concern for civil liberties can express itself in different ways: in support for civil liberties of homosexuals specifically, or for civil liberties more broadly conceived – as support, for example, for free speech. And the more committed a person is to civil liberties, whether broadly or narrowly conceived, the more likely he or she should be to back the rights of persons with AIDS.

How do these various factors tie together in reasoning about AIDS policies? Figure 3.8 lays out a causal model of policy reasoning, simplified for clarity. The logic of the model's layout is quite straightforward; still, one or two comments are in order.

This model plainly is recursive (or causally unidirectional), in conformity with common practice. A variable may be an effect of a variable to its left, a cause of a variable to its right, not the other way round. The model presupposes that citizens may arrive at a position by two routes; by a low road or by a high road. The low road is centered on homophobia and anxiety; the high road, on considerations of civil liberties. Both are important in their own right, in addition to influencing how ignorant people are likely to be of how AIDS is spread. As this model suggests, ignorance is assigned a causally prominent role based on the expectation that insofar as people believe AIDS can be transmitted through casual contact, their response to persons with it will be restrictive rather than supportive.

How citizens think through a position on policy – what considerations they take into account and what weight they give them – is inevitably not uniform or identical from one person to another. Research on issue preferences on racial

issues suggests that the structure of policy reasoning itself varies with education, specifically that the more schooling people have had, the less likely their reasoning about racial issues is to be affect-driven, that is, dominated by their feelings toward blacks (Sniderman, Brody, and Kuklinski, 1984; Sniderman, Hagen, Tetlock, and Brady, 1986). The model is accordingly designed to assess this hypothesis of heterogeneity in policy reasoning as a function of education.

Figures 3.9a and 3.9b offer a graphic but partial representation of a causal model. The complete set of coefficients is presented in Appendix 3.D Table 3.A.4. The dependent variable is a composite index, summing together opinions on whether landlords should be able to evict renters with AIDS and whether employers should be able to fire employees with AIDS. We shall call it the Protection Index, since it indicates to what extent people are willing to protect AIDS victims from possible discrimination. Following convention, causal arrows represent the impact (if statistically significant) of a variable on successive variables, the magnitude of impact being indicated by the (unstandardized) regression coefficient. Item wording for variables introduced into the model is given in Appendix 3. The model is estimated first for the poorly educated (Figure 3.9a), then for the well educated (Figure 3.9b).

Notice first in what way and what kind of ignorance matters. It is of no importance if people believe that AIDS is not spread in ways that it is; but it is of considerable importance if they believe it is transmitted in ways that it is not. Specifically, the greater the number of ways a person believes that AIDS can be transmitted that, in fact, are ways it is exceedingly unlikely to be transmitted, the more likely he or she is to score low on the Protection Index. Moreover, ignorance among the most educated is as costly as among the least. To be sure, the more educated a person is, the less likely he or she is to believe that AIDS is spread by casual contact ($r = -.24$). But the cost of an error is the same for both: Ignorance undercuts support for the rights of persons with AIDS as effectively among the most educated as among the least.

Beyond this, it is plain that the considerations people take account of in working out a position on dealing with persons with AIDS depend significantly on education. Thus, among the poorly educated, anxiety has a substantial impact: The more fearful people are of getting AIDS, the more likely they are to oppose protective policies for persons who have it. Among the well educated, however, anxiety has no effect: People who worry about getting AIDS are neither more, nor less, likely to favor landlords being able to evict or employers being able to fire persons with AIDS.

There is a parallel point. Among the poorly educated, homophobia plays a significant role in policy reasoning – indeed, a triple role. First, it directly discourages protective actions, such as laws protecting people with AIDS from eviction or firing. Second, it strengthens apprehension about getting AIDS, and thereby discourages support for protective policies. Third, it reinforces opposition to civil liberties for homosexuals, and thereby discourages support for protective policies.

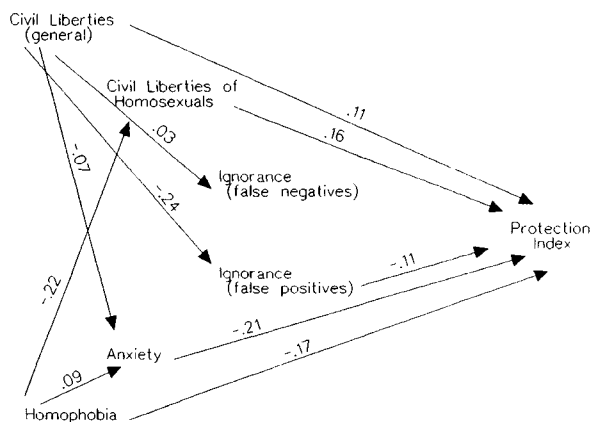


Figure 3.9a. A causal model of attitudes toward protection of the civil liberties of AIDS victims among the poorly educated (unstandardized betas, $n = 299$).

