RENTING ROOMS IN THREE CANADIAN CITIES: ACCEPTING AND REJECTING THE AIDS PATIENT

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ABSTRACT

Following methods previously developed, the social stigma associated with AIDS was investigated by placing 90 telephone calls to landlords advertising rooms for rent in each of three Canadian cities: Windsor, Toronto, and Halifax. Compared to control conditions, calls ostensibly from AIDS patients were likely to elicit negative responses as to availability of the advertised room. The results provided an initial examination of the public's attitude toward conditions such as AIDS. Results were compared with those of previous studies investigating stigmatization of the mentally ill, in which the competing themes of acceptance and rejection were also found. Results were discussed in the context of strategies for measurement of attitudes toward minority or stigmatized groups.

Over the last decade or so, attention has gradually been drawn to the various side effects of both medical and psychiatric treatment. Goffman (1961), Rosenhan (1973), and others, for example, have drawn attention to the unfortunate personal, social, and economic consequences of being labelled mentally ill. Goffman's concept of the "master status" held that persons, once labelled as mentally ill or as possessing some other stigmatizing condition, would be unable to function in "normal" society without being the object of both obvious and non-obvious rejection. Rosenhan (1973) demonstrated that both the attitudes and behaviours of even mental health professionals are sometimes negative, sometimes contradictory, and sometimes ambivalent, in terms of their relationships with and subtle reactions toward patients (see also Page, 1980). The impact of stigmatization, beyond the statement such a process makes about society in general, also has direct effects upon the stigmatized person. Farina, Ghila, Boudreau, Allen, and Sherman (1971) found, for example, that persons performed more poorly, and more nervously, on laboratory tasks when they were told their supervisor believed they were former psychiatric patients, as compared to conditions in which the supervisor purportedly believed they were former medical, nonpsychiatric patients.

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Herein, the general term "AIDS patient" was employed, in deference to common usage. In fact, of course, one may be infected with the AIDS virus without "having" AIDS as an active disease.

Thanks are due also to an anonymous journal reviewer for pointing out the relevance of the Bogardus research, mentioned herein.

Concerning the stigmatizing properties of the mental-illness label, Page (1977, 1983) found that landlords advertising furnished or unfurnished rooms for rent would generally report the rooms were unavailable when telephone enquiries were made by persons describing themselves as present or former psychiatric patients, even though the rooms were known to be unrented at the time. Similar results were found in other experimental conditions in which callers alleged they were calling from prison in order to seek accommodation upon their (ostensibly imminent) release, or in which the caller stuttered, or spoke with a dissonant voice. Such results, together with the studies of Farina et al. (1971), continue to run counter to naive claims that psychiatric stigma does not now exist (e.g., Crocetti, Spiro, & Siassi, 1974) or that the public reacts in a benign fashion to the mentally ill (e.g., Gove, 1975). While we have found in previous research that the general public has not been uniformly negative toward persons with stigmatizing conditions, it is important to examine public attitudes and behaviours under various conditions of measurement. That is, attitudes elicited by procedures such as questionnaires or interviews, especially those in which the respondent may respond abstractly and in which his or her actual behaviour is not observed, have generally proved to be unreliable measures of the public's disposition toward persons perceived as deviant or different (see Lott, 1987).

With the recent appearance of Acquired Immune Deficiency Syndrome (AIDS), a terminal infectious condition, scientists and educators, as well as AIDS patients' organizations, are presently much concerned about the general perception of such individuals by the general public. One aspect of this concern involves the issue of stigmatization. Using a method developed in previous research (e.g., Page, 1977, 1983), which was utilized originally by civil rights and desegregation organizations in the U.S., the present study explored the reactions of a large sample of landlords toward rental enquiries in three Canadian cities. The situation examined, as described below, was one in which telephone enquiries were made, under different experimental conditions, as to the current availability of a publicly advertised room for rent. One such condition involved the polling of landlords, in the context of a confidential research study, as to their willingness to accommodate a hypothetical tenant suffering from AIDS. In a second condition, a comparable sample of landlords was contacted by a person ostensibly suffering from AIDS, and asked if their advertised rooms were still available. In a third condition, landlords were asked only if their rooms were still available. Use of this method previously has shown that the latter (control) condition, if used as described below, locates "still available" rooms with 95 to 100% certainty.

