

Intrapersonal Stigma: The Latent Function of Apartheid and HIV/AIDS Stigmatization in South Africa
and Implications for Interventions

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To the Vanderbilt MHS community for the invaluable support and guidance over the past five years
and
To the beautiful country of South Africa

Introduction

South Africa is a country with an egregious past, a troubled present, and a promising future. Addressing South Africa's current challenges requires acknowledging the impact and legacy of South Africa's political, economic, social and cultural histories. From 1948-1994 under the formal system of Apartheid, South African government legislated a system of racial segregation that systematically deprived or restricted the majority of South African citizens of many basic human rights. These included the right to vote, own land, work, access quality education, and marry. A history of human rights abuse and discriminatory practices against non-white South Africans, however, began long before the official start of formal apartheid. South Africa is wrought with the scourge of discrimination that is deeply rooted in the fabric society.

Many inequities legislated under apartheid persist in modern day South African society through deeply engrained channels of difference between races and between socio-economic classes. Today, interaction among races is severely limited¹. The relative per person personal income of Black South Africans, measured by percent of White South African level, is 13%². Widespread inequality continues to plague the country. South Africa's Gini coefficient is in the top 5 percent of the global distribution (International Monetary Fund, 2013, p. 4). In sum, Apartheid history casts a long shadow over many sectors of present-day South Africa.

This thesis seeks to contextualize current high levels of HIV/AIDS stigmatization (H/A stigma) by applying a structural functionalist perspective to the study of stigmatization throughout South Africa's history and today. Utilizing the concept of latent function from structural functionalist theory and the definition of 'self' defined in social identity theory (STI), I argue that the latent function of apartheid was to institutionalize the politically and socially constructed identity of 'black' South Africans into the psyches of South Africans. Classified as an inferior, devalued and base race, and persistently confronted

¹ "The frequency of interracial talk reported by the lowest LSM group (LSM1-5) has only increased by 1.1%" (Wale, 2014, p.23)

² Leibbrant, M. (2010). Trends in South African income distribution and poverty since the fall of apartheid. *OECD Social, 101*, p.13.

by the poor conditions and demeaning stereotypes associated with their racial classification, many black South Africans internalized this racial identity and developed a negative self-concept. The psychological consequences of a negative self-concept are severe and affect both individual and group psychology.

As defined in current mental health research, ‘self-stigmatization’ occurs when people internalize negative stereotypes and “experience a loss of self-esteem and self-efficacy” (Corrigan et al., 2009, p. 75). Similarly, a USAID report on HIV stigma from 2006, drawing from a range of disciplines, defines ‘internal stigma’ as “the product of the internalization of shame, blame, hopelessness, guilt, and fear of discrimination associated with being HIV-positive”. This report lists “felt, imagined, or self stigma” as possible synonyms for this phenomenon (Brouard & Willis, 2006, p. 2). This thesis will use the term ‘intrapersonal stigma’ in reference to this mechanism of stigmatization. Recent advancements in stigma theory, working off of critique that stigma research was too individually focused, defines stigma as operating at multiple levels: structural, interpersonal and intrapersonal (Link & Phelan, 2001; Parker & Aggleton, 2003; Hatzenbuehler & Link 2014). Intrapersonal stigma is defined here as stigma “occurring within the individual mind or self” (Merriam-Webster, 2015) and seeks to encompass the varying definitions of this mechanism.

I argue that apartheid was able to legitimize the socially constructed differences between races through the mechanism of intrapersonal stigma, thus serving a system-justifying function by maintaining a specific social order. I hold that the centrality of identity to H/A stigma and to apartheid leaves people living with HIV/AIDS in South Africa (PLHA) increasingly vulnerable to stigmatization, discrimination, and psychological impairment through the development of a negative self-concept. Though in all settings H/A stigmatization contributes to the disempowerment of PLHA, this vulnerability is increasingly important in South Africa as the hierarchy of HIV prevalence mirrors the racial hierarchy created under apartheid (Kenyon et al., 2013, p. 1). Therefore, black South Africans are increasingly at risk for intrapersonal stigmatization through the dual identities of race and potential HIV status.

Though stigma operates on structural, interpersonal and intrapersonal levels, current HIV stigma reduction interventions focus almost exclusively on interpersonal level interventions. Drawing from

recent stigma theory that conceptualizes stigma as both a social process and a resource for powerful social actors to effectively serve their own interests, structural stigma often operates through hidden or misrecognized channels and can be difficult to measure using existing tools.

I advocate for the advancement of structural level interventions for stigma operating at the intrapersonal level. This research calls for a social and political movement that garners momentum and support from structural processes, with implications for the individual experience of living with HIV/AIDS. An intervention on this scale could help reform the experience of living with HIV from one clouded by shame, blame and fear to one of empowerment. I believe that this research has significant implications not only for PLHA, but for any other individuals afflicted by intrapersonal stigma. Further, I contend that my proposed intervention, a movement that is both structural and intrapersonal, makes an important contribution to HIV/AIDS stigma literature through both innovation and necessity. As an intervention effort, the Black Consciousness movement provides a model for a structural level intervention, using the momentum, resources, energy and infrastructure of a social movement, to effect change at the intrapersonal level.

This paper will first provide an overview of Apartheid in South Africa to establish context. Next, this paper will discuss several critical theories that inform this research: social identity theory, structural functionalist theory and structural stigma theory. I will then apply this research to the issue of HIV/AIDS in South Africa and conclude with a discussion of the implications of this thesis for current stigma intervention research.

South African Apartheid

Apartheid legislated a society that was fundamentally unequal, leaving those at the bottom with little-to-no power, control, status or resources. The seeds of Apartheid took root over a century before the South African National Party came to power in May of 1948, marking the official start of formal Apartheid, and more accurately began with the rise of Afrikaner nationalism. The South Africa Act of 1909 and the subsequent Union of South Africa of 1910 marked the official legislative deprivation of black South African's political rights. The South Africa Act of 1909 unified the four British colonies in

South Africa: Cape Colony, Natal, Transvaal and Orange Free State. Although the white electorates only represented one fifth of the population, white delegates secured the act and helped create the constitution for the Union of South Africa, leaving blacks limited representation in parliament and no voting rights (Welsh, 2009). That these pieces of legislation simultaneously launched South Africa as a unified and operational political body and launched the legislative disenfranchisement, denial of power, rights, and economic freedom of black South Africans illustrates the deeply embedded nature of racial inequality in South Africa.

For the Afrikaners of the new South Africa, control of the industrialized cities was vital to securing political and economic power. African urbanization was a threat to the Afrikaner party, illustrated by urban area restrictions in place before the official start of formal Apartheid. The 1913 Natives Land Act illustrates the gross land deprivation that was written into early South African law. According to the act, natives, defined as “any person, male or female, who is a member of an aboriginal race or tribe of Africa; and shall further include any company or other body of persons, corporate or unincorporate, if the persons who have a controlling interest therein are natives” could only buy or sell the land of 7% of the country. Though this number increased to 13.5% in 1936, ‘natives’ remained significantly disadvantaged. This act, coupled with the union in 1910, marked the launch of a carefully designed racially and geographically divided South Africa. As the minority population, white South Africans needed to systematically restrict the rights of the majority population to maintain power and control.