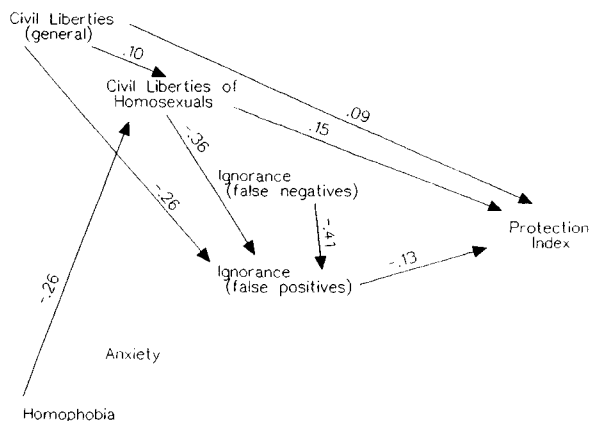


Figure 3.9b. A causal model of attitudes toward protection of the civil liberties of AIDS victims among the well educated (unstandardized betas, $n = 323$).

Now, consider the well educated (Figure 3.9b). Homophobia does not directly discourage support for protective policies. Nor does it inhibit support indirectly, by either stoking fear about AIDS or undercutting support for civil liberties in general. True, homophobia is not entirely toothless among the well educated: It does, for example, undermine support for civil liberties for homosexuals. All the same, education does triple duty: It decreases the likelihood that people will be homophobic; that they will be anxious about getting AIDS; and finally, that frankly emotional considerations such as homophobia or fear, even if present, will dominate reasoning about AIDS policies.

In short, education promotes protection for the rights of persons with AIDS both by decreasing the likelihood that people will take the “low road” and base their judgment on such emotional factors as anxiety and homophobia and by increasing the likelihood they will take the “high road” and base their judgment on such cognitive considerations as support for civil liberties.

Testing food handlers

As a public policy issue, AIDS can be viewed in different lights – as a civil liberties issue, for example, or as an issue of public health. AIDS is neither unique nor especially uncommon in this respect: Many issues can be framed in obviously distinguishable, even radically different, ways. Thus, defense spending may be framed as an issue of national security or, alternatively, of jingoist foreign policy. Such “framing” effects are potentially of importance, both in establishing the determinants of policy preferences and, more broadly, in understanding how it is possible to perform acts seemingly inconsistent with one’s opinions, without actually being inconsistent.

Figures 3.10a and 3.10b present a causal analysis of opinions about whether cooks in restaurants and schools should be tested to verify that they have not been exposed to AIDS. Framing an issue differently need not alter entirely the causal processes underlying opinions about it. Consider the role of ignorance, for example. With respect to protecting persons with AIDS, it is ignorance of how AIDS is *not* spread, not of how it is spread, that counts. And the same is true with respect to mandatory testing. It is erroneously supposing that AIDS is transmitted in ways it is not – not failing to appreciate that it is transmitted in ways it in fact is transmitted – that stokes support for testing.

In addition, there is the striking parallelism of the differential role of emotional factors in shaping policy reasoning depending on education. Thus, anxiety about getting AIDS undercuts opposition to protecting the rights of persons with the disease among the least – but not among the most – educated. Similarly, anxiety undercuts opposition to mandatory testing among the least educated (Figure 3.10a) but not among the most educated (Figure 3.10b).

In one sense, it is perfectly obvious that the way the issue of AIDS is framed makes a difference. After all, put the issue one way, and a clear majority of the public is solicitous of the rights of persons with AIDS; put it another way, and a still clearer majority is not. But what does this suggest about how the framing of the issue affects the causal processes underlying opinions about it?

