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An Analysis of Social Work Students' Knowledge, Values and Attitudes Toward HIV/AIDS

By

Susan Podolsky-Scarth

A Thesis
Submitted to the Faculty of Graduate Studies
in Partial Fulfillment of the Requirements
for the Degree of

Master in Social Work

Faculty of Social Work
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Winnipeg, Manitoba

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THE UNIVERSITY OF MANITOBA

FACULTY OF GRADUATE STUDIES

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An Analysis of Social Work Students' Knowledge, Values and Attitudes Toward HIV/AIDS

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A Thesis/Practicum submitted to the Faculty of Graduate Studies of The University

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of

MASTER OF SOCIAL WORK

Abstract

The Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome have had a substantial impact on thousands of Canadians. The increase of HIV disease in vulnerable populations means that there is an expanding role for social workers to meet the needs of these individuals and to prevent the spread of further infection. The literature on HIV/AIDS reveals that it is a disease surrounded by stigmatization, and discrimination on social, political, personal and professional levels. Although much has been discovered and learned about this disease, deficits in knowledge, and preparation to work with these clients exist.

This exploratory study investigated the attitudes, knowledge and comfort of 134 students enrolled at various stages of the Bachelor of Social Work and Premasters programs at the Faculty of Social Work, University of Manitoba. The role of social work values in professionally preparing these students with appropriate attitudes toward the disease was also investigated. Several additional variables related to experience with the disease, interest in working with the disease, and demographic variables were also incorporated into this study. The results of this study demonstrated that overall, respondents held appropriate attitudes toward the disease, however, deficits in knowledge regarding the populations who have been most impacted by the disease, as well as resources for individuals with HIV/AIDS, were revealed. Respondents' attitudes were found to be significantly related to their ability to apply values to practice situations, their knowledge of the disease, and their attitudes toward being in contact with those with the disease.

It was hoped that this study would increase understanding of how to best prepare students for their professional roles in dealing with a multi-faceted problem such as HIV/AIDS. Implications for future coursework and educational preparation for students to work effectively in their roles as social workers with HIV/AIDS are discussed, as well as the implications for future research.

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CHAPTER I

STATEMENT OF THE PROBLEM

Introduction

The Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) present a significant problem on both societal and professional levels for social workers. Individuals who are affected by HIV disease or AIDS have needs that may require a multitude of services including counseling, social services (Wexler, 1989), advocacy, community outreach, and case management (Wiener & Siegel, 1990). On a broader level, there is a need for preventative programming, education and policy making. Social work, a profession that is recognized for supporting the socially disadvantaged and those who are discriminated against by the larger society, has a significant role to perform in meeting the needs of individuals affected by HIV disease or AIDS. The skills that social workers perform in integrating people with larger systems, their focus on context and environment evolving from work with historically marginalized groups, and their commitment to human rights and fairness are critical to addressing the issues surrounding HIV disease and AIDS. Social work has assumed a role with HIV/AIDS[1], as evidenced by the burgeoning volume of literature on prevention, psychosocial issues, and clinical work with clients. Social workers however, are not untouched by the societal attitudes towards HIV/AIDS, and issues constantly emerge presenting new and complex challenges to many professions, including social work.

The issues surrounding HIV/AIDS, a disease that is associated with marginalized groups, and the experience of extreme stigmatization and discrimination, substantiate it as a complex problem. The fact that HIV is a communicable disease that has resulted in death for most until recently, and is chronic and progressive in nature (Manitoba Health, 1998),

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[1] HIV disease and AIDS are presented as "HIV/AIDS" throughout this study, except where reference is made specifically to HIV disease, or AIDS. Although a shortened notation is used to identify both HIV disease and AIDS, it is recognized that the experiences of those living with HIV infection and AIDS, are unique.

compounds the challenges related to work with HIV/AIDS by arousing fear of contagion, fear and intolerance of groups known to have the disease, and victim blaming. HIV/AIDS requires specialized skills, knowledge and awareness on the part of professionals to intervene effectively with clients, their families, and the community. The degree of stigmatization that is experienced by those who are affected by this disease, not only necessitates that social workers possess an awareness of HIV/AIDS issues, but the role that social workers perform requires that this awareness extend to include the self, in examining individual biases, beliefs and attitudes toward individuals with HIV/AIDS. This study incorporates several issues that reflect the challenges to the profession of social work. Its purpose is to explore through quantitative analysis, several research questions related to the Bachelor of Social Work and Premasters students' knowledge, values, and attitudes toward HIV/AIDS at the Faculty of Social Work, University of Manitoba, in an effort to understand how social workers can best prepare themselves for work in this epidemic.

Rationale for Study

Since its identification almost thirty years ago, HIV/AIDS has grown to epidemic proportions. The disease has been more prevalent and visible in certain countries such as those in South Africa, the Americas (Dansky, 1997), and in larger metropolitan areas, however, the disease touches all people as evidenced by the growing numbers who are affected by HIV/AIDS. Globally over 18 million adults, and approximately 1.5 million children had been infected with HIV by 1995 (Dansky, 1997). It is estimated that by the year 2000, approximately 40 million people will be infected with the disease on a global basis. In North America, there are over 1.5 million individuals who have been infected with HIV disease, and over 250,000 cumulative AIDS cases (Dansky, 1997).

In Canada it is estimated that between 50,000-54,000 people have been infected with HIV disease since the start of the epidemic (Health Canada, 1998). The number of individuals who are affected either directly or indirectly by HIV/AIDS continues to increase. The Canadian AIDS Society (1998) for example, estimates that 17,000 Canadians are infected with HIV and are not aware of their sero-positive status. While the majority of Canadian infections of the disease have been reported in larger metropolitan centers such as Vancouver and Toronto (Health Canada, 1998), statistics reveal that the number of peopled affected by the disease in smaller locals such as Manitoba, are increasing. In Manitoba over 600 people have been infected with HIV, and may more are infected who are not aware of their status (Manitoba Health, 1998). These statistics substantiate a need for social work services and for awareness, education, and professional preparation to effectively help and care for the individuals who have been affected by the disease.

The need for this study is further supported by the shift in incidence of the disease. Originally associated with men of homosexual orientation and hemophiliacs who received infected blood products, HIV/AIDS has affected all segments of the population. According to Health Canada (1998) there has been a decrease in infections among men who have sex with men from 74.6% (1985-1994) to 37.6% in 1997. Increases in diagnoses of HIV infection are now seen in youth where the average age of infection has decreased to 23 years of age, aboriginal people, and women (Health Canada, 1998). The shift in incidence of the disease requires that all social workers possess knowledge, and appropriate beliefs that promote the well-being of individuals affected with HIV/AIDS, regardless of their chosen area of practice (Diaz & Kelly, 1991; Gillman, 1991; O'Hare, Williams, & Ezoviski , 1996). The advances in medical treatment of HIV/AIDS also means that individuals who are sero-positive will live longer lives, increasing the need for the development of appropriate resources, provision of services such as counseling, treatment and support, and enhancing the quality of life.

The need for this study is also reinforced by the professional mandate of social workers. HIV/AIDS has emerged as a relatively new area of practice, and the significance of the disease has led the profession of social work to call on its members to commit to

HIV education. Social workers are ethically obligated to work with clients with HIV/AIDS and their families in practice situations, and to be adequately professionally prepared. (Canadian Association of Social Workers, 1994). Part of this professional preparation entails a self-analysis of values, beliefs and level of knowledge about the disease (Canadian Association of Schools of Social Work, 1990). Social work has a set of professional values that are considered essential to the development of the profession, to the socialization of social workers (King-Pike, 1996), and to guide practice behaviors with clients (Abbott, 1988).

The values of social work are identified as a commitment to client "acceptance, self-determination, and respect of individuality (CASW, 1994, p. 7). They emphasize the "obligation of all people to provide resources, services and opportunities to the benefit of all humanity, and the culture of individuals, families, groups, communities and nations has to be respected without prejudice" (p.7). Identification with these principles and values is not only necessary for competent social work practice (Pearce, in Vass, 1996), but it shapes social workers' perceptions about clients, and their behaviors and beliefs about the world in general. Professional values however, may or may not always be consistent with personal values and beliefs (Hepworth & Larson, 1993). The nature of HIV/AIDS touches on sensitive and moral issues that may be contrary to the personal belief and value systems which individuals carry with them into their professional work, or find difficult to deal with in the absence of adequate educational and professional preparation.

Objectives of the Study

The research on HIV/AIDS reveals that professionals' beliefs and knowledge about HIV/AIDS are related to effective social work practice with these clients (O'Hare et al., 1996; Wiener & Siegel, 1990). Professional values in social work education shape appropriate beliefs and behaviors, and underlie the formation and organization of attitudes towards groups of people. Therefore, these variables are incorporated into this study.