Race mixing threatened to disrupt this tightly controlled system of power. A review of the 1927 Immorality Act and its Amendment in 1950 demonstrates the intense disgust of miscegenation and fears of blood mixing. With the goal to “prohibit illicit carnal intercourse between Europeans and natives and other acts in relation thereto” (“Immorality Act of 1927”), the sexual act between Europeans and natives was punishable by law. Amended in 1950, the Act was updated to include all non-Europeans. Sexual relations among different groups of South Africans was written into law as immoral- a violation of

societal standards of right and wrong conduct. This powerful language reveals the intense fears driving the apartheid regime and reflects the legislated stigma of apartheid.

This thesis will use the Missionvale township of Port Elizabeth as a case study for understanding apartheid and its legacy. Described as “a prototypical model of the *Apartheid city*” (Frescura, n.d.), Port Elizabeth, the largest city in the Eastern Cape, has visibly apparent geographic segregation and high levels of inequality. The coastal, central and western parts of the city are populated by affluent whites, leaving the northern areas populated by mostly coloured and black citizens. Missionvale Township was established as a “location” in 1879. Today, the population of 130,000 reports 70% HIV infection, 75% unemployment, and water, electricity and housing scarcities (“The Missionvale Township,” 2009).

In Port Elizabeth, beginning in the early 1900s under the guise of “colonial segregation planning” (Frescura, n.d.), black citizens looking for work in the city were designated to “locations” on the outskirts of the city. The Native Urban Areas Act of 1923 further defined city borders in Port Elizabeth by race, leading up to the formalization of apartheid rule in 1948. Without a distinct biological difference between races, the early designations of ‘native’ and ‘European’ required significant oversimplification and depended heavily on social factors. Described by University of Cape Town sociology professor Debora Posel, “While understood and represented as a biological phenomenon, “race” was crucially also a judgment about social standing. Constructions of a person’s race were based as much on “mode of living” as on physical appearance” (2001, p. 94).

However arbitrary, these racial constructs were written into law through the Population Registration Act of 1950. The Population Registration Act created a system of classification according to race and enforced these identities through required passbooks. Racial classification determined almost all areas of life, from the ability to get a job, own land, and move around the country, to the ability to have relationships and marry. Drawing categories of race from social, rather than biological, factors kept the apartheid system of social control functioning and allowed for “on-the-ground regulation of social and economic life in racially differentiated ways” (Posel, 2001, p. 93). In sum, race as a socio-legal construct enhanced the system-justifying function of apartheid by enabling the “bureaucratization of “common

sense” notions of racial difference” (2001, p. 87). Described by Posel, “From an ideological point of view, the Population Registration Act demonstrated the National Party’s commitment to the preservation of “racial purity,” one of the central issues during the 1948 election, fanned by the white electorate’s fears of “die swart gevaar” (the black menace) threatening to engulf the cities” (p.98). This fear of blood impurity was written into the legal documents, as the transcript of the House of Assembly Debates (HAD) reveals, “We are country of many races and the people of South Africa have decided once and for all that in this country we must keep the different races pure” (Posel 98, citing HAD, March 8, 1950).

Apartheid segregationist legislation divided Port Elizabeth into "White", "Bantu", "Coloured" and "Asian" suburbs, and demanded that “such areas should be set apart by buffer strips at least 100m wide” (Frescura, n.d.). Conditions of the suburbs were fundamentally unequal, resulting in significantly worse community infrastructure, housing, education, employment opportunities and health care in non-white townships. With the Reservation of Separate Amenities Act of 1953, the unequal quality of public facilities reserved for each race was legally sanctioned. Here, though the manifest functions of apartheid were to keep populations geographically separated and encourage the development of separate nations, the white minority was also able to maintain power and control of the country through not only ‘keeping people away’ (through geographic segregation) but also ‘keeping people down’ through the consolidation of wealth, power and status among the white population (Phelan et al., 2008).

Twenty-years after the end of formal apartheid, South African townships remain racially segregated and plagued by poor infrastructure. In Missionvale, efforts to improve living conditions have been slow and unsuccessful. In June 2014, I spent one month volunteering at Missionvale Care Center. I worked primarily with Community Health Practitioners (CHPs) to study barriers to positive health outcomes in the community. During my time at Missionvale, I shadowed several CHPs as they worked in the community, sat in on their HIV/AIDS support groups, and participated in their HIV 101 training. In addition, I shadowed clinical practitioners in the Missionvale Care Center Clinic. In speaking with a white surgical volunteer and educator at Missionvale Care Center about the status of South African townships today, she attributed the current issues in health, education and housing to poor governance by provincial

and national government. She explained, “At the National government level there has been a really good mindset of providing housing, of providing schooling, etc., etc. Unfortunately, in my opinion, it falls apart at local government levels because people are being bribed” (Personal Communication, October 31, 2014). She feels that, for how much time has passed since the end of apartheid, there has not been ample progress made. She used the example of her domestic worker of 27 years who told her, “my life has gotten better because I met you, not because of 1994” to describe how little the official end of apartheid has improved the lives of many South Africans.

Corroborating these claims, a coloured CHP from Missionvale noted severe bribery within the housing department and widespread exploitation of the sick, poor and uneducated. Serving as a liaison between the Missionvale population and the Care Center, this CHP supports several hundred clients through medical, housing and personal challenges. Upon witnessing several long-time Missionvale residents lose their land plots due to corruption and bribery, she professed that she would rather still be under Apartheid government (Personal Communication, June 24, 2014). This claim illustrates the gravity of the situation persisting in many South African townships. Remarkably, Missionvale was described as having better infrastructure than many other townships in Port Elizabeth (Personal Communication, October 31, 2014).

As feelings of political neglect and hopelessness pervade townships under South Africa’s current democracy, the legacy of apartheid social order still shapes present-day life. Acknowledging the historical context of apartheid and the current status of South Africa’s marginalized populations is critical to understanding how racial and class disparities institutionalized under apartheid influence the identity and self-concept of vulnerable populations. As stated, I contend that the latent function of apartheid was to institutionalize the politically and socially constructed identity of ‘black’ South Africans into South African psyche. Under apartheid, the social identity of black South Africans was reformed to reflect their classification as second-class citizens. Persistently confronted by the negative characteristics associated with their inferior social status, many black South Africans developed a negative self-concept, ultimately fulfilling the interests of those in power by ‘keeping people down’ (Phelan et al., 2008). This thesis will

next review social identity theory to illustrate how identity assumption is inextricable during the formation of a self-concept.

Social Identity Theory

This thesis will use the concept of ‘self’ defined in Social Identity Theory (STI) to analyze the mechanism of self-concept and self-stigmatization in South Africa. Social Identity Theory, developed by Henri Tajfel and John Turner in 1979, is comprised of three individual and three social components. The three individual components are categorization, social comparison, and self-concept. Here, the self is defined as “a sum of two subsystems: a personal identity and a social identity” (Nicholas, 2009, p. 267), highlighting how the self is influenced by social context. The three social ‘legs’ of STI are group status hierarchy, permeability of group boundaries, and legitimacy/illegitimacy. Linking both the individual and social components of STI is the key assumption that “individuals are motivated to strive for a positive self-concept, in particular a positive sense of social identity” (Nicholas, 2009, p. 269).