METHOD

Subjects

Individuals contacted during the present study were 270 landlords (145 female; 125 male) advertising furnished and unfurnished rooms for rent in three Canadian cities, namely, Windsor and Toronto, Ontario, and Halifax, Nova Scotia.

Procedure

Landlords were contacted individually by telephone, within each city (Windsor first, Halifax last), following procedures described in Page (1977, 1983). Rental advertisements were selected from classified listings in the Windsor *Star*, Halifax *Mail Star*, Halifax *Chronicle-Herald*, and Toronto *Star* newspapers (earliest daily editions) and assigned randomly to the experimental conditions described below. As in previous research, calls were placed in morning or early afternoon hours, unless requirements were otherwise specified in the advertisement, in order to ensure maximum availability of rooms. A male caller was used in all cases. No landlord, except in cases of no answer or busy signal, was contacted more than once. No call proceeded unless or until the person in charge of renting the room had been reached.

In condition one, the caller introduced himself as being from the University of Windsor and as conducting a telephone research survey, in different cities, on the "current situation of AIDS patients in the community." The landlord was informed that his or her advertisement had been selected at random as part of the survey, and was then asked directly if he or she would be willing to rent ("would have any problems with renting") the advertised room to a (hypothetical) person with AIDS, "provided the person was otherwise suitable to you." The landlord was then told immediately that his or her name was not required, and that no further contact or information was necessary. As soon as a substantive response had been obtained (usually immediately) the caller said "O.K., thank you very much for your time" and terminated the call. Calls in this condition were intended, and seemingly accepted, as scientifically legitimate enquiries, in the manner of a political, television-viewing, or attitude survey.

All calls were purposely kept as brief as possible, generally of only several seconds duration, and were limited to direct enquiries and initial responses only; that is, individuals were not prompted, or asked to explain or elaborate upon responses beyond indicating whether their room was presently available or had already been rented. "Available" was defined as meaning that no firm rental arrangement had been made with another person at the time of the call. Also as done in previous research, calls were discarded in which the individual in charge of renting the room was not immediately available and thus no clear response could be obtained, or in which the individual did not understand the call, or did not know (or was unsure about) the meaning of the term "AIDS."

In condition two, after reaching the person in charge of the room, the caller asked if it was still available, and then, before a response could be made, added "and also I guess it's only fair to tell you that, according to my doctor, I'm presently an AIDS patient." Upon receiving a substantive response, the caller said "O.K., thank you very much," and ended the call.

In condition three, as a control, the caller simply enquired, upon reaching the person in charge, as to whether the room was available and, upon receiving a substantive response, said "O.K., thanks," and ended the call. No mention of AIDS was made in this condition.

RESULTS AND DISCUSSION

The main results, showing the distribution of positive, negative, and unsure responses, are presented in Table 1.

Most landlords, receiving a legitimate enquiry in the context of a research survey, etc., indicated they would rent their room to an AIDS patient. Most, when contacted by an ostensible AIDS patient, described their room as being not presently available. In the control condition, rooms were described as available 94% of the time; in condition one, disregarding the "unsure" category, they were described as available 74% of the time. In condition two, they were reported as available 18% of the time. (In condition one, "unsure" responses were those in which the person stated explicitly that he or she could not decide, "didn't know for sure," or gave a similar response. In conditions two and three, "unsure" responses were those in which the person stated that the caller would have to be called back later, or that the caller should enquire again later.)

All three cities showed similar patterns of results, with Windsor showing the highest, and Toronto the lowest, rate of negative responses in condition two. Excluding unsure responses, a chi-square test (see Rosenthal & Rosnow, 1984) of the frequency data, collapsed over cities, was highly significant $\chi^2(2, N = 253) = 128.14$, $p < .0001$. For Halifax alone, $\chi^2(2, N = 253) = 38.52$, $p < .001$; for Toronto alone, $\chi^2(2, N = 253) = 38.55$, $p < .001$; for Windsor alone, $\chi^2(2, N = 253) = 60.41$, $p < .001$.

