

1-1-1994

## The effects of an eight-hour affective education program on fear of Aids and homophobia in student nurses

Frances Allen Brown  
*University of Nevada, Las Vegas*

Follow this and additional works at: <https://digitalscholarship.unlv.edu/rtds>

---

### Repository Citation

Brown, Frances Allen, "The effects of an eight-hour affective education program on fear of Aids and homophobia in student nurses" (1994). *UNLV Retrospective Theses & Dissertations*. 403.  
<http://dx.doi.org/10.25669/pfjb-2zk9>

This Thesis is protected by copyright and/or related rights. It has been brought to you by Digital Scholarship@UNLV with permission from the rights-holder(s). You are free to use this Thesis in any way that is permitted by the copyright and related rights legislation that applies to your use. For other uses you need to obtain permission from the rights-holder(s) directly, unless additional rights are indicated by a Creative Commons license in the record and/or on the work itself.

This Thesis has been accepted for inclusion in UNLV Retrospective Theses & Dissertations by an authorized administrator of Digital Scholarship@UNLV. For more information, please contact [digitalscholarship@unlv.edu](mailto:digitalscholarship@unlv.edu).

## **INFORMATION TO USERS**

**This manuscript has been reproduced from the microfilm master. UMI films the text directly from the original or copy submitted. Thus, some thesis and dissertation copies are in typewriter face, while others may be from any type of computer printer.**

**The quality of this reproduction is dependent upon the quality of the copy submitted. Broken or indistinct print, colored or poor quality illustrations and photographs, print bleedthrough, substandard margins, and improper alignment can adversely affect reproduction.**

**In the unlikely event that the author did not send UMI a complete manuscript and there are missing pages, these will be noted. Also, if unauthorized copyright material had to be removed, a note will indicate the deletion.**

**Oversize materials (e.g., maps, drawings, charts) are reproduced by sectioning the original, beginning at the upper left-hand corner and continuing from left to right in equal sections with small overlaps. Each original is also photographed in one exposure and is included in reduced form at the back of the book.**

**Photographs included in the original manuscript have been reproduced xerographically in this copy. Higher quality 6" x 9" black and white photographic prints are available for any photographs or illustrations appearing in this copy for an additional charge. Contact UMI directly to order.**

# **UMI**

A Bell & Howell Information Company  
300 North Zeeb Road, Ann Arbor, MI 48106-1346 USA  
313/761-4700 800/521-0600



THE EFFECTS OF AN EIGHT-HOUR AFFECTIVE EDUCATION  
PROGRAM ON FEAR OF AIDS AND HOMOPHOBIA  
IN STUDENT NURSES

by

Frances Allen Brown

A thesis submitted in partial fulfillment of the  
requirements for the degree of

Master of Science

in

Nursing

Department of Nursing  
University of Nevada, Las Vegas  
December 1994

**UMI Number: 1361079**

---

**UMI Microform Edition 1361079**  
**Copyright 1995, by UMI Company. All rights reserved.**

**This microform edition is protected against unauthorized  
copying under Title 17, United States Code.**

---

**UMI**  
**300 North Zeeb Road**  
**Ann Arbor, MI 48103**

© 1994 Frances Allen Brown  
All Rights Reserved

## APPROVAL

The Thesis of Frances Allen Brown for the degree of Master of Science in Nursing is approved.

Vicky Carwein Aug. 29, 1994  
Chairperson, Vicky Carwein, D. N. S.

Margaret Louis Aug 29, 1994  
Examining Committee Member, Margaret Louis, Ph. D.

Rosemary Witt Aug 29, 1994  
Examining Committee Member, Rosemary Witt, Ph. D.

David E Berry Aug 29, 1994  
Graduate Faculty Representative, David Berry, Dr. P. H.

RHWS  
Dean of the Graduate College, Ronald Smith, Ph. D.

University of Nevada, Las Vegas  
December, 1994

## ABSTRACT

Research was conducted to determine the relationship between fear of AIDS and homophobia, and to determine the effects of an eight-hour affective education program in reducing homophobia and fear of AIDS in associate degree nursing students ( $n = 22$ ). The Neuman Systems Model guided the study and a portion of Bandura's social learning theory provided the framework for the education intervention.

A quasi-experimental time-series design (pretest/posttest I/posttest II) with a control group was used. Instruments to measure homophobia and fear of AIDS were the Homophobia Scale and the Fear of AIDS Scale developed by Bouton and colleagues (1987).

Within group comparisons of fear of AIDS and homophobia were made utilizing Pearson  $r$ . There was no statistically significant correlation found between measures of homophobia and fear of AIDS. To determine the effects of an eight-hour affective education program on homophobia and fear of AIDS, paired  $t$ -tests were computed. There was no statistically significant decrease of homophobia or fear of AIDS in the experimental group ( $n = 11$ ) or the control group ( $n = 11$ ). The hypothesis was that homophobia and fear of AIDS would be decreased in the experimental group as a result of the affective education program. Instead, the experimental group actually had an increase in homophobia and fear of AIDS.

## TABLE OF CONTENTS

	Page
ABSTRACT.....	iii
ACKNOWLEDGEMENTS.....	viii
CHAPTER 1 INTRODUCTION.....	1
Purpose of the Study.....	4
Theoretical Framework.....	4
Hypotheses.....	10
Definition of Terms.....	10
Significance of the Study.....	12
Limitations of the Study.....	14
CHAPTER 2 REVIEW OF RELATED LITERATURE.....	15
The AIDS Epidemic.....	15
The AIDS Epidemic and Nursing.....	17
Risks to Health Care Professionals.....	19
Knowledge and Attitudes Related to AIDS.....	21
Homophobia.....	32
Affective Education.....	61
Summary.....	75
CHAPTER 3 METHODOLOGY.....	77
Population.....	77
Sample.....	77
Design.....	78
Educational Intervention.....	79
Data Collection.....	81
Tools.....	82
CHAPTER 4 FINDINGS AND DISCUSSION.....	89
Description of the Sample.....	89
Fear of AIDS Scale Scores.....	100
Homophobia Scale Scores.....	101
Hypothesis 1.....	103
Hypothesis 2.....	105
Hypothesis 3.....	107
Hypothesis 4.....	109
Other Findings.....	112

CHAPTER 5 SUMMARY, CONCLUSIONS, RECOMMENDATIONS.....	116
Relationship of Fear of AIDS and Homophobia. ....	117
Findings Related to the Affective Education Program. ....	118
Findings Related to the Theoretical Framework. ....	120
Recommendations. ....	121
APPENDIX A APPROVAL: HUMAN SUBJECTS' RIGHTS APPROVAL, SOCIAL BEHAVIORAL SUBCOMMITTEE OF THE INSTITUTIONAL REVIEW BOARD, UNIVERSITY OF NEVADA, LAS VEGAS. ....	123
APPENDIX B COVER LETTER/CONSENT FORM. ....	125
APPENDIX C DEMOGRAPHIC DATA SHEET, FEAR OF AIDS SCALE, HOMOPHOBIA SCALE. ....	129
APPENDIX D PERMISSION TO USE FEAR OF AIDS SCALE AND HOMOPHOBIA SCALE. ....	135
APPENDIX E AFFECTIVE EDUCATION COURSE. ....	137
APPENDIX F CONTROL GROUP COURSE. ....	152
BIBLIOGRAPHY. ....	163

## LIST OF TABLES

Table	Page
1. Frequency Distributions for Experimental and Control Groups by Age (Experimental Group n = 11, Control Group n = 11) . . . . .	91
2. Frequency Distributions for Experimental and Control Groups by Gender (Experimental Group n = 11, Control Group n = 11) . . . . .	92
3. Frequency Distributions for Experimental and Control Groups by Marital Status (Experimental Group n = 11, Control Group n = 11) . . . .	93
4. Frequency Distributions for Experimental and Control Groups by Ethnicity (Experimental Group n = 11, Control Group n = 11) . . . . .	94
5. Frequency Distributions for Experimental (n = 11) and Control (n = 11) Groups by Religion and Attendance at Religious Functions . . . . .	95
6. Frequency Distributions for Experimental (n = 11) and Control (n = 11) Groups by Having a Friend or Close Family Member with HIV/AIDS . . . . .	96
7. Frequency Distributions for Experimental (n = 11) and Control (n = 11) Groups by Number of HIV/AIDS Patients Cared For . . . . .	97
8. Frequency Distributions for Experimental (n = 11) and Control (n = 11) Groups by Number of Homosexuals Known in Lifetime . . . . .	98
9. Frequency Distributions for Experimental (n = 11) and Control (n = 11) Groups by the Number of Homosexuals Presently Known . . . .	99
10. Ranges, Means, and Standard Deviations for Pre and Post Test Scores on Fear of AIDS for Experimental and Control Groups . . . . .	101
11. Ranges, Means, and Standard Deviations for Pre and Post Test Scores on Homophobia for Experimental and Control Groups . . . . .	102

12.	Pearson Correlation Coefficients for the Control Group (n = 11) and Experimental Group (n = 11) on Pretest, Posttest I, and Posttest II Total Scores Between Measures of Homophobia and Fear of AIDS . .	104
13.	Paired T-Tests for Pretest and Posttests on Homophobia for Experimental Group (n = 11) . . . . .	106
14.	Paired T-Tests for Pretests and Posttests on Fear of AIDS for Experimental Group (n = 11) . . . . .	108
15.	Paired T-Tests for Pretests and Posttests on Fear of AIDS for Control Group (n = 11) . . . . .	110
16.	Paired T-Tests for Pretests and Posttests on Homophobia for Control Group (n = 11) . . . . .	111

## ACKNOWLEDGEMENTS

I would like to express my sincere appreciation to Dr. Vicky Carwein, my committee chair. Through her expert guidance and knowledge, this thesis finally became a reality. In addition, I want to thank Dr. Margaret Louis for her research expertise and patience as I struggled with data analyses. Dr. Rosemary Witt assisted me in getting to the point when I wanted to say too much, and for that I thank her. Dr. David Berry's expertise on AIDS research was a tremendous asset for which I am most appreciative. I appreciate all the committee members' work in helping me achieve a most rewarding goal.

I also want to thank Dr. Robert Young and his colleagues at the University of Texas at Austin for granting me permission to utilize the Fear of AIDS Scale and the Homophobia Scale for my data collection.

I want to thank Dr. John Berg for his support and encouragement as I struggled to find the time to complete this thesis. Without his patience and support, I would have found the process much more difficult.

My thanks to my Husband, Jack, for his support over the years that I have been completing this thesis.

## Chapter 1

### INTRODUCTION

There were 339,250 cases of AIDS diagnosed in the United States and 1,764 cases diagnosed in Nevada by the end of December, 1993. There were a total of 165 HIV infections (down from 229 during the Fourth Quarter of 1993) reported to the Clark County Health District during the First Quarter of 1994 (Clark County Health District, April 20, 1994). Health care providers in all practice settings and in all areas of the country will encounter persons with HIV and AIDS (Carwein & Berry, 1991). Nurses, according to Feinblum (1986), have a dramatic effect on the experiences that persons with AIDS have with their illness. The social stigma associated with the sexual connotation of HIV may lead to inferior care unless nurses are educated about homosexuality. Nurses in Nevada will be caring for AIDS patients, many of whom are homosexual. In the United States, AIDS was originally associated with homosexual men, however, in 1994 the fastest growing group to become HIV infected is heterosexual (Carwein & Sabo, 1994). It has been difficult to change the association of the disease with homosexuality. Flaskerud, Lewis, and Shin (1989) stated that the combination of lack of knowledge of HIV and negative attitudes leads to "less than optimal care."

For centuries nurses have provided care for the ill regardless of the health problem or personal attributes, but AIDS challenges that basic professional ethic (Moriarty, 1988). Why are some nurses refusing to provide

care for patients with AIDS when they did not refuse to care for patients with other fatal diseases like smallpox, influenza, tuberculosis, and polio (Moriarty, 1988)? The links between HIV infection and sex, drug use, and birthing involves the most private areas in one's life, so there is value judgement associated with AIDS (Moriarty, 1988).

According to Huerta & Oddi (1992), the devastating effects of AIDS are not confined to individual patients and their families but impact health care workers as well. Nurses harbor significant concerns about their own safety, experience moral conflict, or believe they have the right to refuse to care for HIV infected patients (Huerta & Oddi, 1988). Traditionally nurses have accepted that caring for the sick carries some degree of risk. The benefit to the patient versus significant personal risk is one criterion used to determine duty to provide care. The AIDS problem will not diminish or be eliminated anytime soon and neither will the dilemmas or ethical issues surrounding AIDS care.

The American Nurses' Association (ANA, 1988) has taken the position that increased personal risk or a moral conflict concerning a specific procedure are the only acceptable reasons for refusal to provide care. Prejudice is never an acceptable reason for refusal of care (ANA, 1988). Fear alone cannot justify refusal to provide care, according to Jecker (1990). Therefore, nurses are ethically obligated to provide care to HIV/AIDS patients unless there is significant personal risk. Various factors have been identified which influence nurses' refusal to provide care. The most frequently mentioned are nurses' fear of contagion and their disapproval of patients' lifestyles (Huerta & Oddi, 1992). The association of HIV/AIDS with particular high risk groups such as homosexuals may compound the fear of providing nursing care.

According to Meisenhelder & La Charite (1989), the roots of fear of

contagion lie in the deeply embedded social and cultural values that mold one's perception of illness rather than the scientific evidence of AIDS. Sontag (1978) described the symbolic meaning of illness and identified three elements that add to the perception of the contagiousness of an illness: mystery, death and punishment. A disease that is less understood triggers more fear than an equally deadly but understood illness, so the more mysterious a disease the more contagious it is believed to be (Meisenhelder & La Charite, 1989).

AIDS also symbolizes death, the most feared and unacceptable of human conditions. Death may add the connotation of punishment. The meaning of death becomes moralistic and often is perceived as "just" punishment. People with AIDS endure conviction for irresponsible sinful behavior as well as rejection, an extreme example of blaming the victim (Meisenhelder & La Charite, 1989). By attributing HIV infection to socially unacceptable behavior, one may feel less vulnerable. Fear of contagion comes from both the threat of the serious illness and the social stigma of its label. People fear the cultural rejection this diagnosis implies even more than they fear physical harm. AIDS is a metaphor for the abhorred, and with that symbolic meaning comes a greater affective stress response of fear of contagion (Meisenhelder & La Charite, 1989).

Current medical protocols for the treatment of AIDS are palliative, so the real need of the patient is for the nursing interventions of understanding, support, and comfort measures (Huerta & Oddi, 1992). These are basic nursing skills. Nurses cannot ignore people in need of care (ANA, 1988) and must work together to meet the challenge of the HIV/AIDS epidemic.

### Purpose of the Study

The purpose of this study was threefold: 1) to assess the level of fear of AIDS and homophobia in associate degree nursing students, 2) to investigate the relationship between fear of AIDS and homophobia in the sample, and 3) to examine the effectiveness of an affective educational program in reducing homophobia and fear of AIDS. By understanding and dealing with nurses' values, such a program would reduce homophobia. As a result of reducing homophobia, the fear of AIDS would also be reduced. The specific purposes of the researcher were to design and implement an affective educational program for associate degree nursing students to determine if such a program would reduce homophobia and fear of AIDS.

The questions this study attempted to answer are:

1. Is there a relationship between homophobia and fear of AIDS in associate degree nursing students?
2. Will an affective education program decrease homophobia in associate degree nursing students?
3. Will an affective education program decrease the fear of AIDS in associate degree nursing students?

### Theoretical Framework

The Neuman Systems Model, a nursing model based on General Systems Theory, was the model that guided this study. Whether looking at the profession of nursing, the nurse, or the client, the systems approach applies. Neuman proposed prevention as intervention with the modes of intervention structured within primary, secondary, and tertiary prevention. Client

system stability is attained and maintained through the integrative processes facilitated by the three modes of prevention. The purpose, hypotheses, significance and interventions of the current study are organized within the framework of the primary prevention mode of intervention of the Neuman Systems Model (1989).

The Neuman Systems Model is an open systems approach and is based on the concepts of stress and the reaction to stress (Neuman, 1989). Nursing is concerned about all the variables affecting a client's potential or actual responses to stressors. Stressors are tension-producing stimuli occurring within both the internal and external environment of the client that have the potential to cause disequilibrium. The Neuman Model provides a focus for approaching a wide range of nursing concerns and for understanding the client and the environment (Neuman, 1989).

Environmental stressors are classified as intrapersonal, interpersonal, and extrapersonal. Stressors differ as to their potential for disturbing the client's usual wellness/stability level, or the client's normal line of defense. Intrapersonal stressors refer to forces occurring within the client boundary, such as the autoimmune response. Interpersonal stressors refer to forces occurring outside the boundary of the client between one or more persons, such as communication patterns. Extrapersonal stressors are those forces occurring outside the client's boundary at a distal range, such as financial concerns.

Within Neuman's theory there are five interacting client variables, physiological, psychological, sociocultural, developmental, and spiritual that function in relation to the influence of internal and external stressors. These variables can, as they interrelate, affect the degree to which a client is protected by a flexible line of defense against a stressor or stressors. The flexible line of

defense acts as a protective buffer system for the client's stable state (Neuman, 1989). Certain stressors or multiple stressors have the potential for reducing the effectiveness of the flexible line of defense and may impact the normal line of defense. When the normal line of defense is penetrated, the client presents with symptoms of instability or illness. The normal line of defense surrounds lines of resistance which are activated upon invasion of the normal line of defense. These lines of resistance contain factors that protect the client system integrity. The person has a central core or basic structure of survival factors such as temperature range, ego structures, etc. which are protected by the flexible line of defense (Neuman, 1989).

Potential reactions to intrapersonal, interpersonal, and extrapersonal stressors may be mitigated through the intervention of prevention (Neuman, 1989). The flexible line of defense can be strengthened by early intervention, reducing the magnitude of the reaction. Primary, secondary, and tertiary prevention are the three levels of early intervention, or prevention in the Neuman model.

Primary prevention is the identification and reduction of possible risk factors to strengthen the flexible line of defense. Primary prevention focuses on need determination, goal identification, and education and other supportive interventions. Potential reactions from stressors can be prevented through timely appropriate primary interventions. Secondary prevention relates to symptomatology, ranking intervention priorities, and treatment. Tertiary prevention refers to the actions and resources to stabilize the client following treatment (Neuman, 1989).

When caring for clients with HIV/AIDS, the nurse faces major stress-producing forces either intrapersonally, interpersonally, or

extrapersonally. Society's stigmatizing of persons with AIDS and their caregivers are major stressors. These environmental stressors related to the illness create anxieties and fears in the nurse. HIV threatens the stability and equilibrium of the individual nurse, client, a family, or the community. This stigma-induced stress in the nurse can be mitigated by affective education as primary prevention.

Interpersonal stressors may be evident in the distancing behaviors nurses may demonstrate. Nurses may be uncomfortable about being around persons with different lifestyles, being near clients who are dying, and/or relating to clients' families and significant others. If a nurse has had little interpersonal contact or has negative beliefs about a person's lifestyle choice, it may be stressful to care for HIV-positive clients. Open communication may be diminished, leaving the client to feel abandoned and the nurse feeling inadequate.

Intrapersonal stressors may be partly expressed in the nurse's own belief system about persons infected with HIV. Since the nurse lives and works in a homophobic society, he/she may have some homophobic beliefs that lead to fear of patients who are infected with HIV. There may be issues related to death and dying that the nurse faces, since AIDS at this time is invariably fatal. There may be feelings of hopelessness and helplessness that threaten the stability of the nurse. There may be fears related to distrust of public health officials' reports on transmissibility.

It was postulated that a focus on primary prevention aimed at increasing the strength of a nurse's flexible line of defense as it relates to homophobia and fear of AIDS would better prepare the nurse to effectively manage the care of clients who have HIV/AIDS. By expanding the nurse's awareness and

acceptance of homosexuality as an alternative lifestyle rather than a sickness or moral weakness, providing a supportive learning environment, and promoting reflection on the humanness of gay individuals, the nurse's flexible line of defense will be augmented and strengthened. The greater the expansiveness of the flexible line of defense from the normal line of defense, the greater the protectiveness (Neuman, 1989). Therefore, an eight-hour education course on homosexuality, utilizing the affective domain, presented in a humanistic manner allowing for open sharing was implemented.

The course for the experimental group consisted of mini-lectures addressing attitudes toward homosexuality, common myths and beliefs related to homosexuality and research into the causes. Experiential exercises were planned throughout the course to assist the participants in internalizing the content. There was no planned content regarding HIV/AIDS or fear of AIDS. It was the position of the researcher that there would be a reduction in negative attitudes toward homosexuality as a result of participation in the course.

The course for the control group consisted of mini-lectures addressing attitudes toward assisted suicide/euthanasia and discussions of landmark court cases. Experiential exercises were planned throughout the course to assist the participants in internalizing the content. The content of the course for the control group was chosen for its current relevance in today's society and because it, like issues surrounding the AIDS epidemic, is controversial.

A portion of Bandura's (1969) social learning theory provided the framework for the education intervention in both the experimental and the control group. Strategies of attitude change is the portion the researcher utilized. There are three general approaches to induce attitudinal change, according to Bandura (1969). These are: belief-oriented approach,

affect-oriented approach, and behavior-oriented approach. The belief-oriented approach utilizes exposure to new information and various persuasive communications in an attempt to induce change in attitude by altering belief about an object. The affect-oriented approach modifies both evaluations of and behavior toward an object by altering their affective properties through procedures based on classical conditioning. A behavior-oriented approach is guided by various models of cognitive consistency, such as those of congruity, balance, and dissonance. A commonality of all the approaches is that a person's cognitions about himself and environment are organized and consistent internally (Bandura, 1969). The introduction of new information contradicting existing attitudes creates an aversive motivational state, so the person is likely to try to eliminate the disequilibrium by making cognitive adjustments (Bandura, 1969). Research conducted within the framework of social-learning theory demonstrates the significance of vicarious processes, such as modeling, in learning new modes of behavior (Bandura, 1969).

It was proposed that through an educational program directed toward changing attitudes about gay persons, associate degree student nurses would have more compassion toward clients infected with HIV and thus improve the quality of life for this growing number of clients. Through experiential education it was proposed that the sample would have fewer negative attitudes toward persons with AIDS (PWAs), less fear of contracting AIDS, and feel more professionally competent.

Bandura's (1969) social learning theory supports affective education/experiential learning as a method for changing attitudes. Fear of AIDS and homophobia are affective responses. The Centers for Disease Control and Prevention (CDC) did not use social learning theory to educate the

public or the health professionals about AIDS. The CDC only suggested/taught universal precautions as the strategy to cope with the AIDS epidemic.

### Hypotheses

1. Nursing students' scores on Bouton's Homophobia Scale (Bouton, et al., 1987) will be positively correlated with scores on Bouton's Fear of AIDS Scale (Bouton, et al., 1987).

2. Nursing students who complete an affective education program on understanding homosexuality will demonstrate a significant decrease in levels of homophobia as measured by pretest and posttest scores on the Homophobia Scale (Bouton, et al., 1987).

3. Nursing students who complete an affective education program on understanding homosexuality will demonstrate a significant decrease in fear of AIDS as measured by pretest and posttest scores on the Fear of AIDS Scale (Bouton, et al., 1987).

4. Nursing students in the control group will demonstrate no significant decrease in homophobia or fear of AIDS as measured by pretest and posttest scores on the Homophobia and Fear of AIDS Scales (Bouton, et al., 1987).

### Definition of Terms

Acquired Immunodeficiency Syndrome. AIDS is an acquired illness of the immune system which reduces the body's ability to fight specific types of infections and cancers and is caused by the human immunodeficiency virus.

Human Immunodeficiency Virus. HIV is a retrovirus believed to be the causative agent of AIDS.

Fear of AIDS. For the purposes of this study, fear of AIDS is defined as

an anxious response to the perceived danger of catching the disease that is often accompanied by irrational behavior that may interfere with the care of persons with AIDS (Walsh, et al., 1992). Fear of AIDS will be measured by the Fear of AIDS Scale (Bouton, et al., 1987).

Homophobia. The feelings of anxiety, fear, anger, disgust, and discomfort felt by heterosexuals toward homosexuals (Serdahely & Ziemba, 1984). Homophobia will be measured by the Homophobia Scale of Bouton, et al. (1987).

Attitude. An attitude is a relatively lasting formation of beliefs predisposing one toward some preferential response and expresses underlying values, feelings, and dispositions of a person. There are cognitive and evaluative components to attitudes; they are a state of mind or feeling about a particular subject, matter, or concern (Gaines, et al., 1988).

Associate Degree Nursing Student. A student who is enrolled in a two-year community college program designed to prepare its graduates to take the NCLEX-RN licensing exam to become registered nurses.

Primary Prevention. Primary prevention is an intervention that is used to protect the client's normal line of defense or the usual state of wellness by strengthening the client's flexible line of defense. According to Neuman (1989), the goal is to promote wellness through the prevention of stress and reduction of risk factors.

Flexible Line of Defense. Neuman (1989) explains the flexible line of defense as a dynamic protective buffer system that ideally prevents stressor invasion of the client system. It acts in an accordion-like fashion expanding away from the normal defense line providing greater protection or drawing closer providing less protection. A reaction will occur within the client system

when the normal line of defense has been rendered ineffective; that is, the normal line of defense has been penetrated. Physiological, psychological, sociocultural, developmental, and spiritual variables are related to the flexible line of defense.

Intrapersonal Stressors. Intrapersonal stressors are those internal environmental forces occurring within the client/client system boundary, for example the autoimmune response (Neuman, 1989). In this study, intrapersonal stressors are homophobia and fear of AIDS.

Affective Educational Program. For the purposes of this study, an affective educational program is one specifically designed to explore attitudes, feelings, and beliefs about homosexuality.

#### Significance of the Study

The AIDS epidemic has created ethical dilemmas for the patient, for caregivers and for society, and the response to these dilemmas will shape Americans' lives far into the future (Durham, 1991). The ways in which America responds will reveal our cultural, social, and moral values, a kind of litmus test of our humanity. If caregivers have negative attitudes and misperceptions stemming from lack of knowledge and/or prejudice there is a barrier to compassionate care for people with AIDS (Durham, 1991).

Nurses are part of the general community and susceptible to stereotyping and biases. Public attitudes represent a social issue, whereas, nurses' attitudes carry significant health care consequences. A study by Kelly, et al. (1988) suggested that nurses will experience discomfort and find difficulty in being positive, open, and nonjudgmental with AIDS patients and with gay patients having illnesses other than AIDS. The results of the study also demonstrated

the need for nurses to be better prepared and become more knowledgeable about the lifestyles of sexual preference minorities especially as they are related to health.

Nurses' negative attitudes toward homosexuality can be changed through educational interventions (Young, 1988; Flaskerud, 1989). Young (1988) found more than half the nurses with negative feelings toward homosexuality expressed more positive feelings at the close of an all-day affective education workshop. The workshop considered the nurses' feelings in five areas: 1) recognizing one's own feelings, 2) sharing those feelings voluntarily, 3) understanding why one feels a certain way, 4) assuming responsibility for a feeling, and 5) understanding risks of certain feelings professionally and personally. Unless nurses develop nonjudgemental attitudes and a lack of fear of and discomfort with AIDS and homosexuality, care of AIDS patients and their significant others will suffer (Preston, et al., 1991).