The objectives of the study are:

1) To determine the attitudes of students in the Bachelor and Premasters programs toward HIV/AIDS.

2) To assess respondents' level of knowledge about HIV/AIDS.

3) To determine if potential social workers who are enrolled at various stages of the Bachelor and Premasters programs, could identify and apply values to HIV/AIDS practice situations, in a manner that upholds a value, and adequately meets the needs of those affected directly or indirectly by HIV/AIDS.

4) To explore the relationships between the variables of attitudes, values, and knowledge.

Summary

The purpose of this study is to obtain information on how respondents' identify with social work values, their attitudes and beliefs about HIV/AIDS, their existing level of knowledge of HIV/AIDS, and the relationship among these variables. Other studies conducted with professional social workers have acknowledged a need for both general education, as well as experiential techniques such as role playing to address students' comfort levels and behaviors with HIV/AIDS related issues (Gillman, 1991; O'Hare et al., 1996). It is anticipated that the results of this study will have implications for preparing students to work with potential clients. It must also be emphasized that the purpose of this study is not to evaluate teaching methods, the BSW or Premasters curriculums, or the Faculty of Social Work at the University of Manitoba.

CHAPTER II

REVIEW OF THE PERTINENT LITERATURE

Introduction

Exploring attitudes requires an understanding of HIV/AIDS as a disease. This chapter examines the literature on HIV/AIDS and includes a review of the pertinent studies that have been conducted on professional social workers and students' attitudes, knowledge of, and experiences with the disease. The social work role with HIV/AIDS and the role of professional social work values in preparation for this role are also reviewed in this chapter.

HIV/AIDS and Stigma

"...Reactions to HIV are far beyond purely biomedical issues. The perception of an epidemic is a combination of those infected and how they contracted HIV."

(Steven Dansky, 1994, p. 43)

HIV/AIDS is a disease that has received much attention, creating negative perceptions about those with the disease. The literature has identified the significance of stigma for creating many of the negative perceptions about the disease and those with the disease (Dansky, 1994; Herek & Glunt, 1988; Sontag, 1989). Goffman (1963) identifies stigma as "an attribute that is deeply discrediting", or something that makes a person "different from others" and "of a less desirable kind" (p. 3). The effects of the stigma associated with HIV/AIDS have been extensive, resulting in prejudice, stereotyping, discrimination and isolation of those with the disease (Dansky, 1994; Herek & Glunt, 1988). It has resulted in multiple losses related to health, empowerment, family and friends, and employment (Cadwell, 1991; Haney, 1988). On a societal level, the negative reactions to HIV/AIDS have made it difficult for many to view the disease as a medical condition without associating it with certain groups.

HIV/AIDS is a disease of modern times, however societal reaction to this disease has not differed from reactions to other historically significant diseases such as the black plaque, leprosy and syphilis (Doka, 1997). HIV/AIDS shares the characteristics of epidemics, with the potential to desolate societies, and results in stigmatization of those who are infected. For these reasons, HIV/AIDS has been identified as "the archetype of all the dreaded diseases that have troubled humankind throughout its history" and invokes a deep fear (p. xiv).

HIV/AIDS from a biomedical perspective is defined in the literature as a condition characterized by suppression of the immune system's ability to fend off life threatening diseases, which render an individual subject to a constellation of diseases or opportunistic infections that are fatal (Rathus, Nevid, & Fichner-Rathus, 1997). Similar to other diseases, HIV/AIDS follows a specific course, which begins with infection with the Human Immunodeficiency Virus, or HIV, followed by a relatively long latent period where sero-positive individuals -meaning that they carry the HIV antibody, experience little or no symptoms. Individuals may not be aware of their positive HIV status, until they begin to experience symptoms that include swollen lymph nodes, fever, weight loss, fatigue, and may develop serious, life threatening illnesses such as pneumocystis carinii pneumonia (PCP), Kaposi's sarcoma - a type of cancer, brain infections, and cervical cancer in women which marks the onset of AIDS (Rathus et al., 1997). Approximately one half of all people within ten years of initial infection will develop AIDS and the onset of AIDS, almost always results in death. (Refer to Appendix A for a list of these terms and their definitions.)

Crandall and Moriarty (1995) state that stigma results because illness itself represents a deviancy from the "norm or ideal" (p. 67). Generally, a disease is stigmatizing if it is publicly visible, its onset is "controllable" (p. 69), and it is untreatable or fatal, perceived as contagious, evokes fear of infection or physical danger, and involves moral rejection. These characteristics embody HIV/AIDS. AIDS is characterized by a constellation of visible effects, such as the purplish legions that are caused by Kaposi's sarcoma, and wasting syndrome (Dansky, 1994). The disease is incurable, and is communicable which has raised irrational fears and hysteria concerning contagion through casual contact, and has caused individuals who are infected with the virus to be viewed as posing a health threat to others (Herek & Glunt, 1988).

Dansky (1994) notes that contagion has played a critical role in the HIV/AIDS epidemic. Although knowledge of transmission of HIV is scientifically confirmed, fear and misconceptions surrounding the casual transmission of the disease to an uninfected person remain. Contagion is also of significance to HIV/AIDS as it has a moral implication. Sontag (1978) postulated that "any disease that is treated as a mystery and acutely enough feared will be felt to be morally, if not literally contagious" (p. 5). The moral implications of disease are of significance to HIV/AIDS because of the primary means of transmission of the virus through sexual activity and IV drug use, and through identification with the sexual practices of homosexual men. Dansky (1994) notes that the fear which surrounds the disease is then not limited to contracting a deadly virus, but also "elicits indignation and blame" (p. 17).

Punitive reactions to this disease have led to the distinction between victims of the epidemic to include the blameless - hemophiliacs, infants or those who contract the disease through occupational transmission, and the blameworthy - those who are IV drug users, or who engage in reckless sexual behaviors (Dansky, 1994; Doka, 1997). Many people still blame and morally judge individuals for contracting HIV. According to a recent poll (Moore, 1997), while there is an improvement in attitudes toward the disease, 31% of

Americans still believe that AIDS is a punishment for a decline in moral standards, and 40% believe that AIDS victims have only themselves to blame for contracting the disease. Canadians also hold attitudes which reflect the notion of blame for contracting the disease. Bozinoff and MacIntosh's (1990) Canadian study demonstrated that 36% of Canadians believed a diagnosis of AIDS was a person's own fault, and 33% sometimes believe that AIDS is a punishment for a decline in moral standards.

HIV/AIDS and Dual Stigma

Herek and Glunt (1988) contend that to fully understand the AIDS epidemic, one must possess an understanding of the "intense negative reactions to HIV - infected individuals" (p. 886). The existing stigma attached to HIV/AIDS as a life threatening physical illness, and its association with already marginalized groups, means that HIV/AIDS has a "dual stigma" (p. 887). Since the disease was first identified, it has been associated primarily with specific groups in society. When initially diagnosed in a group of men of homosexual orientation in 1981, the disease became associated only with the homosexual community (Padgug & Oppenheimer, in Fee & Fox, 1992). The initial diagnoses of the disease reflected the strong association with this community by labeling it as "gay related immune deficiency" or GRID (Shilts, 1987, p. 121). The disease was also commonly referred to as "gay plague" in the press, despite that other groups were also affected by the disease by the early 1980's (Padgug & Oppenheimer, in Fee & Fox, 1992, p. 255).

Although gay men were one of the first groups to become involved in the management of the epidemic, educating the public, mobilizing and providing resources to obtain funding for research and programs to address the needs of individuals with the disease, they have largely been viewed as either "villains" or "victims" of the epidemic (Padgug & Oppenheimer, in Fee & Fox, 1992, p. 245). The identification of gay men as a 'high risk group' strengthened the idea that "all gay men were diseased or at risk of being so," reducing their identity to mere association with the disease (p. 254). The association of HIV/AIDS with the homosexual community has served to exacerbate feelings of hatred, blame and prejudice toward gay people (Rathus et al., 1997).

Identification of other 'high risk groups' or those where the prevalence of the disease is pronounced such as with IV drug users, and certain minority groups such as persons of color in the United States (Williams & Hopps, 1988) and Aboriginal people in Canada (Health Canada, 1998), adds to the perception of the disease as one of 'others' and 'not us'. Dansky (1994) notes that the new cases of infection will continue to impact already marginalized groups - the disenfranchised and impoverished, as well as groups of varying cultural background.