This key assumption and definition of ‘self’ is critical in understanding how the mechanism of intrapersonal stigmatization occurred under apartheid. Classified as a lower status group, the marginalized populations under apartheid were likely to develop a negative social identity: “Since social identity derives from memberships in groups, people from low status groups are likely to have a negative social identity” (Nichols, 2009, p. 269). The self, derived in part from one’s social identity, is therefore negatively affected as well. A negative self-concept can have damaging effects on both the individual and a collective population. On the individual level, behaviors include, “Apathy, low levels of aspiration and self-confidence; the attitude of living for the moment and the more serious evidence of criminality” (Onwuzurike, 1987, p. 222). On greater scale, these effects include collective catharsis, collective neurosis and inferiority complex, and stress and crisis (Onwuzurike, 1987). In the case of black South Africans under apartheid, this can actually legitimize existing discriminatory beliefs about the productivity of the marginalized population. Here, the formation of a negative self-concept serves a system-justifying function.

As defined in current mental health research, self-stigmatization occurs when people internalize negative stereotypes and “experience a loss of self-esteem and self-efficacy” (Corrigan et al., 2009, p. 75). Therefore, the development of a negative self-concept is a product of self-stigmatization. As stated, this thesis refers to the psychological process of an individual accepting or internalizing stereotypes as intrapersonal stigmatization. I argue that the most powerful latent function of apartheid was the psychological handicap placed on the black population through the mechanism of intrapersonal stigmatization. Social identity theory and the definition of ‘self’ provides theoretical support for this process. Next, I will review the history of South African identity formations and deformation to highlight how, under apartheid, the social identity of black South Africans was reformed to reflect their classification as second-class citizens.

Identity Under Apartheid

Shaped by history, culture, individual experience, race, gender, etc., identity is a malleable and dynamic concept. South African identity deformations began during colonization. Before the Dutch settlers colonized the land, African identity was described as “specific, firm, and relatively enduring” (Abdi, 1999, p. 149). African identity and mode of living established before the introduction of European colonizers and capitalism “were either destroyed or relegated to the status of uncivilized and backward beliefs, sometimes superstitious practices, and unacceptable challenges to colonial programs and preference” (Abdi, 1999, p. 150). Described as employing “systemic schemes of African identity deformation” (Abdi, 1999, p. 150), the early settlers of South Africa stigmatized and deconstructed African identity through oppression and domination.

Regulation of individual and collective identity was a foundational element of apartheid policy. Since the categories of race created under apartheid were hierarchal, defined based on “descent, appearance, general acceptance and repute” (Posel, 2001, p. 93), distinct racial groups were easily associated with differing levels of inferiority or superiority. Through the construction of these categories and subsequent legislations, the white South Africans in power were able to engrain these channels of difference into the fabric of society. Notably, apartheid did not necessarily *create* new racial

classifications, but instead classified social, cultural, and physical differences between citizens. These differences had been identified even in early discriminatory legislation, (original designations of ‘native’ and ‘European’ required significant oversimplification and depended heavily on social factors) and were written into law under apartheid.

Under discriminatory apartheid law spanning job reservation, education, land tenure, influx control and political representation, native South Africans began to re-form their identity as a subordinate social group. Describing this identity crisis, one South African explains, “Apartheid convinced my parents that whites were God-like creatures, and they urged me to believe the same” (Abdi, 1999, p. 153). Here, the idea of generational identity emerges as youth born under apartheid were socialized into a racial society. Recognizing this detrimental consequence of the apartheid system, some marginalized South Africans sought to reform black identity and negate the discriminatory characteristics associated with being ‘black’. The Black Consciousness Movement aimed to hinder the process of intrapersonal stigmatization through large-scale empowerment efforts.

Black Consciousness

Opposition movements including the formation of the African National Congress (ANC) and Black Consciousness (BC) served as awareness-raising movements to “neutralize a culture of oppression that excluded blacks because of who they were” (Abdi, 1999, p. 153) and reinvigorate African identity and pride. Narrated by Stephen Bantu Biko, a prominent anti-apartheid activist and founder of the Black Consciousness movement, apartheid instilled a deeply rooted sense of inferiority into the minds of black South Africans. Through this process of intrapersonal stigmatization, black South Africans internalized this inferiority and suffered severe psychological consequences:

“The type of black man we have today has lost his manhood. Reduced to an obliging shell, he looks with awe at the white power structure and accepts what he regards as the "inevitable position". Deep inside his anger mounts at the accumulating insult, but he vents it in the wrong direction---on his fellow man in the township, on the property of black people” (1978, p. 28).

Recognizing these powerful effects of a negative self-concept, the Black Consciousness movement worked specifically against the mechanism of intrapersonal stigma: “BC was fighting against “culturally imposed self-negation, self-alienation and feelings of inferiority as major impediments to black liberation” (Abdi, 1999, p. 165 quoting Johnson, 1994, p. 7). Black Consciousness aimed to mentally equip black South Africans for the racism and dehumanization processes of apartheid. The Black Consciousness movement specifically looked at the impact of identity assumptions on the psychological well being of black South Africans and sought to garner large-scale support for opposition efforts. As an intervention effort, the Black Consciousness movement provides a model for a structural level intervention, using the momentum, resources, energy and infrastructure of a social movement, to effect change at the intrapersonal level.

The Black Consciousness Movement (BCM) began mostly among medical students and other affluent, educated black South Africans. Though the ideologies and structure of Black Consciousness fluctuated over time as the political context of apartheid shifted, BCM remained a prominent anti-apartheid force. Black Consciousness shifted from an “intellectual crusade with little grass-roots support” (Moodley, 1991, p.248), in the early 1970s to a controversial political movement following 1976. Though sometimes criticized for its exclusive policies, at one point explicitly excluding whites on the basis of race, BCM left a significant ideological impact on South Africa. The efforts of the BMC lit the fire behind crucial opposition events in anti-apartheid history by providing a source of empowerment and pride for marginalized populations.

Black Consciousness was described as “the decisive mobilizing ideology for united black action on the university and school campus” (Hirshmann, quoting Gaving Lewis, 1990, p.8) and the “single most important factor” influencing the Soweto Uprising of June 16, 1976 (Hirshmann, quoting John Kane-Berman, 1990, p.8). Banned after the 1976 protests, activities of Black Consciousness slowed and its prominence was eventually overshadowed by the African National Congress. Today, Black Consciousness today remains an ideology and vision rather than an active political movement (Moodley, 1991, p.250). Black Consciousness continues to spread its message through structural-level

interventions including “community development programmes, health awareness projects, and women's organizations” (Moodley, 1991, p.250).

In review, classified as a lower status group, the native population under apartheid developed a negative social identity. The self, derived in part from one’s social identity, was therefore negatively affected as well. By assuming the socially constructed identity created under apartheid, and accepting the discriminatory characteristics associated with this identity, many black South Africans experienced crippling internal stigmatization. Described by Biko³ this often-resulted in misplaced anger and an inferiority complex. This thesis argues that the most powerful latent function of apartheid is the mechanism of intrapersonal stigma, illustrated by the experience of many black South Africans. Though controversial at points, the Black Consciousness movement is a critical facet of apartheid history and played a key role in facilitating the end of apartheid. In addition, BCM provides a useful model for a structural level intervention that targets stigma operating on the intrapersonal level.