The framing of an issue like AIDS might make a difference in two different ways. One of these runs as follows. Some fraction of the public is prejudiced against homosexuals. All the same, they feel some inhibition against openly expressing or acting on their homophobia, at any rate under normal circumstances. But AIDS provides a socially acceptable cloak, to dress up and disguise prejudice against homosexuals. Or, more exactly, people may express hostility against gays legitimately – hostility they would otherwise be under pressure to

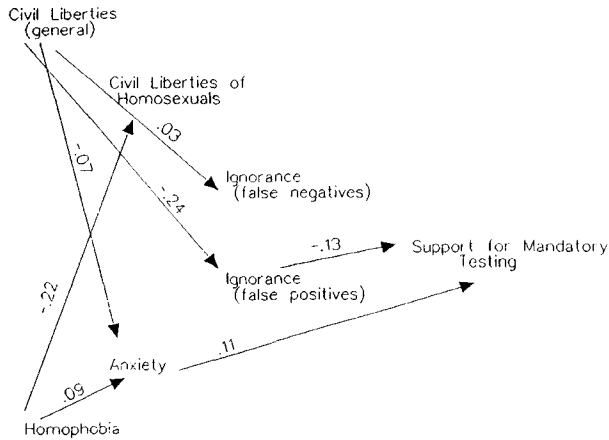


Figure 3.10a. A causal model of attitudes toward mandatory testing among the poorly educated (unstandardized betas, $n = 299$).

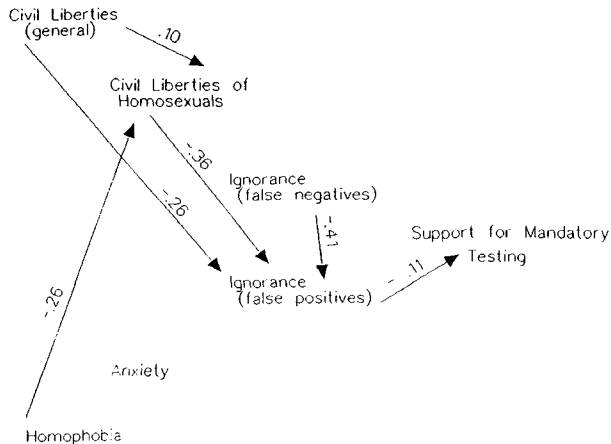


Figure 3.10b. A causal model of attitudes toward mandatory testing among the well educated (unstandardized betas, $n = 323$).

suppress – if the issue of AIDS is suitably framed as a need for mandatory testing and other “preventive” measures in order to prevent the disease from spreading and protect public health.

It is clearly off the mark to conceive of framing effects in this way, as Figures 3.10a and 3.10b show. If framing the issue as one of public health rather than civil liberties has the effect of legitimating the expressions of prejudice, then homophobia should play a still more important role in shaping attitudes about mandatory testing. But as Figures 3.10a and 3.10b both demonstrate, there is no statistically significant path between homophobia and attitudes about mandatory testing of food handlers, in the case of either the least or the most educated.

Moreover, a second strand of evidence, having to do with the role of anxiety, ties neatly together with the first. The more fearful of AIDS a poorly educated person is, the more likely he or she will favor testing of food handlers – hardly surprising considered by itself and consistent with anxiety’s role in undercutting support for persons stricken by AIDS. What is surprising is the magnitude of anxiety’s impact on attitudes toward testing as compared with attitudes about the rights of persons with AIDS. If framing is important insofar as it legitimizes the expression of emotional factors, anxiety must be expected to play a larger role in conditioning attitudes toward testing food handlers than toward eviction or firing of people with AIDS. As Figure 3.10a shows, the facts are the other way round. The impact of anxiety is weaker, not stronger, in the case of attitudes toward mandatory testing. In short, it seems on several counts wrong to suppose that framing effects matter by dint of licensing the expression of prejudices and fears.

But framing effects do matter in a different way. Quite simply, the considerations people take into account in making up their minds depend on how the issue is framed. As we saw (Figures 3.9a and 3.9b), the more supportive a person was of civil liberties, either in general or for homosexuals specifically, the more likely he or she was to support protecting persons with AIDS. In contrast, considerations of civil liberties are nearly irrelevant when people come to make up their minds about testing, despite the quite enormous civil liberties implications of mandatory testing. The person who is strongly supportive of civil liberties considerations is no more likely, for this reason, to oppose mandatory testing than the person who is indifferent to or even contemptuous of them.

CONCLUSION

Our findings show a considerable steadfastness in the commitment of citizens to civil liberties in the face of the AIDS epidemic – a finding worthy of note in a research literature preoccupied with demonstrations of the superficiality of the public’s understanding of and support for the value of tolerance. Our findings also expose the limits of that commitment. Both aspects deserve attention.

A major factor in sustaining tolerance in the face of pressure is education. “There is something about people with more schooling,” Stouffer contended, “which equips them to make discriminations, to appreciate the principles of civil rights, and to handle a value conflict in a more tolerant way than others” (1955, p. 202). It is worth understanding why this is so.