According to a review of HIV/AIDS-related research by Swanson, et al. (1990), there is a scarcity of studies of nursing students' knowledge and attitudes toward AIDS and caring for persons with AIDS. Because the incidence of AIDS is likely to continue to rise, students in nursing programs today will likely encounter AIDS patients throughout their careers. Lester and Beard (1988) found that nursing students who held more negative attitudes towards homosexuals were less willing to provide care to AIDS patients.

According to Flaskerud (1989), some nurses who have refused to care for AIDS patients on the grounds of fear of communicability used the fear of contagion as a cloak for the real objection, the lifestyle of the patient. The patient's lifestyle is a patient attribute and should be used only to individualize

care, not to deny care, according to Flaskerud (1989). "For nursing, care is not a luxury or appendage of practice; it is the practice" (Baranowski, 1988, p. 114).

#### Limitations of the Study

This study focused on the relationship between fear of AIDS and homophobia and an intervention via an educational program designed to decrease the fear of AIDS and homophobia of associate degree nursing students. The study limits itself to a sample of 22 associate degree nursing students, 11 experimental subjects and 11 control subjects, from a community college in the southwest. The subjects were all in the first year of the associate degree nursing program. The small sample size limits generalizations to larger populations.

## Chapter 2

### REVIEW OF RELATED LITERATURE

#### The AIDS Epidemic

The human immunodeficiency virus (HIV) epidemic, including acquired immunodeficiency syndrome (AIDS), is one of the greatest health problems in the United States today. The syndrome was first recognized in 1981 (Kelly, St. Lawrence, Hood, & Cook, 1988). During the period June, 1981, through December, 1993, a total of 361, 509 people in the United States had been diagnosed with AIDS and 220, 871 had died, according to the Centers for Disease Control and Prevention (CDC) (National AIDS Hotline, June 17, 1994). In addition, the Public Health Service estimates that one million (one in 250) Americans are infected with HIV, the virus that causes AIDS. In Nevada there are 1, 879 (1,410 in Clark County) diagnosed AIDS cases (Clark County Health District, April, 1994). There were 165 cases of HIV infection reported to the Clark County Health District (CCHD) during the First Quarter of 1994. At the end of the first quarter of 1994, there was a cumulative total of 1582 adults and 17 children in Clark County who were HIV infected, according to the CCHD (April 20, 1994).

It is projected by the Public Health Service that by December 31, 1994, there will be a cumulative total of 415, 000 to 535, 000 cases of AIDS

diagnosed in the U. S., and that a cumulative total of 320, 000 to 385, 000 people will have died from AIDS (CDC National AIDS Hotline, June 17, 1994). Estimates of the cost of treatment as of July, 1992, were that by 1995, the cumulative costs for office visits, clinics, hospital, social support, & medication will be \$15.2 billion (CDC National AIDS Hotline).

Worldwide, by early 1992, 12.9 million people had been infected with HIV with about one-fifth developing AIDS, and nearly 2.5 million had died (Mann, Tarantola, & Netter, 1992). By 1995, another 6.9 million people will become infected with HIV, and from 1992 to 1995, 3.8 million people will develop AIDS, which is more than the entire history of the pandemic through June 1, 1992, with projections to the year 2000 that between 38 and 110 million adults will have become infected with HIV (Mann, et al., 1992).

Epidemiological and laboratory studies have confirmed that HIV infection is spread by sexual contact with semen, vaginal secretions, or blood; by transfusion of contaminated blood or blood products; and from mother to fetus or newborn. Infection by HIV is difficult to acquire. The virus is fragile and needs a specific condition, that is, a portal of entry such as a cut or a break in the skin or mucus membranes whereby the virus can enter the body. Public health authorities have determined there is no evidence to indicate that HIV can be acquired through casual or close social contact.

The report by CDC (October, 1993) on exposure category of AIDS cases in the United States included 61% men who had sex with men in 1992, and 56% in 1993. The heterosexual category included four percent of male cases in 1992 and 1993, and 42% of female cases in 1992, and 37% of the female cases in 1993. In Nevada, 71% of the AIDS cases were in the homosexual/bisexual men transmission category and two percent in the

heterosexual category. Nevada has a 91% prevalence rate among adult males and nine percent among adult females (Clark County Health District, April, 1994).

The etiological viral agent (HIV) is noted for its phenotypic variability and ability to easily mutate. Future development of vaccines or treatment are, thus, made more difficult. The incubation period is uncertain, but may be many years, so carriers of the virus are chronically infectious (Gostin, 1986).

HIV infection damages the immune system so that the body is unable to defend against other disease causing organisms, such as bacteria, fungi, yeast, and other viruses. HIV invades CD4 cells and interferes with the cell's normal function of defending against common organisms. The person infected with HIV is then vulnerable to opportunistic diseases such as Kaposi's sarcoma, pneumocystis carinii pneumonia, and various lymphomas.

To date, the course of the disease is progressive, despite successful treatment for some opportunistic diseases that have prolonged life in persons with AIDS (PWAs). In its full clinical form, AIDS appears to be invariably fatal (Swanson, et al., 1990). Not only is AIDS a fatal disease; it is a social, psychologic, and moral illness as well, because it forces us to confront the taboo subjects of contagion, homosexuality, and death (McCutchan, 1986).

### The AIDS Epidemic and Nursing

As health care professionals and members of communities, nurses can influence the response of the community to the HIV/AIDS epidemic. Nurses are the health care professionals who have the most contact with individuals infected with HIV and their families/significant others. Nurses are the professionals likely to be called on to provide public information about HIV

disease.

The AIDS epidemic has certainly changed the face of health care. It is changing the way medicine and nursing are practiced. Individuals infected with HIV account for an increasing number of obstetrical, neonatal, psychiatric, and medical-surgical clients. AIDS patients are found in mental institutions, day care centers, and outpatient clinics. AIDS patients come from subgroups of society who previously had low rates of hospitalizations, and with whom nurses had little need to deal with their own attitudes toward these subgroups. (All, 1989).

For centuries nurses have cared for patients regardless of their personal attributes or type of health problem. This basic professional ethic is being challenged by the AIDS epidemic. In a survey of nurses (total number not reported) working in a variety of settings (OB/GYN, ICU, pediatrics, medical/surgical, etc.) throughout the United States, three out of four nurses who responded said they would refuse to care for AIDS patients under circumstances where a patient has made a calculated refusal to cooperate with precautions (Moriarty, 1988).

Individual nurses may not ethically refuse to care for HIV-positive patients without violating the professional code of ethics, except under two specific exceptions. The exceptions are 1) the risk to the nurse exceeds the potential gain for the patient and 2) the nurse's lack of information about HIV/AIDS limits the ability to provide competent care. In the latter case, the nurse would defer to more qualified staff, but would have the duty to learn about the illness in order to provide care in the future (Huerta & Oddi, 1992).

The Committee on Ethics of the American Nurses' Association states that

The nurse provides services with respect for human dignity and the uniqueness of the client, unrestricted by considerations of social or economic status, personal attributes, or the nature of health problems (ANA, 1988).

Nursing makes no allowance for the use of a patient's personal attributes or the nature of the health problem as grounds for discrimination. In most instances it would be considered morally obligatory for the nurse to provide care to AIDS patients. To assist the nurse in making the decision to provide care, there are four criteria:

1. The patient is at significant risk of harm, loss, or damage if the nurse does not assist.
2. The nurse's intervention or care is directly relevant to preventing harm.
3. The nurse's care will probably prevent harm, loss, or damage to the patient.
4. The benefit the patient will gain outweighs any harm the nurse might incur and does not present more than minimal risk to the health care provider.

The nurse has a responsibility to provide care because a special relationship exists between the nurse and patient. The nurse is not at liberty to walk away from those in need. So, when all of the four criteria are met, the nurse is obliged to care for those in need of nursing (ANA, 1988).

### Risks to Health Care Professionals

The CDC first published recommendations for universal precautions as the key to preventing HIV transmission in health care settings in 1987 (Burtis & Evangelisti, 1992). These precautions state that all blood and body fluids of patients should be treated as infectious. As long as universal precautions are

followed, the risk of acquiring HIV infection through patient care has been reported as less than 1 percent, according to Friedlan & Klein (cited in Huerta & Oddi, 1992), or 1 in 200, according to Brown & Brown (cited in Huerta & Oddi, 1992). There seems to be no greater risk to health care workers than to the general population (Allen, 1988). Marcus (1988) reported an ongoing study of 963 health care workers who had received significant exposure to HIV. HIV antibody testing at least 180 days after the exposure found only four workers seropositive for HIV antibodies. Of the four workers who seroconverted, none had other risk factors for HIV infection. The first worker was exposed to the blood of a patient infected with HIV (the exact method of exposure was not described in the current study). The second worker received a deep intramuscular needle stick with a large-bore needle from a coworker during a resuscitation procedure on a patient with AIDS. The third worker received a needle stick from a 21-gauge needle from a coworker during a resuscitation attempt in a patient with AIDS. The fourth worker received two needle stick injuries 10 days apart, once when recapping a needle used in a patient with AIDS and again when she accidentally stuck herself with a needle after drawing blood from a patient with symptomatic HIV infection.

Infection of health care workers following an occupational exposure to HIV frequently is associated with a failure to follow universal precautions (CDC, 1987; CDC, 1988), primarily involving the recapping of needles (Schobel, 1988; CDC, 1987 as cited in Huerta & Oddi, 1992). Also, prolonged contact with blood or body fluids without wearing gloves or when skin is not intact, e. g., chapped, open lesions, has been implicated in seroconversion (CDC, 1988).

The numbers of nurses exposed to HIV are increasing and there are legitimate concerns. There were 13 nurses with documented occupational

AIDS/HIV infection in the United States as reported through September, 1993 (CDC, October, 1993). Although the risk of acquiring HIV infection through the delivery of nursing care is low, the threat of HIV infection should not be treated lightly.

### Knowledge and Attitudes Related to AIDS

HIV disease is certainly not the first epidemic affecting human beings and resulting in fearful reactions. Leprosy, influenza, tuberculosis, syphilis, yellow fever, smallpox, polio, and other communicable diseases have created hysterical reactions from the public. Nursing care was provided during these epidemics. Tuberculosis is the first disease for which it is documented that nurses hesitated to provide care because of fear of contagion and lack of preparation, according to Isenberg (1919) and Stewart (1918, cited in Breault & Polifroni, 1992). The syphilis epidemic of the early 1900s brought out moral issues attributed to biological phenomena, according to Brandt (1988).

Blumenfield, Smith, Milazzo, Seropian, & Wormser (1987) conducted an anonymous survey of nurses (n = 107 in July, 1983 and n = 191 in January, 1984) at Westchester County Medical Center to determine the attitudes of nurses working with AIDS patients. It was not clear if the nurse subjects were all registered nurses. The majority (percentage not reported) of the nurses were full-time with less than three years of nursing experience. The assumption was made that since all areas of the medical center had less than a 10% turnover during the six-month period between surveys that the population was similar in both surveys. A ten-item true/false questionnaire was distributed to all nurses in the medical-surgical units, psychiatry units, intensive care units, and on the prison inpatient service. No reliability or validity was reported for the 10-item

questionnaire.

Differences were examined between each survey and between each nursing unit utilizing the chi-square test. The authors reported that on question one, two-thirds (69% in 1983 and 67% in 1984) of the nurses reported their friends and families expressed concern about associating with hospital personnel who had contact with AIDS patients. Many nurses said they had gone so far as to deny to people outside the hospital that they worked with AIDS patients. Between one quarter (25% in 1984) and one half (52% in 1983) of the nurses reported fear in caring for homosexual men and prisoners because of AIDS. The statistically significant decrease in concern over the 6-month period on the medical-surgical unit ( $p < 0.05$ , no chi-square statistic reported) was attributed to experience and education.

Intensive care nurses (68%) had significantly higher fear of AIDS versus hepatitis than nurses in the other units ( $p < 0.05$ , no chi-square statistic reported). The authors suggested that the difference might be related to the more frequent exposure of the ICU staff to body secretions that would lead to higher fear of a fatal viral infection. Almost half the nurses (50% in 1983 and 39% in 1984) in the study indicated that they would ask for a transfer if they had to care for AIDS patients on a regular basis. The highest percentage of the nurses who would ask for a transfer were ICU nurses (70%,  $p < 0.05$  compared to prison nurses in 1983 and 52%,  $p < 0.05$ , in 1984; no chi-square statistic reported). It is certainly clear from this study, according to Blumenfield, et al. (1987), that nurses who care for PWAs have emotional concerns and fears in regard to working with these patients. The authors suggested that the basis of the concerns may not always conform with recent medical knowledge about the illness.

Katz, Hass, Parisi, Astone, McEvaddy, & Lucido (1987) assessed the perceptions held by 158 liberal arts college students, 70 registered nurses, 53 medical school students, and 152 chiropractic students, of patients and their families. Subjects were asked to rate cancer, AIDS, diabetes, and heart disease, as well as non-ill people on 21 bipolar trait items that were selected to measure moral worth, competence, depression, dependency, and morbidity. Almost all subsamples perceived cancer patients less favorably than diabetics, heart patients, and the non-ill on competence, dependence, depression, and morbidity. Cancer patients were always seen as being more depressed than AIDS patients, but were rated just as favorably as well people on moral worth. Generally, people with AIDS were rated the most negatively and were the most rejected group. "Our data suggest that the perception of AIDS patients as responsible for their illness underlies these extremely negative attitudes" (p.627).

Pleck, O'Donnell, O'Donnel, & Snarey (1988) studied AIDS phobia, and the results suggested that negative attitudes toward AIDS and AIDS patients were common among professional and technical-level health care workers in a major AIDS inpatient-care facility in Massachusetts. Half the respondents agreed with various socially rejecting belief statements, such as "A hospital worker should not be required to work with AIDS patients". A smaller subgroup (five percent) agreed with more extreme moralistic judgments, such as "AIDS is God's punishment for immorality." Indicators of AIDS-stress in hospital staff members, i.e., feeling uncomfortable with AIDS patients, insufficient knowledge, etc. ranged from 9% to 65.2%.

A sample of 1019 nurses in California employed in settings where at least part of their work included direct care to patients were asked about their

perceived risk for contracting AIDS. Despite the fact that the risk is exceedingly small, 24.5% believed they were at high or moderate risk for contracting AIDS in their current work role (van Servellen, Lewis, & Leake, 1988). The majority (94.3%) were female, had a median age range of 35 to 39 years, and had a fairly evenly distributed level of education: 29.2% graduated from diploma programs, 31.2% from AA programs, and 34.1% from BS/BSN programs. When asked about their willingness to accept an assignment caring for AIDS patients, nearly 25% said they would not accept a job caring for AIDS patients. Only one in eight indicated they would not hesitate to care for AIDS patients and slightly more than 50% of the respondents believed hospital nurses should be given the option to refuse to care for AIDS patients. The conclusion of the investigators was that nurses need a better understanding of the etiology, symptoms, and treatment of AIDS patients. Recommendations included future studies to address and alter negative attitudes and beliefs toward AIDS patients (van Servellen, et al., 1988).

Prince, Beard, Ivey, & Lester (1989) using Lazarus's theory of coping and adaptation, conducted a study in which 134 perinatal nurses were asked to note their fear of AIDS in the workplace. Nurse subjects were employed in five midwestern hospitals. More than 85% indicated a moderate to high degree of fear, and 35% indicated a fear of carrying the virus home to family. Over half the nurses thought they were being exposed to AIDS in their work activities and 45% were in favor of mandatory screening for pregnant women. Nearly all the nurses felt that health care personnel should be informed of the HIV status of patients. A large percentage (97%) thought HIV positive neonates deserved equal care to other newborns, but when asked if they would volunteer to care for an AIDS patient, only 24% said they would. Forty-five percent of the

respondents felt all health care workers should be tested for HIV. Fifty-six percent thought nurses should not be fired for refusing to care for HIV positive patients, 32% were neutral, and 12% thought nurses should be terminated.

Epidemics can disrupt the functioning of the social group because of the large numbers of people afflicted by the illness. Responses to the AIDS epidemic, both individual and collective, become powerful determinants of its course (Fullilove, 1989). Two social responses that have great importance are denial of one's personal risk and projection of responsibility onto an "out-group" (gay men and intravenous drug users). Early resolution of denial is crucial for a healthy social response. The danger lies in resolving the denial through projection. If a group is blamed for the epidemic they may be punished and isolated leading to disastrous results in terms of further spread of the disease (Fullilove, 1989). As many as 25% of respondents indicated they would refuse to work with one who is HIV-infected, and the same percentage believed that an employer has the right to fire someone who is infected. Irrational fears are a continuing problem for patients, families, and advocacy groups. Not surprisingly, discrimination has occurred in health care, jobs, and in other areas of life because of both fear of contagion and prejudice (Fullilove, 1989).

Exposure to AIDS is a fearful situation because of the prognosis, the epidemiological magnitude, and many unresolved questions related to the virus. There are concerns related to confidentiality, screening, discrimination, adequacy of infection control, allocation of scarce resources, exposure to spouse and children, and dilemma regarding life-sustaining care, that illustrate enough negatives to produce avoidance in most caretakers (Boland, 1990). In order to lessen the fear of AIDS, it is recommended that there be frequent updates on AIDS, certification in universal precautions, and means of providing

psychological support for those working with AIDS patients (Boland, 1990).

Utilizing the theory of reasoned action, Goldenberg & Laschinger (1991) conducted a study of 46 second-year baccalaureate nursing students in southwestern Ontario. The mean age of the subjects was 20.7 years, and 98% were female. The subjects completed a 31-item questionnaire prior to and following an instructional unit on caring for AIDS patients. The instructional unit consisted of two 2-hour lecture/discussion sessions by AIDS experts. Students' attitudes were found to be significant predictors of intentions to care for AIDS patients during their clinical experiences ( $R^2 = 0.29$ ,  $F [1, 43] = 6.63$ ,  $p < .0003$ ). A pre-post test design was used to test the effect of an AIDS instructional unit on students' attitudes, normative expectations, and intentions to care for AIDS patients. Data were consistent with the predicted relationships among the model components in the study of nursing students' intended care behaviors. The strong intention of the respondents to provide care to PWAs was based on their attitudes toward performing the behavior and their perception of whether or not their significant others would approve of their providing care. Caring for AIDS patients and knowledge of the disease significantly impacted the intention to care for these patients, as shown on the post-test. Neither age nor religion were found to be significant factors associated with attitude nor intention to care for PWAs. The conclusion was that educational interventions had a positive impact on knowledge and attitudes of nursing students. The ultimate effectiveness of AIDS patient care lies in acquiring knowledge of the illness (Goldenberg & Laschinger, 1991).

The results of studies over a five-year period reviewed by Flaskerud (1991), indicated nurses' knowledge of HIV had improved dramatically, but

attitudes and practices had not improved at the same rate. In the literature review, Flaskerud found nurses were distrustful and skeptical about information given to them by national experts about transmission in the workplace. Findings indicated health care workers had made moral and social judgements about HIV infected patients. Attitudes and fears about HIV/AIDS had not changed correspondingly to the knowledge of nurses about HIV/AIDS. No statistical data were reported by Flaskerud (1991), but a three-tiered psychological model for changing knowledge and clinical skills, knowledge and attitudes, and attitudes alone was proposed. Information and demonstration, expression of attitudes and fears, role-playing, group discussions, practice in designing policies, and exposure to various psychocultural groups, and to persons with HIV need to be included in those approaches, according to Flaskerud (1991).

A convenience sample of 16 nurses employed in three acute care hospitals were the subjects in a non-experimental qualitative study of the lived experience of nurses caring for PWAs (Breault & Polifroni, 1992). The researchers found six mutually inclusive as well as exclusive themes representing the nurses' feelings and attitudes. The themes were: fear, anger, sympathy, self-enhancement, fatigue, and helplessness. The researchers used Festinger's theory of cognitive dissonance as the theoretical framework. With regards to AIDS, the conflict between 'I care for AIDS patients' and 'AIDS is a fatal and contagious disease' could be viewed as dissonant, producing psychological discomfort (Breault & Polifroni, 1992). The nurses in the study did not feel support from other nurses who were not involved in AIDS care. Fear was not found to be a significant factor in the care of PWAs.

Gallop, Lancee, Taerk, Coates, & Fanning (1992) examined the multiple

factors that contributed to the perception of risk of acquiring AIDS to nurses in the workplace. The survey of 560 nurses, using a four point scale of agreement, indicated that fear of contagion remained a major concern, in spite of fairly high levels of knowledge about AIDS and high levels of experience in caring for PWAs. Three percent of the nurses considered the risk of contracting AIDS high, and 16% considered the risk moderate, if recommended precautions were taken. Fifteen percent were very concerned about risk to their family by caring for PWAs, and 20% were fairly concerned. Thirty-nine percent of the nurses were concerned that there isn't enough known yet to know what kind of precautions should be taken, 30% were fairly concerned. When asked specifically about anxiety over providing care where bodily fluids are involved, it was apparent that fear of contagion was intense (23% were very anxious and 32% fairly anxious). Procedures for universal precautions and familiarity with the illness did not seem to reduce the fear of contagion. The researchers suggested that hospital administrators, educators, and others in authority must find ways of dealing with the fears and concerns that are so very real for those nurses in direct contact with patients who have AIDS.

Walsh (1992) reported on a survey by Akinsanya and Rouse (1992) examining nurses' knowledge of AIDS and attitudes toward persons with AIDS. The study revealed that there was a need to strengthen the knowledge base for practice and that there should be intensified training programs in HIV/AIDS for nurses. The study indicated that poor attitudes of hospital nurses toward persons with AIDS might be related to inadequate knowledge for practice. The researchers indicated a belief that education alone cannot guarantee a change in attitude and recommended constructing systematic and sensitive education programs to assist in the development of nonjudgmental

attitudes.

Walsh (1992) also reviewed the 1989 research findings of Bond, Rhodes, Phillips, Setters, Foy, & Bond (1990), which revealed insecurity nurses had about their knowledge and experiences relating to HIV/AIDS, in spite of the wide publicity about HIV/AIDS. There was concern about risk of infection through dealing with HIV positive patients in 53% of the nurses. Having experience with HIV positive patients made no difference in the nurses' concern about personal infection. Of the 85% who had read a policy relating to personal infection, 75% considered it adequate. In spite of that information, the nurses were still worried about the risk. Twenty-three per cent believed they should have the right to refuse to care for patients with HIV/AIDS, and fourteen per cent believed they should have the right to refuse to care for infected drug abusers, homosexuals, or bisexuals. Only seven per cent believed they should have the right to refuse care to patients who are hemophiliacs. The results showed that experience with HIV/AIDS patients made no difference in whether or not the community nurses thought they should have the right to refuse care of HIV/AIDS patients.

Kemppainen, St. Lawrence, Irizarry, Weidema, Benne, Fredericks, & Wilson (1992) surveyed 581 nurses with varying levels of nursing education to assess the nurses' willingness to care for persons with AIDS. Conclusions were that nurses who were the most experienced in AIDS patient care, employed in hospitals with high prevalence rates, and who considered themselves most knowledgeable about infectious diseases were less willing to provide nursing care to AIDS patients. It was concluded that greater reluctance to provide care was not due to lack of cognitive knowledge, lack of experience in AIDS patient care, or to nursing education. It was not clear, according to the

researchers, what formed the basis for the observed differences. Perhaps one explanation might lie in the philosophies that accompany different forms of nursing education. Diploma and ADN education prepares nurses to perform technical nursing care. BSN/MSN education provides the technical education, but it also stresses the nurses' biopsychosocial role in patient care, according to the researchers. The sheer burden of the numbers of AIDS patients in a high prevalence setting may be a source of professional dissatisfaction especially if technical tasks take up so much time that human aspects of care had to be neglected.

Kemppainen, et al. (1992) utilized nurses employed at five VA medical centers across the United States. Hospitals were selected to represent settings that fell at the high, middle, and low range of AIDS patient admissions. The final sample size was 571 employees (479 females, 62 males, and 30 with sex unreported) with an age range of 20 to 60. About a quarter (24.1%) had diploma-level preparation, 25% were educated at the AD level, 42.3% at the BSN level, 7.6% had MSN education, and one percent reported other nursing education. Staff nurses comprised 79% of the subjects, eight percent were head nurses, and 13% filled other staff roles.

Each subject received a 500-word description of a male who showed worsening health over six months and was eventually diagnosed with AIDS. He was admitted with a diagnosis of pneumocystis pneumonia. The vignette described the details of the nursing assessment. Each respondent then completed a Nursing Willingness Scale (NWS) that elicited the nurses' willingness to perform a variety of nursing care tasks. The NWS consisting of 13 items constructed specifically for this study, assessed nurses' willingness to perform tasks for AIDS patients ranging from delivering a meal tray to

administering a blood transfusion. Content validity was first established by a panel of AIDS-experienced registered nurses. The instrument was then pilot-tested on 354 nursing service employees before it was finalized for this study. Each nurse was asked an additional question to control for differing levels of knowledge about infectious disease. The question asked each nurse to estimate personal knowledge about infectious disease on a 10-point Likert scale.

A three (AIDS prevalence of high, moderate, or low) by two (nursing education divided into diploma/AD or BSN/MSN) multivariate analyses of variance (MANOVA) was conducted. The dependent measures were the 13 items of the NWS. Significant differences were found between nurses employed in hospitals with different AIDS prevalence rates ( $F = 4.84, p < .0001$ ) and a significant interaction between prevalence and nursing education ( $F = 1.83, p < .007$ ). Significant multivariate findings were then analyzed by univariate ANOVA to clarify the nature of the differences. Significant univariate results were then analyzed with post hoc Duncan's comparisons. A univariate ANOVA was done to evaluate whether nurses from hospitals with varying prevalence rates regarded themselves as having different levels of knowledge about infectious diseases and was significant ( $F = 12.89, p < .0001$ ).

In summary, there are many studies reflecting the negative attitudes of the public and health care providers, including nurses, toward persons with HIV infection. The literature suggests these negative attitudes toward HIV/AIDS patients are related to fear of contagion, lack of knowledge about AIDS, lack of trust in public health officials to provide accurate information about transmissibility, concerns expressed by the nurse's significant others/family, and discomfort in being around individuals with a lifestyle outside mainstream

society.

### Homophobia

According to Paul and Weinrich (1982), homosexual activities and people are mysterious to most Americans. Supposedly, the public prefers to know nothing about homosexuality, as it is often considered to be too intense to handle. Sexual attraction among members of the same sex has been amply documented in many cultures throughout recorded history.

It is difficult to obtain statistics related to the number of individuals in the general population who are homosexual. Diamond (1993), in reviewing studies in the United States and elsewhere, concluded that it is unreasonable to consider the often used 10% of the male population as regularly engaging in same-sex activity, and that it is more likely half that number. According to Dr. June Reinish, Director of the Kinsey Institute, there are an estimated four percent to eight percent of American men who are predominantly homosexual (Small, 1993).

Pharr (1988) explored the sinful (immoral) theory and the sickness (abnormal) theory of homosexuality. In exploring the sickness theory, Pharr (1988) says that homosexuality is simply a matter of sexual identity, which, along with a heterosexual identity, is formed in ways that are not conclusively understood. It is not healthier to be heterosexual; what is unhealthy is the homophobia of society that leads to condemnation and stress (Pharr, 1988). The American Psychiatric Association removed homosexuality from the list of mental disorders in 1973.