Professionals' Attitudes Toward HIV/AIDS

> AIDS, a most controversial phenomenon to besiege us in this decade, can be understood as resulting in both a scientific/medical crisis and a socio-political crisis. A kind of moral panic characterizes the socio-political crisis, and all social actors - professional and lay people alike - are subject to this panic's pronouncements and illogic.
>
> (Ron Clarke, 1989, p. 1)

HIV/AIDS has touched people both personally, and professionally. The spread of the disease has not only had an impact on those who provide direct care to persons with the disease, but has had a similar impact on those who provide support and counseling services to these individuals. With the initial onset of the disease, the accompanying panic and fear surrounding the social response to HIV/AIDS was experienced by many of these professionals. Healthcare professionals held concerns regarding their safety when in contact with those with the disease. Many held concerns that negatively influenced their work to provide care for infected individuals (Gerbert, Maguire, Badner, Altman, & Stone, 1989). The effects of stigma were also apparent with many of the professionals who worked with the disease. The literature reveals that stigma, issues related to sexual orientation and death and dying, operate in many professions to create fear of HIV/AIDS (Gerbert et al., 1989). In addition to this sense of fear, reactions to the disease on the part of professionals often encompassed stress and anxiety regarding how to best treat and manage HIV/AIDS, and deal with the new situations that have confronted professionals. Many professionals have experienced burnout, helplessness and grief from their work with individuals who have succumbed to the disease (Gabriel, 1991). There is a body of literature that suggests that professionals in various fields of practice still demonstrate negative attitudes, and are not prepared to deal with HIV/AIDS issues.

Reactions of Other Professions

Negative attitudes toward HIV/AIDS are not uncommon among healthcare practitioners. Several studies have demonstrated that fear of contracting the disease plays a significant role in influencing healthcare professionals' intent to provide care to AIDS patients and their comfort level when in contact with HIV infected patients. Fear of contagion is a factor frequently cited in the literature that also influences professionals' willingness to work with HIV/AIDS.

Kelly, St. Lawrence, Hood, Smith and Cook's (1987) study demonstrated the effects of stigma attached to the disease which influenced physicians' comfort level. The physicians in their sample demonstrated less willingness to interact socially with an AIDS patient, held an AIDS patient responsible for their condition and more deserving of their illness, but less deserving of sympathy and understanding. These physicians viewed the AIDS patient as more dangerous to others and more deserving of quarantine. Based on their findings, Kelly et al. (1987) concluded that a diagnosis of AIDS carries an "emotional charge and elicits judgmental, negative evaluations about the patient" that can negatively impact physicians' comfort, and the development of healthy relationships with these patients (p. 791).

Simon, Weyant, Asabagi, Zucker and Koopman's (1991) study of medical students demonstrated that negative attitudes toward HIV/AIDS, and the association of this disease with homosexual behaviors were evident with their sample. Those who demonstrated lower levels of comfort in performing physical exams on patients at high risk, were less willing to treat persons with HIV/AIDS. The students in their sample who demonstrated greater levels of homophobia and less professionalism were also less willing to treat patients. Vermette and Godin's (1996) study also demonstrated that attitudes toward a diagnosis of AIDS were related to nurses' intention to provide home care services to AIDS patients. They also demonstrated that feeling less professionally responsible to care for a patient whom the nurses perceived as being responsible for their disease, was of relevance in their study.

Pomerance and Shields (1989) demonstrated that a substantial number of hospital workers in their study experienced negative personal reactions in their work related experiences with AIDS. Respondents in their study reported discomfort when interacting with these patients. Homosexuality also appeared to be threatening to the respondents in their sample. The workers who reported greater fear of homosexuality held fears about contracting HIV through coming into contact with these patients. They also demonstrated that the workers in their sample who had the least knowledge of the disease, were more likely to report high levels of perceived risk and stress. Pomerance and Shields concluded from their study that "without an awareness of their own psychosocial reactions to HIV infected persons hospital workers may be ill equipped to deal with those of their patients" (p. 192).

Henry, Campbell, and Willenbring's (1990) study of hospital workers demonstrated that homosexual bias was highly correlated with understanding of the disease, and with behaviors and attitudes related to AIDS patients, suggesting that "homosexual bias may strongly affect employee attitudes and behaviors, as well as the assimilation of AIDS related medical knowledge" (p. 44). Those who were less homophobic, had greater knowledge of the disease, greater confidence in AIDS related medical information and personal contact with the disease, held more positive attitudes toward the disease, and their behaviors were reflective of these positive attitudes.

Reactions of Social Work Students and Professional Social Workers

Since the beginning of the epidemic, social workers have recognized HIV/AIDS as a social problem and have identified the challenges that have faced the profession (Knight, 1996; Merdinger, Miller Wrenn, & Parry, 1990). Over the last two decades, a burgeoning amount of literature has surfaced that has addressed the challenges that HIV/AIDS presents to social workers. The studies of social workers have investigated their attitudes, comfort in working with HIV/AIDS, and their understanding of the disease. Studies by Dhooper, Royse and Tran (1987/88), Gillman (1991), O'Hare et al. (1996), Peterson (1992), Royse, Dhooper and Hatch (1987), Shi, Samuels, Richter, Stoskopf, Baker, and Sy (1993), and Wiener and Siegel (1990), suggest that social workers are not removed from the bias, fear and stigma associated with HIV/AIDS. Irrational fear of contagion and homosexuality, difficulty dealing with issues such as sexuality, death and dying, helplessness and despair, blaming the victim, and professional inadequacy have been identified as some of the issues that social workers experience in work with HIV/AIDS (Cadwell, 1991; Gabriel, 1991; Macks, 1988; Shernoff, 1988).

The studies of students' and professional social workers' attitudes toward the disease are limited in number and geographically to colleges in the United States. There are limited Canadian studies, with one Manitoban study (Frankel, Frankel & Grosser, 1992).

Wexler (1989) and Royse et al. (1987/88) have identified the values of the profession in educationally preparing social workers to deal with HIV/AIDS, however none of these studies have formally evaluated the role that values play in this process. In many of these studies, there is little evidence to suggest that practicing social workers and social work students are adequately prepared with an understanding of the disease, and the skills and practice behaviors for work with this population.

Social Workers' Knowledge of HIV/AIDS

Wexler's (1989) study of social welfare students found that the respondents in her sample held appropriate beliefs and attitudes toward the disease however, they lacked specific knowledge of the disease that was weakly and positively correlated with students' attitudes toward the disease. Deficits in knowledge of the disease consisted of how the disease has impacted minorities and IV drug populations. Wexler concluded that "social work curricula regarding AIDS should focus on instilling the knowledge and techniques that will allow students to act in ways consistent with the profession's values" (p. 147).

Peterson's (1992) study assessed the knowledge of National Association of Social Workers (NASW) members, which identified specific areas of understanding and deficits in knowledge of the disease. The social workers in this sample were knowledgeable about transmission of the virus, and were less knowledgeable about how the epidemic has impacted specific sub-populations. Peterson identified the lack of difference in knowledge on minority issues between the respondents who had either personal or professional reasons for being informed about the disease and those who did not, as a concern.

Shi et al. (1993) also reported that specific understanding of the disease was needed for the ethnic and cultural differences among people with the disease. They concluded that greater understanding of counseling terminally ill patients, women, children, IV drug users and gay clients, and the resources available to these clients were needed.

Frankel et al. (1992) reported that "it is clear that social work students lack a comprehensive knowledge of the basic facts about AIDS" (p. 54). The social work students in their first sample were generally more informed about transmission, treatment and risk reduction, than they were about diagnosis. Similarly, Dhooper et al. (1987/88) determined that the majority of their sample were not knowledgeable about the disease, and lacked understanding centered around how the disease was transmitted and risks of contagion.

While the specific findings of these individual studies may not be generalized, in combination, they reveal that social workers possess specific areas where knowledge of the disease is lacking which directly impacts their work with clients, and have highlighted areas where further preparation is needed. These studies reveal that social workers are likely to be unprepared to work with populations who are at risk for contracting HIV and require further understanding of the disease regarding the populations that are most affected, how to intervene with these groups, the resources available to those infected with the disease, and general knowledge regarding diagnosis and treatment of the disease.

Social Workers' Attitudes Toward HIV/AIDS

Social workers resistance to work with HIV/AIDS reveals the detrimental effects of stigma associated with the disease and has been documented in several studies. Merdinger, et al. (1990) for example, reported a case of a student who refused to work with a client who had been diagnosed with AIDS. The school responded with a "concerted investigative and interventive effort in the areas of education, values and practice, as well as institutional and school policy" (p. 32). Although students participated in an educational program which incorporated information on risk behaviors, populations infected, and a review of the NASW policy statement on AIDS, Merdinger et al. reported a small number of students who continued to have concerns of the disease, and would reject working with an HIV infected client. The resistance to work with this population has been revealed in further studies on social work students and social workers.