To begin with, education builds support for the rights of persons with AIDS by building support for civil liberties. Specifically, the more schooling people have had, the more likely they are to favor civil liberties, both in general and for homosexuals specifically ($r = .39$ and $.29$, respectively). And, the more likely they are to favor civil liberties, the more likely they are, in turn, to oppose suggestions that employers should be able to fire or landlords evict people with AIDS (Figures 3.9a and 3.9b).

But there is a further point. Not only does education inculcate habits of mind that promote tolerance of persons with AIDS. It also combats those habits of

mind that undermine tolerance. Thus, the more educated people are, the less likely they are to be ignorant of how the disease is spread ($r = -.24$). On top of this, the more educated they are, the less likely they are to be homophobic ($r = -.12$). And each of these effects of education – cutting ignorance and combatting bigotry – encourages support for the rights of persons with AIDS (Figures 3.9a and 3.9b).

Of course education is not foolproof. However much schooling people have had, some of them will be homophobic. Even so, the more schooling people have had, the less important is homophobia in shaping reactions to persons with AIDS. The same is true of anxiety about getting AIDS. Although homophobia and anxiety undercut support for the rights of persons with AIDS among the poorly educated, neither has a statistically significant impact among the well educated (Figures 3.9a and 3.9b). The lesson of these results, put broadly, is this. Education plays a prophylactic role: It reinforces tolerance and undercuts bigotry in two ways – directly by inhibiting the frequency of aversive factors like homophobia; and indirectly by inhibiting the strength of their impact.

All the same, there are sharp limits to the public's commitment to civil liberties: Although a large majority supports the rights of persons with AIDS, a still larger majority favors mandatory testing. From one point of view, this may seem only one more illustration of the tendency of the average citizen to support democratic values at the level of principle only to desert them at the level of policy (cf. Jackman, 1978; Schuman, Steeh, and Bobo, 1985) – another illustration, if you like, of the disjunction between attitudes and action. We should like to suggest an alternative tack, by taking account of the importance of framing effects.

Many citizens hold competing values: They care, for example, about public health and about civil liberties. In this there is no cognitive inconsistency, at any rate not in the abstract. But the considerations they care about can come into conflict in particular situations. The effect of framing is to prime values differentially, establishing the salience of the one or the other. Framing thus tends to guarantee a disjunction between acts and (some) attitudes, not because the attitude is not sincerely held, but because it has not been primed while a competing value has. The consequence, as we have seen, is that a majority of the public supports the rights of persons with AIDS when the issue is framed to accentuate civil liberties considerations – and supports as well mandatory testing when the issue is framed to accentuate public health considerations.

Support for the rights of persons with AIDS has so far prevailed over fear and intolerance, evidence that good ideas do stand a fighting chance against bad ones. Looking to the future, however, it is difficult to be optimistic. AIDS cases have doubled and redoubled, doubling and redoubling through 1991, accounting by 1995 for as many deaths as heart disease and cancer combined. The result will be to place the average citizen under still more pressure – pressure to stop the spread of the disease by any means necessary, pressure to scapegoat homosexuals and other groups for introducing it. It is difficult, in these circumstances, to be confident that the public will persist in its support for gay rights and the rights of

persons with AIDS – difficult partly because fear and intolerance are bound to be excited, difficult still more fundamentally because the value of tolerance, in addition to being vulnerable to the intolerance promoted by fear, is vulnerable as well to the altogether legitimate value of public health.

APPENDIX 3.A: SAMPLE DESIGN AND SAMPLING ERRORS

The 1985 sample was stratified by county, based on 1980 census data on residential telephone incidence, updated with data on new telephone installations at the state level and current projects of households by county. Within geographic areas, telephone numbers were randomly selected by systematic sampling proportionate to local prefix allocation density, to correct for nonlisted telephone biases. Within households, respondent selection was systematic, focusing first on the youngest adult male. Up to four callbacks were made, on different days or times of the day, to reach an adult in each household.

The 1977 sample was based on a cluster sample design. There were 240 primary sampling units (PSU), weighted in proportion to population. Within PSUs, key addresses were selected in two ways: by random selection from telephone directories and by a special method of cluster formation to take account of nontelephone households. Cluster households were systematically listed, to eliminate interviewer selection biases; and within households, systematic selection criteria of age and sex were applied.