Weinberg (1972) coined the word, homophobia, by which he meant the fear felt by heterosexuals when in the presence of homosexuals and the

self-hatred experienced by gays because of their homosexuality. Hudson and Ricketts (1980) expanded Weinberg's definition of homophobia to include not only close contact with gays, but distal contact as well. Homophobia represents the affective or emotional feelings of anxiety, disgust, aversion, anger, discomfort, and fear that heterosexuals may experience related to homosexual persons (Serdahely & Ziemba, 1984). According to Paxton and Susky (1988), homophobia has affected our culture in many ways. Sexually, American culture is highly neurotic. Society is sex-saturated, and at the same time is sex-negative. Homophobia affects the perception of risk and influences development of educational programs, services, and research (Paxton & Susky, 1988). Del Martin, a pioneer lesbian leader, observed that homophobia is used as a weapon to force people to conform to conventional gender roles. This has crucially affected heterosexual women, as feminists and lesbians are portrayed as enemies of motherhood and a danger to the family and children (Paul & Weinrich, 1982).

O'Donnel, O'Donnel, Pleck, Snarey, & Rose (1987) assessed the psychosocial responses of 237 professional and technical-level health-care workers to AIDS using four indices: AIDS-Contact, AIDS-Phobia, Homophobia, and AIDS-Stress. The study took place at a major AIDS patient-care facility in Massachusetts, a 500-bed university-affiliated referral hospital providing care to a diverse patient population. A positive correlation was found between AIDS-Phobia and the indices of Homophobia ( $r = 0.62$ ,  $p < 0.01$ ) and AIDS-Stress ( $r = 0.55$ ,  $p < 0.01$ ). There was a negative correlation between AIDS-Contact and the indices of AIDS-Phobia ( $r = -0.18$ ,  $p < 0.01$ ) and AIDS-Stress ( $r = -0.25$ ,  $p < 0.01$ ). According to the researchers, it is likely that AIDS-Phobia and ultimately AIDS-Stress are higher because of negative

attitudes about homosexuality. Hospital workers are not immune to AIDS fears but close contact with AIDS patients would allow them to come to terms with their fears. The authors suggested that most would benefit from special education and support in the process, so it would be justified to devote special resources to AIDS education.

Royse and Birge (1987) studied 161 (71% women and 29% men) medical, nursing, and paramedic students for the purpose of exploring how attitudes toward homosexuals may be associated with fear of AIDS and empathy toward PWAs. The subjects were 95 first-year medical students, 48 undergraduate nursing students, 20 graduate nursing students, 15 undergraduate allied health students, and 35 other undergraduate and graduate students enrolled in a physiology course. The median age was 22.0 years with 82% never married, 16% married, and two percent divorced or separated. A 28-item questionnaire used in other studies was slightly modified. The instrument had four separate scales: Empathy for AIDS Victims, Fear of AIDS, Social Distance From AIDS Victims, and Homophobia. Response choices were in the five-point Likert format of strongly agree to strongly disagree. Reliability coefficients for the scales ranged from .83 for Social Distance to .70 on the Homophobia scale.

In analyzing the effect of homophobia on attitudes toward PWAs, respondents were first divided into those scoring high or low on homophobia. Categorized accordingly, 54% of the respondents were low in homophobia, and the more homophobic respondents were significantly more fearful ( $t_{159} = -8.44$ ,  $p < .001$ ), in need of greater social distance ( $t_{159} = -8.78$ ,  $p < .001$ ) and less empathetic towards PWAs ( $t_{159} = 7.74$ ,  $p < .001$ ). The effect of homophobia on empathy was analyzed using step-wise multiple regressions. There was

greater homophobia associated with less empathy ( $B = -.59, p < .0001$ ). More than a third of the variation in empathy was explained by homophobia (adjusted  $R^2 = .39, p < .0001$ ) while no other variables were significant. The relative effect of homophobia on the fear of AIDS was assessed by a second regression.

Greater homophobia was associated with greater fear of AIDS ( $B = .53, p < .001$ ). Slightly over a third of the variation (adjusted  $R^2 = .36, p < .001$ ) in the fear of AIDS was explained by homophobia. Homophobia was found to be a better predictor of fear of AIDS than age, sex, marital status, or desired health career. The results suggested that students in health careers may need some additional instruction related to AIDS and homosexuality. Unless health-care students are provided information about homosexuality, AIDS patients run the risk of receiving inferior care (Royse & Birge, 1987).

In an exploratory study, Pleck, et al. (1988) investigated three dimensions of the responses of hospital staff to AIDS: 1) attitudes toward AIDS and AIDS patients (AIDS-phobia), 2) degree of contact with AIDS patients (AIDS-contact), and 3) job-related stress in working with AIDS patients (AIDS-stress). In particular, the study examined homophobia as a determinant of AIDS-phobia, AIDS-phobia and AIDS-contact as predictors of each other, and the impact of AIDS-contact on AIDS-stress. The sample was comprised of 237 hospital workers: 114 RNs, 44 technicians, 32 house officers, 27 LPNs and aides, and 20 social workers. The mean age was 31.3 years, with 75.6% female.

Indices were developed for AIDS-phobia, AIDS-contact, and AIDS-stress and were assessed by alpha coefficients. Final indices were: AIDS-Phobia (16 items,  $\alpha = .764$ ), AIDS-Contact (15 items,  $\alpha = .828$ ), and AIDS-Stress (8 items,  $\alpha = .658$ ). Hierarchical multiple regression analyses of the

predictors of AIDS-phobia, AIDS-contact, and AIDS-stress were completed. AIDS-phobia and AIDS-contact were tested as predictors of each other. Both AIDS-phobia and AIDS-contact were considered as predictors of AIDS-stress. AIDS-phobia and AIDS-contact were correlated at  $r = -.23$ , phobia and stress at  $r = .54$ , and contact and stress at  $r = -.25$ , all  $p < .01$ . There were significantly higher negative attitudes toward AIDS and AIDS patients among older staff, staff in positions other than social services, and staff with low contact with AIDS patients.

Homophobia was the strongest predictor of AIDS-phobia. Job category and other background variables accounted for 8.5% of the variance in AIDS-phobia and 7.5% of the variance in AIDS-contact. Homophobia predicted an additional 27.5% for a total adjusted  $R^2$  of .437. The strong predictive influence of homophobia on negative attitudes toward AIDS is intuitively plausible, according to the authors. How people feel about AIDS is largely a function of how they feel about homosexuality. A low degree of contact and AIDS-phobic attitudes are associated with stress. AIDS-phobia and AIDS-contact were tested as predictors of each other, and both were predictors of AIDS-stress (phobia and contact,  $r = -.23$ ,  $p < .01$ , phobia and stress,  $r = .54$ ,  $p < .01$ , contact and stress,  $r = -.25$ ,  $p < .01$ ).

A sample of 495 undergraduate college students attending a midwestern university were surveyed to examine their knowledge and attitudes toward AIDS and the relationship between acceptance of homosexual behaviors and their knowledge and fear of AIDS (Goodwin & Roscoe, 1988). There were 196 males, 292 females, and 7 with sex unreported. The mean age was 18.2 years. Findings suggested these college students had moderate knowledge about

AIDS prevalence, high risk groups, transmission, and symptoms. On 21 of 32 knowledge items, two-thirds gave correct responses for knowledge. Results indicated some fear about transmission. There were 7 respondents (1.4%) in the top quadrant on the measure of fear of AIDS and 148 (30%) in the lowest quadrant. The other 68% indicated at least some concern. Statistically significant differences were found in the comparison of male and female responses. More males reported fearfulness on the following items: avoiding known or suspected homosexuals,  $\chi^2 (2, N = 488) = 12.69, p < .001$ ; avoiding places where homosexuals might be present,  $\chi^2 (2, N = 488) = 13.69, p < .001$ ; fighting to have a child with AIDS removed from their child's school,  $\chi^2 (3, N = 488) = 21.87, p < .001$ ; and keeping their own child home if a classmate had AIDS,  $\chi^2 (3, N = 488) = 15.33, p < .001$ .

Assessment of students' acceptance of homosexual behaviors found a highly nonaccepting attitude. Forty-five percent of respondents fell into the least accepting quadrant and only five percent in the most accepting quadrant. In comparing males' and females' answers, males were significantly less accepting on three items: laws allowing sex between same sex consenting adults,  $\chi^2 (3, N = 488) = 16.39, p < .001$ ; their own association with homosexuals,  $\chi^2 (3, N = 488) = 39.35, p < .001$ ; and learning a friend was homosexual,  $\chi^2 (3, N = 488) = 12.05, p < .005$ . Participants, in general, were not accepting of homosexual behavior, but males were less accepting. Those who were most highly accepting of homosexual behavior were the least fearful of catching the disease. The sample was found to be fairly knowledgeable regarding AIDS, even though fears and concerns about transmission of the

disease continued to exist. Education programs addressing misconceptions about AIDS and directed at helping to lessen individuals' inappropriate fears of the disease were recommended as a result of the study.

Croteau & Morgan (1989) concluded that homophobia has been intricately and destructively woven into responses to AIDS in almost every aspect in the United States. The issue of homosexuality must be addressed in effective education about AIDS. Examples were cited of how homophobia has been evident in antigay messages and how gay men and women have been excluded in AIDS education programs. Some examples include: 1) Paul Cameron in the Family Research Institute newsletter recommended facial tattooing of HIV-infected persons as a "social quarantine". 2) In 1985, Margaret Heckler, then Secretary of Health and Human Services, stated "We must conquer AIDS before it affects the heterosexual population and the general population ... before it becomes an overwhelming problem" (p. 87).

Austin, Hong, & Hunter (1989) conducted a study to assess how fear of AIDS is related to knowledge about AIDS, empathy towards PWAs, and attitudes toward homosexuality. The sample consisted of 420 students, 211 men and 209 women, with a mean age of 19.6 years, from a college in Queensland. Attitudes toward AIDS and homosexuality were assessed by an 18-item questionnaire using a 5-point Likert-type scale. Reliability tests showed an alpha of .86 and a split-half of .83. A stepwise regression analysis showed attitude toward homosexuality ( $M = 3.12$ ,  $SD = 1.07$ ) was the most important contributor to fear of AIDS explaining 25.76% ( $R^2 = .285$ ,  $p < .001$ ) of the variance in predicting fear of AIDS. Other variables that significantly correlated with fear of AIDS included empathy toward PWAs ( $R^2 = .323$ ,  $p < .001$ ) and

church attendance ( $R^2 = .341$ ,  $p < .001$ ). The remaining variables of knowledge about AIDS and sex of the subject accounted for .56% of the variance. Subjects who had more empathy toward PWAs ( $M = 4.12$ ,  $SD = .87$ ) displayed less fear of AIDS. Thus, attitude toward homosexuality was found to be the most important contributor to fear of AIDS.

A partial replication of Bouton's studies of 1987 & 1989 by McDevitt, Shehan, Lennon, & Ambrosia (1989) for the purpose of examining the properties of a new scale assessing adults' attitudes toward AIDS and the presence of sex differences in these attitudes, and the association between them and attitudes toward homosexuality, demonstrated significant associations between fear of AIDS and homophobia. The magnitude of the association in the study by McDevitt, et al. (1989) was higher than in the study by Bouton and colleagues. Bouton, Gallaher, Garlinghouse, Leal, Rosenstein, & Young (1987, 1989) found a correlation of .55 ( $p < .001$ ) between the fear of AIDS and homophobia. McDevitt, et al. (1989) administered a new 14-item AIDS phobia and 21-item homophobia Likert scales to University of Northern Colorado students in 1986 ( $n = 358$ ) and 1988 ( $n = 375$ ). Cronbach's alpha equalled or exceeded .89 for each scale for the two administrations. In both samples (1986 group,  $r = .75$ ,  $p < .001$ ; 1988 group,  $r = .70$ ,  $p < .001$ ) measures of AIDS phobia and homophobia were highly associated. Sex differences were present for homophobia in both the 1986 group, [ $t(356) = 4.32$ ,  $p < .001$ ] and in the 1988 group, [ $t(373) = 6.95$ ,  $p < .001$ ]. Sex differences were present for AIDS phobia [1986 group,  $t(355) = 3.95$ ,  $p < .001$ ; 1988 group,  $t(373) = 5.59$ ,  $p < .001$ ]. Men reported more fear than women in both instances. Findings were also consistent with Herek and Glunt's (1988) suggestion that attitudes toward AIDS

are partly formed on the basis of preexisting attitudes toward homosexuals.

Four written vignettes were presented to 300 undergraduate college students depicting "Mark" with either AIDS or leukemia and having a romantic partner of either "Robert" or "Roberta" (St. Lawrence, Husfeldt, Kelly, Hood, & Smith, 1990). Subjects then completed a Prejudicial Evaluation Scale, Social Interaction Scale, and Interpersonal Attraction Inventory. The findings indicated subjects had much more negative attitudes toward an ill homosexual man than a heterosexual man, regardless of the diagnosis. A multivariate analysis of variance (MANOVA) on the prejudicial items revealed significant main effect differences. The main effect for type of disease (AIDS or leukemia) was  $F = 25.37, p < .0001$ , for sexual preference it was  $F = 2.76, p < .001$ , and for interaction of disease with sexual preference it was  $F = 2.20, p < .05$ , all  $df = 12, 284$ . On the seven-item social interaction scale the MANOVA revealed significant main effect differences for type of disease, i. e., AIDS or leukemia, ( $F = 29.93, p < .0001$ ) and sex preference ( $F = 2.26, p < .05$ , all  $df = 7, 289$ ).

Anderson (1992) used the "just world" hypothesis to explain victim blaming. The study presented two written vignettes to 79 introductory psychology students, 51 women and 28 men, with an average age of 21.6 years. The vignettes described a 26-year-old college educated man who had AIDS. In one vignette he was living with a female lover, in the other a male lover. The heterosexual vignette was read by 40 subjects and the homosexual vignette by 39 subjects. After reading the vignettes the subjects completed a blame scale. The participants also completed a scale measuring intolerance toward gay men and a fear of AIDS scale. A gay man was assigned more personal blame for contracting AIDS than a heterosexual man (variance in the blame scores was 27.8%). The more intolerant subjects were toward gay men

and the more fearful they were of AIDS, the more likely they were to blame the gay man for having AIDS. Experience with a human sexuality course, age, or gender did not contribute significantly to the variance in blame scores. In stepwise multiple regressions on blame scores, only two variables were significant for gay men with AIDS. Intolerance contributed 32.1% of the variance and fear of contact contributed 9.5% of the variance [ $R = .64$ ,  $F(2, 36) = 12.84$ ,  $p = .0001$ ].

Kunkel and Temple (1992) investigated the relationship between AIDS and homophobia, including the role of gender, marital status, religion, and church attendance as possible mediating variables. The sample ( $n = 507$ ) consisted of 203 men and 304 women enrolled in introductory psychology classes who responded to questionnaires. A Pearson correlation coefficient was computed and a significant relationship was found between scores on the Fear of AIDS scale (Bouton, et al., 1987) and scores on the Homophobia scale (Bouton, et al., 1987) ( $r = .483$ ,  $p < .05$ ). Men and women reported the same level of fear of AIDS. Men were more homophobic than women ( $t = 5.45$ ,  $p < .05$ ). No difference was found between single and married individuals on fear of AIDS, but those who were never married were more homophobic than the married subjects ( $t = 2.95$ ,  $p < .05$ ). There was an effect of religiosity on homophobia [ $F(5, 257) = 2.68$ ,  $p < .05$ ]. A significant effect of church attendance on the measure of Fear of AIDS was found [ $F(4, 260) = 2.89$ ,  $p < .05$ ]. There was also a significant effect of church attendance on homophobia [ $F(4, 260) = 2.93$ ,  $p < .05$ ].

Several studies examined attitudes toward AIDS and homophobia among nurses, including nursing students and nurse faculty (Kelly, St. Lawrence, Hood, & Cook, 1988; Lester & Beard, 1988; van Servellen, 1988;

Young, 1988; Scherer, Haughey, & Wu, 1989; D'Augelli, 1989; Scherer, Wu, & Haughey, 1991; Eliason & Randall, 1991; Rae, Brown, & Calder, 1992; Mueller, Cerney, Amundson, & Waldron, 1992; Jemmot & Cruz-Collins, 1992; Scherer, Haughey, Wu, & Kuhn, 1992, & Meisenhelder, 1994).

In a study by Kelly, et al. (1988) examining nurses' attitudes toward AIDS patients, results demonstrated nurses reacted more negatively towards a patient described as having AIDS than towards a leukemia patient described identically. The names of 500 nurses out of a pool of 5,000 practicing nurses participating in a state medical center's continuing education programs unrelated to AIDS were randomly selected for recruitment to participate in the study. Out of the 500 nurses, 166 (32.2%) anonymously completed and returned the research packet. Of the sample, 91% were registered nurses, average age was 39.7 years, and the average professional practice experience was 15.1 years. The sample was 94% female.

The research packet contained a 500-word description of a patient and a set of three inventories on which they recorded impressions of the person described in the vignette. Each subject read a single randomly assigned vignette describing a homosexual or heterosexual male diagnosed with either AIDS or leukemia.

The three inventories used in the study were: the Prejudicial Evaluation Scale, the Social Interaction Scale, and the Interpersonal Attraction Inventory. Data were first analyzed by multivariate analyses of variance (MANOVAs) to determine if subjects assigned different ratings to the portrayals taking into account all items in each category. They were followed by univariate analyses of variance (ANOVAs for F-tests) for each item to determine specific attitudes associated with the portrayals. The most statistically stringent and appropriate

method for analyzing results when there is a large number of separate attitude items is considered to be the testing for multivariate significance before conducting F-tests, according to the researchers.

Multivariate analysis of variance revealed significant main effect attitude differences on the Prejudicial Evaluation Scale for the portrayed disease ( $F = 15.78, p < .0001$ ), for sexual preference of the patient ( $F = 2.26, p < .05$ ), and for the interaction of sexual preference and disease type ( $F = 2.15, p < .05$ ). Univariate ANOVAs were performed for each attitude item to determine the nature of the overall effects. A patient with AIDS relative to when his illness was leukemia, was evaluated as significantly more responsible for his illness ( $F = 78.88, p < .0001$ ), deserving the illness ( $F = 35.51, p < .0001$ ), dangerous to others ( $F = 139.72, p < .0001$ ), of less importance to the world if he died ( $F = 10.69, p < .001$ ), deserved to be quarantined ( $F = 43.33, p < .0001$ ), deserved to lose his job ( $F = 20.53, p < .0001$ ), and as one who should consider suicide ( $F = 6.29, p < .05$ ). Compared to an identically described leukemia patient, the AIDS patient was evaluated much more harshly. Whether the patient had AIDS or leukemia, the subjects evaluated homosexual patients as more responsible for being ill ( $F = 15.69, p < .0001$ ), less deserving of sympathy and understanding ( $F = 9.65, p < .005$ ), and more deserving of what happened to them ( $F = 12.29, p < .001$ ).

Significant MANOVA main differences were found on the Social Interaction Scale for type of disease ( $F = 23.46, p < .0001$ ) and for sexual preference ( $F = 2.54, p < .05$ ). Results of univariate F-tests on the Social Interaction Scale items showed nurses were less willing to have contact with AIDS patients than with leukemia patients in all areas assessed, including simple conversations ( $F = 23.47, p < .0001$ ), attending the same social

gathering ( $F = 34.25, p < .0001$ ), working in the same office ( $F = 61.50, p < .0001$ ), renewing an apartment lease ( $F = 47.19, p < .0001$ ), or maintaining a past friendship ( $F = 51.40, p < .0001$ ). Attitudes toward gay patients, regardless of their illness, paralleled the desire not to interact with AIDS patients. Subjects were less willing to converse ( $F = 7.52, p < .01$ ), attend the same party ( $F = 7.63, p < .01$ ), allow children to visit ( $F = 5.90, p < .05$ ), or continue past friendship ( $F = 4.21, p < .05$ ) with the patient labeled as homosexual compared to one labeled heterosexual. The results of the study suggested that nurses respond to both AIDS patients and homosexuals with interchangeable and nearly identical negative attitudes.

Lester and Beard (1988) studied nursing students for the purpose of exploring their knowledge, fears, beliefs, and other attitudes regarding AIDS in order to implement effective teaching strategies and better prepare nursing students to cope with challenges involved in the care of AIDS patients. All students in a four-year baccalaureate nursing program were invited to participate. The sample of 177 sophomore (28.8%), junior (36.2%), and senior (35%) students were 82% of the total student enrollment. Most of the subjects were 25 years of age or younger (64%) with only 08% 36 years or older. An attitude questionnaire was derived by asking students in a sophomore communicable disease class to write down and hand in a list of their thoughts, feelings, beliefs, knowledge, and areas of lack of knowledge about AIDS. A large amount of data was collected and results categorized into the attitude questionnaire. The knowledge questionnaire was developed from what was known about AIDS at the time of the research. Content validity was established by a group of nurse experts made up of nursing faculty and infection control nurses. Pretesting was done on a group of licensed practical nurses and no

test-retest reliability was done. The alpha coefficient was .60 for the questionnaire.

There was an overwhelming agreement among the students that AIDS patients deserve the same care as other patients, but nearly 49% said they preferred not to care for AIDS patients. There was a large number of neutral responses (22.6%) to the question. There were significant differences among respondents in terms of whether or not they believed students should be assigned to AIDS patients ( $X^2 = 17.85$ ,  $p < .001$ ). There were 33.3% who thought nursing students should be assigned to AIDS patients, but 36.2% thought they should not be assigned. There were 21.5% who were neutral and 9% of responses were missing.

Most (73.4%) did not have a child at home. Most of the students' information came from the media (70.6%) rather than from nursing journals (18.1%). The majority (85.3%) of students were not acquainted with an AIDS patient and had not provided nursing care (83.1%) for an AIDS patient. Twenty-four percent of students agreed or strongly agreed they would begin mouth-to-mouth resuscitation on an AIDS patient even without the availability of a protective device, but 54.8% said they would not. Rather than provide care to an AIDS patient, 17.5% said they would quit their job. More sympathy for AIDS patients who were not homosexual was expressed by 62% of the students.

Almost all of the students wanted to know more about AIDS (94.3%) and 79.7% thought more funding should be provided for AIDS research. Significant correlations were found between many variables. Younger students tended to have children at home ( $r = -.53$ ,  $p < .01$ ), and if they had children at home they thought they should not be assigned to AIDS patients ( $r = -.23$ ,  $p < .01$ ). When

students were either acquainted ( $r = .24, p < .01$ ) with or had been assigned ( $r = .25, p < .01$ ) to AIDS patients they reported that students should be assigned to them. There was less fear of caring for them if they were acquainted with AIDS patients ( $r = -.20, p < .01$ ) or if they had cared for them ( $r = -.19, p < .01$ ). Homophobic students also had an increased fear of AIDS ( $r = .30, p < .01$ ). There was fear of contracting AIDS during routine care and taking it home ( $r = .33, p < .01$ ). There was more fear of AIDS than any other disease ( $r = .22, p < .01$ ) and they were unwilling to provide care to patients with AIDS ( $r = -.36, p < .01$ ). The students believed AIDS patients should be isolated from the public ( $r = .39, p < .01$ ) and would rather quit the job than take care of AIDS patients ( $r = .43, p < .01$ ). There was more homophobia in the students at the higher educational level ( $r = .25, p < .01$ ).

Students scoring high in knowledge scored high in fear ( $r = .28, p < .01$ ). There was fear of catching the virus during routine care ( $r = .23, p < .01$ ) and carrying the virus home ( $r = .24, p < .01$ ). There was reluctance to care for AIDS patients due to fear of getting the disease ( $r = .23, p < .01$ ) and they didn't believe students should have to care for AIDS patients ( $r = -.19, p < .01$ ). They said they were less prejudiced against homosexuals ( $r = .18, p < .01$ ).

Students who had a high fear score were less willing to care for AIDS patients ( $r = -.35, p < .01$ ). These students preferred not to care for AIDS patients ( $r = .68, p < .01$ ), would not volunteer to care for an AIDS patient ( $r = -.33, p < .01$ ), would not care for an AIDS patient out of duty ( $r = -.20, p < .01$ ), and would quit a job rather than give care to AIDS patients ( $r = .48, p < .01$ ). They did not believe in assigning AIDS patients to students ( $r = -.46, p < .01$ ).

A relationship was found between high fear score and four variables related to homophobia. Those with high fear scores felt more sympathy for the nonhomosexual AIDS patients ( $r = .31, p < .01$ ), would feel uncomfortable caring for a homosexual patient ( $r = .26, p < .01$ ), believed AIDS was God's way of punishing homosexuals ( $r = .20, p < .01$ ), and admitted that their nursing care may be adversely affected by their feelings toward homosexuals ( $r = .25, p < .01$ ).

Those students willing to provide care for AIDS patients thought they were entitled to the same care as any other patient ( $r = .38, p < .01$ ) and believed children with AIDS should be allowed to attend school ( $r = -.46, p < .01$ ), were willing to provide mouth-to-mouth on an AIDS patient even without an available protective device ( $r = -.52, p < .01$ ), and believed students should be assigned to AIDS patients ( $r = .58, p < .01$ ). They believed, though, that AIDS was God's punishment for homosexuality ( $r = .32, p < .01$ ) and that their feelings about homosexuality might adversely affect their nursing care ( $r = .22, p < .01$ ).

Findings indicated that students with high fear scores were less willing to care for AIDS patients, had higher knowledge scores, and were more homophobic. Although 96.6% of the students thought AIDS patients were entitled to the same care as any other patient, 49% preferred not to care for a patient with AIDS. It is interesting that in this study increased knowledge was related to increased fear.

Van Servellen, et al. (1988) surveyed registered nurses to determine their AIDS-related experience, knowledge, fears, and attitudes. Surveys were mailed to 3,000 randomly selected nurses in the state of California who worked in settings where at least part of their work involved direct patient care. There

was a final group of 1,019 nurses whose responses were analyzed. Data were collected to assess nurses' overall knowledge about AIDS and their styles of practice. Items in the survey included such areas as knowledge of symptoms, whether or not the nurses counseled patients regarding risk factors, etc. Information collected on attitudes of nurses and their fears about AIDS or AIDS care included such items as: willingness to accept an assignment, nurses' perceived personal risk, etc. Information was obtained about the nurses' backgrounds and actual AIDS-related experiences including continuing education.

Most of the respondents (94.3%) were female with a median age range of 35 to 39 years. The highest level of nursing education was: 29.2% graduated from diploma programs; 31.2% completed AA programs; and 34.1% graduated from BS/BSN programs. There were only 4.4% holding MN/MSN degrees and only one with a DNS/PhD degree. Most nurses in the study worked full time with a median range of experience of 10 -15 years.

In completing the task of identifying key symptoms indicative of the early stages of AIDS, nurses were asked to distinguish between AIDS-related and unrelated symptoms. Only 11.9% distinguished correctly between AIDS-related and unrelated symptoms and therefore identified all symptoms correctly. Most nurses (68.7%) knew about groups whose behaviors placed them at high risk, but only 10% correctly identified low risk groups. The majority (81.6%) answered correctly a question on isolation precautions to take when caring for an AIDS patient. The nurses (10.9%) answering incorrectly chose an overcautious approach to isolation precautions. A series of questions were asked that included whether or not assessment forms used by the nurses contained sexual histories with a majority (91.3%) stating they did not routinely

take sexual histories on their patients. Only 17.5% stated they counseled patients about risk of exposure to the AIDS virus.