Since condition one defined positive and negative responses somewhat differently from the other conditions, chi-square tests ($df = 1$) were also calculated excluding data from this condition. For the data collapsed over cities, $\chi^2(1, N = 174) = 106.47$, $p < .0001$; for Windsor alone, $\chi^2(1, N = 60) = 51.50$,

TABLE 1

Distribution of Positive, Negative, and Unsure Responses[a]

	Halifax[b]			Toronto[c]			Windsor[d]		
Response	Yes	No	Uns.	Yes	No	Uns.	Yes	No	Uns.
Condition 1	21	6	3	25	3	2	20	4	6
2	6	23	1	8	19	3	2	28	0
(control) 3	27	1	2	28	2	0	29	1	0

Overall Distribution[e]

	Yes	No	Uns.	
Condition 1	66 (74%)	13	11	(N = 90)
2	16 (18%)	70	4	(N = 90)
3	84 (94%)	4	2	(N = 90)

[a] (N = 30 per condition, 90 per city; total N = 270)
[b] ($\chi^2 = 38.52$, $p < .0001$)
[c] ($\chi^2 = 38.55$, $p < .0001$)
[d] ($\chi^2 = 60.41$, $p < .0001$)
[e] ($\chi^2 = 128.14$, $p < .0001$)

$p < .001$; for Toronto alone, $\chi^2(1, N = 60) = 25.08, p < .001$; for Halifax alone, $\chi^2(1, N = 60) = 32.63, p < .001$.

In condition one, in which landlords' acceptance of a hypothetical AIDS patient was surveyed, a somewhat unanticipated result was found. Several respondents explicitly described their responses (whether positive or negative) as "tentative." Such responses thus took the form "Probably" or "I guess so, but . . ." or "Probably not, unless. . . ." Responses classified as positive (Table 1), but which were tentative, included, for example, qualifying comments such as "I guess so, but I'd have to meet him," "Yes, as long as they (sic) were okay medically," or "Probably, but it depends on what he was like," etc. Responses which were negative, but tentative, involved comments such as, "Not really, maybe, but probably not, depending on who it was" or "I don't think so, unless I knew he wasn't a homo or something," etc. Still other responses, though decisively positive or negative in tone, appeared to reflect unfavourable attitudes and beliefs. Some respondents thus made spontaneous comments expressing fears about the reactions or safety of neighbours, or of other (present or potential) tenants. Overall, 24 positive and six negative responses were tentative, as defined above. A chi-square test of data from condition one, excluding these responses, showed that the landlords involved were still considerably more willing than unwilling to say that they would rent to an AIDS patient, $\chi^2(1, N = 49) = 22.17$, $p < .01$. As consistent with previous research using similar methods, no differences in any condition were found for male versus female landlords. Also, none of the spontaneous comments, referred to above, used the feminine rather than masculine third-person pronoun to refer to an AIDS patient.

Clearly, many respondents polled in condition one were not entirely certain of their position; overall, 11 stated explicitly that they were unsure and could give no definite answer. Yet, of those responding to enquiries directly from an ostensible AIDS patient, in no case did a landlord ask the caller a clarifying question about the condition, and, in almost every case, responses as to availability were given with little or no hesitation. The four "unsure" responses in condition two (Table 1) involved asking the ostensible patient to call back later, or offering to call him back later in the evening, possibly to allow for consultation with another person about the issue of AIDS in regard to a prospective tenant. It is recalled that, in this condition, the respondent had the option of simply reporting that the room was no longer available, thus avoiding the matter of AIDS completely.

Based on the overall pattern of results, the following observations may be offered:

The general public does seem to perceive, act upon, and thus establish, AIDS as a socially stigmatizing condition. Also, perhaps as a partial consequence of recent media attention given to the question of AIDS-infected teachers or children in schools, and to cases such as that of a restaurant chef being fired, it remains to be determined as to how greatly the public is realistically open or amenable to objective, factual information about the condition. Such information thus competes with self-interest, human foibles, plus the desire of otherwise concerned citizens for security and maximum freedom from life's complications and avoidable hassles.