Identity Today

Since the end of apartheid, African identity has only experienced further disjuncture. In post-apartheid South Africa, divisions have formed within the previously unified black population. Described as “a majority of have-nots and a tiny elite of haves” (Abdi, 1999, p. 158), the black population now experiences geographic and developmental segregation among their own race. Policy such as Affirmative Action increases inequalities among black South Africans by only effectively serving the rising middle class. Although 1.5 million blacks have joined the middle class since the 1980s, there is overwhelming agreement that affirmative action has not helped “the vast majority of the poor” (Alexander, 2007, p. 99). Discussing the growing inequality within the black community, a review of the National Crime Prevention Strategy describes, “the breakdown of communal solidarity linked to the dissolution of apartheid and the increased social mobility of sections of society, not only undermines cohesion but reinforces insecurity about personal worth” (Bruce, 2006, p. 35). Here, self-conception, derived in part from one’s social identity, continues to suffer. This review goes further to actually define the legacies of

³ See excerpt from *I Write What I Like*.

apartheid as “underlying low self-esteem” and “internalized negative racial stereotypes” (Bruce, 2006, p. 35). The authors cite these legacies as contributors to current high levels of violence, echoing Biko’s 1978 observations on insult and anger.

The inferior living, working and educational conditions legislated under apartheid persist in present day South Africa. Black South Africans, representing almost 80% of the population, report statistically significant differences in rates of school attendance, employment, and residency in informal dwellings than their white counterparts. According to the 2014 Report of the South Africa Reconciliation Barometer Survey, although there has been an increase in interracial integration, the poor remain excluded from this process. Further, findings conclude that historical memory of apartheid injustices is decreasing: “South Africans – and especially white South Africans – appear to be forgetting the brutal realities of apartheid” (Wale, 2014, p. 12). The authors of this study believe that confronting this history is critical for increased forgiveness and reduced vengeance. I argue that remembering and acknowledging this history is also critical for contextualizing current inequities between groups.

Without marked improvements in equity between races or socio-economic classes, there is little indication that issues of identity and self-worth have improved among black South Africans. This is of particular significance as a negative self-concept created through the mechanism of intrapersonal stigmatization can impact the collective functioning of an entire population (Onwuzurike, 1987). In South Africa, this can continue to legitimize prejudiced beliefs about the productivity of the marginalized populations, thus continuing to serve a system-justifying function. I contend that the latent function of apartheid was to institutionalize the politically and socially constructed identity of black South Africans into the psyches of South Africans. This thesis will next define manifest and latent functions in structural functionalist theory to clarify how the highly detrimental mechanism of intrapersonal stigmatization was often hidden or misrecognized under apartheid. Operating through deeply engrained channels, this latent function was also system-justifying.

Structural Functionalist Theory

Structural functionalism is a sociological and anthropological theory that understands society as a structure with various interconnected parts. Structures are defined as “organizing principals on which sets of social relations are systematically patterned” (Bonilla-Silva, 1997, p. 476), and play a key role in structural stigma theory, defined later. According to Robert Merton’s work on social structures, a function can either be manifest or latent. Manifest functions are defined as “the intended consequences of an act that contributes to the existence of a system” (Helm, 1971, p. 51). For example, under apartheid law, one manifest function of apartheid was to keep people geographically segregated, executed through laws such as the 1950 Group Areas Act and the 1953 Reservation of Separate Amenities Act.

Contrastingly, latent functions are defined as “the unintended (or unrecognized) functions of an act that contributes to the existence of a system” (Helm, 1971, p. 51). Latent functions can be deceptive and not overtly recognized. This paper argues that the most powerful latent function of apartheid is the dehumanization of the black population facilitated by the construction of a negative self-concept⁴. Creating this psychological handicap was established through intrapersonal stigmatization.

This latent function is both what Catherine Campbell et al. (2005) call an ‘identity-protective’ function and what Jost and Banaji (1994) call a ‘system-justifying’ function. As the minority population, white South Africans needed to systematically restrict the rights of the majority population to maintain power and control. Race mixing threatened to disrupt this tightly controlled system of power. Intrapersonal stigma among the black population served an identity-protective function by shielding the white population from power or status loss. Defining an identity-protective function, the authors describe, “Psychodynamic thinkers speak of the existence among humans of a universal unconscious fear of collapse and chaos... This process of stigmatization or “othering” is thought to serve an “identity-protective” function by producing feelings of comfort and security and a sense of personal invulnerability to threats and dangers that might otherwise appear overwhelming” (Campbell et al., 2005, p.808). Here,

⁴ Though this paper will only analyze the ‘black’ population under apartheid, classified as the lowest social group, I do not assume that *only* the black population experienced internalized stigma or identity deformations.

the perpetuation of negative racial stereotypes among the black population validated the white South African's status as a superior race and quelled fears of power loss.

I argue that the latent function of apartheid served a system-justifying function as well by perpetuating an established social order. Jost and Banaji define a system-justification as, "the psychological process by which existing social arrangements are legitimized, even at the expense of personal and group interest" (1994, p. 2). A system-justifying function is reliant on what the authors describe as a 'false consciousness' or, "the holding of beliefs that are contrary to one's personal or group interest and which thereby contribute to the maintenance of the disadvantaged position of the self or the group" (Jost & Banaji, 1994, p. 2). Here, the authors describe how a system-justifying function can keep specific populations from reaching their full potential through internalized stigmatization. Under apartheid, many black South Africans internalized their inferior racial identity and developed a negative self-concept. This latent function of apartheid is system-justifying as it serves to keep marginalized populations in place through the self-perpetuation of discriminatory stereotypes: "The notion of system-justification is necessary to account for previously unexplained phenomena, most notably in the participation by disadvantaged individuals and groups in negative stereotypes of themselves, and the consensual nature of stereotypic beliefs despite differences in social relations within and between groups" (Jost & Banaji, 1994, p. 1).

Conceptualizing the process of intrapersonal stigmatization and construction of a negative self-concept among black South Africans as a latent, system-justifying function has significant research implications. As a latent function, this phenomenon was difficult to address, measure, and construct effective interventions to reduce. Black Consciousness was the most successful attempt to reverse this process of self-stigmatization. BCM sought to reform the experience of being black in South Africa into one of pride and empowerment. Looking at the case of HIV/AIDS, current stigma reduction research does not have the tools to identify, measure and analyze intrapersonal stigma. Existing scales and surveys do not appropriately capture the psychological consequences (Ward, 2014). Therefore, I advocate a structural

level intervention to address stigma operating at the intrapersonal level. I believe that the Black Consciousness movement can provide a useful reference for such an intervention.

This paper encourages an examination of the structural and intrapersonal processes through which H/A stigma operates with the hope of improving stigma interventions beyond the interpersonal level. This paper will next illustrate how recent stigma theory, conceptualizing stigma as a power-driven structural process operating in a system of inequality (Parker & Aggleton 2003, Campbell 2007), underpins this research. This literature review reveals how fundamental principals of current stigma theory, including power, status and inequality, mirror the fundamental principals of apartheid.