In measures of AIDS-related fears and attitudes nurses were asked about their perceived level of risk of contracting AIDS. About a quarter (24.5%) of the surveyed nurses believed they were at high or moderate risk for contracting AIDS due to risk of exposure in their current work role. Nearly half (48.5%) reported the average nurse would be considerably uncomfortable discussing sexual matters with a male homosexual. More than one third (38.4%) reported a great deal or moderate levels of discomfort in caring for these patients. Nearly one quarter (23.1%) indicated they would absolutely not accept a job caring for patients with AIDS and only one in eight (12.4%) indicated they would provide care without hesitation. A little over half of the nurses (53.6%) indicated that hospital nurses should be given an option to refuse to take care of AIDS patients or patients suspected to have AIDS-related symptoms.

As a result of the findings, Van Servellen, et al. (1988) recommended continuing education focusing on basic facts about AIDS including epidemiological and scientific information. Another recommendation included emphasizing counseling practices to assist people in decreasing chances of contracting AIDS. Since facts don't override attitudes and fears under all circumstances serious attention should be given to the fears and negative attitudes of nurses. It has long been recognized that fears of caregivers are one cause of nonhumanistic treatment of patients. These fears get expressed in fragmented depersonalized care, patient isolation, and overly cautious behaviors, according to Van Servellen, et al. (1988). Education guided by theories of change can be effective in altering professionals' attitudes. It is

possible to identify ingredients of educational programs that will foster and sustain attitudinal change.

Van Servellen, et al. (1988) concluded that when it comes to negative attitudes and fears a process of unfreezing is necessary, which refers to the process of overcoming resistance to change. Barriers to change revealed in the study included fear of AIDS transmission but also included an unwillingness to care for AIDS patients partly related to discomfort about caring for male homosexuals. The data supported moral indignation as part of the dynamics involved in the refusal of nurses to care for AIDS patients. Programs addressing nurses' biases, whether indirectly or directly, will be more successful if guided by principles of attitudinal changes, according to the authors. Statistical analyses of data were not reported in the study.

In central Pennsylvania, Young (1988) conducted two workshops with a similar format on AIDS to provide the latest information on the disease and to attend to nurses' affective learning needs. The author found 64% of nurses indicated negative feelings toward homosexuality, 27% had neutral feelings, and nine per cent had positive feelings. Participants were 22 registered nurses who worked in positions that were related directly to actual or potential AIDS clients. Nurses were given two pretests: a 20-item cognitive questionnaire related to information about the immune system and a three-item test consisting of open-ended questions about feelings.

The same instruments were administered at the end of the workshop and individually matched with pretest responses. A panel of three sexuality researchers independently assigned the expressed feelings into negative, positive, or neutral categories. Positive feelings were assigned 3, neutral assigned 2, and negative assigned 1. Pretest and posttest responses were

matched and the small sample paired t-test was used to calculate the significance of change ( $t = 14.12$ ,  $p = 0.01$ ). The pretest and posttest were used as a teaching tool as well as instruments to measure change. Each nurse in the group read aloud the feelings expressed on the questionnaire that was randomly redistributed. Feelings were discussed openly while the owner of each feeling remained anonymous. Considerations of feelings dealt with five major areas: 1) recognizing one's own feelings, 2) voluntarily sharing feelings with others, 3) understanding reasons for feeling a certain way, 4) assuming responsibility for one's own feelings, and 5) understanding the professional and personal risks certain feelings carry.

At the beginning of the workshop, 14 subjects (64%) indicated negative feelings, six subjects (27%) indicated neutral feelings, and two subjects (9%) indicated positive feelings. Upon completion of the workshop, 11 subjects (50%) indicated the same category of feelings in the pretest and posttest. Eight (57%) of the 14 subjects who had expressed negative feelings on the pretest moved to the neutral category on posttest measures. According to the author, of those 11 subjects who did express a difference in feelings pretest to posttest, all were in the positive direction. In evaluating the subjects' desire to change, the author found that of the 14 who initially expressed negative feelings, eight subjects (57%) at first stated they did not want to change those feelings. Of those eight, half expressed on the posttest feelings that were no longer negative. Only two of the six who pretested and posttested in the negative feeling category stated they did not want to change both before and after the workshop. Of those 20 subjects (91%) who did not initially express positive feelings, 13 (65%) stated they didn't want to change those feelings; yet six actually did express feelings in a more positive direction, and of that same 13

subjects, six (46%) indicated they did not want to change their feelings when the workshop ended.

Young (1988) stated that more than half of those with negative feelings toward homosexuality expressed more positive feelings upon completion of the workshop and showed that methods used may have been instrumental. Until workshops are conducted using the methods and comparing the results with control groups in which feelings are not addressed, can we assume the change was due to the teaching method. The example from AIDS workshops reveals the great need for nurses to examine feelings in the broad area of human sexuality and the specific area of homosexuality to discover how quality of care may be affected by these feelings, according to Young (1988).

A study by Scherer, et al. (1989) addressed attitudes of 540 western New York nurses about providing care to AIDS patients. Forty-seven per cent of those surveyed believed they had the right to refuse care to AIDS patients. Although most (86%) were sympathetic toward the AIDS patients who acquired the illness from homosexual practices, fifty-nine per cent had less sympathy toward that patient than one who acquired the illness from a blood transfusion. Half of the nurses were fearful of contracting AIDS from the patients.

D'Augelli (1989) assessed rural nurses' fear of AIDS and homophobia during a conference on AIDS in rural Pennsylvania. Subjects were knowledgeable about AIDS, wished to learn more, and were moderately worried about contracting AIDS. Some subjects showed irrational fears, such as being served in a restaurant by a waiter with AIDS (34%), being at a dinner party with a guest who had AIDS (20%), and sharing meals and utensils (52%). Subjects generally held negative views of gay men and lesbians even though few had any knowledge of gay people. There was a significant correlation

( $r = .53$ ,  $p < .001$ ) between homophobic attitudes and AIDS phobia. These findings suggest that feelings about gay men may influence the nature of the care that AIDS patients who are gay might receive.

Scherer (1991) explored nurses' attitudes toward caring for homosexual patients and examined how these attitudes related to variables such as age, sex, education, and marital status. Data suggested that the care of AIDS patients may be complicated by the fact that a lot of the patients are homosexual. Fewer than 60% agreed that homosexuality is an alternate lifestyle that should not be condemned. Only slightly more than half (55%) reported they would feel comfortable in a therapeutic relationship with a homosexual patient. About 25% of the nurses had become more negative about homosexuality since the AIDS epidemic. There were 59% of the sample who felt more sympathetic toward individuals who acquired the disease from a transfusion as compared to those who contracted the disease from homosexual practices.

Eliason and Randall (1991) studied nursing students' attitudes toward lesbians in relation to students' age, sex-role identity, and familiarity with lesbian life-styles. One hundred thirty-four from a pool of 200 nursing students from a large midwestern university volunteered to participate in the study. Most (94%) were Caucasian; 58% were single; 29% were in a committed relationship; and 10% were married. Seventy-nine percent were less than 22 years of age, 16% were freshman, 21% sophomores, 29% juniors, and 33% seniors. Most (98%) students reported they were heterosexual. Social class, according to self-report, representations included 18% working-class, 76% middle-class and six percent upper-class students. Each subject completed a demographic questionnaire, the BEM Sex Role Inventory (BSRI) and 14

political issue statements regarding abortion, the Equal Rights Amendment, AIDS, nuclear weapons, feminism, day care, and lesbian concerns.

Students were asked to view two photographs of women both labeled as lesbians. The attire of the women in the photographs was manipulated to represent feminine and nonfeminine conditions. Subjects were asked to rate how familiar they were with lesbians, how acceptable lesbianism was, how likely they would be to initiate social contact with the individual, and the attractiveness of the woman in the photograph. A control group ( $n = 25$ ) rated the attractiveness of the photos for the purpose of gathering attractiveness ratings and personality data on the photographs without knowing the sexual orientation. Whether the photographic depiction of feminine vs. nonfeminine or the label "lesbian" affected the acceptability ratings of the lesbian life-style, the likelihood of social contact with a lesbian, or the attractiveness of the photographs was determined through a two-way analysis of variance. A main effect for attractiveness in the feminine vs. nonfeminine conditions was the only statistically significant finding. The photographs depicting the feminine condition were rated as more attractive than the nonfeminine condition [ $F(1, 118) = 10.70, p < .01$ ].

Control subjects rated the photographs as equally attractive in both feminine and nonfeminine conditions. Subjects in the control and experimental groups rated the feminine photograph similarly, but the experimental group rated the nonfeminine photograph more negatively ( $t = 2.54, p = .02$ ). The results suggested that lesbian phobia is common among female nursing students. Fifty percent of the students indicated that lesbian life-styles are not acceptable, and 15% thought there should be laws against lesbian sexual behavior. There were only 24% who would be willing to invite a lesbian to their

home. Many believed that lesbians seduce “straights.” Familiarity with lesbians appeared to predict nurses' acceptance. A disconcerting finding for health care providers is that 28% of the sample believed that lesbians are a high-risk group for AIDS.

Martindale & Barnett (1992) conducted a study to identify attitudes of nursing faculty toward persons with AIDS. The sample of 45 associate degree nursing faculty in a southern state completed a questionnaire consisting of 17 knowledge items with true/false response categories and 37 attitude items measured on a 5-point Likert-type scale where 1 = little and 5 = much of the attribute. Homophobia, fear, and willingness to care for PWAs were the attitudes measured. Low scores represented little homophobia and fear of AIDS, and little willingness to give care. High scores represented a great deal of phobia and fear, and more willingness to provide care. Over half of the subjects believed health care workers were at a high risk for contracting HIV on the job, and 25% believed one should wear gloves and gown when going into the room of an AIDS patient. There was a high correlation between homophobia and fear ( $r = .68, p < .01$ ). Both homophobia and fear were correlated negatively with the willingness to care for a patient with AIDS ( $r = -.65, p < .01, r = -.64, p < .01$ , respectively). There was not a significant correlation between knowledge and any other variables.

The majority (76%) of the faculty indicated that their personal feelings would not affect their nursing care. Almost three-fourths (70%) said they would provide care to AIDS patients and 61% indicated that PWAs should be assigned to their students. The data suggested that the more homophobic the faculty member was the more fearful of AIDS. The results showed no

statistically significant relationship between basic knowledge of AIDS and homophobia, fear of AIDS, or the intent to care for persons with AIDS. Persons with more fear and homophobia were less willing to care for a person with AIDS. The findings suggested that learning in the affective domain should be promoted by directing AIDS education toward changing attitudes and values.

Rae, et al. (1992) found no significant correlation between nurses' attitudes toward AIDS and attitudes toward homosexuality in a survey of 331 nurses in a 600-bed teaching hospital. The purposes of the survey were 1) to gather information about employees' knowledge and attitudes regarding AIDS and 2) to provide a basis for the development of an AIDS educational program at the hospital. Most of the nurses were female (95%) with a mean age of 34 years. The nurses were from a variety of practice areas, i. e., surgery, critical care, medicine, etc. There did appear to be a relationship between attitudes toward AIDS, knowledge about AIDS, having cared for AIDS patients, and learning opportunities. The authors also found males had significantly more positive ( $p = .02$ ) attitudes toward homosexuality than did females. The authors did not report the correlation coefficients in the article.

Mueller, et al. (1992) examined undergraduate and graduate nursing and dental hygiene students' attitudes and attitudes of nursing faculty toward HIV, how the attitudes related to behavioral intentions and the natural change among nursing undergraduates over time. The 222 participants who completed the questionnaire were 110 undergraduate nursing students, 51 dental hygiene students, 36 graduate nursing students, and 25 nursing faculty. The instrument was a 66-item questionnaire consisting of nine subscales. The subscales consisted of items derived from published scales or items created especially for the study. The scales used to measure homophobia were the Heterosexuals'

Attitudes Toward Homosexuality (HATH) and a Homophobia scale. The HATH scale is a more general attitude scale with positive statements and the Homophobia scale specifically relates to anxiety and fear about homosexuality. The HATH subscale was taken from the scale developed by Larsen, Reed, & Hoffman (1980). The Homophobia subscale was from the Homophobia scale developed by O'Donnell, et al. (1987). In general, the authors found the two measures of attitudes toward homosexuality correlated relatively high with each other ( $r = -.76$ ), as well as the three measures of behavioral intentions ( $r = .67$  and  $r = .73$ ). The authors did not report the probability levels for the correlations just described.

A multivariate analysis was conducted to analyze differences between the four academic status groups on nine scale scores. A significant difference between the four groups was found, Hotelling's  $T^2 = 2.99$ ,  $F(27, 608) = 2.25$ ,  $p < .001$ . One-way analyses of variance were then conducted to compare scale scores across the four groups. Significant differences on seven of the nine scales were found: Heterosexual Attitudes Toward Homosexuality,  $F(3, 212) = 5.58$ ,  $p < .001$ ; Homophobia,  $F(3, 212) = 6.47$ ,  $p < .001$ ; Attitudes Toward Intravenous Drug Users,  $F(3, 212) = 7.77$ ,  $p < .001$ ; AIDS-Related Work Stress,  $F(3, 212) = 5.74$ ,  $p < .001$ ; AIDS-Phobia,  $F(3, 212) = 8.15$ ,  $p < .001$ ; Behavioral Intentions to Work With AIDS Patients,  $F(3, 212) = 3.63$ ,  $p < .02$ ; and Behavioral Intentions to Work with Homosexual Patients,  $F(3, 212) = 4.60$ ,  $p < .01$ . Tukey's HSD analysis tested specific group differences. Nursing faculty held significantly different views from dental hygiene students on all seven scales that produced overall effects. On only the Homophobia scale did the faculty and the graduate students differ significantly. Views of the undergraduate nursing

students and faculty significantly differed on six of the seven scales, all but the behavioral intentions concerning AIDS patients. On three scales, the undergraduate nursing students held significantly more positive attitudes than the dental hygiene students: Attitudes Toward Intravenous Drug Users, AIDS-Related Work Stress, and Heterosexual Attitudes Toward Homosexuality. Nursing faculty and nursing graduate students were found to hold the most positive attitudes and behavioral intentions in a comparison across groups. The least positive attitudes and behavioral intentions were reported by dental hygiene students. The data suggested negative attitudes toward HIV patients related to general attitudes about homosexuality and drug use, as well as negative attitudes about HIV/AIDS.

Jemmot, et al. (1992) examined predictors of intentions to care for AIDS patients among 153 nursing students, 95% women, at a university in New Jersey. The mean age was 23.5 years. Fifty-five percent were sophomores and 45% seniors. Results indicated support for the hypothesis that students who had stronger avoidance behavior intentions to work with AIDS patients had lower scores in knowledge about AIDS ( $r = -.37, p < .0001$ ), perceived greater personal risk in giving AIDS patient care ( $r = .32, p < .0001$ ), and expressed more negative attitudes toward homosexuals ( $r = .34, p < .0001$ ) and intravenous drug users ( $r = .35, p < .0001$ ). There was no evidence that AIDS content in the nursing curriculum impacted attitudes toward homosexuality or intravenous drug users. The researchers stated that AIDS education efforts should emphasize attitudinal issues and humanism in patient care.

Scherer, et al., (1992) researched critical care nurses' attitudes toward caring for patients with AIDS. The convenience sample ( $n = 236$ ) consisted of 93% women from 17 states with a mean age of 35. Ninety-one percent reported

they had cared for AIDS patients. The data suggested nurses were afraid of contracting the disease from patients (59%) and of not knowing if their patients had AIDS (67%). The nurses also had concern about upsetting their significant others by caring for AIDS patients (40%).

Meisenhelder (1994) studied registered nurses for the purpose of testing the strength of six factors contributing to "fear of contagion", an anxious response to the perceived threat of AIDS. The survey was conducted through the mail. Fear of contagion was measured with the 14-item Fear of AIDS Scale (Bouton, Gallaher, Garlinghouse, Leal, Rosenstein, & Young, 1987). Homophobia was measured by the 7-item Homophobia Scale (Bouton, et al., 1987). Six knowledge questions about HIV transmission were included. Fear of Death was measured by a single question on a 5-point rating scale: "I am afraid of death." Fear of the unknown was measured on a 5-point scale using the statement, "I don't trust scientists when they say AIDS cannot be transmitted by touching or social contact." Fear of punishment was measured on a 5-point scale with the statement, "If I found out I had AIDS, I would be afraid of my friends' or my family's reaction." Emotional involvement was conceptualized to represent the degree of identification. Two questions were developed by the author with a 5-point rating scale concerning degree of emotional involvement with homosexuals or PWAs in any type of professional or social relationship. The two questions were not reported.

The study used a mail survey with 200 randomly selected registered nurses from the Massachusetts state registry listing. There was a 57% return rate with the sample consisting of 114 registered nurses. Subjects ranged in age from 22 to 65 (mean = 41). There was a broad distribution of specialty areas with the largest group (37%) in adult acute or intermediate care. Almost

half (48%) were diploma graduates, 10% associate degree graduates, 25% baccalaureate graduates, and 16% were master's degree graduates.

Homophobia ( $r = .60$ ,  $p < .0001$ ), lack of knowledge ( $r = .48$ ,  $p < .0001$ ), fear of the unknown ( $r = .56$ ,  $p < .0001$ ), and lack of emotional involvement ( $r = .46$ ,  $p < .0001$ ) were all highly correlated to fear of contagion. Fear of punishment was significantly correlated to fear of contagion, though to a lesser degree ( $r = .17$ ,  $p < .035$ ). Fear of death was not correlated ( $r = .03$ ). In a multiple regression of fear of contagion with homophobia, lack of knowledge, lack of emotional involvement, and fear of the unknown, 57% of the variance in fear of contagion was predicted ( $R^2 = .569$ ,  $p < .000$ ). Education ( $r = -.219$ ,  $p < .009$ ) and hours per week working ( $r = -.193$ ,  $p < .021$ ) were the only demographic variables significantly correlated with fear of contagion. Higher education was associated with lower levels of fear and the more hours worked, the lower the level of fear. The author expressed the belief that more hours worked led to increased contact, and therefore increased emotional involvement with people who are HIV positive.

It is often assumed that fear of HIV contagion stems from the threat of a lethal disease and from lack of information related to transmission. According to Meisenhelder (1994), the results of the study contradict those beliefs. Fear of death had no relationship to fear of contagion or to any of the other variables. Lack of knowledge was the weakest predictor of fear. According to the findings, fear of HIV contagion is strongly related to homophobia, fear of the unknown, and lack of emotional involvement (the inability to identify with a person who may be HIV positive).

Homophobia is pervasive in America. As a part of this homophobic

society, nurses are influenced by the same beliefs and values held by the larger society. In an analysis of American health care literature from 1983 to 1987, Schwanberg (1990) found that 61% of the empirical studies, letters to the editor, policy statements, and opinion papers expressed negative views of homosexuals. Recent media coverage of gays' and lesbians' attempts to achieve equal rights brought out public reactions indicating that there are still strong homophobic feelings in our society (Grossman, 1994). There have been studies of college students and various healthcare groups as described in the above literature review indicating that homophobia influences fear of AIDS. One study found no correlation between homophobia and fear of AIDS. In the studies examining attitudes toward AIDS and homophobia among nurses, nursing students, and nurse faculty, homophobia was found to be a contributor to fear of AIDS in all but two (Rae, et al., 1992; Scherer, et al., 1992). In conclusion, AIDS is occurring in a society that disapproves of homosexuality. Within this social context there are affective responses to HIV infection.

#### Affective Education

AIDS education programs for nurses must include affective components to help nurses deal with feelings related to caring for patients with a fatal disease as well as affective components to help alleviate negative feelings toward those labeled as homosexual (Young, et al., 1989). Feelings and attitudes are closely associated. How an individual feels toward a situation often predicts the individual's behavior. Attitudes are learned and predispose an individual to react to a situation in a fairly predictive way, according to Fishbein (1969). Since attitudes are learned they can be unlearned, but the change takes time.

According to Bandura (1977) change is mediated through cognitive processes and people need corrective learning experiences in order to change. Modeling and vicarious processes are some fundamental means by which new behaviors are acquired and existing behaviors modified (Bandura, 1977). Attitudes are important determinants of actions, so any changes brought about in the attitudinal domain will affect behavior, according to Bandura (1977).

There are three general approaches, according to Bandura (1969), to induce attitudinal change: belief-oriented approach, affect-oriented approach, and behavior-oriented approach. The assumption made in the belief-oriented approach is that people can be induced to change attitudes with new information about the attitude object. The belief-oriented approach may be somewhat limiting unless there is an accompanying means of reinforcement. The affect-oriented approach utilizes procedures based on classical conditioning. An example is pairing attributes of attitude objects with verbal stimuli or pictorials. Other examples include modeling and desensitization. In modeling, the person is exposed to one or more other individuals (present, or in film) who demonstrate behaviors to be adopted by the person (Rimm & Masters, 1974). Essentially, modeling is using imitation as a method of behavior change. Desensitization, according to Murray & Huelskoetter (1991) is "an experience of gradual exposure, relearning, and retraining, whereby the person places self near or in the feared situation by small steps and degrees until the fear is overcome" (p. 433). The behavior-oriented approach and consistency doctrines assume that disruption of internal equilibrium constitutes a basic determinant of attitude change. Cognitive dissonance and performance of counter-attitudinal behavior such as role-playing are examples.

According to Allport (1958), role-playing and other techniques that lead

to a kind of “forced empathy” is one of modern social science’s boldest advances. It is a way of feeling what it’s like to be in someone else’s shoes. It may also lead to insight into one’s own motives, anxieties, and projections. Social support appears to be a necessary part of overcoming prejudiced social norms (Allport, 1958).

Anderson (1982) studied 64 female nursing students who were seniors in a midwestern university school of nursing. There were 38 students in the experimental sample and 26 in the control group. Pre- and posttests were given to experimental and control samples exposed to a 2-hour workshop on homosexuality. Pretest and posttest measures were obtained on the Survey of Attitudes Toward Deviance-Homosexuality Scale, a 50-item Likert-type attitude and belief scale about homosexual males. Thirty-seven in the treatment group and 23 in the control group completed the posttest. The entire experimental sample changed more than 35 points in a positive direction from pre- to posttest ( $t = 8.08, p < .001, 36 \text{ df}$ ). Control group change was less than a point. The experimental group was divided into Group A (those who attended a segment at which presenters did not identify themselves as homosexual until after the posttest) and Group B (presenters immediately identified themselves as gay). As a result of the workshop experience, female nursing students had less negative views and less stereotyping of a homosexual male.

Serdahely & Ziemba (1984) hypothesized that a unit on homosexuality that emphasized role playing and debunking myths would significantly decrease scores on a measure of homophobia. The unit of study was presented as part of an undergraduate course on human sexuality to the treatment group ( $n = 41$ , 26 women and 15 men). The control group ( $n = 47$ ) contained 29 women and 18 men who were enrolled in an undergraduate drug

education course. The mean age of the control group was 22 years. The mean age for the treatment group was 20.7 years. Students came from a wide variety of academic majors. No one particular curriculum predominated in either the treatment or control group. Subjects were pretested with a modified version of the Index of Homophobia (Hudson & Ricketts, 1980). The pretest median was used to divide the treatment and control group students into two groups: those above the median and those below the median. A student's t-test was used to determine if there were statistically significant changes between treatment and control groups. No significant differences between the control and treatment groups were found on the pretest scores ( $t = 1.11$ , 86 df,  $p < 0.26$ ). After treatment, there was a statistically significant difference between the means of the control and the treatment group.

The mean difference in pretest and posttest scores for the "above the median" category was 0.6 for the control group and -5.6 for the treatment group. A t value of 2.45 was found for 37.55 df with a one-tailed probability of 0.01. In the category "below the median", the mean difference in pretest and posttest scores was -0.5 for the control group and -0.3 for the treatment group. A t value of -.06 for 34.62 df was found with a two-tailed probability of .950. There was an average decrease of 5.6 points in the "above the median" treatment group and an increase of 0.6 points in the control group. The treatment groups' scores decreased after treatment and also when compared to controls, there was a statistically significant difference between the means ( $p = .01$ , no statistic reported in the article for this p value). There was no significant difference between the means of the treatment group and control group in the "below the median" category. Results of the study suggested that homophobic scores decreased for students whose pretest scores were above the median (high

homophobia) and were exposed to the homosexuality unit. The students in the “below the median” category did not have a significant increase in scores of homophobia; therefore, the respondents did not appear to become homophobic following the treatment.

Young, et al (1989) conducted an all-day workshop with 200 nurses from rural New York and Pennsylvania and measured changes in knowledge and attitude toward AIDS and homosexuality before, immediately after, and three months after the workshop. The pretest and posttest consisted of demographic and open-ended questions, a 10-item knowledge test, and a 17-item attitude scale. The scores on the knowledge test ranged from 0 to 10, with 10 being the highest level of knowledge. The average score of participants on the pretest was 4.7, a score of 8.0 on the posttest, and a score of 6.9 on the three-month follow-up test. There was a statistically significant increase in knowledge from the pretest to the posttest ( $t = -22.06$ ,  $df = 132$ ;  $p < 0.001$ ) and from the pretest to the three-month follow-up ( $t = -8.64$ ,  $df = 117$ ;  $p < 0.001$ ).

Attitude scores ranged from 17 (most negative feelings) to 75 (most positive feelings), with 51 representing “uncertain.” The mean pretest score on attitude was 55.8, posttest was 58.6, and follow-up was 59.2. There was a significant increase in a positive direction from pretest to posttest on attitude scores ( $t = -7.13$ ,  $df = 128$ ;  $p < 0.001$ ) and from pretest to three-month follow-up ( $t = -3.10$ ,  $df = 110$ ;  $p < 0.002$ ). The program was introduced with a film providing general information on AIDS followed by discussion of the disease from infection to death, including information on transmission and statistics. There was emphasis on the specific behaviors that place individuals at risk rather than labeling groups of people as high risk. Homosexuality was addressed related to stereotypes with particular attention focused on the affective responses of the

participants. Ample time was allocated to the discussion of misconceptions about homosexuality and for dialogue and questions from participants. A variety of teaching methods were used such as role-playing, discussions, group activities, reading about homosexuality, and discussing feelings with friends and colleagues. These affective education strategies were found to have successfully influenced nurses to change attitudes to more positive ones. The change was associated with a decrease in fear and an increase in willingness to care for PWAs. The program's affective component was more closely related to behavioral change than was cognitive education.

Flaskerud, et al. (1989) interspersed a combination of lecture, discussion groups, and question and answer periods in a one-day workshop at a major medical center in southern California to determine the effects of an AIDS continuing education conference on the knowledge and attitudes of nurses. There were 125 subjects in the study who were pretested and posttested using a structured questionnaire measuring AIDS-related knowledge and attitudes, as well as satisfaction with the conference. AIDS epidemiology and etiology, infection control, psychosocial and institutional support for health care workers, sexual history taking and counseling, attitudes toward risk behaviors and the major transmission groups, and legal and ethical issues were all included in the content of the program.