The present results, while clearly exploratory, do raise the issue of how public attitudes toward stigmatizing conditions are to be conceptualized and measured. Different conditions of measurement elicit different cues for respondents as to what constitutes a "good," informed, or humanitarian response. Thus, procedures such as surveys, interviews, questionnaires, or research polls, which do not involve actual or anticipated contact with a member of a stigmatized group, may elicit more positive attitudes than do unobtrusive methods such as those used in the present study (see Gibbs, 1980; Lott, 1987; Page, 1977, 1983). Reliance on obtrusive attitude measures therefore invites an inaccurate, indeed naive, portrayal of how stigmatized and minority groups are actually perceived, and thus reacted to, in real communities. The scientific, humanitarian ethic, increasingly present over the last two decades, tends to see "progress" in public acceptance of groups such as blacks, certain religious groups, stutterers, women, persons of lower social class, the mentally ill, and so on. However, while some such progress has occurred, many individuals still express rejecting or ambivalent attitudes toward stigmatized persons. These attitudes often follow the basic pattern of public acceptance and enlightenment, that is, when attitudes are assessed reactively or obtrusively, combined with private avoidance and/or rejection, that is, when behaviour and attitudes are assessed unobtrusively (see, e.g., Farina et al., 1971; Gibbs, 1980; Goffman, 1961; Page, 1980, 1983; Rappaport & Cleary, 1980; Rosenhan, 1973). The use of both attitudinal and behavioural measures allows assessment of differences according to whether the respondent believes his or her responses are detectable or observable by others, and thus whether or not he or she might be open to possible embarrassment or to potential charges of prejudice or discrimination. One recalls, for example, LaPiere's (1934) classic study in which restauranteurs indicated on the telephone that Chinese couples would not be served, but in which most such couples were served when they actually entered the restaurants.

The present study was, of course, ill-equipped to gather substantive information about the extent of misconceptions or inaccurate beliefs about AIDS within the general public. These beliefs, however, seemed to exist and indeed to be rather widespread. (In the context of landlords' comments reported previously, it might be noted that in fact the AIDS virus is highly unlikely to be contracted from an AIDS patient within the same household, from casual social contact, or in a situation in which the same amenities of living are shared, that is, such as dishes, linens, or washrooms. AIDS is not an inherently or exclusively "homosexual" disease. Also, employers in Canada have no legal right to know if an employee is carrying the AIDS virus, and it is seemingly contrary to the Canadian Human Rights Code to deny or terminate employment on account of AIDS or other disabling conditions not relevant to job performance [Suzuki, 1987]).

An important study by Weitz (1972), in the area of race relations, showed that negative attitudes and reactions may not be detectable with conventional measures. Weitz, using large university student samples, found that attitudes toward blacks were favourable and racially tolerant when questionnaire measures were used. When Weitz later brought the same subjects back to perform laboratory tasks on a separate occasion, in what subjects believed was a second study unconnected with the first, the white students frequently showed subtlely rejecting nonverbal behaviours, and generally increased "social distance" when

working with blacks as co-workers on the laboratory tasks. Weitz generally interpreted such findings as indicating "repressed affect" as a factor in interracial relationships. In situations such as in the present study, an avoidance factor, vis à vis the stigmatized person, must also be considered. Thus, while conventionally measured attitudes toward such persons might well follow the humanitarian norms of acceptance and nondiscrimination, avoidance of such individuals may be an actual consequence where such can be accomplished without the expectation of being detected on the part of the behaving person. Similar results were obtained by Lott (1987), who found that men did not show unfavourable or prejudicial attitudes toward women on various "paper and pencil" measures, but did, in unobtrusively observed work situations, show various avoidance behaviours, more negative statements, and increased social distance specifically toward female co-workers. In a study of employment practices regarding skilled and semi-skilled jobs in Halifax, Renner and Gillis (1987) also found that while 75% of all job categories were described in interviews with employers as being open to either sex, only 24% of these jobs actually were filled by both sexes.