Structural Stigma Theory

As this literature review reveals, in the past few decades of theoretical advancement, ‘stigma’ has grown from an individual static attribute to a social process and a resource for powerful social actors to effectively serve their own interests. Rather than exclusively analyzing stigma at the individual level, stigmatization is now understood on the structural level as well. Using the theories of structural stigma and stigma power, this paper will illustrate how the mechanism of intrapersonal stigma can effectively ‘keep people down’ (Phelan et al., 2008) in systems of inequality.

Structural stigma is defined as, “societal level conditions, cultural norms, and institutional policies that constrain the opportunities, resources and well being of the stigmatized (Hatzenbuehler, 2014, p. 2). Here, stigma plays a critical role within an established social structure. ‘Stigma power’ is defined as a resource used in “instances in which stigma processes achieve the aims of stigmatizers with respect to exploitation, management, control or exclusion of others” (Link & Phelan, 2014, p. 24). Similarly, the concept of stigma power is embedded in social structures, as the interests of the stigmatizers are part of a social system through which power is exercised.

Structural stigma and stigma power are terms that formed out of an ongoing critical review of stigma theory. Critique of stigma research has consistently argued that stigma theory is too individually focused (Link & Phelan, 2001; Parker & Aggleton, 2003; Hatzenbuehler & Link 2014). Introduced in the Journal of Social Science and Medicine in 2014, these terms are new and stand as markedly broader

conceptions of stigma than their theoretical precursors. Stigma researchers most often cite Goffman's 1963 work, *Stigma: Notes on the Management of a Spoiled Identity*, in their discussion of stigma theory. Here, Goffman defines stigma as "an attribute that is significantly discrediting" (1963, p. 3). From this popular interpretation, stigma is seen as a static characteristic played out at the individual level. In contrast, recent stigma theory understands stigma as a social process serving the specific interests of the stigmatizer. Stigma operates on both a macro and micro level.

In 2001, sociologists Link and Phelan, followed by Parker and Aggleton in 2003, laid the foundations for the new theories of structural stigma and stigma power by reanalyzing stigma through a sociological perspective. In their 2001 article, Link and Phelan define stigma as the convergence of four interrelated components: labeling human difference, attaching dominant cultural beliefs of negative characteristics to the labeled individuals, a separation of 'us' and 'them', and status loss and discrimination. These four components operate in a system of power; the social production of stigma is contingent upon the interests of social actors who can exercise power. The authors summarize, "Stigma is entirely dependent on social, economic and political power- it takes power to stigmatize" (Link & Phelan, 2001, p. 375).

Working off these theoretical advancements, Parker and Aggleton (2003) situate stigma within a specific cultural and social context. The authors argue that stigma "feeds upon, strengthens and reproduces existing inequalities of class, race, gender and sexuality" (p. 13). Several other authors endorse this conception of stigma as a function of power and control in systems of inequality. In "I Have and Evil Child at My House: Stigma and HIV/AIDS Management in a South African Community," Catherine Campbell et al. (2005) explain, "Various forms of stigma are united by the way in which they serve to support systems of social inequality and social difference and to reinforce the interests of powerful social actors seeking to legitimize their dominant status" (p. 809). Again, the notion of power and stigma play an important role in maintaining social inequalities. Echoing this theory, authors Ngozi Mbonu, Bart van den Borne and Nanne DeVries (2009) explain, "stigma is used by individuals and communities, in cultures where communal life is common, to produce and reproduce inequality" (p. 3).

Lastly, in a later paper (“Dying Twice”), authors Catherine Campbell, Yugi Nair, Sbongile Maimen and Jillian Nicholson (2007) confirm these understandings of stigma, noting, “stigma often serves to legitimize already existing power inequalities—playing what Jost and Banaji (1994) call a ‘system justifying function’” (p. 409). Here, again, stigma is defined as a social process linked to power and existing in structures of social inequality. Michel Foucault’s work on power and knowledge and Pierre Bourdieu’s work on power and culture play fundamental roles in developing this stigma function.

Foucault and Bourdieu’s theories help clarify how systems of power, in place since the formation of the country in 1909, have become entrenched, latent and engrained in South African culture. In this same way, their work shows how mechanisms of stigmatization and discrimination have become deeply rooted systems able to perpetuate through individuals. Foucault’s work focuses on how “regimes of power embedded in different knowledge systems” (Parker & Aggleton, 2003, p. 17) effectively exercise control over individual and social bodies. Supporting this concept, Foucault defines subjectification as “social control exercised not through physical force, but through the production of conforming subjects and docile bodies” (2003, p. 17). In South Africa, the apartheid system was able to produce conforming subjects and docile bodies through the mechanism of intrapersonal stigmatization. Black South Africans conformed to the principals of the apartheid government through internalizing their status as an inferior race.

Complementing this, Bourdieu’s work focuses on how social hierarchies exist and reproduce relatively uncontested and oftentimes without recognition. Bourdieu’s theory of cultural socialization argues that all individuals are competing for shared resources and pursuing their specific interests. Parker and Aggleton apply Bourdieu’s work to stigma theory to construct stigma as a system-justifying function within this process. In the pursuit of specific interests, they note, “Stigma is deployed by concrete and identifiable social actors seeking to legitimize their own dominant status within existing structures of social inequality” (2003, p. 18). Stigma, understood with this frame of knowledge, serves the maintenance of a specific social order through “the production of negatively valued difference” (2003, p. 17). Under apartheid, the South African government created a system that legislated negatively valued difference

between races. Intrapersonal stigmatization among vulnerable populations maintained this social order through the production of confirming subjects.

These prominent theoretical influences help shape the conception of stigma as a social process operating at the structural level, ultimately leading to the development of ‘structural stigma’ and ‘stigma power’ in 2014. In an attempt to provide an inclusive analysis of stigma, the concept of structural stigma demonstrates how stigma operates at *multiple* levels: intrapersonal, interpersonal, and structural. Whereas interpersonal stigma is often overt and more easily measured, structural stigma operates through hidden or “misrecognized” channels. Here, Bourdieu’s theories of symbolic power and misrecognition inform this concept. Bourdieu defines symbolic power as, “the capacity to impose upon others a legitimized vision of the social world and the cleavages within that world” (summarized by Link & Phalen, 2014, p. 25). As a judgment of value and worth, stigma becomes a form of symbolic power. Here, power again plays a vital role, echoing Link & Phelan’s point in their 2001 article, noting, “it takes power to stigmatize” (p.75).

Bourdieu’s theory of symbolic power notes that both the stigmatizers and the stigmatized can misrecognize the execution of symbolic power. As structural processes like discrimination and exclusion are often embedded in the everyday practices of social and cultural life (e.g. through policy, laws, and institutional practices), stigmatization can be indirect or hidden. Further, Link and Phelan describe how the needs of stigmatizers need not even be explicit or upfront. They explain, “From a stigma-power perspective an individual stigmatizer’s interests need not be expressed or even acknowledged as his/her aims are effectively achieved at the macro-level” (2014, p. 25). Here, the authors define stigmatization as a latent function-- a misrecognized, embedded process that contributes to the existence of a system.