Participants were retested two to three months following the conference. Flaskerud, et al. (1989) developed an instrument based on a literature review and review of other available instruments measuring the concepts of knowledge, attitudes, and satisfaction which was used to pretest, posttest, and retest each participant. Using a repeated measures analysis of variance, pretest/posttest and pretest/retest, changes in knowledge and attitudes were

examined. Pretest/posttest changes were significant in both knowledge  $F(1, 124) = 24.73, p = 0.00$  and attitudes ( $F(1, 124) = 16.56, p = 0.01$ ) and were retained at retest ( $F(1, 124) = 6.93, p = 0.01$ ;  $F(1, 124) = 16.30, p = 0.00$ ). Knowledge levels increased and attitudes improved following the educational program. A post hoc comparison using two-tailed  $t$  tests, with alpha set at 0.005, was done to determine pretest/posttest and posttest/retest changes in scores for the knowledge and the attitudes scales. The effectiveness of the educational program in increasing knowledge levels and improving attitudes of the sample was supported by the significant pretest/posttest differences in both knowledge and attitudes.

Support for the interpretation that changes in knowledge and attitudes had been sustained in the three-month period since the conference was found when neither posttest/retest differences in knowledge nor in attitudes was significant ( $t$ -value of -1.26 and -1.53, respectively with two-tailed probability of 0.213 and 0.130, respectively). The sample was divided into a low-knowledge and a high-knowledge group, and differences in knowledge for each of the two groups were determined with the use of two-tailed  $t$  tests. Support was found for the interpretation that changes in knowledge occurred in the group that was least knowledgeable. There were significant differences in pretest/posttest and pretest/retest scores of the low knowledge group but not in the posttest/retest scores. None of the differences were significant in the high knowledge group. According to Flaskerud, et al. (1989), most investigators agree that AIDS - related knowledge can be changed with traditional teaching of facts, but to change attitudes other teaching methods are needed. Repetitive learning and demonstrations, attitude examination exercises, role playing, audio visuals, discussion groups, and experiential components are needed.

Flaskerud (1991) proposed a three-tiered psychoeducational model for changing nurses' knowledge and clinical skills, knowledge and attitudes, and attitudes alone. The first tier covers knowledge and the second and third build on the first and each other, and have an added dimension of focusing on attitudes. Nurses' attitudes about HIV infection are influenced by fears of infection and anxiety over lack of information. To bring about a change in attitudes requires more than just providing additional information about HIV/AIDS and clinical skills. Attitudes are also formed by negative social and moral judgements about homosexuality.

Flaskerud (1991) proposed educational strategies with a strong affective component in a nonthreatening environment in order for participants to openly express feelings. An affective education program dealing with fear of AIDS and homophobia would include identifying what frightens or angers nurses about homosexuality. Involving gay men, HIV infected individuals, PWAs, and drug users in the programs would give the nurses opportunities to engage in dialogue with persons they may not have known previously. D'Augelli (1989) and Fish and Rye (1991) suggest involving gay men in educational programs to provide ample opportunities for interactions with homosexuals to reduce homophobia.

Affective exercises and a 1 1/2 hour panel discussion were the approaches used by Peters and Connell (1991) in a one-day workshop to meet the affective objectives of psychosocial sensitivity and awareness of both the discomforts and the rewards of caring for HIV infected or AIDS patients. The workshop was developed through the continuing education program of the Indiana University School of Nursing in Indianapolis. A panel of persons living with AIDS, which included self-identified homosexual men, heterosexual

women with children, and substance abusers, discussed their coping with death and altered relationships, their specific experiences in receiving care that were helpful and supportive, or painful and destructive, and their concern for their caregivers. Affective exercises consisting of loosely structured discussions of feelings, attitudes, opinions, and beliefs in an accepting atmosphere followed the panel discussion. Discussing sex "out loud" in a professional context may help in desensitizing the subject. Participants were helped to sort out facts from feelings. According to the authors, the key to the success of an affective education program is for the instructor to remain nonjudgmental during frank expressions by participants that may seem insensitive, rigid, or state irrational ideas and beliefs about PWAs. In an evaluation of the workshop at the end of the session, a majority of the participants reported knowledge acquisition and increased comfort and acceptance of persons with AIDS. As of 1991, the workshop had been presented five times, according to the authors.

Oermann and Gignac (1991) studied the relationships among knowledge, attitudes, and willingness to care for patients with AIDS. The subjects were 166 Canadian nursing students and faculty. A descriptive-correlational design was used in which four levels of BScN students and faculty completed the "AIDS Knowledge and Attitudes Assess Test". Parts one, two, and three measured knowledge component, and part four was a Likert-type scale with weighted responses dealing with attitudes and issues such as AIDS testing and human rights of PWAs. Scores related to knowledge about AIDS increased as students progressed through the program except for the measure of attitudes and willingness to care for or have contact with PWAs. Faculty scored similarly to students on part four, but had the highest knowledge scores. Attitude scores were low across the student groups and the faculty. An

ANOVA indicated significant differences across the groups in the mean scores on disease typology ( $F = 5.86, p < .001$ ), technical practice ( $F = 8.10, p < .001$ ), communication skills ( $F = 6.37, p < .001$ ), and on total knowledge ( $F = 10.63, p < .001$ ). No significant difference was found on attitude scores based on the year of the nursing program.

Relationships between knowledge and attitude scores for each group were examined using Pearson's  $r$ . Significant positive relationships between knowledge and attitudes for the total sample were revealed ( $r = 0.15, p < .05$ ) and for students in the first year ( $r = 0.42, p < .05$ ) and the third year ( $r = 0.37, p < .05$ ). A trend toward significance was found for the second year ( $r = 0.35, p = 0.058$ ). As a whole, subjects with more knowledge about AIDS expressed more positive attitudes toward PWAs. A significant difference in total knowledge score between subjects who knew a homosexual and those who did not was found ( $t = 2.08, df = 119, p < .05$ ). Attitude scores were relatively low in all groups, including faculty. The authors advocated that educational strategies be developed for improving attitudes toward AIDS patients and creating a greater willingness to participate in patient care. Teaching strategies need to address both the cognitive and affective domains. Furthermore, affective learning should be subject to the same pedagogic demands as other domains of learning, so development of positive attitudes cannot be left to chance.

Eliason and Randall (1991) suggested that nursing faculty include lesbian culture in discussions of subcultures. Using workshops, panel discussions, and guest speakers in the nursing curriculum will expose students to the richness and diversity of alternative lifestyles. Students should be assigned to lesbian clients and/or experiential role-play situations in clinical settings.

Piskur and Degelman (1992) addressed the use of written materials about the determinants of sexual orientation as a way of affecting scores assessing attitudes toward homosexuality when measured immediately after the reading. The sample consisted of 105 students, 50 men and 55 women, who were attending a church-affiliated liberal arts college. Ages ranged from 18 to 45 years with the mean age 21. Homophobia was measured by a modified version of the Index of Homophobia, now the Index of Attitudes Toward Homosexuals (IAH) developed by Hudson & Ricketts (1980). Researchers placed subjects in one of three groups: experimental group, informational control group, or no-information control group. The authors developed articles for both the experimental group and the informational control group. The article for the experimental group focused on research tending to support a biological explanation of sexual orientation. The informational control group read an article summarizing research that did not find differences in circulating levels of sex hormones in homosexual and heterosexual men. Subjects completed the attitude scale after reading the summary article. Subjects in the no-information control group completed the scale without any reading. Scores on the IAH for all condition-gender combinations were analyzed in a three (information condition) by two (gender) ANOVA. A statistically significant main effect of information condition ( $F_{2, 99} = 3.22, p < .05$ ) was found. The mean scores for the experimental, information control, and no-information control groups were 71.8, 80.2, and 77.0, respectively. The mean for the experimental group was significantly different from that of the information control group and the combined control conditions ( $p < .05$ ) but not in the no-information control group ( $p > .10$ ). No statistically significant difference was found between the means of the two information control groups ( $p > .10$ ).

There was no statistically significant main effect of gender ( $F_{1, 99} = 2.23, p > .10$ ), but an analysis of attitude scores yielded a statistically significant interaction between information condition and gender ( $F_{2, 99} = 3.13, p < .05$ ), primarily related to the relatively low mean score for women in the experimental group. Further confirmation was found by analyzing the simple main effects of information condition for men and women. For women the scores reflected significantly more positive attitudes toward homosexuals ( $F_{2, 99} = 5.00, p < .01$ ), but in men no significant effect was found ( $F_{2, 99} = 1.19, p > .10$ ).

Exposure to a written summary of research that supports biological determinants of homosexuality can effect scores assessing attitudes toward homosexuality when measured immediately after the reading was the major finding of the study. The reading resulted in significantly lower (less negative) scores for women than men when compared to control conditions where subjects read nothing or read a research summary focusing on absence of hormonal differences between homosexual and heterosexual men. One possible explanation is that women may be more open to change following receipt of relevant information than men. The finding of lower scores for women was complicated by the fact that much of the summarized research dealt primarily with men without any effort to assess social expectations in the testing situation. The finding did not enable the identification of specifically what in the summary article was associated with less negative scores. The authors identified two limitations of the study: 1) Students were in a church-affiliated college, and research has shown an association between religiosity and negativity toward homosexuals and 2) A single reading of an article followed by

an immediate measure of attitude was used. It is noteworthy, however, that the reading of a summary article does provide the kind of information to which people are exposed through the newspaper and magazines.

Programs addressing the affective domain and intended to change values and attitudes need to be developed (Martindale & Barnett, 1992). In the study, faculty said their prejudice against homosexuals would not affect their nursing care, but results showed persons with more fear and homophobia were less willing to give care to PWAs. The authors thought respondents may have answered some questions in a socially acceptable way and not aware of the affect their attitudes had on their willingness to give care to PWAs. The study is discussed in detail earlier in this paper.

Social problems such as AIDS have a strong affective component, according to Pederson (1993) and cannot be dealt with only by providing factual information. Pederson (1993) conducted an experimental study employing a posttest control design within the context of a larger investigation by Pederson in 1990. The research aims of the study were to: 1) compare the effectiveness of structured controversy with lecture in influencing beliefs about and attitudes toward providing care for PWAs and 2) determine the accuracy of nursing faculty perceptions of nursing students' beliefs about and attitude toward providing care for PWAs. The study employed a convenience sample of a class of 51 senior BSN students enrolled in a required nursing course in a midwestern university. Forty of the students were basic students and 11 were RN-to-BSN students. A 20-item questionnaire was developed patterned after Ajzen and Fishbein (1980) guidelines in order to measure factors influencing students' intention to provide care for PWAs. The Ajzen and Fishbein (1980) model maintains that one's attitude toward performing a behavior is determined

by one's beliefs about a given behavior and evaluations of outcomes of that behavior.

The control condition was a lecture on AIDS and the experimental condition was structured controversy. In the treatment condition small group members argued both for and against the position that "All nurses who provide patient care should be expected to provide care for persons with AIDS" (p. 77). Groups were then compared using t-tests on posttest responses to individual attitude and belief items. Students' responses to the scale of attitude items and the scale of behavioral beliefs multiplied by their corresponding evaluation were factor analyzed. A one-way analysis of variance measured the differences between groups on each extracted factor. With the use of t-tests, faculty perceptions of how students would respond were compared with actual responses. Students in the treatment (structured controversy) group were significantly more positive than students who had listened to the lecture on Belief Factor 1,  $F(1, 45) = 4.18, p = .05$  (structured controversy group,  $M = 28$ ; lecture group,  $M = -.30$ ). Between groups differences did not reach significance on Belief Factor 2,  $F(1, 45) = 1.43, p = .24$ ; or the Attitude Factor,  $F(1, 45) = .87, p = .36$ . Independent t-tests on individual attitude and belief scale items compared students in the structured controversy with students who listened to the lecture. Students in structured controversy were more positive on five of the six attitude items, all four belief items, and three of the four evaluations of the importance of an outcome of providing care for PWAs.

Independent t-tests showed faculty predicted students would believe more strongly that working with PWAs would involve working with people living a homosexual lifestyle than students actually believed  $t(81) = -2.95, p < .01$  (faculty,  $M = 6.06$ ; student,  $M = 5.31$ ). Faculty predicted students would be less

positive than students actually were about providing care to PWAs. These items were safety,  $t(81) = 2.72, p = .01$  (faculty,  $M = 4.23$ ; student,  $M = 5.00$ ); not stressful,  $t(81) = 1.95, p = .06$  (faculty,  $M = 2.23$ ; student,  $M = 2.27$ ); and beneficial,  $t(81) = 1.79, p = .08$  (faculty,  $M = 5.06$ ; student,  $M = 5.58$ ).

Several reasons may explain why students who participated in the structured controversy condition had significantly more positive attitudes and beliefs. According to the authors, students' beliefs were influenced by: 1) cognitive rehearsal as they prepared their arguments, 2) the conceptual conflict that occurred when they encountered new ideas through planning and arguing, and 3) counter-arguing their previously held positions. In addition, structured controversy provides a nonthreatening setting in which to discuss attitudes and beliefs. Social problems such as AIDS cannot be dealt with only on a level of factual knowledge. Faculty might consider structured controversy as an effective technique of addressing controversial issues in nursing.

AIDS education represents a challenge to nurses. AIDS education programs must emphasize attitudinal change as well as updated knowledge (Young, 1989). Factual knowledge is not adequate to deal with social problems such as AIDS which have a strong affective component (Pederson, 1993). This review of the literature has examined some educational strategies for incorporating an affective component into AIDS education.

### Summary

Studies of nurses and student nurses indicate a relationship exists between attitudes toward AIDS and attitudes toward homosexuality. Furthermore, the negative attitudes toward homosexuals so common in our society, may adversely affect the care provided to HIV infected patients.

Variables such as gender and religiosity have been investigated as mediating variables in fear of AIDS. Although Bouton and colleagues found only a 0.55 correlation ( $p < .001$ ) in their 1985 study and 0.48 ( $z = 1.40$ ,  $p > 0.10$ ) in 1989, other studies have found a strong correlation ( $r = 0.68$ ,  $p < .01$ , Martindale & Barnett, 1992;  $r = 0.60$ ,  $p < .0001$ , Meisenhelder, 1994;  $r = 0.75$ ,  $p < .001$  &  $r = 0.70$ ,  $p < .001$ , McDevitt, et al., 1986 & 1988, respectively;  $r = 0.62$ ,  $p < .01$ , O'Donnell, et al., 1987; and  $r = 0.64$ ,  $p < .001$ , Mueller, et al., 1992).

There are some problems in interpreting the data in many studies. Although claims of relationships between the variables of fear of AIDS and homophobia are made, few show correlations of the magnitude of 0.7, the generally held value to indicate a strong correlation between variables. Whether or not homophobia drives fear of AIDS or whether some other variable drives both has not been clearly shown.

Another area of investigation was affective education. There is evidence in the literature that attitudes can change through programs specially designed to explore feelings and utilizing experiential techniques. Further study of attitudes toward AIDS and homosexuality and methods to facilitate change of negative attitudes are relevant in order to facilitate a more therapeutic environment for people who are HIV infected.

## Chapter 3

### METHODOLOGY

The purpose of this study was threefold: 1) to assess the level of fear of AIDS and homophobia in associate degree nursing students, 2) to investigate the relationship between fear of AIDS and homophobia in this sample, and 3) to examine the effectiveness of reducing homophobia and fear of AIDS through an affective educational program. The specific purposes were to design and implement an affective educational program for nursing students to determine if such a program would change attitudes toward homosexuals and reduce fear of AIDS.

#### Population

The population consisted of nursing students in an associate degree nursing program at a community college in the southwest. The Department of Nursing offers two programs, a practical nursing certificate program which encompasses the first year of the associate degree program, and an associate degree nursing program. There were 75 students in the first level (practical nursing program) and 79 students in the second level (associate degree program).

#### Sample

The 22 subjects of the study were student nurses in the first year of an associate degree program at a community college in the Southwest who will be

eligible to take the LPN exam upon the completion of this first year of study. All participants were at the same level of the curriculum and had minimal experience in HIV/AIDS content or in caring for patients with HIV/AIDS. A convenience sample of students was obtained. The affective education program was held during the final three weeks of the semester, at a time when students were preparing for final examinations. This may largely explain the low number of students willing to participate in the study. The researcher went to the regularly scheduled nursing classes to explain the study and asked for volunteers to participate in the study.

In order to protect human subjects' rights, a Protocol Form was submitted to the Department of Nursing Human Subjects' Rights Committee for approval. Approval was granted on April 15, 1994. The Human Subjects' Rights Protocol Form was submitted to the Office of Research Administration at UNLV for final approval prior to data collection. Approval was granted on April 20, 1994. See Appendix A.

Each participant in the study received a cover letter and consent form. See Appendix B. Participation was voluntary and confidentiality was maintained. Participant consent was validated by signing a consent form.

### Design

To determine the effects of the educational program on homophobia and fear of AIDS of associate degree nursing students, a quasi-experimental time-series design was utilized. Subjects were randomly assigned to either the experimental or control group. The time-series (pretest/posttest I/posttest II) design was used to allow for change within groups over time. Pretest to posttest comparison of scores assisted in determining the effects of the experimental

variable. Comparison of the pretest scores between the experimental and control groups identified the level of fear of AIDS and homophobia of each group prior to the intervention. Posttest scores of the experimental and control group were compared to identify any changes for both groups. Data on selected demographic and independent variables of age, gender, ethnicity, marital status, religion, previous exposure to homosexuality, and experience in AIDS care were collected and analyzed to compare the groups, identify variables affecting homophobia and fear of AIDS, and to identify future needs in nursing and AIDS care.

The following research hypotheses were proposed: 1) nursing students' scores on a homophobia scale will be positively correlated with scores on a fear of AIDS scale, 2) nursing students who complete a program on understanding homosexuality will demonstrate a significant decrease in levels of homophobia as measured by pretest and posttest scores on a homophobia scale, 3) nursing students who complete a program to increase understanding of homosexuality will demonstrate a significant decrease in fear of AIDS measured on a fear of AIDS scale, and 4) nursing students in the control group will demonstrate no significant decrease in homophobia or fear of AIDS measured on a homophobia scale and fear of AIDS scale.

#### Educational Intervention

The course on homosexuality was conducted in three consecutive weekly evening sessions. Each session was two hours in length. A one-hour home module was completed between sessions one and two and between sessions two and three. There were a total of eight hours of education.

The course objectives and content were developed from several sources

found in the literature (Blumenfeld, 1992, e.g.). The course focused on reducing negative attitudes toward homosexuals and homosexuality for the purpose of decreasing homophobia and fear of AIDS. There were informational and experiential components. The learning experiences were selected from a review of the literature on homophobia.

The methods of presentation of the course content varied depending on the specific objectives of each session. The methods included were: lecture-discussion, audiovisuals, role playing, group exercises, and outside reading assignments. Each session consisted of a didactic portion and an experiential portion. The combination of these methods has been shown to be effective (Blumenfeld, 1992).

The three two-hour sessions were spaced one week apart to allow for absorption and assimilation of experiences of the previous week. This also provided time for completion of home assignments. The sessions were conducted in a college classroom during the Spring, 1994, semester. A course syllabus was provided to the participants and included objectives, selected readings, class exercises, and handouts. The complete course outline is described in Appendix E.

The control group met with the researcher for the same number of hours in the morning on the same day as the experimental group. The content of that course was related to assisted suicide/euthanasia and no content on AIDS or homosexuality was discussed. The teaching methods were the same as for the experimental group, which included mini lectures, group exercises, role playing, and outside reading assignments. See Appendix F.

### Data Collection

All students were invited to participate in the study on a voluntary basis. Each participant in the study was given information by the investigator regarding the nature of the study and a letter of consent to sign prior to data collection. The consent form described the nature of the study, confidentiality issues, and a method for the participant to withdraw from the study. Prior to beginning the first session all subjects completed three instruments: Fear of AIDS Scale (Bouton, et al., 1987), Homophobia Scale (Bouton, et al., 1987), and a Demographic Information Tool. Data on selected demographic and independent variables of age, gender, educational level, race, marital status, religion, previous exposure to homosexuality, and experience in AIDS care were collected and analyzed to compare groups, identify possible variables affecting homophobia and fear of AIDS, and identify future research needs in nursing and AIDS care. Fifteen minutes were allowed for completion. The instruments were distributed and collected by the researcher.

The Fear of AIDS Scale and the Homophobia Scale were administered a second time immediately following the final session of the course (posttest I) and again 6 weeks later (posttest II). Posttest II data collection included two additional items: 1) GPA and 2) Did you discuss the class with anyone in the other group? Code numbers were used to identify subjects in order to match demographic, pretest, and posttest information. The posttest II scales were administered by the investigator during a pre-arranged time at the college. Posttest II was administered to determine temporal stability (Campbell & Stanley, 1963). The subjects completed the scales in the presence of the researcher to assure control of information.

The control group completed the Fear of AIDS Scale, the Homophobia

Scale, and the Demographic Information Tool during the same week as the experimental group. The scales were administered by the researcher during scheduled class sessions. Posttests I and II were administered by the researcher to the control group during the same weeks as the experimental group.

### Tools

A 15-item demographic questionnaire was developed by the researcher for the purpose of collecting selected demographic data. These data were used to identify similarities and differences between the experimental and control groups on key variables and to examine relationships between the demographic data, Fear of AIDS Scale, and Homophobia Scale.

Fear of AIDS was measured by Bouton's, et al. (1987) Fear of AIDS Scale. Bouton, et al. (1987) used Thurstone's method of equal-appearing intervals in constructing this scale. The authors generated approximately 40 items. Twenty statements remaining after an initial culling were administered to 90 freshman students taking introductory psychology courses at the University of Texas at Austin. The 20 items were then used in three different orders to control for order bias. Judges rated the degree to which each statement expressed a fear of AIDS using an 11-point scale. A low rating was an indication of little fear of AIDS and a high rating indicated high fear of AIDS. On each statement, the authors identified the median and semi-quartile range. Statements were included in the scale if the medians fell outside the middle range of possible values, and if they had a relatively low variability. No positive statement with a median value higher than 3.92, and no negative statement with a rating lower than 9.53 was included in the final set of items. Additionally, no

statement with a semi-interquartile range (Q) value higher than 1.76 was included. Positive and negative statements were equally selected. A final scale of 14 statements was selected (Bouton, et al, 1987).

This 14-item scale was then administered to a group of students (n = 528) at the University of Texas at Austin. Scores of 0, 1, 2, 3, & 4 were assigned to the response choices. The response choices are strongly agree, agree, undecided, disagree, and strongly disagree. A score for each subject was obtained by summing the values of each item. The positive items ranged from strongly agree (0) to strongly disagree (4) and the negative items were scored in reverse order. This scoring results in the higher the score the greater the fear of AIDS. Possible scores ranged from 0 to 56 (Bouton, et al., 1987).

Homophobia was measured by Bouton's, et al. (1987) Homophobia Scale which was constructed concurrently with the development of the Fear of AIDS scale, using the same initial sample. Thirty statements about homosexuals and homosexuality were developed, of which 18 statements remained after the initial culling. The same sample of students used in the Fear of AIDS Scale development rated these 18 statements after they had rated the Fear of AIDS Scale items. Three different orders of the statements were used to control for position bias. Items were rated on a 11-point scale with one (1) indicating the statement was sympathetic to homosexuals (or positive) and eleven (11) indicating the statement was negative. A median and semi-interquartile range (Q) value for each statement was calculated. Each item included in the final scale had a median falling outside the middle range of possible values, a relatively low degree of variability, and an approximately equal number of positive and negative statements. The final scale consisted of three (3) positive and four (4) negative items for a total of 7 items (Bouton, et al.,

1987).

The 7-item Homophobia Scale was then administered to a group of students ( $n = 528$ ) at the University of Texas at Austin. The positive items ranged from strongly agree (0) to strongly disagree (4) on a 5-point scale. Negative items were scored in reverse order. Possible scores range from 0 (extremely positive) to 28 (extremely negative) toward homosexuals and homosexuality (Bouton, et al., 1987).

The Fear of AIDS Scale and the Homophobia Scale were administered by Bouton, et al. (1987) in the fall of 1985 to 528 students enrolled in introductory psychology classes at the University of Texas at Austin to assess the reliability of the instruments. Two alternative forms were administered utilizing the same items but in different orders. Groups of students were alternately assigned one of the two forms.

Cronbach alpha reliabilities of .80 for the Fear of AIDS Scale and .89 for the Homophobia Scale were found, making them highly reliable. The correlation between the two scales was 0.55 ( $p < .001$ ). However, the amount of variance shared between the two was only 30% (Bouton, et al., 1987).

A factor analysis was conducted on each of the scales. The principle-factor-with-iteration method with an oblique rotation was used. The factor analysis of the Fear of AIDS Scale identified three quite different variables. Fear of Contact had the highest factor loadings for items 1, 4, 6, 7, 9, 12, 34, and 35. The common subject of these items was degree of contact. The first factor accounted for 32.3% of the variance. The second factor, called the Public Health factor because items were related to questions of public health, accounted for 11.9% of the variance and included items 20, 23, and 29. The third factor, accounting for 8.2% of the variance, was called Personal factor and

included items 10, 21, and 31. Themes of personal fear of contracting AIDS made up the Personal factor subscale.

For the Homophobia Scale, a single factor accounting for 60.6% of the variance was identified by the factor analysis. The extremely high reliability plus the large percentage of variance accounted for led Bouton and his colleagues to conclude that the scale seemed to be measuring a single variable of attitude toward homosexuals and/or homosexuality. The median correlation between individual items and the total Homophobia Scale score was 0.76, with the lowest correlation 0.72.

All 21 items of the two scales were then combined in a single factor analysis using the same procedure as described above. Four factors were found. Factor 1 contained all the Fear of Contact items (Factor 1 from the Fear of AIDS Scale) along with item 31 ("I am worried about catching AIDS in a public restroom."). Factor 2 contained only the Homophobia Scale items. All other items were distributed between factors 3 and 4 (Bouton, et al., 1987). Separate factor analyses were computed on all 21 items on the two scales for males and females because of the possibility of sex differences. The results were essentially unchanged.

The three subscales (Fear of Contact, Public Health factor, & Personal factor) scores of the Fear of AIDS scale were correlated with the Homophobia Scale score. The correlation between the Homophobia Scale score and the Fear of Contact subscale was 0.57 ( $p < 0.001$ ), between the Public Health subscale 0.13 ( $p < 0.001$ ), and between the Personal subscale 0.27 ( $p < 0.001$ ). The subscale correlations were computed separately for males and females. The correlation between Fear of Contact subscale and Homophobia was 0.58 ( $p < 0.01$ ) for males and 0.55 ( $p < 0.01$ ) for females. The correlation between

the Public Health factor subscale and Homophobia was not significant for males ( $r = .08$ ) but was for females ( $r = .23$ ,  $p < .01$ ). The difference between the two correlations was not significant,  $z = 1.76$  (Bouton, et al., 1987).