Dhooper et al. (1987/88) for example, found that social workers demonstrated concern for social distance when in contact with HIV/AIDS, and many indicated that they would refuse to work with these patients. Their study also demonstrated social workers' negative attitudes toward those with the disease, that many morally judged those with the disease, and those who did not agree that "homosexuality was an acceptable lifestyle" (p. 118) held concerns for social distance. Greater understanding of the disease however, was associated with lower levels of concern for social distance and fear of the disease, and greater empathy for those with the disease. Their study identified the important role of knowledge of the disease as an "antidote for unreasonable fear of AIDS " (p. 122).

Royse et al. (1987) found similar results in undergraduate and graduate social work students who did not consistently display empathy toward persons with the disease, but possessed fear of HIV/AIDS and deficits in knowledge about the disease. They demonstrated that knowledge was a better predictor of fear of the disease, and greater levels of knowledge were associated with greater empathy. Shi et al. (1993) also demonstrated social workers' resistance to work with this population. Many of the respondents tended to feel uncomfortable with clients who had been diagnosed with the disease, and felt that "they should not be required" to work with these clients (p. 272). Knowledge of the disease, and whether previous training had been received on HIV/AIDS was positively associated with their attitude toward serving these clients.

Wiener and Siegel's (1990) study demonstrated that appropriate comfort levels toward being in contact with those with the disease were significantly associated with level of understanding of the disease, and less negative attitudes toward the disease. Many of the social workers in their sample however, "were concerned that in the future researchers will discover that AIDS can be transmitted in ways not now recognized" (p. 21). Their study also demonstrated that those who were more homophobic and held negative moral attitudes toward the disease were the least comfortable in providing services to individuals with the disease. These findings demonstrated "the need for social work education to dispel the myths and stereotyped attitudes regarding gay individuals" (p. 23).

O'Hare et al. (1996) examined the variables of homophobia and fear of HIV/AIDS in a group of liberal arts students. Their study demonstrated that a significant number of students held negative feelings toward gay people with irrational fears of contracting HIV/AIDS. Their findings revealed that students who endorsed civil and gay rights, values that were consistent with social work values, demonstrated statistically lower levels of homophobia and fear of the disease. Personal experience knowing a gay person or someone who is HIV positive also had a significant positive effect on homophobia and fear of the disease. O'Hare et al. concluded that "unrealistic anxiety associated with AIDS may have a deleterious effect on social workers' ability to treat clients" (p. 57).

Gillman (1991) found that social workers also possess negative attitudes toward other minority groups that have been significantly affected by the disease. The respondents in her study demonstrated positive attitudes toward homosexuals, however, negative attitudes toward IV drug users were evident. Many of the social workers in her sample stated some degree of resistance to work with HIV infected clients, or that they would prefer not to have any clients with the disease.

Additional variables relating to social work with HIV/AIDS have also been explored in the literature. Working with terminally ill patients has been reported as both the greatest difficulty and opportunity for personal growth (Gillman, 1991), and previous experience working with terminally ill patients was demonstrated to have had a positive affect on social workers' comfort level in working with HIV/AIDS patients (Wiener & Siegel, 1990). The role of religion was also found to be of relevance to the moral issues that have surrounded HIV/AIDS. Frankel et al. (1992) reported significant differences for religion on both knowledge scores and attitudes toward the disease. Their study demonstrated that identifying oneself as "Christian" was significantly related to less appropriate attitudes, while "identification as Catholic (was) associated with less knowledge of the disease, and preference for greater social distance from persons with the disease" (p. 65). They suggest that less appropriate attitudes toward AIDS may "flow from the perceived connection between AIDS and homosexuality, and the teachings of some Christian churches, regarding the "immorality" of some homosexual lifestyles" (p. 54).

Professional Social Work Practice with HIV/AIDS

> Social work is a professional practice involving the conscious and deliberate use of self. The social workers' self is the medium through which knowledge, attitudes, and skill are conveyed. Professional social workers must have a well-developed and developing self-awareness and self-understanding.
>
> (Barry Cournoyer, 1991, p. 10)

The Social Worker's Role

Historically, as in the contemporary environment, the social work role has been to interface with individuals, communities and their environment to facilitate individual growth, belonging, and integrate individuals more fully into society (Compton & Galaway, 1994). Borne from volunteerism and the early charity organizations of the late nineteenth century, social work has become recognized as a profession that supports the socially "disadvantaged, disenfranchised" and those who are "oppressed" and discriminated against by the greater society (Hepworth & Larson, 1993, p. 2; Howe, 1980). During its earlier years, social work's focus was primarily on the economically disadvantaged, however, it has evolved as a profession to include work in an ever changing and diverse society, and HIV/AIDS reflects the changing role of social workers in the contemporary environment.

The role of social work practice has been identified as one that enhances the social functioning of individuals, groups and communities through prevention, restoration, remediation, with the underlying objective of promoting social justice (Hepworth & Larson, 1993). Thus, the purpose of social work practice is to provide services and supports to vulnerable persons to prevent problems from occurring, assist individuals to maximize their potential, work to eliminate or ameliorate the effects of problems, and advocate on behalf of individuals to ensure equality of treatment, resources, and opportunities. When the epidemic first called upon Canadian social workers to respond, social workers did so using many of the traditional social work skills that have been employed with other marginalized groups. Social work with HIV/AIDS gradually emerged as a field of practice that involved work in care and treatment, policy development, and to a lesser degree, prevention (Rowe & Ryan, 1998). Social work has responded to the needs of the epidemic and has been identified as a "core profession" for providing services to people with AIDS, services that range from counseling, bereavement work, and advocacy (Abramson, 1990, p. 169). The profession's focus on context and environment frames the role of social work to deal with issues surrounding stigma, avoidance, and intolerance attached to the disease (Cadwell, 1991; Kelly, 1996).

The literature has emphasized that in order to fulfill their role, social workers have a responsibility to their own self-awareness of attitudes, feelings, and beliefs about clients which affects their ability to adequately identify and meet client's needs, and initiate change on individual and social levels (Cournoyer, 1991; Hancock, 1997). The CASW (1997) has emphasized that "social workers must be clear about their own beliefs and potential biases. When social workers cannot identify with a client and feel their attitudes or biases are interfering with the client's ability to receive good service, they have a responsibility to act" (p. 18).

The role and professional obligation of social work with HIV/AIDS has been clearly recognized in the literature. This role is first and foremost reflected at the most basic level in the Code of Ethics (CASW, 1994). Howe (1980) identifies that codes of ethics are "symbolic documents that try to shape the public's view of the profession (p. 183). The professional values of social work reflect how the profession views itself and how it is viewed by others (Abbott, 1988). The Code of Ethics, which flows from the value base of the profession, presents the ideals of the profession, which define social workers' responsibilities to clients, colleagues and the public. These ethics extend to encompass work with HIV/AIDS and the expectation is that social workers will be able to carry out their professional mandate with these clients.

The role of social work in HIV/AIDS has also been acknowledged and recognized by the profession itself. In 1989, the Ontario Association of Professional Social Workers (1989) issued a statement specifically outlining the role of social work in "social action and advocacy" (p. 3), "access to and development of services and resources" and "testing" (p. 4), and "confidentiality" and "disclosure" (p. 5) of HIV/AIDS issues. In 1990, the CASW prepared a kit to assist social workers to deal with the HIV/AIDS epidemic with the premise that all practicing social workers would have professional exposure to these issues (Blue, 1990). The role of social work with HIV/AIDS has also been acknowledged and supported by the CASSW (1990) who put forth recommendations for integrating HIV/AIDS coursework into the curriculum to reflect HIV/AIDS knowledge, and clarification of values and attitudes. Consistent with the profession's "commitment to social justice and to care for the most vulnerable in society" the CASW (1997) has recently emphasized that "social workers should be active in the HIV field" (p. 10), and recognizes the role of social workers to include changing the environment, helping to prevent HIV infection and providing care and support for people living with HIV/AIDS, their caregivers and the communities.

The literature also defines the social work role as one which assumes a proactive part in initiating change and meeting clients' needs (Clarke, 1989), in providing empowerment to persons with AIDS (Haney, 1988), ensuring that services are equitably delivered (Ryan & Rowe, 1988), and in the provision of accurate information on the disease and attitudes toward HIV/AIDS (Lifshitz, 1996). Consistent with their professional commitment, social workers should avoid being judgmental about how their clients contracted the disease or about life-style (Kelly, 1996; M. Gosselin, personal communication, August 17, 1998). The role encompasses the recognition, respect and advocacy of human rights (Reamer, 1993; Ryan & Rowe, 1988) and requires that social workers become visibly involved within institutions and the community in educating, preventing, organizing and advocating (Pookhay, 1996). The social worker must also have a clear understanding of their role from a multidisciplinary perspective (Lifshitz, 1996).