Both 1985 and 1977 samples were subject to weighting by region, sex, and age. The average completion rate, based on the universe of households contacted, is approximately 50 percent. For those unfamiliar with the Field Poll, Constantini and Davis (1986) provide estimates of bias since 1948, emphasizing the dependability of the data both in absolute and in comparative terms.

APPENDIX 3.B: INTERVIEWING MODE

The 1985 interviews were conducted over the telephone; the 1977 interviews, face to face. What difference is this likely to make? And, in the event it does make a difference, how will it affect the principal findings we have reported?

Telephone and face-to-face interviewing arguably differ in a number of respects relevant to our study. Some evidence suggests, for example, that phone samples tend to be somewhat better educated, younger, and better off economically than personal interview samples (Groves and Kahn, 1979). This sampling bias does not, however, threaten the finding of increases in tolerance over time. For the increases show up not merely for the samples taken as a whole but within each of their principal parts – comparing just the well educated in 1985 with the well educated in 1977, the poorly educated in 1985 with the poorly educated in 1977 (see Figure 3.6).

A different and potentially decisive issue is the relation, if any, between interviewing mode and self-disclosure biases.

Considerable research on the relation between interviewing method and self-disclosure has been done (e.g., Schuman and Presser, 1981; Bradburn et al., 1981). Schuman and Presser, for example, find that telephone interviews facilitate the expression of socially undesirable or personally embarrassing statements. For example, respondents are more likely to disclose arrests for drunk driving in phone interviews than in face-to-face ones. These disclosure effects, though small, are worth consideration.

Our concern of course lies with a potential interaction between interviewing mode and the expression of antihomosexual opinions. Californians, we found, are less likely to express antihomosexual opinions in 1985 than they were in 1977. Now, in 1985 they were interviewed over the phone, in 1977 face-to-face. So insofar as interviewing modes make a difference, the 1985 figures are slightly biased upward, the 1977 figures slightly biased downward. But of course these biases would reduce, rather than inflate, the finding we observed of greater tolerance in 1985 than in 1977. In short, the tolerance findings reported in our chapter show up in spite of, not because of, interviewing mode effects.

APPENDIX 3.C: ITEM WORDING

Figure 3.4

Law allowing child custody to lesbian mother or gay father: "Would you approve or disapprove of a law allowing a lesbian mother/gay father the right to be granted custody of the children in a divorce if the court finds her/him fit in all other ways to take care of the children?"

Law eliminating gay housing discrimination: "Would you approve or disapprove of a law that would make it illegal to discriminate against homosexual persons by anyone selling or renting housing in California?"

Law allowing homosexual marriage: "Would you approve or disapprove of a law that would permit homosexual people to marry members of their own sex and to have the regular marriage laws apply to them?"

Law forbidding job discrimination: "Would you approve or disapprove of a law that would forbid discrimination against homosexual persons for other kinds of jobs or employment in California?"

Figures 3.9 and 3.10

Ignorance (false positives) and ignorance (false negatives): Variables used are described in Figure 3.4.

Protection Index: This index was comprised of the questions from Figure 3.7 dealing with the right to evict and the right to fire persons with AIDS. One point was given for each tolerant answer, creating a three-point scale.

Support for mandatory testing: Wording of the question is as it appears on Figure 3.7.

Civil liberties (general): "I am going to read the description of various types of people. For each description I would like you to tell me whether you think a person like this should or should not be allowed to make a public speech in your community. (1) A member of the Communist party; (2) a person who believes that blacks are genetically inferior to other persons; (3) a member of the Ku Klux Klan. Next I am going to read these same descriptions again. This time I would like you to tell me whether you feel a book written by this type of person should or should not be available for general public reading at your local public library." One point was given for each tolerant answer, so that a seven-point scale was created.

Civil liberties of homosexuals: The civil liberties questions described in Figure 3.4, with the exception of the question dealing with homosexual marriage, were used to create a five-point scale of tolerant responses.

Anxiety: "How worried are you that you or someone that you are close to might get AIDS?" Responses included very worried, somewhat worried, not too worried, and not at all worried. Scoring responses created a four-point scale ranging from low to high anxiety.

Homophobia: The questions dealing with feelings toward male and female homosexuals described in Figure 3.5 were used to create an eight-point scale ranging from the most positive to the most negative feelings toward homosexuals.

Age: Coded as actual age in years.

Income: "Now we don't want your exact income, but just roughly could you tell me if your annual household income before taxes is under \$10,000, \$10,000 to \$20,000, \$20,000 to \$30,000, \$30,000 to \$40,000, or more than \$40,000." Further probes were asked of those who responded, so that a ten-point scale consisting of \$5,000 intervals was created.