Form A and Form B of the Fear of AIDS Scale were compared. No significant difference was found between the means of the two forms of the scales,  $F(1, 522) = 0.31$ ,  $p > .50$ , or for the Homophobia Scale  $F(1, 522) = 3.26$ ,  $p < 0.10$ . The Fear of AIDS Scale had a mean score of 31.83 ( $SD = 8.78$ ) and the Homophobia Scale had a mean score of 14.82 ( $SD = 7.02$ ). There was weak support for the hypothesis that a single attitude or factor would underlie the two measures. Alternatively, if the two attitudes were independent of one another then at least two attitudes would be measured by the scales. Bouton, et al. (1987) concluded, "These data suggest that the attitudes measured by the two scales are relatively independent of one another and do not represent a single underlying attitude. That is, there is little, if any, evidence in our data to suggest that fear of AIDS is simply another way of expressing homophobia" (p. 613). According to the authors, both the Homophobia and Fear of AIDS Scales appear to be reliable measures of the attitudes they were designed to measure.

Other studies have used the 14-item Fear of Aids Scale and the 7-item Homophobia Scale developed by Bouton, et al. (1987). Young, et al. (1991) conducted a survey in 1989 to measure attitudes toward fear of AIDS and homophobia. The sample ( $n = 478$ ) consisted of 225 males and 252 females enrolled in introductory psychology classes at the University of Texas at Austin. The mean Fear of AIDS Scale score was 27.76 and the mean Homophobia Scale score was 14.35. The correlation between the two scales was 0.48 ( $z = 1.40$ ,  $p > 0.10$ ), which failed to reach significance.

Young, et al. (1993) conducted another study of 353 subjects (204 males,

149 females) to investigate the effects of reading about AIDS on fear of AIDS, knowledge of AIDS, and homophobia. The subjects were introductory psychology students at the University of Texas at Austin. Fear of AIDS and homophobia were measured by the scales developed by Bouton, et al. (1987). Subjects were assigned to one of three conditions, according to the article they read. One article declared the risk of contracting AIDS through casual contact is understated by public health officials. Another article asserted that the risk of contracting AIDS through casual contact is overstated by public health officials. The third condition was the control article related to cholesterol levels and heart disease.

Magazine articles had a significant main effect on fear of AIDS,  $F(2, 341) = 41.45, p < .001$ . Using homophobia as a dependent variable there were no differences among the three conditions,  $F(1, 341) = 1.16, p > .05$ . In contrast, fear of AIDS was affected by reading the magazine article about AIDS.

Meisenhelder (1994) used the instruments developed by Bouton, et al. (1987) to measure fear of AIDS and homophobia in a sample of 114 registered nurses. The purpose of the study was to test the relationships of homophobia, fear of the unknown, fear of death, and fear of punishment as predictors of fear of HIV contagion. Homophobia and fear of HIV contagion were measured by the Homophobia Scale and the Fear of AIDS Scale developed by Bouton, et al., (1987). Homophobia was highly correlated with Fear of Contagion ( $r = .60, p < .0001$ ). Other variables that correlated with fear of contagion included Fear of Unknown ( $r = .56, p < .0001$ ), Lack of Emotional Involvement ( $r = .46, p < .0001$ ), and Lack of Knowledge About Transmission ( $r = .48, p < .0001$ ).

The above studies illustrate that the tools selected to measure fear of AIDS and homophobia for the present study have been used by other

researchers and have been found to be valid and reliable. Differences exist in the findings of the studies in terms of the relationship between fear of AIDS and homophobia. Meisenhelder (1994) found a significant correlation while other researchers found the relationship to be less than significant.

## Chapter 4

### FINDINGS AND DISCUSSION

#### Description of the Sample

The sample population consisted of 22 associate degree nursing students from a community college in the southwest. Students were randomly assigned to an experimental ( $n = 11$ ) or control ( $n = 11$ ) group. The data collection occurred in May and June, 1994. All students volunteered to participate in the study and 100% were retained through final posttesting. An initial plot analysis identified a person in the experimental group whose scores on all measures of fear of AIDS and homophobia were further from the mean than scores of other subjects. Data analyses were completed with and without that person's scores, and statistically there was not enough effect found to justify leaving that person out of the sample.

The frequency distributions for the demographic variables of age, gender, marital status, ethnicity, religion, and frequency of attendance at religious functions for the sample are presented in Tables 1 to 5. The experimental group ranged in age from 26 to 52 with a mean age of 38.18 years. Approximately one-half (45.5%) were under 35 years of age and approximately one-half (54.6%) were over 35 years of age. The control group ranged in age from 24 to 50 with a mean age of 35.91 years. Approximately one-half (45.5%) were under 35 years of age and approximately one-half (54.6%) were 35 years of age and older.

The majority of subjects in both the experimental and control groups were female, 8 (72.7%) in the experimental group and 9 (81.8%) in the control group. The experimental group had a higher percentage of subjects who were married than did the control group, 90.9% and 63.6%, respectively. The experimental group had one subject who was divorced, whereas the control group had two subjects who were divorced and two subjects who were single. For both the experimental and control groups, the majority of the subjects were caucasian, 81.8% in both groups.

Religious affiliations differed between the control and experimental groups. One person reported the religious affiliation as Agnostic, one reported Jewish, two persons reported LDS affiliation, and no one reported Catholic affiliation in the control group. Protestant affiliation (45.5%) had the highest representation in the control group. There were two Catholic (18.2%) and no Agnostic or Jewish affiliations in the experimental group and the most predominant affiliations were equally divided among LDS (27.3%), Protestant (27.3%), and Other (27.3%).

Attendance at organized religious functions showed a different pattern between the experimental and the control groups. A higher percentage of subjects in the control group attended religious functions at least once per week (45.5%) compared to the experimental group (18.2%). Experimental group subjects attended religious functions less frequently (72.8% attended only several times per year to rarely/never) than did subjects in the control group (54.6% attended several times per year to rarely/never).

Table 1  
Frequency Distributions for Experimental and Control Groups by Age  
(Experimental Group n = 11, Control Group n = 11)

Age in Years	Experimental		Control	
	Frequency	Percent	Frequency	Percent
24 - 33	5	45.5	5	45.5
34 - 43	1	9.1	4	36.3
44 - 53	5	45.5	2	18.2
Total	11	100.0	11	100.0

Table 2  
Frequency Distributions for Experimental and Control Groups by Gender  
(Experimental Group n = 11, Control Group n = 11)

Gender	Experimental		Control	
	Frequency	Percent	Frequency	Percent
Male	3	27.3	2	18.2
Female	8	72.7	9	81.8
Total	11	100.0	11	100.0

Table 3

Frequency Distributions for Experimental and Control Groups by Marital Status(Experimental Group n = 11, Control Group n = 11)

Marital Status	Experimental		Control	
	Frequency	Percent	Frequency	Percent
Single	0	0	2	18.2
Married	10	90.9	7	63.6
Divorced	1	9.1	2	18.2
Total	11	100.0	11	100.0

Table 4  
Frequency Distributions for Experimental and Control Groups by Ethnicity  
(Experimental Group n = 11, Control Group = 11)

Ethnicity	Experimental		Control	
	Frequency	Percent	Frequency	Percent
Asian	1	9.1	0	0
Caucasian	9	81.8	9	81.8
African American	1	9.1	1	9.1
Native American	0	0	1	9.1
Total	11	100.0	11	100.0

Table 5  
Frequency Distributions for Experimental (n = 11) and Control (n = 11) Groups  
by Religion and Attendance at Religious Functions

Religion	Experimental		Control	
	Frequency	Percent	Frequency	Percent
Agnostic	0	0	1	9.1
Catholic	2	18.2	0	0
Jewish	0	0	1	9.1
LDS	3	27.3	2	18.2
Protestant	3	27.3	5	45.5
Other	3	27.3	2	18.2
Total	11	100.0	11	100.0

  

Attendance	Experimental		Control	
	Frequency	Percent	Frequency	Percent
Once Per Week	2	18.2	5	45.5
Once Per Month	1	9.1	0	0
Several Per Year	4	36.4	1	9.1
Rarely/Never	4	36.4	5	45.5
Total	11	100.0	11	100.0

In response to the question, "Do you or have you ever had a friend or close family member with HIV infection or AIDS?", 81.8% of the experimental group answered *no* compared to 72.7% of the control group, and only 18.2% in the experimental group and 27.3% in the control group answered *yes*. See Table 6.

Table 6  
Frequency Distributions for Experimental (n = 11) and Control (n = 11) Groups  
by Having a Friend or Close Family Member with HIV/AIDS

Friend/Family Member	Experimental		Control	
	Frequency	Percent	Frequency	Percent
Yes	2	18.2	3	27.3
No	9	81.8	8	72.7
Total	11	100.0	11	100.0

In response to the question, "How many HIV/AIDS patients have you cared for?", eight (72.7%) subjects in the experimental group and five (48.5%) in the control group responded that they had never cared for a patient with HIV/AIDS. Two (18.2%) of the experimental group and four (33.3%) of the control group have cared for 1 to 3 HIV/AIDS patients. One (9.1%) in the experimental group and two (18.2%) in the control group have cared for 4 to 6 HIV/AIDS patients. See Table 7.

Table 7

Frequency Distributions for Experimental (n = 11) and Control (n = 11) Groups  
by Number of HIV/AIDS Patients Cared For

Number Patients	Experimental		Control	
	Frequency	Percent	Frequency	Percent
0	8	72.7	5	48.5
1 - 3	2	18.2	4	33.3
4 - 6	1	9.1	2	18.2
Total	<hr/>	<hr/>	<hr/>	<hr/>
	11	100.0	11	100.0

Subjects were asked how many homosexuals they had known in their lifetime and how many they presently knew. All subjects in both the control and experimental groups had known at least one homosexual. In the experimental group 27.3% had known more than 10 in their lifetime compared to 45.5% of the control group. Two (18.2%) subjects in the control group reported having known more than 20 in their lifetime. All subjects presently knew at least one person who was homosexual. No one in the experimental group reported knowing more than 10 homosexuals presently, compared to only one in the control group. Most subjects in both the experimental (90.9%) and control (81.8%) groups presently knew one to five homosexuals. See Tables 8 and 9.

Table 8

Frequency Distributions for Experimental (n = 11) and Control (n = 11)  
Groups by Number of Homosexuals Known in Lifetime

Lifetime	Experimental		Control	
	Frequency	Percent	Frequency	Percent
1 - 5	6	54.5	3	27.3
6 - 10	2	18.2	3	27.3
11 - 15	2	18.2	2	18.2
16 - 20	1	9.1	1	9.1
21 - 30	0	0.0	2	18.2
Total	11	100.0	11	100.0

Table 9  
Frequency Distributions for Experimental (n = 11) and Control (n = 11)  
Groups by the Number of Homosexuals Presently Known

Presently Known	Experimental		Control	
	Frequency	Percent	Frequency	Percent
1 - 5	10	90.9	9	81.8
6 - 10	1	9.1	1	9.1
11 - 15	0	0	1	9.1
Total	11	100.0	100.0	11

(Note: All subjects knew at least one person who is homosexual).

In summary, descriptive statistics revealed some differences on many variables between the experimental and control groups: age, gender, marital status, religious affiliation, and frequency of attendance at organized religious functions. The subjects in the control group had more experience in caring for HIV/AIDS patients than did the experimental group. In the experimental group, approximately three-fourths had not cared for HIV/AIDS patients compared to less than half of the control group. Subjects in the experimental group have known fewer homosexuals than the control group. Of the experimental group, just over one-fourth knew more than 10 homosexuals compared to just under one-half of the control group.

### Fear of AIDS Scale Scores

The possible total score range for the Fear of AIDS Scale was 0 to 56. Low scores indicated low fear of AIDS and high scores indicated high fear of AIDS. Table 10 presents the ranges, means, and standard deviations for the two groups on pretest and posttests I and II scores. Overall, the two groups differed on pretest fear scores and remained different at posttests I and II. The control group's pretest scores ranged from 22 to 29 with a mean of 26.36, while the experimental group's pretest scores ranged from 14 to 31 with a mean of 24.18. The control group's scores on posttest I ranged from 19 to 31 with a mean of 25.64, while the experimental group's scores on posttest I ranged from 20 to 32 with a mean of 24.00. The control group's scores on posttest II ranged from 23 to 30 with a mean of 25.91, while the experimental group's scores on posttest II ranged from 20 to 37 with a mean of 26.09.

Table 10  
Ranges, Means, and Standard Deviations for Pre and Post Test Scores on  
Fear of AIDS for Experimental and Control Groups

Experimental Group	<u>n</u>	Range	$\bar{X}$	<u>SD</u>
Pretest	11	14 - 31	24.18	4.71
Posttest I	11	20 - 32	24.00	3.52
Posttest II	11	20 - 37	26.09	4.72
Control Group	<u>n</u>	Range	$\bar{X}$	<u>SD</u>
Pretest	11	22 - 29	26.36	2.06
Posttest I	11	19 - 31	25.64	4.11
Posttest II	11	23 - 30	25.91	2.12

#### Homophobia Scale Scores

The possible total score range for the Homophobia Scale was 0 to 28. Low scores indicated little homophobia and high scores indicated high homophobia. Table 11 presents the ranges, means, and standard deviations for the two groups on pretest and posttests I and II scores. Overall, the two groups

differed on pretest homophobia scores and remained different at posttests I and II. The control group's pretest scores ranged from 12 to 24 with a mean of 15.09, while the experimental group's pretest scores ranged from 10 to 18 with a mean of 13.64. The control group's scores on posttest I ranged from 12 to 19 with a mean of 14.09, while the experimental group's scores on posttest I ranged from 10 to 18 with a mean of 14.46. The control group's scores on posttest II ranged from 11 to 17 with a mean of 13.91, while the experimental group's scores on posttest II ranged from 9 to 20 with a mean of 14.91.

Table 11

Ranges, Means, and Standard Deviations for Pre and Post Test Scores on  
Homophobia for Experimental and Control Groups

Experimental Group	<u>n</u>	Range	$\bar{X}$	<u>SD</u>
Pretest	11	10 - 18	13.64	2.58
Posttest I	11	10 - 18	14.46	2.58
Posttest II	11	9 - 20	14.91	3.36
Control Group	<u>n</u>	Range	$\bar{X}$	<u>SD</u>
Pretest	11	12 - 24	15.09	3.56
Posttest I	11	12 - 19	14.09	2.47
Posttest II	11	11 - 17	13.91	2.02

Hypothesis 1. Nursing students' scores on Bouton's Homophobia Scale will be positively correlated with scores on Bouton's Fear of AIDS Scale.

Pearson correlation coefficients were computed to identify the relationship between homophobia and fear of AIDS scores in the experimental and control groups and are presented in Table 12. In the control group the mean scores on the pretest for homophobia and fear of AIDS were negatively correlated ( $r = -0.39, p > .05$ ). That is, as pretest scores on the Homophobia Scale increased, pretest scores on the Fear of AIDS Scale decreased. Post test I mean scores on homophobia and fear of AIDS for the control group were not significantly correlated ( $r = 0.12, p > .05$ ). Posttest II mean scores on homophobia and fear of AIDS were negatively correlated ( $r = -0.37, p > .05$ ). That is, as posttest II scores on the Homophobia Scale increased, posttest II scores on the Fear of AIDS Scale decreased.

In the experimental group the mean scores on the pretest for homophobia and fear of AIDS was  $r = 0.55, p > .05$ . Posttest I mean scores on homophobia and fear of AIDS for the experimental group were not significantly correlated ( $r = 0.46, p > .05$ ). Posttest II mean scores on homophobia and fear of AIDS were not significantly correlated ( $r = .52, p > .05$ ). None of the relationships were statistically significant. Therefore, hypothesis 1 was not supported.

Table 12  
Pearson Correlation Coefficients For the Control Group (n = 11) and  
Experimental Group (n = 11) on Pretest, Posttest I, and Posttest II Total Scores  
Between Measures of Homophobia and Fear of AIDS

Groups by Time	r
Control Group	
Pretest	-0.39
Posttest I	0.12
Posttest II	-0.37
Experimental Group	
Pretest	0.55
Posttest I	0.46
Posttest II	0.52

P > .05 for all (Two-tailed)

Hypothesis 2. Nursing students who complete an affective education program on understanding homosexuality will demonstrate a significant decrease in levels of homophobia as measured by pretest and posttest scores on Bouton's Homophobia Scale (Bouton, et al., 1987).

Student nurses who completed the affective education program on homosexuality did not demonstrate a significant decrease in homophobia as measured by posttest I and posttest II scores on Bouton's Homophobia Scale. See Table 13. The scores on posttest I actually increased from the pretest scores (mean difference of .81 with  $t = -1.44$ ,  $p = .81$ ). Scores increased slightly from posttest I to posttest II (mean difference of .46). The mean difference between pretest and posttest II scores was 1.27 ( $t = -1.49$ ,  $p = .67$ ). Therefore, hypothesis 2 was not supported.

Table 13  
Paired T-Tests for Pretests and Posttests on Homophobia  
For Experimental Group (n = 11)

Pretest		Posttest I		t-value	DF	p*
$\bar{X}$	<u>SD</u>	$\bar{X}$	<u>SD</u>			
13.64	2.58	14.45	2.58	-1.44	10	.81
Pretest		Posttest II		t-value	DF	p*
$\bar{X}$	<u>SD</u>	$\bar{X}$	<u>SD</u>			
13.64	2.58	14.91	3.36	-1.49	10	.67
Posttest I		Posttest II		t-value	DF	p*
$\bar{X}$	<u>SD</u>	$\bar{X}$	<u>SD</u>			
14.45	2.58	14.91	3.36	-.58	10	.57

p\* (2-tailed probability)

Hypothesis 3. Nursing students who complete an affective education program on understanding homosexuality will demonstrate a significant decrease in fear of AIDS as measured by pretest and posttest scores on the Fear of AIDS Scale (Bouton, et al., 1987).

Student nurses who completed the affective education program on homosexuality did not demonstrate a significant decrease in fear of AIDS as measured by posttest I and posttest II scores on Bouton's Fear of AIDS Scale (Bouton, et al., 1987). See Table 14. The scores remained essentially the same on pretest and posttest I (mean difference of .18 with  $t = .20$ ,  $p = .84$ ). Scores actually increased from pretest to posttest II (mean difference of 1.91 with  $t = -2.10$ ,  $p = .06$ ), the opposite of the predicted direction. Thus, hypothesis 3 was not supported.

Table 14  
Paired T-Tests For Pretest and Posttests on Fear of AIDS  
For Experimental Group (n = 11)

Pretest		Posttest I		t-value	DF	p*
$\bar{X}$	<u>SD</u>	$\bar{X}$	<u>SD</u>			
24.18	4.71	24.00	3.52	.20	10	.84
Pretest		Posttest II		t-value	DF	p*
$\bar{X}$	<u>SD</u>	$\bar{X}$	<u>SD</u>			
24.18	4.71	26.09	4.72	-2.10	10	.06
Posttest I		Posttest II		t-value	DF	p*
$\bar{X}$	<u>SD</u>	$\bar{X}$	<u>SD</u>			
24.00	3.52	26.09	4.72	-2.60	10	.03

p\* (2-tailed probability)

Hypothesis 4. Nursing students in the control group will demonstrate no significant decrease in homophobia or fear of AIDS as measured by pretest and posttest scores on the Homophobia and Fear of AIDS Scales (Bouton, et al., 1987).

Hypothesis 4 was supported. Student nurses who completed the program on assisted suicide/euthanasia (control group) did not demonstrate a significant decrease in fear of AIDS or homophobia as measured by pretest and posttests I and II scores on Bouton's Fear of AIDS Scale and Homophobia Scale (Bouton, et al., 1987). Scores did decrease by 0.72 between the pretest and the posttest I measure of fear of AIDS, but it was not a statistically significant decrease ( $t = .57$ ,  $p = .58$ ). Scores on posttest II increased from posttest I by 0.27. There was a mean difference of 0.45 between the pretest and posttest II ( $t = .49$ ,  $p = .64$ ). See Table 15.

Homophobia scale scores decreased between the pretest and posttest I by 1.00 ( $t = .79$ ,  $p = .45$ ). Scores on the homophobia measure dropped by .18 from posttest I to posttest II. The difference between the mean scores pretest to posttest II on the homophobia measure was 1.18 ( $t = .90$ ,  $p = .36$ ). See Table 16.

Table 15  
Paired T-Tests For Pretests and Posttests on Fear of AIDS  
For Control Group (n = 11)

Pretest		Posttest I		t-value	DF	p*
$\bar{X}$	<u>SD</u>	$\bar{X}$	<u>SD</u>			
26.36	2.06	25.64	4.11	.57	10	.58
Pretest		Posttest II		t-value	DF	p*
$\bar{X}$	<u>SD</u>	$\bar{X}$	<u>SD</u>			
26.36	2.06	25.91	2.12	.49	10	.63
Posttest I		Posttest II		t-value	DF	p*
$\bar{X}$	<u>SD</u>	$\bar{X}$	<u>SD</u>			
25.64	4.11	25.91	2.12	-.20	10	.85

p\* (2-tailed probability)

Table 16  
Paired T-Tests For Pretests and Posttests on Homophobia  
For Control Group (n = 11)

Pretest		Posttest I		t-value	DF	p*
$\bar{X}$	<u>SD</u>	$\bar{X}$	<u>SD</u>			
15.09	3.56	14.09	2.47	.79	10	.45
Pretest		Posttest II		t-value	DF	p*
$\bar{X}$	<u>SD</u>	$\bar{X}$	<u>SD</u>			
15.09	3.56	13.91	2.02	.90	10	.36
Posttest I		Posttest II		t-value	DF	p*
$\bar{X}$	<u>SD</u>	$\bar{X}$	<u>SD</u>			
14.09	2.47	13.91	2.02	.41	10	.69

p\* (2-tailed probability)

### Other Findings

An analysis of variance (ANOVA) was performed to test the significance of differences between the means of the scores on the Fear of AIDS Scale and on the Homophobia Scale for both the experimental and control groups. Pretest scores on fear of AIDS and on homophobia were not found to be significantly different between the experimental and control groups, although it had initially appeared they were. Therefore, the two groups were statistically alike to begin with, and they remained alike after the affective education program was presented. The affective education program was not effective in reducing homophobia in the experimental group. See Tables 17 and 18.

Table 17  
ANOVA Between Groups on Fear of AIDS ( $p < .05$ )

Source Pretest	SS	DF	MS	F	Sig. of F
Experimental	7.09	1	7.09	.89	.36
Control	7.09	1	7.09	.89	.36
Residual	150.15	19	7.90		
Total	157.24	20	7.86		

  

Source Posttest I	SS	DF	MS	F	Sig. of F
Experimental	8.01	1	8.01	.55	.47
Control	8.01	1	8.01	.55	.47
Residual	274.95	19	14.47		
Total	282.95	20	14.15		

  

Source Posttest II	SS	DF	MS	F	Sig. of F
Experimental	2.50	1	2.50	.19	.66
Control	2.50	1	2.50	.19	.66
Residual	239.31	19	12.59		
Total	241.81	20	12.09		

Table 18  
ANOVA Between Groups on Homophobia (p < .05)

Source Pretest	SS	DF	MS	F	Sig. of F
Experimental	6.23	1	6.23	.66	.43
Control	6.23	1	6.23	.66	.43
Residual	178.91	19	9.42		
Total	185.14	20	9.26		

  

Source Posttest I	SS	DF	MS	F	Sig. of F
Experimental	3.43	1	3.43	.62	.44
Control	3.43	1	3.43	.62	.44
Residual	105.81	19	5.57		
Total	109.24	20	5.46		

  

Source Posttest II	SS	DF	MS	F	Sig. of F
Experimental	13.26	1	13.26	2.18	.16
Control	13.26	1	13.26	2.18	.16
Residual	115.41	19	6.07		
Total	128.67	20	6.43		

This chapter has presented the results of data analyses of the study. Analyses of data were presented along with the findings related to the hypotheses. Hypotheses one, two, and three were not supported. Hypothesis four was supported. The following chapter will discuss the findings, present conclusions and make recommendations for future study.

## Chapter 5

### SUMMARY, CONCLUSIONS, RECOMMENDATIONS

The purpose of this study was threefold: 1) to assess the level of fear of AIDS and homophobia in associate degree nursing students, 2) to investigate the relationship between fear of AIDS and homophobia in the sample, and 3) to examine the effectiveness of an affective education program in reducing homophobia and fear of AIDS. To determine the effects of the affective education program on fear of AIDS and homophobia of student nurses, a quasi-experimental time-series design was utilized. The experimental group was composed of 11 associate degree student nurses attending a community college in the southwest. The control group was composed of 11 associate degree student nurses attending the same community college. Participation in the study was voluntary. The majority of the participants were caucasian, married females. There was no predominant religious affiliation in the experimental group, but the control group had a majority who were protestant. The primary prevention mode of intervention of the Neuman Systems Model (1989) was utilized as the theoretical framework for the study. A portion of Bandura's (1969) social learning theory provided the framework for the affective education intervention.

The experimental group participated in an eight-hour affective education program on homosexuality. The program was divided into three, two-hour weekly sessions with two one-hour home modules between sessions one and

two and between sessions two and three. The control group participated in an eight-hour program on assisted suicide/euthanasia. The program was divided into three, two-hour weekly sessions with two one-hour home modules between sessions one and two and between sessions two and three. Both the experimental and the control groups completed a demographic information tool, a pretest measure of fear of AIDS (Bouton's Fear of AIDS Scale), and a pretest measure of homophobia (Bouton's Homophobia Scale). Both scales were again administered to the experimental and control groups as Posttest I immediately following the program and Posttest II six weeks later.

#### Relationship of Fear of AIDS and Homophobia

It was predicted that fear of AIDS and homophobia would be positively correlated on pretest. This relationship was analyzed using Pearson  $r$  correlation. No statistically significant relationship was found between measures of fear of AIDS and homophobia on either the experimental or control group's measures on posttests I and II. Other researchers have found a significant correlation between the two measures as documented in the literature review. Kunkel & Temple (1992) found a significant correlation, but found the amount of variance accounted for in the relationship to be a small 23%. They concluded that other variables were influencing the relationship. The small sample size of the present study prohibits drawing any conclusions as to why there was not a correlation. Perhaps attitudes concerning AIDS and homosexuals are becoming less strongly associated as more people from a variety of backgrounds (women & children, e.g.) become HIV infected and develop AIDS. Maybe fear is also decreasing simply because more and more HIV people are being cared for.

### Findings Related to the Affective Education Program

It was predicted that homophobia and fear of AIDS would decrease as a result of a program designed to reduce homophobia. However, no statistically significant decrease in either fear of AIDS or homophobia was demonstrated as a result of the affective education program. It was an interesting finding that the control group attending an assisted suicide/euthanasia program actually did have a decrease in scores on both homophobia and fear of AIDS, although not a statistically significant decrease. The experimental group actually scored higher on the homophobia scale on posttest I and posttest II than on pretest. The experimental group scores on the posttest I Fear of AIDS Scale had a mean decrease of 0.18 from pretest and an increase of almost two points on posttest II.

The experimental and control groups appeared different to begin with on descriptive statistics. In a small sample size any differences to begin with may be magnified. Subjects in the control group had known more homosexuals than did the experimental group. The literature has shown that having a friend who is homosexual was related to lower homophobia scores (Herek, 1988). The experimental group was 27.3% male compared to 18.2% male in the control group. Studies have shown that males are more homophobic than females (Kunkle & Temple, 1992; Fish & Rye, 1991; Bouton, et al., 1989; & Herek, 1988). The experimental group was 27.3% LDS compared to 18.2% of the control group. Some studies have shown that religious affiliation influences degree of homophobia. For example, Kunkle & Temple (1992) found homophobia to be higher in subjects who were LDS compared to other religious affiliations. Although the means and standard deviations on pretest measures of both fear of AIDS and homophobia gave the appearance that the

two groups differed to begin with, an ANOVA revealed that the groups were not significantly different.