University courses, and conventional texts in abnormal psychology, tend to describe and dichotomize behaviour as healthy or sick, normal or abnormal, tolerant or prejudiced, and so on. "Normal" people, however, appear to have the capacity to exemplify both sides of these dichotomies, depending on their perception of the surrounding situation, and, in effect, to allow ambivalent or even contradictory attitudes to co-exist. In fact, it is possible that the emotional or affective components of attitudes (e.g., on a positive-negative or liking-disliking dimension), in previous research on stigmatization and prejudice have been overemphasized. That is, it is possible that members of stigmatized minorities may or may not be actively disliked by the majority (as one would dislike a person perceived as obnoxious) but may still be rejected or avoided, possibly for different, more practical reasons. One such reason was provided many years ago by social exchange theory (Thibaut & Kelley, 1959). Individuals generally seek to maximize rewards and minimize perceived psychological costs in present or potential interpersonal relationships. Similarly, one avoids the unfamiliar as well as the disliked. When provided with an immediate and seemingly legitimate escape mechanism, many will thus seek to avoid the hassles, unfamiliarities, and complications of establishing relationships with others perceived as different, aside from what the nature of that differentness may be.

Lastly, the types of variables involved in the present study are reminiscent of those in early research on the nature and structure of attitudes, such as that undertaken by Guttman (1950), Thurstone (1929), Bogardus (1925, 1931, 1959), and others. Bogardus, for example, was the first to describe the construction of "social distance" scales, by which attitudes toward minority groups could be assessed. Such scales required subjects to accept or reject test items reflecting various degrees of social contact or intimacy with a minority group member. From the sum of specific item scores, viewed by Bogardus (1925, 1931, 1959) as having "cumulative meaning," the strength of the respondent's attitude toward the minority could be derived. The present results seem generally consistent with Bogardus's basic position that a real or anticipated social situation which compromises a person's preferred level of social distance, for example, the possibility of having a stigmatized individual as a tenant, is likely to maximize the possibility

of discriminatory behaviour against a "target" person—at least when the subject does not believe he or she is under surveillance. Yet, while Bogardus and his contemporaries clearly made major contributions to the conceptualization and measurement of attitudes, our knowledge of when and where attitudes will be expressed as observable actions remains incomplete. Subjects, for example, do not always act or express attitudes toward minorities in a manner which would be logically predicted on the basis of abstract social distance measures (see Warner & DeFleur, 1969). In addition, much research on the behavioural aspects of attitudes has had to be satisfied with comparing what subjects say, feel, or believe about minorities with what they *say* they would actually do in specific situations. Clearly, what they say does not necessarily predict their actual behaviour, that is, until our knowledge of the "social psychology" of attitudes and behaviour, with special reference to situations in which subjects do not believe their behaviour is being monitored, is much more complete than it is at present.

CONCLUSIONS

The present sample of landlords, for the most part, responded by indicating acceptance of the AIDS patient in a situation in which they did not anticipate actual contact with such a person. In situations where potential contact appeared certain, but in which they could decline help or involvement seemingly without detection, their behaviour indicated considerably more rejection and avoidance than it did acceptance. The present results, as discussed above, are similar to those in previous research on other types of stigma in the community, such as that of mental illness. Evaluation techniques aimed at assessing community attitudes toward stigmatizing conditions must, in the future, take more sophisticated account of the difference between the ideal and the real, and be better equipped to expose and examine such a difference when it is found. Future research would be particularly valuable vis à vis groups such as landlords or employers, whose attitudes and behaviours toward stigmatized groups would seem particularly critical as indicators of community acceptance or rejection.

RESUME

A partir de méthodes déjà utilisées, on a examiné le stigma social associé au SIDA en faisant 90 appels téléphoniques à des propriétaires qui annoncent des chambres à louer dans trois villes canadiennes: Windsor, Toronto, et Halifax. Comparativement à des conditions de contrôle, les appels provenant de personnes se disant atteintes du SIDA ont suscité des réponses négatives par rapport à la disponibilité de la chambre annoncée. Les résultats fournissent un premier aperçu des attitudes du public face à des situations comme le SIDA. Ces résultats ont été comparés avec ceux d'études antérieures concernant les personnes atteintes de troubles mentaux. On discute de stratégies pour mesurer les attitudes face aux minorités ou aux groupes socialement étiquetés.

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