Ideology: "Generally speaking, in politics do you consider yourself a conservative, liberal, middle-of-the-road, or don't you think of yourself in these terms?" If the respondent was a liberal or conservative, he or she was asked: "Do you consider yourself a strong or not very strong conservative/liberal?" If the respondent was middle-of-the-road, he or she was asked: "Do you think of yourself as closer to conservatives or closer to liberals?" If the respondent didn't think of himself in these terms, the question was asked: "If you had to choose, would you consider yourself as being conservative, liberal, or middle-of-the-road?" Responses were coded on a seven-point scale ranging from strong conservative, moderate conservative, leaning conservative, to middle-of-the-road with symmetric responses for liberals on the upper half of the scale.

Party identification: "Generally speaking, do you usually think of yourself as a Republican, a Democrat, an independent, or what?" If respondent answered Democrat or Republican: "Would you consider yourself a strong or not very strong Republican/Democrat?" If the respondent answered independent, no preference, or don't know on initial question: "Do you think of yourself as closer to the

Republican or Democratic parties?" Responses were used to create a seven-point scale ranging from strong Republican, moderate Republican, lean Republican to independent, with symmetric scoring for Democrats on the upper end of the scale.

APPENDIX 3.D

Table 3.A.1. Comparison of unstandardized betas in causal diagrams.

Relationship	Protection Index		Mandatory testing	
	Figure 3.9a poorly educated	Figure 3.9b well educated	Figure 3.10a poorly educated	Figure 3.10b well educated
<i>Age</i>				
Anxiety	-.01	<i>a</i>	<i>a</i>	<i>a</i>
Ideology	-.02	<i>a</i>	-.02	<i>a</i>
Party identification	.02	-.02	.02	-.02
Civil liberties for homosexuals	<i>a</i>	-.01	<i>a</i>	-.01
Protection Index	-.02	-.01	<i>b</i>	<i>b</i>
Mandatory testing	<i>b</i>	<i>b</i>	<i>a</i>	-.01
<i>Income</i>				
Civil liberties (general)	.19	<i>a</i>	.19	<i>a</i>
Ignorance (FN)	-.03	<i>a</i>	-.03	<i>a</i>
Mandatory testing	<i>b</i>	<i>b</i>	.04	<i>a</i>
<i>Party identification</i>				
Ideology	.20	.59	.20	.59
Mandatory testing	<i>b</i>	<i>b</i>	-.06	<i>a</i>
<i>Ideology</i>				
Homophobia	-.25	-.16	-.25	-.16
Civil liberties for homosexuals	<i>a</i>	.13	<i>a</i>	.13
Ignorance (FN)	<i>a</i>	.09	<i>a</i>	.09
Mandatory testing	<i>b</i>	<i>b</i>	<i>a</i>	.08
<i>Civil liberties (general)</i>				
Ignorance (FN)	.03	<i>a</i>	.03	<i>a</i>
Ignorance (FP)	-.24	-.26	-.24	-.26
Anxiety	-.07	<i>a</i>	-.07	<i>a</i>
Civil liberties for homosexuals	<i>a</i>	.10	<i>a</i>	.10
Protection Index	.11	.09	<i>b</i>	<i>b</i>
<i>Homophobia</i>				
Civil liberties for homosexuals	-.22	-.26	-.22	-.26
Anxiety	.09	<i>a</i>	.09	<i>a</i>
Protection Index	-.17	<i>a</i>	<i>b</i>	<i>b</i>

Table 3.A.1 (cont.)

Relationship	Protection Index		Mandatory testing	
	Figure 3.9a poorly educated	Figure 3.9b well educated	Figure 3.10a poorly educated	Figure 3.10b well educated
<i>Civil liberties for homosexuals</i>				
Ignorance (FP)	^a	-.36	^a	-.36
Protection Index	.16	.15	^b	^b
<i>Anxiety</i>				
Protection Index	-.21	^a	^b	^b
Mandatory testing	^b	^b	.11	^a
<i>Ignorance (FN)</i>				
Ignorance (FN)	^a	-.41	^a	-.41
Protection Index	-.11	-.13	^b	^b
Mandatory testing	^b	^b	-.13	-.11

Note: Only relationships between variables that were significant in at least one of the four analyses are included. FN = false negatives and FP = false positives.

^a Indicates beta not significant.

^b Indicates variable not included in this model.