During the time between posttest I and posttest II data collection a controversial supplement came out in the local newspaper entitled "Homosexual Agenda Exposed", a very negative article that drew a lot of response from the public. In addition, a local group that had been trying to elicit support for a petition to deny minority status protection for gays had been appearing on television. Perhaps the subjects in the experimental group were more negatively influenced by these events than were the control group subjects, for whatever reasons. Since the experimental subjects had just participated in a program related to homosexuality their anxiety levels may have been raised by the cognitive dissonance created by the different issues.

Perhaps the experimental group was sensitive to pleasing the researcher at the time of the pretest resulting in false lower scores at that time. Subsequently, feeling a threat to their value system, they scored higher on the posttest measures. Since the experimental subjects had less familiarity with homosexuals and had cared for fewer HIV/AIDS patients to begin with, attendance at a program where homosexuality was discussed may have been threatening and provoked a negative reaction. Perhaps the program should have been longer to help work through the feelings. There was no planned discussion of HIV/AIDS in the experimental group, but occasionally a student brought up the topic. The researcher redirected the conversation. It might have been helpful to have actually had HIV/AIDS content as part of the program.

One student in the experimental group was particularly negative about homosexuals throughout the program despite attempts of the researcher to model positive attitudes. Two other students expressed more negative feelings

during the last session following a “coming out” role playing of a “family.” These students may have influenced the responses on posttests I and II of other less negative students by kindling some latent feelings of homophobia.

In conclusion, the findings in this study did not support the widely held belief that there is a correlation between homophobia and fear of AIDS. Furthermore, the findings did not support the researcher’s affective education program as a means of reducing homophobia or fear of AIDS. One must keep in mind that the sample size was too small to make generalizations to larger populations.

#### Findings Related to the Theoretical Framework

The Neuman Systems model (1989) was the conceptual model utilized to guide the study, in particular the concepts of primary prevention, stressors, lines of defense, and the impact of stressors on the nurse. A portion of Bandura’s (1969) social learning theory provided the framework for the educational intervention. The concepts of Bandura’s belief-oriented approach, affect-oriented approach, and behavior-oriented approach relate to strategies of attitude change.

The Neuman Model proposes that certain nursing actions directed toward primary prevention will increase the integrity of an individual’s lines of defense before the stressor’s impact. Primary prevention is intervention before contact with the stressor to help reduce the stressor’s effects through appropriate anticipation and preparation (Zeimer, 1983).

Caring for patients with AIDS or HIV infection and caring for patients who have different lifestyles from the nurse may be stressors. Primary prevention through supportive affective education has the potential to raise a

nurse's flexible line of defense as indicated by coping behaviors and strategies. Lines of defense influence the responses to stressors so the relative level of the lines of defense would lead to a reduction of the impact of the stressor (Zeimer, 1983).

The present study did not indicate that primary prevention through an affective education program to strengthen nursing students' flexible lines of defense through presentation of information about homosexuality was effective. The impact of intrapersonal stressors (fear of AIDS and beliefs about homosexuality) was not effectively lessened as demonstrated by measures of homophobia and fear of AIDS.

It may be that social learning theory (Bandura, 1969) may not be the best model for guiding a program to reduce fear of an illness such as AIDS or homophobia. Perhaps there was something occurring in the group setting, such as the interpersonal dynamics or the nonverbal behavior of the researcher that could have interfered with the outcome measures. Having another person assisting in the presentation of the program might have been helpful, e. g. someone who is gay.

These findings lead to questions about the utilization of Neuman's Model and/or Bandura's social learning theory as a basis for decreasing fear of AIDS and/or homophobia. According to Bandura (1977), theory sometimes disregards the enormous complexity of human beings.

## RECOMMENDATIONS

Based on the results of this study, the following recommendations for further study are suggested:

1. This study should be repeated using a larger sample size.

2. The content, methods, and length of the affective education program should be further investigated.
3. Reliable and valid measures of homophobia and fear of AIDS need to be further developed and continually refined.
4. Include measures of knowledge of AIDS to assess the influence on fear of AIDS and homophobia.
5. Replication of this study using a stronger intervention such as having a co-facilitator who is gay.
6. Replication of this study using registered nurse subjects.
7. Use a factorial design to control for personality styles and other factors such as educational preparation and years in nursing since people may benefit differently from various kinds of information and strategies.

APPENDIX A

HUMAN SUBJECTS RIGHTS APPROVAL



**TO:** Frances Brown

**FROM:** Dr. William Schulze, *W. Schulze* Director, Office of Research Administration

**DATE:** April 20, 1994

**RE:** Status of Human Subject Protocol entitled:  
"Effects of An Eight-Hour Affective Education Course on  
Fear of AIDS and Homophobia in Student Nurses"

---

This memorandum is official notification that the protocol for the project reference above has been approved. This approval is for a one year duration. At the end of the year, you must notify this office if the project will be continued.

If you have any questions or require any assistance, please give us a call.

## APPENDIX B

### COVER LETTER AND CONSENT FORM



April, 1994

Dear Student Nurse:

As a graduate student in the Department of Nursing at the University of Nevada, Las Vegas, I am conducting a research study related to life crisis issues. Nurses are likely to be involved in the care of patients with life crisis issues, values and beliefs different from the nurse. To prepare nurses to care for patients with diverse health situations you are being asked to participate in an eight hour course at no cost to you. No course credit is being given for participation, just the increased knowledge about the topics under study. If you agree to participate in the study you will be asked to attend three class sessions to be held over a three week period for a total of six hours of in-class work. There will be an additional one-hour home assignment between class sessions one and two, and between class sessions two and three, for a total of two hours of home study.

If you agree to participate you will be assigned at random to one of two groups who will be given information related to the topic of AIDS or Right-To-Die. At the beginning of the course you will be asked to complete a demographic data sheet as well as a questionnaire. It will take approximately 20 minutes to complete the questionnaire and the data sheet. You will be asked to complete the questionnaire again at the end of the last class session and again six weeks later.

Participants may experience some emotional discomfort. If you wish, you may seek assistance from the College counselors. However, any discomfort is anticipated to be no different from that experienced by nurses caring for patients with life crisis situations such as AIDS or Right-To-Die.

All information is confidential and data will be reported in the aggregate only. No identifying names or information will be used.

Your participation is entirely voluntary and will not impact your standing in your nursing program. You may also withdraw at any time.

If you wish to obtain information about the results of the study, you may contact me during the summer or fall of 1994.

Sincerely,

Frances A. Brown, M.S.Ed., R.N., C.S.  
Graduate Student, Department of Nursing  
University of Nevada, Las Vegas



I have read the cover letter and I consent to participate in the research study being conducted by Frances Brown, M.S.Ed., R.N., a Graduate Student at the University of Nevada, Las Vegas and in conjunction with the Department of Nursing at Community College of Southern Nevada.

It is my understanding that all information requested of me will remain confidential and results will be reported as grouped data only. The information obtained from me will be used only for the present study. There will be no charge to me. I also understand that my consent and participation is entirely voluntary and that I have the right to withdraw at any time.

Any questions or concerns that I have may be directed to Frances Brown at 877-1133, extension 363 or to Dr. Vicky Carwein at 895-3693.

I understand the information that has been provided to me about the study and what is expected of me. My signature below is my consent to participate in the study.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Participant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Investigator

## APPENDIX C

### DEMOGRAPHIC INFORMATION TOOL

#### FEAR OF AIDS SCALE

#### HOMOPHOBIA SCALE

## DEMOGRAPHIC DATA

Please complete the following:

Age: \_\_\_\_\_ Sex: \_\_\_\_ M \_\_\_\_ F

Marital Status: \_\_\_\_ married \_\_\_\_ divorced \_\_\_\_ single  
other \_\_\_\_\_

Ethnic Group: \_\_\_\_ Asian \_\_\_\_ African American \_\_\_\_ Caucasian  
\_\_\_\_ Hispanic \_\_\_\_ Native American Other \_\_\_\_\_

Religion: \_\_\_\_ Atheist \_\_\_\_ Agnostic \_\_\_\_ Catholic  
\_\_\_\_ Jewish \_\_\_\_ LDS \_\_\_\_ Protestant  
Other \_\_\_\_\_

Frequency of attendance at organized religious functions:

\_\_\_\_ at least once/week \_\_\_\_ at least once/month  
\_\_\_\_ several times/year \_\_\_\_ rarely/never

Highest level of education in a field other than nursing:

\_\_\_\_ Associate Degree \_\_\_\_ Baccalaureate Degree  
\_\_\_\_ Master's Degree \_\_\_\_ Not Applicable

Have you ever provided nursing care to a patient or patients with HIV  
infection or AIDS? \_\_\_\_ yes \_\_\_\_ no

If yes, how many patients have you cared for? \_\_\_\_\_

Do you or have you ever had a friend or close family member with HIV  
infection or AIDS? \_\_\_\_\_ yes \_\_\_\_\_ no

Do you or have you ever known anyone who was homosexual?  
\_\_\_\_\_ yes \_\_\_\_\_ no

How many homosexuals have you known during your lifetime? \_\_\_\_\_

How many homosexuals do you presently know? \_\_\_\_\_

NOTE: Students were not asked to disclose whether or not they were gay,  
because the researcher believed that privacy would be a risk with such a small  
group.

## FEAR OF AIDS SCALE

Circle the response that best describes how you feel.

	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree
1. I wouldn't mind being in the same room with with a friend who had AIDS.	0	1	2	3	4
2. A centralized file containing the names of all people known to have AIDS virus should be created.	0	1	2	3	4
3. If I found out a friend had AIDS, I would be afraid to hug him/her.	0	1	2	3	4
4. I would object to sending my non-infected child to a school which had a child who had AIDS.	0	1	2	3	4
5. I believe public officials when they say AIDS cannot be transmitted through casual contact.	0	1	2	3	4
6. I am afraid that I will get AIDS.	0	1	2	3	4
7. AIDS children should be allowed to attend public school.	0	1	2	3	4
8. Compared with other public health problems, I think AIDS is a very minor problem.	0	1	2	3	4
9. If I found out that my lover had AIDS, I would still have sex with him/her.	0	1	2	3	4

- |   |           |
|---|-----------|
| 10. The seriousness of AIDS is greatly overblown by<br>the media.                   | 0 1 2 3 4 |
| 11. AIDS will become a severe and widespread epidemic.                              | 0 1 2 3 4 |
| 12. I am worried about catching AIDS in a public<br>restroom.                       | 0 1 2 3 4 |
| 13. Even if a friend had AIDS, I wouldn't mind touching<br>him/her.                 | 0 1 2 3 4 |
| 14. If I found out a friend or lover had AIDS I would be<br>afraid to kiss him/her. | 0 1 2 3 4 |

Bouton, R. A., Gallaher, P. E., Garlinghouse, P. A., Leal, T., Rosenstein, L. D., & Young, R. K. (1987). Scales for measuring fear of AIDS and homophobia. Journal of Personality Assessment, 51, 606 - 614.

## HOMOPHOBIA SCALE

Circle the response that best describes how you feel.

	Strongly	Disagree		Disagree	Undecided	Agree	Strongly
	Disagree		Disagree		Agree		Agree
	0	1	2	3	4		
1. Homosexuals contribute positively to society.	0	1	2	3	4		
2. Homosexuality is disgusting.	0	1	2	3	4		
3. Homosexuals are just as moral as heterosexuals.	0	1	2	3	4		
4. Homosexuals should have equal civil rights.	0	1	2	3	4		
5. Homosexuals corrupt young people.	0	1	2	3	4		
6. Homosexuality is a sin.	0	1	2	3	4		
7. Homosexuality should be against the law.	0	1	2	3	4		

Bouton, R. A., Gallaher, P. E., Garlinghouse, P. A., Leal, T., Rosenstein, L. D., & Young, R. K. (1987). Scales for measuring fear of AIDS and homophobia. Journal of Personality Assessment, 51, 606 - 614.

## APPENDIX D

### PERMISSION TO USE THE FEAR OF AIDS SCALE AND HOMOPHOBIA SCALE



January 25, 1994

Frances Brown, M.S. Ed., R. N., C.S.  
7700 Parakeet Avenue  
Las Vegas, NV 89128

Dear Ms. Brown:

I have received a number of requests for reprints of the AIDS papers which appeared in the Journal of Personality Assessment and in the Journal of Applied Social Psychology. Many people have asked for additional information. Because of this I have sent you the enclosed. If you get more than you wanted, accept my apologies. Please find:

- 1) A reprint of the AIDS and Homophobia scales paper;
- 2) Reprints of three papers which used those scales;
- 3) Form A of the 1989 questionnaire. The 1989 questionnaire differs from the 1988 questionnaire slightly: Items 36 and 37 are new (2 control items from the change scales on page 4 were discarded). In addition, a few items on the knowledge scale (pages 5, 6, and 7) have been updated to reflect current information.

It should be noted that Form B, which is not included, is simply Form A with items 1-35, 38-60, and 61-77 arranged in a different order.

Finally, you may use and/or reproduce any of this material if you will be using it for research purposes.

If you have any questions, please don't hesitate to ask.

Sincerely,

A handwritten signature in black ink, appearing to read "Robert K. Young".

Robert K. Young  
Professor

## APPENDIX E

### AFFECTIVE EDUCATION COURSE EXPERIMENTAL GROUP

## Session One

### Attitudes Toward Homosexuality

#### Course Outcomes

Following this session the participant will be able to:

- 1) Explore personal feelings related to homosexuality.
- 2) Discuss beliefs and misconceptions that heterosexual Americans have about gay persons.
- 3) Define homophobia, heterosexism, coming out, oppression, prejudice, and social power.
- 4) Discuss the influence of society's attitudes on the attitudes of nurses.

#### AGENDA

Pretests and biographical information

Introduction to the course

Balloon exercise to build trust

Break (10 minutes)

Discuss common beliefs and myths.

Assignments for home module I

Adjournment

#### Course Outcome 1

- 1) Explore personal feelings related to homosexuality.

Discuss:

Ground rules and information about the presenter

### Confidentiality

Respect for the ideas of others

No attacking and no blaming others in the group

Speak from own experience and not speak for others

Encourage personal risk taking

### Working Assumptions:

Homophobia is a form of oppression and is devastating and insidious.

We cannot be blamed for homophobia as it is not our fault, but we must accept responsibility for it within ourselves.

People can and do grow and change.

Homophobia is pervasive and it hurts all people.

A goal that is worth working for is to develop a sense of community where all folks are valued and supported.

### Balloon Exercise

Materials: Balloons, magic marker

As concerned nurses, you attempt to support all your patients and keep them afloat physically and psychologically, hoping to help them. I am going to toss out a number of balloons that are different colors and shapes representing the diversity of your patients. It is up to you to keep them afloat by whatever means possible. As you toss each balloon into the center of the group, shout out the group your balloon represents.

Some possible groups: "large people", "small people", "middle-aged people", "people with disabilities", "gays", "lesbians", "African-Americans", "Native Americans", etc.

## Course Outcome 2

- 2) Discuss beliefs and misconceptions that heterosexual Americans have about gay people.

Common beliefs (Kirk & Madson, cited in Durham, 1991):

There aren't many homosexuals in America.

All gays are easy to spot - there are telltale signs.

Gays are gay because of sin, insanity, and seduction.

Gays are kinky, loathsome sex addicts.

Gays are unproductive and untrustworthy members of society.

Gays are suicidally unhappy because they are gay.

Common Myths (Blumenfeld, 1992):

Homosexuality is abnormal and sick.

Lesbians are failed females.

Gay males are feminized.

Gay men and lesbians are promiscuous.

Homosexuals could change.

### Exercise

Write myths on newsprint and have participants come and tear up the myth and then receive applause from the group.

## Course Outcome 3

- 3) Define homophobia, heterosexism, coming out, oppression, prejudice, and social power.

Definitions from Blumenfeld (1992):

Homophobia: "The fear and hatred of those who love and sexually desire those of the same sex. Homophobia, which has its roots in sexism, includes prejudice, discrimination, harassment, and acts of violence brought on by that fear and hatred" (p. 283).

Heterosexism: "The system of advantages bestowed on heterosexuals. It is the institutional response to homophobia that assumes that all people are or should be heterosexual and therefore excludes the needs, concerns, and life experiences of lesbians, gays, and bisexuals" (p. 283).

Coming Out: "The process, often lifelong, in which a person acknowledges, accepts, and in many cases appreciates his or her lesbian, gay, bisexual, ... identity. This often involves the sharing of this information with others" (p. 283).

Oppression: "The systematic subjugation of a disempowered social group by a group with access to social power, or prejudice and power" (p. 283).

Prejudice: "A set of negative beliefs, generalized to apply to a whole group of people" (p. 283).

Social power: "Access to and availability of resources needed to get what you want and influence others" (p. 283).

#### Course Outcome 4

4) Discuss the influence of society's attitudes on the attitudes of nurses.

#### Prejudice

Upon discovering personal prejudices, thoughtful persons often attempt to remove them. Prejudices are based on years of learning and incorrect assumptions, so removal is often difficult. Many people think that their

prejudices are not hurtful as long as they are aware that they have them and therefore rationalize their lack of change. For nurses, though, prejudices are not that harmless. There have been reports of hostile and violent behaviors by nurses toward hospitalized homosexual AIDS patients (Young, 1988).

### Discussion Exercise

"What will the world be like without homophobia in it -- for everyone, male and female, whatever sexual identity?" (Pharr, 1988, p. 6).

Starters For Discussion (Pharr, 1988):

"Kids won't be called tomboys or sissies; they'll just be who they are, able to do what they wish" (p. 7)

"People will be able to love anyone, no matter what sex; the issue will simply be whether or not she/he is a good human being, compatible, and loving" (p. 7).

"Affection will be opened up between women and men, women and women, men and men, and it won't be centered on sex; people won't fear being called names if they show affection to someone who isn't a mate or potential mate" (p. 7).

Discuss the following belief systems about homosexuality (Aguero, et al., 1984).

"One, a heterosexual person may believe that homosexuality is largely determined by learning and personal choice. Basically, these people are likely to believe that a person can become a homosexual, if he/she does not watch his/her step" (p. 96).

"The second set of beliefs is the view that homosexuality is a physiological (or genetic) disorder. This belief produces attitudes toward homosexuality that are basically similar to attitudes toward the handicapped" (p. 97).

### Home Module I

Completion of this home study module will enable the participant to:

- 1) Identify key components of the American Nurses Association (ANA) policies related to the care of people with alternate lifestyles.
- 2) Experience the personal feelings that might be associated with prejudice or stigma.
- 3) Increase awareness of the extent of prejudice/stigma in society.

#### Activities

Read the ANA policies.

Challenge heterosexist jokes.

Check out a library book that depicts homosexual lifestyle and carry it around/read in public.

Write down your experiences and share in the next class.

### Session Two

#### Impact of Oppression on Society

Following this session the participant will be able to:

- 1) Explore the causes of inclusion and exclusion.
- 2) Explore the negative impact of homophobia on society.
- 3) Ventilate and process emotions about exposing the myths about homosexuality taught during growing up.
- 4) Explain some of the ways in which oppression of a group limits members of the dominant group.

## AGENDA

Share out-of-class experiences/assignments

Guided visualization

Break

Activity on stereotyping

Light activity to add closure to the emotionally charged class: a poem

### Course Outcome 1

1) Explore the causes of inclusion and exclusion.

All oppression, including sexism, racism, homophobia, etc., are linked by a common origin - power and control (Pharr, 1988).

Blaming victims and supporting it with stereotypes takes people 'off the hook.'

Isolation is a major component of oppression. People are expected to assimilate into the dominant culture (Pharr, 1988).

Until 1973, homosexuality was considered by the established psychiatric associations as a disorder. Still today some clinicians respond to their homosexual clients from a negative perception (Blumenfeld, 1992).

Individuals may maintain oppressive behaviors to gain certain rewards, to protect their self-esteem against doubts or conflicts, or to enhance their value systems (Blumenfeld, 1992).

### Course Outcome 2

2) Explore the negative impact of homophobia on society.

Locks everyone into rigid gender roles that inhibit creativity and self expression (Blumenfeld, 1992).

Integrity of homosexual people is compromised by pressure to treat others badly, which is contrary to basic humanity (Blumenfeld, 1992).

Inhibits the ability to form close relationships with members of one's own sex (Blumenfeld, 1992).

It may be one cause of premature sexual involvement, increasing chance of teen pregnancy to prove "normality" (Blumenfeld, 1992).

Inhibits a unified and effective governmental and societal response to AIDS (Blumenfeld, 1992).

Diverts energy from more constructive endeavors (Blumenfeld, 1992).

### Guided Visualization

Purpose: Have participants empathize with the person in the scenario.

Scenario:

You have no responsibilities. All you have to do is relax for a few moments and listen to a story I will share with you. Clear your minds and imagine yourself the person in this story.

You are single and living in a residence hall in college. People are discussing their dates for the weekend. You are listening to your stereo and looking through a magazine. Your roommate says, "I am going out with \_\_\_\_\_ again tonight. We are going out to dinner and then to the college dance." Several others mention their plans and who they're seeing. Someone asks you what you're doing tonight and says, "You're not going to stay here and study, are you?" You respond by saying, "I'm just gonna mess around here, no big plans." The group discusses fixing you up with someone, and you say, "Maybe some other time."

They continue to talk about dates and plans. You just nod your head and

smile and joke with them about love and sex so they won't be suspicious.

You start to think about the friend you've been seeing for three months and wish you could tell your roommate and the others about the good times you have together and how it feels to be in love. You know you can't.

Finally, when they all leave you dress and meet your friend in front of the residence. You're glad to see each other, but you can't hug and kiss. You go to dinner at a restaurant. You can't look into each others eyes too long or touch each other.

You go to a movie together. You would prefer to go to the college dance, but you can't. You sit beside each other at the movie, but you don't touch. When the movie is over you wish there were some place you could go together where you could be intimate. You can't go to your room at the residence. You'd like to tell the world about your love, but you're afraid you'd be disowned, kicked out of college, or not get a job - just because of who you love (Blumenfeld, 1992).

Now slowly 'come back' to our group. Open your eyes slowly. Process the activity by having participants share their thoughts, feelings, and emotions.

Ask if anyone has ever had the experience of seeing someone of whom their friends or family would not approve.

### Course Outcome 3

3) Ventilate and process emotions about exposing the myths about homosexuality taught during growing up.

### Discussion:

Question 1: When you were growing up, what were all the names you heard

related to gays and lesbians (positive, negative, or neutral)?

Question 2: What stereotypes did you hear about gays and lesbians while growing up?

Question 3: What have you found out to be not true about gays and lesbians related to the things you heard growing up? (Blumenfeld, 1992).

#### Mini Lecture

As we grew up three primary situations revolved around our learning about homosexuality. These were: 1) We heard nothing, so homosexuals did not exist; 2) We heard something, but it was loaded with negative stereotypes; or 3) We were given accurate information. It is more likely that most people would have had the experience of the first two (Blumenfeld, 1992). Let's talk about how to clear up some of these myths.

#### Course Outcome 4

4) Explain some of the ways in which oppression of a group limits members of the dominant group.

#### Activity

Read the following scenario to the group.

John met a woman and they seemed to “click” immediately. He told her that he was a carpenter with a local contractor. Things had been going smoothly for the month they had been together. By chance she went to a shop to get her hair done for a date with John on the weekend. She saw John standing there in the shop with his scissors and comb in hand. A wierd, shocked expression came over her face, and she ran from the shop. He felt like he had been caught with his pants down. He followed her, but she wouldn't talk to him. He continued to

phone her but she would not return his calls.

He went to see her about a week later. She explained how hurt she had been, and then asked him, "Who and what are you anyway?" He explained why he thought he had to lie to her and she seemed somewhat relieved. She said that she did sort of think he was gay when she saw him there in the shop. Now that she realizes that he isn't gay, she is angry with him because he did not tell her the truth (Blumenfeld, 1992).

Discuss the scenario.

### Home Module II

Completion of this home study module will enable the participant to:

- 1) Increase awareness of the research into the origins of homosexuality.
- 2) Write a positive paragraph about a homosexual.

### Reading Assignments

1. Associated Press (June 4, 1993). Gays, lesbians debate research on origin of homosexuality. Review Journal, B, 13.
2. Born or bred (1992, February 24). Newsweek Magazine, 46 - 53.

Bring in a written positive paragraph about a homosexual to share in class.

### Session Three

#### Attitude Sensitization in Nurses

Following this session the participant will be able to:

- 1) Experience emotionally what it is like to be gay or lesbian.

- 2) Identify interventions and actions that could assist the nurse in coping with the challenges of providing care to all patients regardless of sexual orientation.

## AGENDA

Share the home assignments

Role Play "Coming out"

Break

Nursing Activity

Posttest

## Course Outcome 1

- 1) Experience emotionally what it's like to be gay or lesbian.

### Coming-Out Role Play (Blumenfeld, 1992)

Ask for volunteer actors (6).

Each character is given a written role to play.

Characters: Mother, Father, Grandfather/Grandmother, Daughter/Son, Daughter's/Son's Roommate, Sister/Brother.

The actors are gathered around the holiday dinner table.

The audience is asked to put themselves in the shoes of the characters and to stay in touch with their feelings.

The characters are given sheets with the roles described and are instructed to try to become the person described on the sheet as best as you can.

Grandparent: So, \_\_\_\_\_, have you met any nice young woman/man at school?

Grandchild: No, Grandma/Grandpa.

Mother: Oh, come on. A beautiful girl/handsome boy like you! Tell us. We are interested and want to know. I'm your mother. Tell us more about what you and your roommate do together.

Daughter/Son: Okay - Okay. I want to say something, but first - I want you to know that I love you very much. I can't stand the distance between us any more. \_\_\_\_\_ and I are more than just roommates. We are lovers. We are so in love and we are very happy together.

After the role playing, the characters are asked about their feelings.

The audience is then asked to share their experiences.

## Course Outcome 2

2). Identify interventions and actions that could assist the nurse in coping with the challenges of providing care to all patients regardless of sexual orientation.

### Situation:

Mrs. Jones is a 41-year-old mother of three children. She was admitted to your inpatient unit because of depression. Mr. Jones, her husband, was recently admitted to the coronary care unit (CCU) because of a myocardial infarction. Mrs. Jones has been involved in a lesbian relationship with Karen for the past 18 months. Karen visits Mrs. Jones daily, and they spend their time in Mrs. Jones' room during the visits. Mrs. Jones' children come in to visit also. All of them go visit Mr. Jones in CCU.

You are the nurse in charge of this unit. What are your thoughts and feelings? Do you see these thoughts and feelings as being helpful or not? How can you be most helpful to Mrs. Jones? How can you help the staff

members who may be angry or threatened? (Doshier & Assey, 1989).

Discuss ways in which you as nurses can take the lead in helping to work through the negative attitudes toward patients.