The above identified roles and responsibilities of social workers with the HIV/AIDS epidemic necessitate that social workers "acknowledge and deal with their own prejudices to avoid misunderstanding, rejection and mistrust" (Lifshitz, 1996, p. 40). Failure to recognize any personal biases that run counter to the values of the profession can subconsciously reinforce the attitudes and stereotypes that have ostracized persona with AIDS (Lifshitz, 1996) and fear of HIV/AIDS may prevent social workers from believing in the "intrinsic worth of all human beings" (Dhooper et al., 1987/88, p. 122). Furthermore, negative attitudes held by social workers surrounding HIV/AIDS can be subconsciously reinforced to clients (Lifshitz, 1996) and the impact of stigma can appear in more subtle forms in therapy (Cadwell, 1991) of which clients can easily detect (Dhooper et al., 1987/88).

Clearly, the effect of beliefs that run counter to the values of the profession have serious impact on relationships with clients, and social workers' own sense of preparedness to deal with these issues. Cournoyer (1991) identifies that to be effective practitioners, social workers must have a "substantial and sophisticated" understanding of who they are, how "they appear to others", "what issues stimulate closed thinking", "what topics trigger maladaptive emotional reactions", and "the kinds of people or behaviors that elicit unhelpful responses from them" (p.10).

Professional Values in Social Work with HIV/AIDS

Social workers are challenged in their role with HIV/AIDS clients, both on a professional level as well as on a personal level. On a professional level, they will be tested with issues surrounding the rights of individuals with the disease, protection from discrimination, and in resolving the ethical and social dilemmas that are posed to the profession, as the disease continues to affect already marginalized groups (Ryan & Rowe, 1988). Social workers will be faced with new clients, and new situations that they must remedy. On a personal basis, social workers are confronted with issues regarding sexual orientation, death and dying, and their own beliefs about IV drug use and certain lifestyles.

In his evaluation of social work training, Clarke (1989) identifies the discrepancy between personal and professional values as a "professional dissonance" - where "social workers are responding to the AIDS crisis from a personal and not a professional value" (p. 17). Social workers are "caught between personal values and irrational fears and professional obligations" when confronted with HIV/AIDS (p. 27). The literature has revealed that in carrying out their roles with these clients, social workers should be comfortable with themselves, and be able to make others comfortable with them (Kelly, 1996). Clarke (1989) contends that social workers cannot remain true to their roles, when the issues that have surfaced with the HIV/AIDS epidemic are beyond their comfort level.

Personal values and deficits in knowledge about the disease have been identified as two factors that contribute to discrepancies between the values of the profession and social workers' attitudes toward individuals with HIV/AIDS. The relationship between societal, personal, and professional values influences social workers' beliefs toward specific groups and their interactions with clients (Abbott, 1988; Clarke, 1989). Because social workers are subjected to the same societal influences that shape the personal values of the general public (Abbott, 1988; Horner & Whitbeck, 1991), they are exposed to HIV/AIDS in a socially constructed context as one that predominantly affects groups such as homosexual men, intravenous drug users and minorities, which perpetuates stigma and the discrimination that surrounds this disease (Clarke, 1989). As previously identified, HIV/AIDS presents as a challenge for professionals as it is not only a stigmatized disease (Doka, 1997), it is associated with already stigmatized groups in society (Cadwell, 1991; Crandall & Moriarty, 1995; Herek & Glunt, 1988; Stine, 1993). In responding to the epidemic, Clarke (1989) emphasizes this challenge as emerging from the role of social workers as both "social actors", observing social constructs of the disease, and social workers, who must also observe a code of ethics which is guided by the principles of humanism and egalitarianism (p. 41). The negative reactions of social workers to the disease are a function of social values, replacing or overcoming professional values.

The research to date does not specify with certainty whether social workers' possess characteristic personal values that are consistent with professional social work values. Horner and Whitbeck (1991) identify that social work students may have values distinguishable from the general public, however these values do not necessarily reflect those of the profession. Students bring with them into their professional education, varying personal values and beliefs that have been shaped by societal values that may not be congruent with a professional value base. Identification with social work values is an essential aspect of education that will prepare students to deal with stigmatized groups (Frans & Moran, 1993).

The importance of social work values has been well documented in the literature. The unique role of social work stems from its value base which is seen as central to the identity of the profession (Horner & Whitbeck, 1991) and defines professional social work practice (Frans & Moran, 1993; King-Pike, 1996; Pearce, in Vass, 1996; Sharwell, 1974; Varley, 1963, 1968). Social work values are founded on the precepts of humanitarianism and egalitarianism (CASW, 1994) and "represent formulations of preferred behavior and imply a usual preference for specific means, ends, and conditions of life" (Hayes & Varley, 1965, p. 40). They include values such as respect of individuality, enhancing of individual worth and dignity of all persons which underlie the core values of confidentiality, social justice, human rights and self-determination (CASW, 1994; King-Pike, 1996). The specific set of values that characterizes the social work value base is deemed critical to shaping professionally appropriate beliefs (Hayes & Varley, 1965), behaviors (Abbott, 1988), decision making processes (Pearce, in Vass, 1996), and ultimately, practice with clients (Abbott, 1988).

The significance of social work values occupies a central role in social work education however, few current studies are available on how students specifically learn about and integrate the values into practice with clients (Wodarski, Feit, & Green, 1995). The findings of studies that have been conducted on social work values and learning reveal contradictory results: several studies found no support for differences in beginning and graduating students' identification with values (Brown, 1970; Dyer, 1977; Hayes & Varley, 1965; Judah, 1979; Lusk & Miller, 1985; Varley, 1963; Yamatani, Page, Koeske, Diaz, & Maguire, 1986), other studies (Frans & Moran, 1993; Merdinger, 1982; O'Connor & Dalgleish, 1986; Sharwell, 1974) have revealed significant changes in beginning and graduating students, while others (Moran, 1989; Wodarski, Pippin, & Daniels, 1988) have demonstrated mixed results on the effects of education on learning values. Two studies (King, 1982; Neikrug, 1977) have sought to demonstrate value based decision making behavior in professional practice situations, which produced contradictory results. Despite the deficits in specific or consistent findings, the studies in combination reveal that social work education in general, tends to have a positive effect on students' knowledge of and identification with core values.

In order for students to become effective practitioners in social work, they must identify with, and incorporate the values into their personal belief system (Frans & Moran, 1993; Varley, 1963). It is through a curriculum which espouses these values that students learn or assimilate this set of beliefs and allows them to make a transition from student to professional in acquiring these values (Varley, 1968).

Values and Ethical Dilemmas in Work with HIV/AIDS

Ethical dilemmas that arise in practice situations with HIV/AIDS have been identified as both a challenge to social work, as well as an opportunity for social workers to shape appropriate responses (Reamer, 1993). Ethical issues in work with HIV/AIDS have not been sufficiently or substantively addressed by social workers (Abramson, 1990; Reamer, 1993). The ethical dilemmas that arise in practice situations with HIV/AIDS require that social workers balance the benefits and risks of their actions. On the one hand, their actions are guided by a code of ethics which operationalizes the values of the profession, but on the other hand, HIV/AIDS presents new situations where the ethically correct thing to do is not always evident.

Abramson (1990) identifies that "for every psychosocial problem that social workers must attend to for their clients, there are concomitant moral issues that create dilemmas, distress and uncertainty for the practitioner (p. 169). There are few established guidelines for the ethical situations that arise in practice with HIV/AIDS, and social workers must rely on their judgment and knowledge of ethics outlined in the Code of Ethics to resolve many of these issues. Abramson (1990) states that "AIDS and society's understanding of and reaction to it are too new, and much more dialogue and debate are needed" (p. 172) before a moral framework for dealing with ethical issues is possible.

The most apparent ethical dilemmas presented to social workers include issues surrounding confidentiality (Abramson, 1990; Reamer, 1991, 1993; Ryan & Rowe, 1988; Taylor, Brownlee, & Mauro-Hopkins, 1996; Taylor, in Rowe & Ryan, 1998), support of a client who may knowingly put others at risk (CASW, 1997), the rights of persons with HIV/AIDS, discrimination or access to resources and opportunities, or social justice issues (Reamer, 1991, 1993; Ryan & Rowe, 1988). The clients' right to self-determination surrounding issues of testing and treatment (Reamer, 1993), and the question of supporting assisted suicide (Neron, 1996; Neron, in Rowe & Ryan, 1998) are also issues that have been identified. The underlying values presented in these ethical dilemmas of confidentiality, self-determination, and social justice, are values that are identified to be strongly embraced by the profession of social work (King-Pike, 1996).