Recognizing that stigma operates through multiple and sometimes misrecognized channels, this paper encourages an examination of the structural and intrapersonal pathways of H/A stigmatization. HIV/AIDS in South Africa provides a powerful case study for examining multiple forms of stigmatization. Post-apartheid South Africa is wrought with the scourge of discrimination rooted in South Africa’s political history and manifesting itself today through H/A stigmatization. Discrimination is embedded in today’s ‘new South Africa’, still living under the long shadow of apartheid.

HIV/AIDS in South Africa

South Africa has the third highest national rate of infection in the world, with an estimated 6.1 million people living with HIV/AIDS in South Africa as of 2012 (UNICEF, 2013). An estimated 17.9% of the population between ages 15-49 are living with HIV/AIDS (Central Intelligence Agency, 2014), noting a particularly heavy burden on the most productive members of society. Morbidity among society's most productive members can have grave economic repercussions on social growth and development. This thesis recognizes that the current status of HIV/AIDS in South Africa is due to a confluence of factors. There are many critical forces that increase the vulnerabilities of PLWHA in South Africa that this paper will not be able to address. Some of these include issues of religion, poverty, youth rebellion, sexual intimacy and promiscuity, pathologies of African sex, and competing beliefs of health and medicine ("Dying Twice"). Most notably, South Africa has faced significant political roadblocks in regards to the cultural acceptance of HIV/AIDS and the expansion of prevention and treatment programs. Rather than explicate the range of drivers impacting South Africa's current HIV/AIDS epidemic, this thesis seeks to contextualize current high levels of H/A stigma and offer informed recommendations for reduction interventions.

According to the 2013 Report of the South Africa Reconciliation Barometer Survey, HIV/AIDS was cited as the second leading cause of social division in South African society (Wale p.14). In 2013, this report found that 20.7% of South Africans cite HIV/AIDS discrimination as the foremost cause of social division. Replacing political parties and race as leading factors of societal division, HIV/AIDS stigmatization and subsequent discrimination is taking a remarkable toll on modern South African life (Wale, 2013, p. 14). Summarized by a South African researcher, HIV/AIDS was easily able to pick up where apartheid left off:

"It lay bare and exacerbated the social prejudices, stereotypes, the economic inequalities, discriminatory practices and political injustices which do exist but which tended to be ignored, namely homophobia, racism and puritanism... The coincidence of a new disease in marginalized

communities, in troubled and insecure times during the 1980s, was a recipe for a new wave of prejudice and discrimination” (Grundlingh, 1999, p. 59).

The parallel timing of South Africa’s rising democracy and the advent of HIV/AIDS in South Africa, however, created significant barriers to prevention, advocacy and reduction of stigma. As this paper argues, H/A stigmatization can serve an important identity-protective function by protecting the stigmatizer from vulnerability; on the cusp of a new democracy for South Africa and in the wake of Apartheid, HIV/AIDS threatened to tarnish the image of South Africa’s new democracy. Here, stigma of HIV/AIDS serves to ‘keep people away’ (through avoiding a dangerous virus) but also to ‘keep people down’ by reigniting apartheid-era discriminatory practices. Citing one example, a South African professor explains: “fears of a new social order reactivated racism masquerading as concerns about AIDS in desegregated swimming pools and lavatories” (Grundlingh, 1999, p.59).

The legacy of apartheid in South Africa played a significant role in shaping the course of the HIV/AIDS epidemic through several means. Without strong political support for prevention and treatment efforts, HIV spread quickly throughout the most vulnerable parts of the country. Described in all-encompassing terms:

“There can be no doubt that HIV/AIDS flourishes most in areas that are burdened by racism, unemployment, homelessness, welfare dependency, unhygienic circumstances, prostitution, crime, a high school drop-out rate, social unrest, wide-spread poverty, civil conflict and political violence, migrant labour, poor health status, and particularly the oppression and brutalization of women and children” (Grundlingh, 1999, p. 58).

Looking at Missionvale as a case study, many of these cited issues plague this community. As previously stated, the population of 130,000 reports 70% HIV infection, 75% unemployment and water, electricity and housing scarcities. Though in all settings H/A stigmatization contributes to the disempowerment of PLWHA, in the South African context H/A stigmatization contributes to the disempowerment of the same population that was disempowered under apartheid. According to a 2013 article on HIV prevalence by race in South Africa, the hierarchy of HIV prevalence mirrors the racial hierarchy created under

apartheid. The article states, “In 2004 adult HIV prevalence varied by a factor of 40 between South Africa's racial groups – 0.5%, 1%, 3.2% and 19.9% in 15–49 year old whites, Indians, coloureds and blacks respectively” (Kenyon et al., 2013, p.1). Therefore, black South Africans are increasingly vulnerable to self-stigma through the dual identities of race and potential HIV status.

South Africa exhibits high levels of H/A stigmatization. Described by Justice Edwin Cameron, the first public official to come out as HIV positive in the country, stigma is one of the most powerful afflictions of the virus. “For stigma – a social brand that marks disgrace, humiliation and rejection – remains the most ineluctable, indefinable, intractable problem in the epidemic. Stigma is perhaps the greatest dread of those who live with AIDS and HIV – greater to many even than the fear of a disfiguring, agonizing and protracted death” (2005, p. 53). H/A stigma affects a patient both externally and internally. Externally, the effects of stigma can alter a patient’s ability to access care, establish a support system at home or in a local community, or find employment. Shame, blame, fear and self-loathing are few among many internal manifestations of stigma.

Rather than the physical effects of the virus or examples of interpersonal discrimination, Cameron points to the intrapersonal manifestations of stigma as the most potent effects of the virus. This assertion becomes a central thread throughout his book, noting, “Stigma’s irrational force springs not only from the prejudiced, bigoted, fearful reactions others have to AIDS- it lies in the fears and self-loathing, the self-undermining and ultimately self-destructing inner sense of self-blame that all too many people with AIDS or HIV experience themselves” (2005, p.53), and later, “the most intractable element of stigma is the disfiguring sense of shame that emanates from the internal world of some with HIV or AIDS. This sense colludes with external stigma, overcoming efforts to deal with the disease rationally, keeping those with AIDS or HIV in involuntary self-imposed isolation, casting a pall of contamination and silence over the disease” (2005, p.70). From these admissions, Cameron expresses the painful consequences of internalizing the stereotypes associated with being HIV positive. Here, critical parallels emerge between intrapersonal stigma among black South Africans and among PLHA.

Social, cultural and economic contexts are critical contributing factors to the prevalence of H/A stigmatization in South Africa. According to a 2005 study on H/A stigma from the Ekuthuleni community in the KwaZulu-Natal province, stigma can serve as a symbolic resource. Symbolic context, described as “the wider field of social representations within which stigma is located” (Campbell et al., 2005, p. 812), frames stigmatization as a symbolic resource; without access to material resources, stigmatization becomes a vehicle to boost self-esteem (Campbell et al. 2005; Campbell et al., 2007). Here, H/A stigma becomes “a way of asserting claims to respectability” (Campbell et al., 2005, p. 815). Further, according to a 2009 literature review on H/A stigma in Sub-Saharan Africa, this process of establishing and discriminating against an inferior “other” through H/A stigmatization serves a structural function as well. The authors explain, “Because PLWHA are labeled as the “other” by the community, people try to secure the social structure, safety and solidarity by casting out offenders or reaffirming social values” (Ngozi, 2009, p. 4). Again, a consideration of the South African context helps explain this tendency. In South Africa, many populations exhibit high levels of community life. Exacerbated by conditions of poverty, this interplay of social factors leads to increased stigmatization (Campbell et al., 2005; Campbell et al., 2007; Mahajan et al., 2008). Summarizing the observations of Orr and Patient (2003), non-productive members of a society characterized by conditions of poverty are often rejected from community life (Campbell et al 2007, p. 412). In the South African context, stigmatization serves to maintain social order, control and conformity.