APPENDIX F

ASSISTED SUICIDE/EUTHANASIA COURSE  
CONTROL GROUP

## CONTROL GROUP

### Session One

#### Attitudes Toward Assisted Suicide

##### Course Outcomes

Following this session, the participant will be able to:

- 1) Explore personal feelings related to assisted suicide.
- 2) Discuss beliefs and perceptions that Americans have about assisted suicide.
- 3) Define euthanasia, assisted suicide, living will and advanced directives.
- 4) Discuss the influence of society's attitudes on the attitudes of nurses.

##### AGENDA

Pretests and biographical information

Introduction to the course

Balloon exercise to build trust

Break (10 minutes)

Discuss common beliefs and perceptions

Assignments for home module I

Adjournment

##### Course Outcome I

- 1) Explore personal feelings related to assisted suicide

**Discuss:**

Ground rules and information about the presenter

Confidentiality

Respect for the ideas of others

No attacking and no blaming others in the group

Speak from own experience and not speak for others

Encourage personal risk taking

**Working Assumptions:**

Denial and fear of death are strong in American culture.

Cultural myths affect nurses in the same ways as they affect the rest of society.

Suicide can be a decision that is made by a person who is sane.

The “right to die” issue is controversial.

**Balloon Exercise**

Materials: Balloons, magic marker

As concerned nurses, you attempt to keep your patients afloat physically, hoping to make them “all better”. I am going to toss out a number of balloons that are different colors and shapes representing the diversity of diagnoses in your patients. It is up to you to keep them afloat by whatever means possible. As you toss each balloon into the center of the group, shout out the illness your balloon represents. Some possible diagnoses: cancer, AIDS, progeria, sickle cell crisis, near drowning, Alzheimer's disease, etc.

**Course Outcome 2**

2) Discuss beliefs and perceptions that Americans have about assisted suicide.

**Beliefs and Perceptions:**

Many Americans favor physician-assisted suicide.

A number of medical ethicists oppose physician-assisted suicide. Many hold the belief that once the legal barrier to physician-assisted suicide is broken, there will be little justification for limiting this practice to the terminally ill.

**Exercise: Wants and Fears Cards**

On the three- by five-inch card, write down what you would like to get out of this workshop on one side (the 'wants' side of the card) and on the other side, write down the anxieties and fears you walked into the class with (the 'fears' side of the card). Do not put your name on the card. When you have finished, I will collect the cards, shuffle them, and pass them back so each person gets to read another's card.

**Course Outcome 3**

3) Define euthanasia, assisted suicide, living will, and advanced directives.

Euthanasia: "Good or pleasant death" (Lindberg, et al., 1994, p. 369).

Euthanasia is divided into active euthanasia, which means to actively assist in the death process and passive euthanasia, which means allowing to die or not interfering with the death process (Lindberg, et al., 1994).

Assisted Suicide: Usually refers to physician-assisted suicide. Dr. Kevorkian uses the term 'obiatry' to mean "going to one's death with the aid of a doctor" (Cox, 1993, p.94).

Living Will: A document asking health professionals "to comply with the person's request for life with quality and death with dignity" (Lindberg, et al.,

1994, p. 369).

Advanced Directives: “Documents such as Durable Powers of Attorney and Living Wills that allow a person to plan for the management of health care and/or financial affairs in the event of incapacity” (Lindberg, et al., 1994, p. 370).

#### Course Outcome 4

4) Discuss the influence of society’s attitudes on the attitudes of nurses.

Read and discuss a vignette on society’s attitudes on loss, grief, and death. Participants will be divided into small groups of four to read and discuss and then report to the whole class.

#### Home Module I

Completion of this home study module will enable the participant to:

- 1) Review the “Code For Nurses With Interpretative Statements” developed by the American Nurses Association (1985).
- 2) Experience the personal feelings that might be associated with the concepts of assisted suicide/euthanasia.
- 3) Increase awareness of the extent of anxiety about the end of life in society.

#### Activities

Read the “Code For Nurses With Interpretative Statements” by ANA (1985).

Discuss assisted suicide/euthanasia with an acquaintance.

Challenge someone’s beliefs about assisted suicide/euthanasia.

Check out a library book about assisted suicide/euthanasia and carry it around/read in public.

Write down your experiences and share in the next class session.

## Session Two

### Ethical Dilemmas and Nursing Practice

Following this session the participant will be able to:

- 1) Explore ethical dilemmas faced by nurses in relation to the dying patient, the family, and other health professionals, particularly the physician.
- 2) Explore the "right-to-die" issues.
- 3) Discuss the issue of quality of life.
- 4) Explore the cases of Karen Ann Quinlan and Nancy Cruzan.

## AGENDA

Share out-of-class experiences/assignments

Guided visualization

Break (10 minutes)

Light activity to add closure to the emotionally charged class

Adjournment

## Course Outcome I

- 1) Explore ethical dilemmas faced by nurses in relation to the dying patient, the family, and other health professionals, particularly physicians.

Nurses face issues of truth telling, promise keeping, suicide, and refusal of treatment.

Explore together the following questions (Lindberg, et al., 1994):

Should a patient be told he or she is going to die if the person seems unable to cope with the information? If family members do not want the individual to be told?

Should a nurse promise not to divulge a patient's awareness of impending death?

What if the nurse disagrees with the patient's decision to refuse life-saving treatment?

Under what circumstances, if ever, is suicide morally defensible? Does the nurse have the right to interfere?

## Course Outcome 2

### 2) Explore the right-to-die issues.

There are issues of withholding treatment and withdrawing treatment.

Some consider withholding treatment to be negative euthanasia. Discuss the historic 1963 case on the East Coast where a couple gave birth to a premature baby with Down's syndrome. Details of the case are found in Ellis and Hartley (1992, p. 264-265).

It is of particular concern to consider nurses' feelings when a decision is made to remove life-supporting measures. Strong emotional attachments are formed over long periods of caring for a patient, even if the patient has been in a vegetative state. Nurses may have difficulty "letting go."

### Course Outcome 3

#### 3) Discuss the issue of quality of life.

Consider what your responses might be to the following situations (Zerwekh and Claborn, 1994).

Close your eyes and visualize the patients.

Situation 1: A twenty-four- year-old patient who is quadriplegic keeps asking you to disconnect his ventilator. He believes he has nothing to live for. His family rarely visits him.

Situation 2: The husband of a woman with advanced Alzheimer's disease states that he can no longer watch his wife of 50 years suffer. He states that she would not want to live this way. She is presently being treated for dehydration, malnutrition, and a respiratory tract infection. She is combative and frequently has to be sedated. A feeding tube for her is being contemplated since she refuses to eat.

Following visualization of each situation, discuss your beliefs and feelings in terms of your role as a nurse.

#### Discussion:

Question 1: When you were growing up, what did your family talk about in relation to death and dying?

Question 2: What family values related to death and dying do you still hold? Not hold?

#### Course Outcome 4

4) Explore the case of Karen Ann Quinlan and Nancy Cruzan.

Participants will break up into small groups of four and read the Quinlan and Cruzan cases. The group will discuss the ethical issues related to the cases and their own beliefs and feelings and then share with the whole class.

#### Home Module II

Completion of this home study module will enable the participant to:

- 1) Develop an awareness of cases in which mercy killing has been done.
- 2) Write a reaction to specific cases where mercy killing was done.

#### Reading Assignments

1. "I gave Him all the Morphine ... in My Bag. It Wasn't Easy" (from "Death on Request, cited in Brock, 1992).
2. "She Wanted Out Now" (from "Death on Request", cited in Brock, 1992).
3. "Death Wish Honored, Despite Doubts" (from "Death on Request", cited in Brock, 1992).

#### Session Three

##### Developing Self-Understanding

Following the session the participant will be able to:

- 1) Experience emotionally what it is like to be faced with your own crisis of wanting to die.

- 2) Identify interventions and actions that could assist the nurse in coping with the challenges of providing care to patients who may request assisted suicide.

## AGENDA

Share the home assignments

Experiential exercise

Break (10 minutes)

Nursing Activity

Posttest

## Course Outcome 1

- 1) Experience emotionally what it is like to be faced with your own crisis of wanting to die.

## Exercises

Write today's date, your birth date, your projected death date.

Design a headstone for yourself.

Write your obituary.

Share the experience with the class.

Visualize yourself in a helpless state in the hospital. You are asking to have life support removed because your quality of life has deteriorated. Your family is agreeing with you, but the hospital physicians and nurses will not grant your requests.

Discuss your feelings in small groups, then share with the class.

#### Course Outcome 2

- 2) Identify interventions and actions that could assist the nurse in coping with the challenges of providing care to patients who may request assisted suicide.

Write down at least two nursing interventions and share with the whole class.

Discuss the interventions.

## BIBLIOGRAPHY

## Bibliography

- Aguero, J. E., Bloch, L., & Byrne, D. (1984). The relationships among sexual beliefs, attitudes, experience, and homophobia. Journal of Homosexuality, 10, 95 - 107.
- Ajzen, I. & Fishbein, M. (1980). Understanding Attitudes and Predicting Social Behavior. Englewood Cliffs, NJ: Prentice-Hall.
- Akinsanya, J. & Rouse, P. (1992). Who will care? A survey of the knowledge and attitudes of hospital nurses to people with HIV and AIDS. Journal of Advanced Nursing, 17, 400 - 401.
- All, A. (1989). Health care workers' anxieties and fears concerning AIDS: A literature review. The Journal of Continuing Education in Nursing, 20 (4), 162 - 165.
- Allen, J. R. (1988). Health care workers and the risk of HIV infection. Hastings Center Report, 18 (2), 2 - 4.
- Allport, G. W. (1958). The Nature of Prejudice. Garden City, New York: Doubleday.
- American Nurses Association (1985). Code For Nurses With Interpretive Statements. Kansas City: ANA.
- American Nurses Association Committee on Ethics (1988). Statement regarding risk versus responsibility in providing nursing care. In Ethics in Nursing: Position Statements and Guidelines. Kansas City, MO: ANA.
- Anderson, C. L. (1982). The effect of a workshop on attitudes of female nursing students toward male homosexuality. Journal of Homosexuality, 7, 57 - 69.
- Anderson, V. N. (1992). For whom is this world just? Sexual orientation and AIDS. Journal of Applied Social Psychology, 22 (3), 248 - 259.
- Associated Press (1993, June 4). Gays, lesbians debate research on origin of homosexuality. Review Journal, B, 13.
- Austin, D., Hong, S. M., & Hunter, W. (1989). Some determinants of fear about AIDS among Australian college students. Psychological Reports, 64, 1239 - 1244.

- Bandura, A. (1969). Principles of Behavior Modification. New York: Holt, Rinehart, & Winston.
- Bandura, A. (1977). Social Learning Theory. Englewood Cliffs, NJ: Prentice-Hall, Inc.
- Baranowski, M. V. (1988). Review of the Primacy of Caring: Stress and Coping in Health and Illness by P. Brenner and J. Wrubel. Image, 20 (2), 113 - 114.
- Blumenfeld, W. J. (1992). Homophobia: How We All Pay the Price. Boston: Beacon Press.
- Blumenfield, M., Smith, P. J., Milazzo, J., Seropian, S., & Wormser, G. P. (1987). Survey of attitudes of nurses working with AIDS patients. General Hospital Psychiatry, 9, 58 - 63.
- Boland, B. K. (1990). Fear of AIDS in nursing staff. Nursing Management, 21, 40 - 44.
- Bond, S. G., Rhodes, T., Phillips, P., Setters, J., Foy, C., & Bond, J. (1990). HIV infection and AIDS in England: The experience, knowledge, and intentions of community nursing staff. Journal of Advanced Nursing, 15, 249 - 255.
- Born or bred (1992, February 24). Newsweek Magazine, 46 - 53.
- Bouton, R. A., Gallaher, P. E., Garlinghouse, P. A., Leal, T., Rosenstein, L. D., & Young, R. K. (1989). Demographic variables associated with fear of AIDS and homophobia. Journal of Applied Social Psychology, 19 (11), 885 - 901.
- Bouton, R. A., Gallaher, P. E., Garlinghouse, P. A., Leal, T., Rosenstein, L. D., & Young, R. K. (1987). Scales for measuring fear of AIDS and homophobia. Journal of Personality Assessment, 51(4), 606 - 614.
- Brandt, A. M. (1988). The syphilis epidemic and its relation to AIDS. Science, 239, 375 - 380.
- Breault, A. J. & Polifroni, E. C. (1992). Caring for people with AIDS: nurses' attitudes and feelings. Journal of Advanced Nursing, 17, 21 - 27.

- Brock, D. W. (1992). Voluntary active euthanasia. Hastings Center Report, 22, 10 - 21.
- Burtis, R. E. & Evangelist, J. T. (1992). Will universal precautions protect me? A look at staff nurses' attitudes. Nursing Outlook, 40 (3), 133 - 138.
- Campbell, D. T. & Stanley, J. C. (1963). Experimental and Quasi-Experimental Designs For Research. Chicago: Rand McNally.
- Camus, A. (1948). The Plague. New York: Random House.
- Carwein, V. & Berry, D. (1992). HIV issues for rural hospitals in US frontier areas. Journal of Rural Health, 8 (3), 221 - 226.
- Carwein, V. & Sabo, C. (1994). Women and HIV/AIDS. Journal of the Association of Nurses in AIDS Care, 5, 15 - 21.
- Centers For Disease Control and Prevention (1988). Guides for counseling and antibody testing to prevent HIV infection and AIDS. Morbidity and Mortality Weekly Report, 36, 509 - 514.
- Centers for Disease Control and Prevention (1993). HIV/AIDS Surveillance Report, Third Quarter Edition. Atlanta: CDC.
- Centers For Disease Control and Prevention (1994). National AIDS Hotline. 1-800-342-AIDS.
- Centers For Disease Control and Prevention (1987). Update: Human immunodeficiency virus infection in health-care workers exposed to blood of infected patients. Morbidity and Mortality Weekly Report, 36, 285 - 288.
- Clark County Health District (April 20, 1994). HIV/AIDS Surveillance Update. Las Vegas: Clark County Health District.
- Cox, D. W. (1993). Hemlock Cup. Buffalo, NY: Prometheus.
- Croteau, J. M. & Morgan, S. (1989). Combating homophobia in AIDS education. Journal of Counseling and Development, 68, 86 - 91.
- D'Augelli, A. R. (1989). AIDS fears and homophobia among rural nursing personnel. AIDS Education and Prevention, 1 (4), 277 - 284.

- Diamond, M. (1993). Homosexuality and bisexuality in different populations. Archives of Sexual Behavior, 22, 291 - 310.
- Dosher, S. & Assey, J. L. (1989). Instructor's Manual For Psychiatric-Mental Health Nursing (2nd ed.). Philadelphia: J. B. Lippincott Co.
- Durham, J. D. (1991). The HIV epidemic: ethical and legal dimensions. In J. D. Durham & F. L. Cohen (Ed.), The Person With AIDS: Nursing Perspectives (2nd ed.). New York: Springer.
- Eliason, M. & Randall, C. (1991). Lesbian phobia in nursing students. Western Journal of Nursing Research, 13 (3), 363 - 374.
- Ellis, J. R. & Hartley, C. L. (1992). Nursing in Today's World. Philadelphia: J. B. Lippincott.
- Feinblum, S. (1986). Pinning down the psychosocial dimensions of AIDS. Nursing and Health Care, 7, 255 - 257.
- Fish, T. A., & Rye, B. J. (1991). Attitudes toward a homosexual or heterosexual person with AIDS. Journal of Applied Social Psychology, 21 (8), 651 - 667.
- Fishbein, M. (Ed.), (1967). Attitude Theory and Measurement. New York: John Wiley & Sons.
- Flaskerud, J. H. (1989). AIDS/HIV Infection: A Reference Guide for Nursing Professionals. Philadelphia: Saunders.
- Flaskerud, J. H. (1991). A psychoeducational model for changing nurses' AIDS knowledge, attitudes, and practices. The Journal of Continuing education in nursing, 22 (6), 237 - 244.
- Flaskerud, J. H., Lewis, M. A., & Shin, D. (1989). Changing nurses' AIDS-related knowledge and attitudes through continuing education. The Journal of Continuing Education in Nursing, 20 (4), 148 - 154.
- Fullilove, M. T. (1989). Anxiety and stigmatizing aspects of HIV infection. Journal of Clinical Psychiatry, 50 (11), 5 - 8.
- Gaines, J., Iglar, A. F., Michal, M. L., & Patton, R. D. (1988). Attitudes towards AIDS. Health Values, 12 (4), 53 - 57.

- Gallop, R. M., Lancee, W. J., Taerk, G., Coates, R. A., & Fanning, M. (1992). Fear of contagion and AIDS: nurses' perception of risk. AIDS Care, 4 (1), 103 - 109.
- Goldenberg, D. & Laschinger, H. (1991). Attitudes and normative beliefs of nursing students as predictors of intended care behaviors with AIDS patients: A test of the Ajzen-Fishbein theory of reasoned action. Journal of Nursing Education, 30, 119 - 126.
- Goodwin, M. P., & Roscoe, B. (1988). AIDS: students' knowledge and attitudes at a midwestern university. Journal of American College Health, 36, 214 - 221.
- Gostin, L. (1986). Introduction. In Michael D. Witt (Ed.), AIDS and Patient Management: Legal, Ethical, and Social Issues. Owings Mills, MD: Rynd Communications.
- Gross, L. (1991). Out of the mainstream: sexual minorities and the mass media. Journal of Homosexuality, 21, 19 - 46.
- Grossman, A. H. (1994). Homophobia: a cofactor of HIV disease in gay and lesbian youth. Journal of the Association of Nurses in AIDS Care, 5 (1), 39 - 43.
- Herek, G. M., & Glunt, E. K. (1988). An epidemic of stigma: public reaction to AIDS. American Psychologist, 43 (11), 886 - 891.
- Hudson, W. W. & Ricketts, W. A. (1980). Strategy for the measurement of homophobia. Journal of Homosexuality, 5, 357 - 372.
- Huerta, S. R. & Oddi, L. F. (1992). Refusal to care for patients with human immunodeficiency virus/acquired immunodeficiency syndrome: issues and responses. Journal of Professional Nursing, 8, 221 - 230.
- Isenberg, M. A. (1919). The need for more and better tuberculosis nurses. American Journal of Nursing, 20, 121 - 123.
- Jecker, N. S. (1990). The responsibility to treat AIDS patients. AIDS Patient Care, 4 (1), 2 - 4.
- Jemmott, L. S., Jemmott, J. B., & Cruz-Collins, M. (1992). Predicting AIDS patient care intentions among nursing students. Nursing Research, 41 (3), 172 - 177.

- Katz, I., Hass, G., Parisi, N., Astone, J., Mc Evaddy, D. & Lucido, D. (1987). Lay people's and health care personnel's perceptions of cancer, AIDS, cardiac, and diabetic patients. Psychological Reports, 60, 615 - 629.
- Kelly, J. A., St. Lawrence, J. S., Hood, H. V., & Cook, D. J. (1988). Nurses' attitudes toward AIDS. Journal of Continuing Education in Nursing, 19(2), 78 - 83.
- Kemppainen, J., St. Lawrence, J. S., Irizarry, A., Weidema, D. R., Benne, C., Fredericks, C. D., & Wilson, M. (1992). Nurses' willingness to perform AIDS patient care. Journal of Continuing Education in Nursing, 23 (3), 110 - 117.
- Kunkel, L. E. & Temple, L. L. (1992). Attitudes towards AIDS and homosexuals: Gender, marital status, and religion. Journal of Applied Social Psychology, 22 (13), 1030 - 1040.
- Larsen, K., Reed, M., & Hoffman, S. (1980). Attitudes of heterosexuals toward homosexuality: a Likert-type scale and construct validity. The Journal of Sexual Research, 16, 245 - 257.
- Lester, L. B., & Beard, B. J. (1988). Nursing students' attitudes toward AIDS. Journal of Nursing Education, 27 (8), 399 - 404.
- Le Vay, S. (1991). A difference in hypothalamic structure between heterosexual men and homosexual men. Science, 253, 1034 - 1037.
- Lindberg, J. B., Hunter, M. L., & Kruszewski, A. Z. (1994). Introduction to Nursing (2nd ed.). Philadelphia: J. B. Lippincott Co.
- Mann, J., Tarantola, D. J. M., & Netter, T. W. (1992). AIDS in the World. Cambridge: Harvard University Press.
- Marcus, R. (1988). Surveillance of health care workers exposed to blood from patients infected with the human immunodeficiency virus. New England Journal of Medicine, 319 (17), 1118 - 1123.
- Martindale, L., & Barnett, C. (1992). Nursing faculty's knowledge and attitudes toward persons with AIDS. Journal of the Association of Nurses in AIDS Care, 3 (2), 9 - 13.
- Mc Cutchan, J. A. (1986). What you can do to stop the AIDS panic. RN, 49, 18 - 21.

- Mc Devitt, T. M., Sheehan, E. P., Lennon, R., & Ambrosia, A. L. (1989). Correlates of attitudes toward AIDS. The Journal of Social Psychology, 130 (5), 699 - 701.
- Meisenhelder, J. B. (1994). Contributing factors to fear of HIV contagion in registered nurses. Image, 26 (1), 65 - 69.
- Meisenhelder, J. B. & La Charite, C. (1989). Fear of contagion: the public response to AIDS. Image, 21 (1), 7 - 9.
- Moriarty, M. (1988). Why AIDS wracks the conscience of nursing. RN, 51, 58 - 65.
- Mueller, C. W., Cerny, J. E., Amundson, M. J., & Waldron, J. A. (1992). Nursing faculty and students' attitudes regarding HIV. Journal of Nursing Education, 31 (6), 273 - 279.
- Murray, R. B. & Huelskoetter, M. W. (1991). Psychiatric and Mental Health Nursing (3rd ed.). Norwalk, Connecticut: Appleton & Lange.
- Neuman, B. N. (1989). The Neuman Systems Model (2nd ed.). Norwalk, Connecticut: Appleton & Lange.
- O'Donnell, L., O'Donnell, C. R., Pleck, J. H., Snarey, J., & Rose, R. M. (1987). Psychosocial responses of hospital workers to acquired immunodeficiency syndrome (AIDS). Journal of Applied Social Psychology, 17 (3), 269 - 285.
- Oermann, M. H., & Gignac, D. (1991). Knowledge and attitudes about AIDS among Canadian nursing students: educational implications. Journal of Nursing Education, 30, 217 - 221.
- Paul, W. & Weinrich, J. D. (1982). Introduction. In W. Paul, J. D. Weinrich, J. C. Gonsiorik, & M. E. Hotvedt (Ed.), Homosexuality: Social, Psychological, & Biological Issues. Beverly Hills: Sage Publications, Inc.
- Paxton, C. & Susky, D. (1988). AIDS, homophobia and sexual attitudes. Health Values, 12 (4), 39 - 43.
- Pederson, C. (1993). Structured controversy versus lecture on nursing students' beliefs about and attitude toward providing care for persons with AIDS. The Journal of Continuing Education in Nursing, 24 (2), 74 - 81.

- Peters, F. & Connell, K. (1991). Incorporating the affective component into an AIDS workshop. The Journal of Continuing Education in Nursing, 22 (3), 95 - 99.
- Pharr, S. (1988). Homophobia: A Weapon of Sexism. Inverness, CA: Chardon Press.
- Piskur, J. & Degelman, D. (1992). Effect of reading a summary of research about biological bases of homosexual orientation on attitudes toward homosexuals. Psychological Reports, 71, 1219 - 1225.
- Pleck, J. H., O'Donnell, L., O'Donnell, C., & Snarey, J. (1988). AIDS-phobia, contact with AIDS, and AIDS-related job stress in hospital workers. Journal of Homosexuality, 15, 41 - 54.
- Preston, D. B., Koch, P. B., & Young, E. W. (1991). AIDS: experiences and attitudes of nurses from rural communities in Pennsylvania and New York. AIDS and the Hospice Community, 7, 109 - 125.
- Prince, N., Beard, B., Ivey, S., & Lester, L. (1989). Perinatal nurses' knowledge and attitudes about AIDS. JOGNN, 18, 363 - 369.
- Rae, D., Brown, Y., & Calder, B. (1992). Nurses' knowledge about and attitudes toward patients with AIDS. The Journal of Continuing Education in Nursing, 23 (2), 69 - 75.
- Rimm, D. C. & Masters, J. C. (1974). Behavior Therapy: Techniques and Empirical Findings. New York: Academic Press.
- Royse, D. & Birge, B. (1987). Homophobia and attitudes towards AIDS patients among medical, nursing, and paramedical students. Psychological Reports, 61, 867 - 870.
- Scherer, Y. K., Haughey, B. P., & Wu, Y. B. (1989). AIDS: what are nurses' concerns? Clinical Nurse Specialist, 3, 48 - 54.
- Scherer, Y. K., Haughey, B. P., Wu, Y. B., & Kuhn, M. M. (1992). AIDS: What are critical care nurses' concerns? Critical Care Nurse, 12, 23 - 29.
- Scherer, Y. K., Wu, Y. B., & Haughey, B. P. (1991). AIDS and homophobia among nurses. Journal of Homosexuality, 21 (4), 17 - 27.

- Schwanberg, S. L. (1990). Attitudes toward homosexuality in American health care literature 1983 - 1987. Journal of Homosexuality, 19(3), 117 - 136..
- Serdahely, W. J., & Ziemba, G. J. (1984). Changing homophobic attitudes through college sexuality education. Journal of Homosexuality, 10, 109 - 115.
- Small, M. F. (1993). The gay debate: is homosexuality a matter of choice or chance? American Health, 12, 70 - 77.
- Sontag, S. (1978). Illness as Metaphor. New York: Farrar, Straus, & Giroux.
- St. Lawrence, J. S., Husfeldt, B. A., Kelly, J. A., Hood, H. V., & Smith, S. (1990). The stigma of AIDS: fear of disease and prejudice toward gay men. Journal of Homosexuality, 19 (3), 85 - 101.
- Swanson, J. M., Chenitz, C., Zalar, M. & Stoll, P. (1990). A critical review of human immunodeficiency virus infection - and acquired immunodeficiency syndrome - related research: the knowledge, attitudes, and practice of nurses. Journal of Professional Nursing, 6(6), 341 - 355.
- Van Servellen, G. M., Lewis, C. E., & Leake, B. (1988). Nurses' responses to the AIDS crisis: implications for continuing education programs. The Journal of Continuing Education in Nursing, 19, 4 - 8.
- Walsh, G. (1992). AIDS: fear of contagion among nurses. British Journal of Nursing, 1 (2), 66 - 71.
- Weinberg, G. (1972). Society and the Healthy Homosexual. New York: St. Martins.
- Young, E. W. (1988). Nurses' attitudes toward homosexuality: analysis of change in AIDS workshops. The Journal of Continuing Education in Nursing, 19 (1), 9- 12.
- Young, E. W., Koch, P., & Preston, D. (1989). AIDS and homosexuality: a longitudinal study of knowledge and attitude change among rural nurses. Public Health Nursing, 6, 189 - 196.

- Young, R. K., Gallaher, P., Belasco, J., Barr, A., & Webber, A. W. (1991). Changes in fear of AIDS and homophobia in a university population. Journal of Applied Social Psychology, 21 (22), 1848 - 1858.
- Zeimer, M. M. (1983). Effects of information on postsurgical coping. Nursing Research, 32, 282 - 287.
- Zerwekh, J. A. & Claborn, J. C. (1994). Nursing Today: Transition and Trends. Philadelphia: W. B. Saunders Co.