Confidentiality.

Several authors have cited ethical issues which stem from these three values. Reamer (1988) has identified confidentiality as an enduring social work value, and issues surrounding confidentiality and warning of third parties are identified as one of the most serious ethical dilemmas for social workers (Taylor, in Rowe & Ryan, 1998). Breach of confidentiality is one of the most frequently cited ethical dilemmas in the literature on HIV/AIDS. Taylor et al. (1996) and Bourgon (in Rowe & Ryan, 1998) identify the issue of confidentiality and issues of safety as one ethical dilemma that surrounds work with HIV infected clients. Ryan and Rowe (1988) cite the responsibility of the social work profession to protect confidentiality and apprise clients of their rights to confidentiality (p. 325). Reamer (1993) identifies confidentiality with respect to contract tracing and testing for HIV infection. Similarly, Abraham's (1990) study found that "keeping secrets from the client" and "keeping secrets from others who might be at risk" (p. 170), were the most conflicting issues for social workers.

One of the most evident ethical dilemmas that has arisen in practice situations concerns the issue of balancing a clients' right to confidentiality with the safety of third parties who may be in danger. In these situations, the social worker is faced with whether to disclose confidential information about the client's health status to protect another person, or to withhold that information to preserve confidentiality. Taylor et al. (1996) note that breaking client confidentiality can result in job loss, rejection and isolation of HIV infected clients, and can prevent others from seeking testing or counseling. The impact of not upholding confidentiality has serious ramifications for persons with the disease. Upholding confidentiality in this situation also has ramifications if a third party were to become infected with the virus. Confidentiality has been regarded as an important social work value (Reamer, 1988, Taylor et al., 1996), and is necessary to establish therapeutic relationships with clients (Hancock, 1997). The importance of confidentiality to the client therapist relationship, and its significance to HIV/AIDS means that confidentiality should only be breached as a last resort (Reamer, 1991). However, the question arises - when is it appropriate to break confidentiality, and when should confidentiality be upheld?

There are few established guidelines for handling ethical dilemmas around confidentiality. The Tarasoff case has been referred to in the application of confidentiality to HIV/AIDS related practice situations (Taylor, in Rowe & Ryan, 1998). Although the case (Tarasoff v. Regents of University of California, 1976) does not set a Canadian precedent, and did not deal specifically with HIV infected clients, it set limits on a practitioner's duty to maintain confidentiality over disclosure (Taylor, in Rowe & Ryan, 1998). However, the assessment of danger to a third party, and interpretation of risk is left to the practitioner to define (Taylor et al., 1996). Reamer (1991) notes that when working with situations that require social workers to consider the client's right to confidentiality verses disclosure, social workers should explore with their clients alternatives and inform them on the limits of confidentiality, and be aware of risk factors. The CASW (1997) emphasizes that "social workers should be aware of their responsibilities and develop procedures that allow them to provide the required information and still safeguard client confidentiality" (p. 33).

While confidentiality has been specifically articulated and identified consistently by different authors, many authors who have identified ethical issues surrounding HIV/AIDS, have not explicitly used the names of these values to identify the issues related to the disease. The lack of consistent articulation of values has also been identified in the literature on social work values in general where "practice values cited in the literature were not consistently articulated", however, "confidentiality is presumed to be sufficiently understood so that no other words are necessary to state this value" (King-Pike, 1996, p. 340).

Self-determination.

In exploring the literature on the role of specific social work values and HIV/AIDS, some, but not all authors identified ethical issues pertaining to 'self-determination.' Other authors identified terms that were found in the definitions of these values, to identify relevant issues to HIV/AIDS. For example, Pookhay (1996), identified "being involved in the decision making process" as crucial to empowering women with HIV/AIDS (p. 141). Decision making is the action inherent in self-determination, when clients have exercised their right to make choices and be involved in the development of solutions. Decision making around childbearing issues, and about the quality of life for women with HIV/AIDS is recognized as an ethical issue pertaining to clients' right to self-determination (Pookhay, 1996). Self-determination has also been identified in the literature on HIV/AIDS with respect to clients' termination of treatment, assisted suicide and euthanasia (Neron, in Rowe & Ryan, 1998). Similarly, Neron (1996) identifies informed consent as "central to client self-determination", or client's right to be provided with full information with which to base decision making (p. 289) as an issue relevant to treatment and termination of that treatment. Reamer (1993) identifies the value of self-determination as central to voluntary testing and HIV infection.

Other issues concerning self-determination have surfaced with regard to end of life discussions, or clients' termination of treatment, and assisted suicide (Neron, 1996; Neron, in Rowe & Ryan, 1998). Self-determination has been identified as a central value of professional social work practice, which entails the right of clients to make their own choices and decisions (Hancock, 1997). Social workers should recognize the client's right to guide their treatment, and right to have their choices and decisions upheld. Social workers have been confronted with having to balance whether to support a client's decision to end their life when they are in the advanced stages of their disease, against the personal harm that may come to that client or others, and the client's capacity to make an informed decision. Neron (in Rowe & Ryan, 1998) identifies that in dealing with this ethical dilemma, social workers must "consider what constitutes harm" (p. 289). In determining whether to uphold or violate the value of self-determination, social workers must be open to discussion with their clients, and possess knowledge of the ethical, legal, and related counseling issues.

Social justice.

Social justice has been articulated less consistently in the literature. Authors have commonly identified terms that frame the definition of 'social justice' to include elimination of discrimination through development of appropriate policies on HIV/AIDS and "commitment to social change" (Ryan & Rowe, 1988, p. 324). Abramson (1990) and Taylor et al. (1996) identify the discrimination that follows from breaching confidentiality. Other authors focus on the discrimination that follows from the stigma attached to HIV/AIDS (Cadwell, 1991; Pookhay, 1996). Reamer (1991) identifies the discrimination which results from the different treatment that is extended to certain groups with the disease and limits access to resources. Also identified is the discrimination which results from a diagnosis of HIV/AIDS and how this can impact a community in terms of allowing HIV positive individuals access to education, and services.

In upholding the value of social justice, social workers work with vulnerable groups to ensure that they have equal access to resources, opportunities, and services (Ryan & Rowe, 1988). As part of their responsibility for eliminating inequities, social workers must advocate for services, policies that address unequal treatment, and support policies that "guarantee that the special needs of minorities and stigmatized groups are incorporated into systems with care" (p. 324). Social workers must also weigh the rights of clients against calls for quelling the spread of the disease through mandatory testing and screening (Reamer, 1993). Such policies may force infected individuals to leave the system, and prevent them from seeking treatment. In these circumstances, social workers in keeping with the value of social justice and the client's right to decide, are likely to support proposals for voluntary testing with strict confidentiality. In their work with HIV/AIDS, social workers are faced with balancing conflicts between social agencies' policies and clients' rights, and confronting their own personal values and fears of work with HIV/AIDS. Ryan and Rowe (1988) identify that these dilemmas force social workers to choose between upholding and advancing the values of the profession, the accountability of the social work profession, and their own beliefs and values that are influenced by religion and family.

When social workers are presented with these ethical dilemmas, Abramson (1990) identifies that they must undergo "clarification of concepts and articulation of values and norms, as well as systemic analysis of issues and justification of conclusions" (p. 169). In dealing with the ethical dilemmas that HIV/AIDS presents, social workers must act in ways that are in keeping with the best interests of their clients. This can only be achieved through a careful examination of the ethical issues presented, knowledge of counseling issues, and of the impact of their decisions in upholding particular values, or violating those values.

Conceptual Framework for the Study

The variables of attitudes, knowledge about HIV/AIDS and students' ability to identify and operationalize social work values are the primary variables explored in this study. These variables were incorporated in the conceptual model which outlines the relationships between these variables, as obtained from the preceding review of literature on attitudes toward HIV/AIDS, and social work values. Although other environmental issues may play a role with HIV/AIDS, these were the most salient variables selected from a review of the literature for this study. Refer to Figure 1 for the conceptual model.

The preceding discussion identified the inter-relationships between the variables of social work values, attitudes and knowledge of HIV/AIDS, as illustrated in the model. The outer sphere of the conceptual model represents the environment where societal values and attitudes toward HIV/AIDS are formed. The issues surrounding stigma, shame, blame, fear of contagion, and anxieties surrounding sexuality and morality, as identified in the literature by Clarke (1989), Dansky (1994), Doka (1997) and Herek and Glunt (1988), characterize the social context of HIV/AIDS.