According to a 2007 study on community responses to H/A stigma, the sources of stigma are abundant and include family members, community members, neighbors, health workers, teachers and religious group members (Campbell et al., 2007, p. 406). As H/A stigmatization is generated through a multitude of sources, similar to the pervasiveness of race during apartheid, stigma is persistent in many areas of South African life and culture. Citing examples from this study, due to the highly stigmatized nature of HIV/AIDS family members often denied an HIV/AIDS diagnosis within the family, limited a family members access to care, or disowned relatives who had died from the virus. Findings of a national HIV/AIDS household survey in South Africa in 2005 corroborate these findings as “29% of South

African stated that they would not buy food from a vendor who has HIV” and, “41% felt that people with HIV/AIDS should expect to have restrictions placed on their freedom” (Simbayi, 2007, p.2). Described as, “rooted within individual psyches of families and communities” (Campbell et al., 2005, p. 809), H/A stigma is deeply engrained in current South African society.

Illustrated in this research, H/A stigma in South Africa operates on multiple levels: intrapersonal, interpersonal and structural. In the same way that being classified as ‘black’ under Apartheid created powerful social ramifications throughout all areas of life, the label ‘HIV+’, carries significant social consequences. H/A stigmatization allows for the creation of a sub-standard “other” by charging the HIV/AIDS label with connotations of inferiority and immorality. As discussed, historical, cultural and economic forces heavily influence H/A stigmatization in South Africa. In areas without access to material resources, stigmatization becomes a vehicle to boost self-esteem and assert claims to respectability (Campbell et al. 2005; Campbell et al., 2007). In tight-knit communities, stigmatization serves a structural function by excluding nonproductive members of society. Here, H/A stigmatization becomes a resource for the exploitation, control or exclusion of others within a system of power. With the modern conception of stigma as a power-driven structural process operating in a system of inequality (Parker & Aggleton, 2003, Campbell et al., 2007), this research illustrates how intrapersonal stigma serves to effectively ‘keep people down’ (Phelan et al., 2008). Though stigma operates on structural, interpersonal and intrapersonal levels, current HIV stigma reduction interventions focus almost exclusively on interpersonal level interventions. Next, this thesis will review current H/A stigma interventions to highlight critical gaps in this research. Drawing from recent mental health research, this thesis encourages an examination of the structural and interpersonal processes through which H/A stigma operates with the hope of improving stigma interventions beyond the individual level.

Self-Stigma Interventions

The majority of current H/A stigmatization reduction interventions target stigma operating at the interpersonal levels. In a 2011 systematic review of 19 studies of HIV/AIDS intervention, not a single study measured internal stigma. Contrastingly, all 19 studies measured attitudes towards PLWHA

(Sengupta et al., 2011). In a 2001 study of 30 stigma reduction interventions, of the 21 studies explicitly focusing on reducing H/A stigma, only two studies targeted at-risk and infected individuals. Four studies targeted a combination of at-risk, infected, and general individuals. The remaining 15 studies, aimed to “increase tolerance of PLHA among different segments or proxies of the general population” (Brown et al., 2001, p. 8). Notably, of the nine non-HIV/AIDS stigma reduction interventions, eight studies focused on the stigma of mental illness. Only one intervention “attempted to reduce perceptions of stigma among affected individuals, rather than reducing stigma toward affected persons” (2001, p.13). However, one author of this study, Bruce G Link, is a distinguished stigma researcher and advocate of expanding stigma interventions beyond the individual level (See: Link & Phalen, 2001, Link & Phalen, 2014 Phelan, Phalen, Link & Dovidio, 2008).

Findings from a systematic review of H/A stigma interventions from 2003-2013 showed a similar pattern. Reviewing 48 H/A interventions in 28 countries, the authors found that only two studies considered intrapersonal level interventions. Unsurprisingly, the most common intervention was at the interpersonal level. This review worked off of the first global review of H/A interventions conducted in 2003. Again, of the 22 studies reviewed then, only two studies targeted PLWHA coping strategies. The remaining studies targeted general perception and tolerance (Stangl et al., 2013).

This assessment will not report on the effectiveness of these interventions and instead seeks to reveal gaps in stigma intervention research. Though stigma operates on structural, interpersonal and intrapersonal levels, current HIV stigma reduction interventions focus almost exclusively on the interpersonal level interactions. This thesis argues that self-stigmatization can result in a negative self-concept with severe implications on an individual’s psyche and the productivity of an entire population. Therefore, this thesis encourages incorporating research from self-esteem interventions employed in mental health studies to address internal, as well as external, stigmatization.

Self-Stigma in Mental Illness Research

A growing body of literature, mostly in psychiatric studies, seeks to explicate the relationship between self-stigma and self-esteem. This mental health research provides a strong definition of self-

stigma and suggests interventions that may be applicable for H/A stigma reduction studies. In mental health research, self-stigma is first critically separated into public and self-stigma. While public stigma deals with stereotypes, prejudice, and discrimination, self-stigma occurs when people internalize stereotypes and “experience a loss of self-esteem and self-efficacy” (Corrigan et al., 2009, p. 75). Consistent with conclusions from this research on a negative self-concept from social identity theory, Corrigan et al. outline the damaging effects of demoralization resulting from intrapersonal stigmatization. On an individual level, self-stigma yields a “why try” response that effects motivation and self worth. On a larger scale, low self-efficacy can greatly impact productivity as work and living pursuits are hindered as well (Corrigan et al., 2009, p. 76).

Differentiating between self-stigma and perceived stigma, Patrick W. Corrigan et al. (2006) define self-stigma as a three-step model: “Stereotype agreement, self-concurrence, and self-esteem decrement” (p.875). In their research on self-stigma and implications for self-esteem, Corrigan et al. found a statistically significant association between stereotype agreement and self-concurrence and self-esteem decrement. These findings confirm the mechanism of self-stigma on PLHA discussed in this paper. As many black South Africans came to accept the discriminatory identity established under apartheid, PLHA can agree with public stereotypes and internalize them. Lastly, this research advocates self-empowerment to negate the damaging effects of self-stigma (Corrigan, 2012), echoing Black Consciousness efforts to empower black South Africans under apartheid by reinvigorating black identity.

Here, mental health research stands at the forefront of self-stigma research. Unlike current H/A stigma research, the mechanism of intrapersonal stigma is inextricably tied to stigma theory and to stigma reduction interventions in many mental health studies. Through the explication of intrapersonal stigmatization among PLHA in South Africa, this thesis illustrates how stigma operates through the same mechanisms for PLHA as described in research with people living with mental illnesses. Therefore, I encourage the application of current self-stigma theory in mental health research for H/A stigma intervention work.