The three inter-linked spheres within the broader sphere or context of HIV/AIDS are influenced by these negative aspects of the disease. Both personal and professional values have been identified in the literature as relevant to social work practice with HIV/AIDS. The set of personal values may reflect many of the societal values toward the disease. When students begin social work education, they bring with them values and beliefs, some of which may or may not be consistent with social work values. The values and beliefs surrounding HIV/AIDS or the societal values, influence personal values and beliefs that students may carry with them into their social work education. The influence of societal, personal and professional values forms the basis for students' beliefs, opinions and feelings, or their attitudes toward HIV/AIDS, which social workers carry with them into their professional practice with clients. The set of personal values over-riding professional values, or the professional dissonance identified by Clarke (1989), has been demonstrated in studies of social workers attitudes toward the disease by Dhooper et al. (1987/88), Gillman (1991), O'Hare et al. (1996), Shi et al., (1993), Royse et al., (1987), and Wiener and Siegel (1990). The sphere identified as knowledge is related both to values

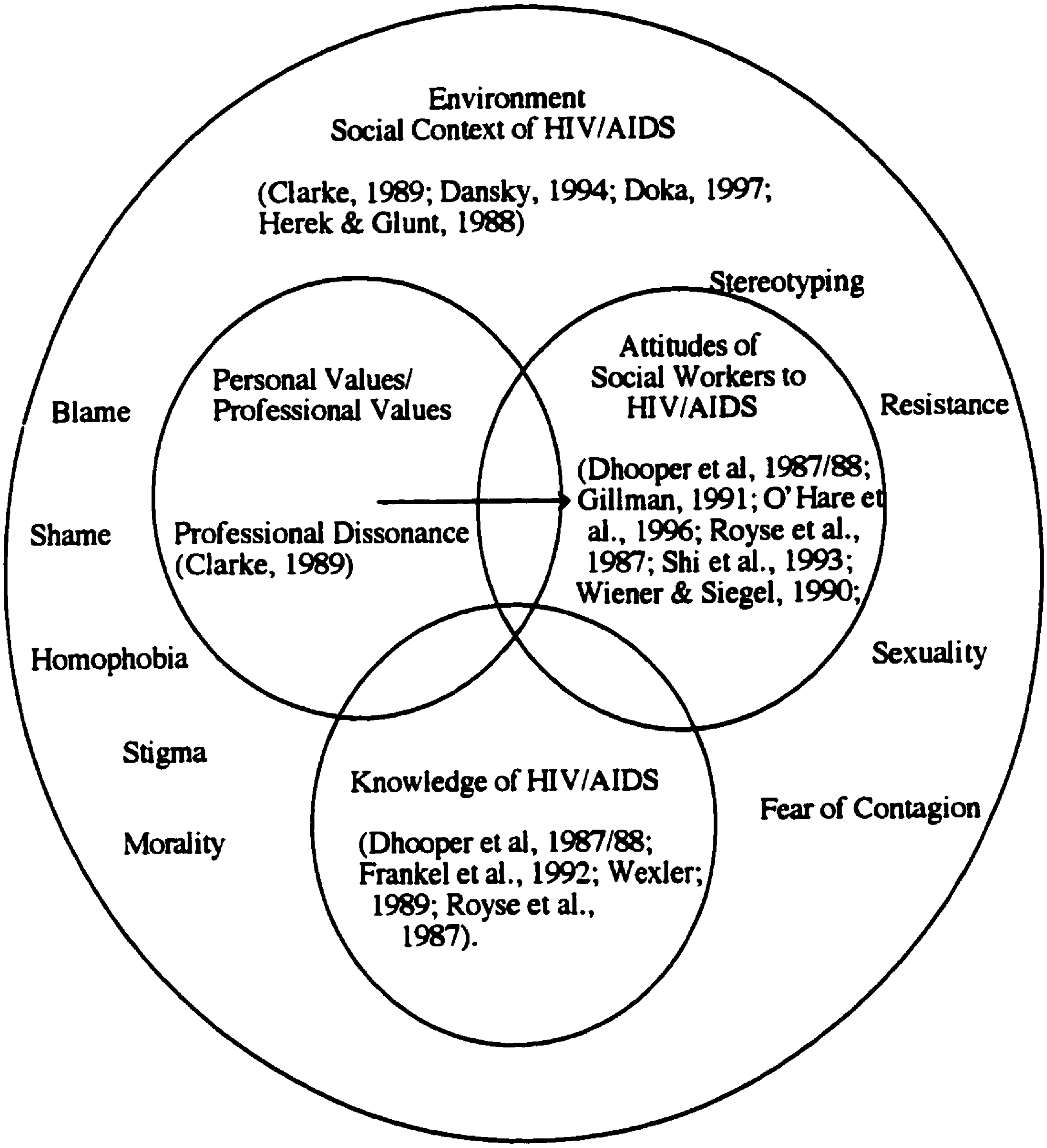

Figure 1. Conceptual model.

and attitudes, and has been identified in the literature to be positively associated with attitudes toward the disease, as well as social workers' professional preparation to deal with these issues. Similarly to the environmental influences that can negatively impact social work with HIV/AIDS, professional education which prepares social workers with appropriate values, attitudes, and knowledge of the disease can also positively impact the broader environment, or the societal context of HIV/AIDS.

Summary

This chapter has presented an overview of the issues surrounding HIV/AIDS that are problematic from both societal and professional perspectives, and has identified the significance of attitudes, values, and knowledge of the disease in social work practice with HIV/AIDS. The relationship between these variables has been presented in the conceptual framework presented in this chapter, and provides the basis for exploring the relationships between these variables.

CHAPTER III

RESEARCH DESIGN AND METHODOLOGY

Introduction

This chapter presents an overview of the dependent and independent variables explored in this study. The research questions were formulated and presented based on the preceding literature review and conceptual framework. An overview of the data collection procedures, the study's design, instrumentation, as well as ethical considerations for involvement of the respondents in this study are also provided in this chapter.

Study Questions and Variables

The following research questions were proposed for this study:

Research Question 1:	Will respondents with more positive or accepting attitudes towards HIV/AIDS identify more strongly with core professional social work values?

The primary research question of this study entailed the relationship between attitudes toward HIV/AIDS, a dependent variable, and social work values, an independent variable. This question was incorporated into the study to determine whether there was a significant relationship between the scores on the social work values measure and students' attitudes, and the direction of this relationship. An additional variable of comfort with the disease has also been identified in the literature as a variable related to attitudes toward those with the disease. This variable was included as a sub-scale of attitudes toward

HIV/AIDS. Additional research questions were incorporated into the study to further investigate the relationship between attitudes and social work values, and the sub-scale of attitudes or comfort with the disease.

Further research questions were incorporated to examine the factors related to attitudes and learning of values. Students at the Faculty of Social Work, University of Manitoba learn about values as they progress through the program. The Faculty of Social Work at the University of Manitoba adheres to the criteria on curriculum requirements which incorporate the values into the program, as an associate member of the Council on Social Work Education (CSWE), and accredited by the Canadian Association of Schools of Social Work (CASSW). Students are exposed to experiences that facilitate "the appreciation of the social work purposes and the development of social work values and professional judgment" through coursework, and through a field practice component which reflects the social work values (CASSW, 1993, p. B-3).

Social work values are reflected in course content in general. The values are woven into course content throughout the programs, and more specifically in a course that is taken midway through the Bachelors program, and in the first year of the Premasters program. Students in both of these programs are required to complete a supervised field placement which emphasizes the application of values and skills to practice situations (University of Manitoba, 1998; CASSW, 1993). It is in field placements where students integrate and are evaluated on their knowledge and skills in applying values. The variables of 'year in program', 'enrollment in a field placement', and having taken a 'values course', independent variables, were incorporated into this study, given that these are the means through which students are expected to learn values.

<u>Research Question 2:</u>	Do respondents with more positive or accepting attitudes toward those with HIV/AIDS also possess greater knowledge of the disease?

Based on the literature on attitudes towards HIV/AIDS, and knowledge of the disease, it was presented that some social workers with greater understanding of the disease, would also have more accepting attitudes toward HIV/AIDS. It was also expected that those with more accepting attitudes toward contact with the disease, the sub-scale of attitudes, would also possess a greater understanding of the disease. The relationship between attitudes toward contact with the disease, a dependent variable, and knowledge of HIV/AIDS, an independent variable, was also explored in this study.

<u>Research Question 3:</u>	What additional variables are related to attitudes toward HIV/AIDS, core professional social work values and knowledge of the disease?

The variables of attitudes, values and knowledge were explored with several additional variables that are relevant to social work and HIV/AIDS. Previous experience with the disease, such as through coursework on HIV/AIDS, or volunteer or professional work, personal experience with the disease, and professional interest in HIV/AIDS were additional independent variables incorporated into this study. Demographic variables of age, income, program year, and cultural background were included in the analysis. Given that identification with a religious group has also been identified in the literature to be significantly associated with attitudes toward the disease, this independent variable, along with the variable of spirituality, was also incorporated into this study.