The current body of literature on self-stigma reduction interventions is new and has several limitations. Across the board, measuring stigma and the effectiveness of interventions to reduce stigma is quite difficult. Intrapersonal stigma in particular, as a notably under-researched mechanism of stigma, is increasingly difficult to quantify and analyze. In empirical research, stigma is measured most frequently through survey measures and scales. However, as this thesis illustrates, there are several forms of stigma and each requires unique scales of measurement (Ward, 2014). For example, the Rosenberg Self-Esteem Scale is a useful tool in self-stigma reduction interventions, but may not apply to perceived stigma or interpersonal stigma reduction strategy. As this body of research is relatively new, appropriate scales are not always implemented in stigma reduction interventions. Data from a 2010 review of current stigma measurements by Brohan et al. found that relevant measurement tools are not always available in research studies. The authors describe, “Across the 57 papers identified as focusing on these three aspects of stigma, only 14 different scales were used to assess the three types of stigma, and some of these scales did not meet acceptable scores for internal consistency or test-retest reliability” (Ward, 2014, n.p). Without the ability to appropriately measure stigma, there are limitations to current research on self-stigma reduction interventions. Future research may consider alternative measures for stigma, for example, “qualitative data and implicit measures” (Ward, 2014, n.p.), to complement survey and scale measurements.

Through research on self-stigma reduction intervention in mental health is fairly new and has some limitations, several key findings emerge from existing empirical studies. According to a narrative literature review on self-stigma interventions in 2014, authored by Yanos et al., there are six central intervention approaches: healthy self-concept, self-stigma reduction program, ending self-stigma, narrative enhancement, coming out proud and anti-stigma photo-voice intervention. The majority of these interventions are group interventions led by professionals with the primary mean of action being psychological education and cognitive restructuring. Size and frequency of group interventions varied. Other strategies included an emphasis on narration to create meaning out of experiences with stigma and behavioral decision making tactics. Regardless of the specific intervention used, self-stigma reduction

interventions shared the same goals, described as to “increase self-esteem, hope and self-efficacy (which have all been consistently found to be inversely associated with self-stigma) and decrease social avoidance” (Yanos et al., 2014, p. 2).

Earlier analyses share similar conclusions. According to a critical literature review from 2012, looking specifically at interventions to improve self-stigma, (Mittal et al., p. 974), combining attitude/belief adjustment interventions with coping mechanisms most effectively reduced self-stigma. This literature review examined 14 articles and found that eight reported improvements in self-stigma. Overall, the authors identified six interventions to reduce self-stigma, with the most frequent interventions being psychoeducation or psychoeducation combined with cognitive restructuring. In their analysis, the authors critically differentiated between two approaches. The first approach sought to change stigmatizing beliefs and attitudes while the second, supported by several stigma researchers from their review, focused more specifically on cognitive restructuring and coping skills. The authors describe this second form of interventions as, “interventions that encourage participants to accept the existence of stigmatizing stereotypes without challenging them and that enhance stigma- coping skills through improvements in self-esteem, empowerment, and help- seeking behavior” (Mittal et al., 2012, p. 979). This critical review concludes by recommending cognitive restructuring in stigma reduction approaches.

At present, there are only a small handful of researchers working to develop self-stigma reduction interventions. Therefore, much of this research is cyclical and works off of the same data: “Most of the current work is done by the same researchers and data is simply replicated to give the guise of progression” (Ward, 2014). However, there are several indications that this field is expanding fruitfully. According to a 2014 review of interventions targeting mental health stigma, the authors conclude that progress is being made to close gaps in self-stigma research. Comparing their findings to a 2012 review of empirical studies of self-stigma strategies, the authors describe notable advancements in intervention tools. “The rapid growth in the development of interventions targeting self-stigma is reflected by the fact that a recently published review of internalized stigma treatment approaches excluded three newer approaches that are discussed in the current review” (Yanos et al., 2014, p. 1). And later, “Our review of

published interventions designed to reduce self-stigma reveals a notable increase in the development, implementation and investigation of such interventions in the decade since the publication of initial papers focusing on self-stigma measurement, prevalence and impact” (p.7). In sum, research on intrapersonal stigma reduction interventions is advancing.

This thesis advocates for a structural level intervention targeting stigma operating at the intrapersonal level. The Black Consciousness movement specifically looked at the impact of identity assumptions on the psychological well being of black South Africans and sought to garner large-scale support for opposition efforts. As an intervention effort, the Black Consciousness movement provides a model for a structural level intervention, using the momentum, resources, energy and infrastructure of a social movement, to effect change at the intrapersonal level. I contend that current self-stigma research in mental health helps to explicate the psychological mechanism of intrapersonal stigma and provides a resource for intervention efforts beyond the interpersonal level.

Conclusion

Recognizing the profound impact of political, social, cultural and geographic history on a country’s present conditions, this thesis contextualizes current high levels of HIV/AIDS stigmatization by applying a structural functionalist perspective to the study of stigmatization. I argue that the latent function of apartheid was to institutionalize the politically and socially constructed identity of ‘black’ South Africans into South African psyche. Classified as an inferior, devalued and base race, and persistently confronted by the poor conditions and demeaning stereotypes associated with their racial classification, many black South Africans internalized this racial identity and developed a negative self-concept. I hold that the centrality of identity to stigma and to apartheid leaves people living with HIV/AIDS in South Africa increasingly vulnerable to stigmatization, discrimination, and psychological impairment through the development of a negative self-concept. Further, as this thesis shows, the experience of health and illness is beyond simply biological. Political, cultural, historical, demographic and social forces heavily affect the experience of living with HIV/AIDS in post-Apartheid South Africa. Addressing the current challenge of HIV/AIDS in South Africa requires an interdisciplinary approach.

This paper encourages recognition of the structural and intrapersonal processes through which H/A stigma operates with the hope of improving stigma interventions beyond the interpersonal level. Acknowledging that this research is still growing and interventions are not fully formulated, mental health literature has important implications for H/A stigma research. As several parallels exist between the research on intrapersonal stigma among people living with a mental illness and among PLHA, I argue that leaders in stigma intervention should work off of the advances in mental health self-stigma reduction research to expand current H/A stigma interventions.

There are several questions that remain unanswered in this research. Stigmatization is deeply engrained in South African culture and reducing current H/A stigmatization demands reduction efforts through all levels on which stigma operates. Though this research focuses on improving H/A stigma interventions on an intrapersonal level, I recognize that structural changes must accompany interventions around empowerment and self-concept. The responsibility to effect positive change does not solely rest upon PLHA, and efforts to change a deeply engrained system of discrimination and identity in South Africa will be challenging. Though intrapersonal stigma is a psychological phenomenon, I believe that a structural level intervention is necessary to garner the support and infrastructure for large-scale social change. Further, though the Black Consciousness Movement had several polarizing facets, I believe that its ideology of overturning the oppression of black identity to reinvigorate African identity and pride is important for studying the issue of HIV/AIDS in South Africa. I believe that a similarly structured approach that garners support on a structural level for an intrapersonal phenomenon could reform the identity of being HIV positive. I am hopeful for the future of H/A stigma intervention research and believe that this thesis can help to further advancements in the field.

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