In addition to further exploring the relationships between attitudes, values and knowledge, the demographic data was also used to gain an understanding of the survey population. Research questions were also incorporated into this study to gain insight into students' interest in working with death and dying, as this is relevant to HIV/AIDS. It has also been suggested in the literature on HIV/AIDS that inter-disciplinary education is requisite to understanding this problem, therefore students were also asked to specify whether they would be interested in participating in a multidisciplinary course, and to comment on the courses they would see as valuable in their HIV/AIDS education.

Method of Analysis

The analysis of the research questions was conducted using statistical tests of significance at an alpha of <.05, with SPSS (Norusis, 1994). The open-ended data was explored for themes and trends, and a content analysis of the data was conducted where appropriate. Data on attitudes toward the disease, and attitudes toward contact with the disease, although measuring attitudes toward the disease, were treated as separate variables when conducting the analysis of the data.

Research Design

The study on students' knowledge, attitudes toward HIV/AIDS, and social work values consists of exploratory survey research using self-administered questionnaires. Respondents consisted of Bachelor of Social Work students at the University of Manitoba who were enrolled in courses at both the Fort Garry Campus, and the Winnipeg Education Center (WEC), and Premasters students at the Fort Garry Campus.

Rationale for Research Design

Survey research was selected as a method of data collection, as it was considered an appropriate and valuable means of gathering the information from students, and is consistent with the purpose of this study. Survey research is one of the most frequently used forms of research, and is useful in measuring the "attitudes and orientations" in a large group of people (Rubin & Babbie, 1993, p. 334; Grinnell & Williams, 1990; Dillman, 1978), such as with the BSW and Premasters student population. Survey research allowed a larger number of students to be reached, than was possible through alternative methods such as personal interviews, which can be time-consuming. It was also a method of preserving students' anonymity and confidentiality (Grinnell & Williams, 1990). Survey research presented as a practical method of data collection, given the desired number of participants and the type of data that was required to more accurately reflect the attitudes, values and knowledge of social work students.

Sample Population Selection and Sources of Data

The sources of data for this study consisted of primary data: students' responses to questions on the survey. Selection of respondents was on a voluntary basis and in accordance with the guidelines for ethical consideration as outlined in a later section of this thesis. Selection was not stratified according to whether students had taken Introduction to Social Work Practice and a Field Placement; rather, these were used as control variables in the analysis of data. In order to ensure that an adequate sample of students were selected for the study, students at all levels of the BSW program at both the Fort Garry Campus and WEC, and those enrolled in the Premasters program at the Fort Garry Campus were informed of the study. Students in several classes were informed of the study to ensure that the study's results would not be based on the reported values, knowledge, and attitudes of only a few students.

Data Collection Methods

Although several methods of data collection were proposed for this study, in an attempt to maximize the number of respondents the method selected entailed asking instructors, and students from the Premasters, and beginning, intermediate and completing year levels of the Bachelors program to participate in the survey during class time. It was anticipated that the questionnaires could be completed in the class setting by the students who volunteered with their consent and with the consent of the professor. In most instances, however, time did not allow for completion of the surveys in class. Approximately 50% of the questionnaires were completed during class time, and the remaining were completed outside of class time. In those classes where professors provided consent to have the questionnaires completed during class time, all students were in agreement with using the class for this purpose.

Course instructors were contacted by the researcher, and briefly informed of the purpose of the study. Notices advertising the study were also posted on all student bulletin boards at the Faculty. Copies of the research proposal abstract, as well as copies of approval from the Ethics Committee and the Dean of Social Work were provided to professors who had requested further information on the study. All course instructors provided consent for the student researcher to come into their class to talk to the students about the study, and distribute questionnaires to them. This was done at a time that was convenient for the instructors and students.

The researcher took approximately ten minutes at the beginning of each class to inform the students of the study. Following introduction of the researcher, students were provided with an information sheet as well as a copy of the questionnaire (refer to Appendix B for a copy of the information sheet). They were briefly informed about the purpose of the study, the educational value of the study, that it was voluntary and anonymous. Students were also informed that the results of the study would be aggregated, thus, the analysis would not focus on individual responses. In addition, students were informed that their decision to participate in the study, would not be reflected in their course grades, nor would their decision affect their academic standing at the University of Manitoba.

Students were also informed that the questionnaire would take approximately 30 minutes of their time. Students were also provided with an opportunity to ask any questions, or provide their comments with respect to the study. Students were advised to enclose the survey in an envelope that was provided to them, by a specific date to a drop box at the Helen Mann Library. Follow-up with the assistance of course instructors was conducted to remind students to complete the questionnaires and return them as quickly as possible. Additional questionnaires were made available to students at this time. Data collection commenced November 12, 1998, and was completed on December 9, 1998.

Although this method of data collection did not allow for a true random selection of students, it was chosen over using a mail-out, as the student body was accessible during class time, and it was anticipated that informing the students in person of the study, rather than through a mail-out would result in a higher participation rate in the study. This method was also less costly than conducting a mail-out, and did not require obtaining a list of student names which may have violated the Faculty's policy on confidentiality.

Selection of a Pre-Test Group

Pre-testing of the values sections of the questionnaire was incorporated as an additional step in this research to enhance the clarity and validity of the values instruments. Five masters students who had completed coursework in research and instrumentation were asked to review the values instruments. These students were approached by the researcher and informed that their participation in the research was voluntary and would be anonymous. These students were provided with an information sheet, and a consent form. (refer to Appendixes C and D). The masters students were informed that the pre-test package could be placed in the sealed envelope provided to them, and returned to the researcher's mailbox. They were also informed of their obligations as subjects in this pre-test: there was approximately one hour needed to complete this pre-test which could be done at a time that was convenient for them, and in a setting of their choice, there was no financial cost to them, nor would their participation in this pre-test affect their academic standing at the University of Manitoba.

Ethical Considerations

The ethical issues pertinent to this study included voluntary participation, invasion of privacy and anonymity, integrity of the researcher, as well as sharing of the research findings (Kazdin, 1992). These ethical issues were addressed in the design of the study, by verbally informing students of the study, and providing them with the written information form outlining the purpose, involvement in and their rights as respondents in the research. The respondents in this study had agreed to participate on a voluntary basis. Students' were verbally informed of the true nature of the study so as not to deceive them of its intent and objectives. Students were also informed of their time commitment for participation in the study, and as part of the research, they would be required to share information of a personal nature about their beliefs on complex subjects, as well as their values. Students were also advised that prior to providing their consent they could withdraw from the research study at any time.

As this study was conducted in a manner that protected students' anonymity, invasion of privacy did not pose a risk to respondents. Students were advised that the study was anonymous and they should not provide any information on the questionnaire that would reveal their name, or would allow them to be personally identified. The questionnaires were coded as a means of keeping track of the number that were distributed, and the course in which they were completed, however this did not allow for identification of respondents who completed the survey.

In order to ensure that students anonymity as participants in the study was maintained, questions which identified the student's gender were omitted from the demographic section of the survey. This was done as the majority of students in the Faculty of Social Work are female, and in answering questions related to the respondents' gender, males may have felt that their responses could have been easily identified. Students were also asked to identify if they knew anyone who had HIV disease. As this is considered a personal question and some students may feel uncomfortable or that their privacy was invaded, the question was accompanied by a statement on the survey indicating that this question was optional. Respondents were also advised that the results of the study will be published and information will be available to students, faculty, and others who are interested in the study.

Instrumentation

The questionnaire used in the survey contained five sections that included questions which tapped into students' attitudes toward and knowledge of HIV/AIDS, an open-ended section on social work values, and a forced choice section on values, and finally, a section which contained demographic questions. Demographic questions were completed last in the questionnaire, as beginning with more interesting questions and leaving those that respondents are likely to find less stimulating to the end, such as the demographic information, further ensured that more respondents would complete all of the questions included in the survey (Rubin & Babbie, 1993).

The instruments used in this study included the Attitudes Towards AIDS Scale (Goh, 1993) which contained an attitudes scale and a knowledge scale of AIDS. Social work values were measured through an instrument that contained one open-ended and one forced choice section of case scenarios, developed by the researcher. Demographic questions were also developed by the researcher. Refer to Appendix E for a complete copy of the research questionnaire.

Attitudes toward HIV/AIDS.

Attitudes toward HIV/AIDS and knowledge questions are found in sections I and II of the questionnaire, respectively. The Attitudes Toward AIDS Scale (Goh, 1993) has been selected to measure attitudes and knowledge as it is recent and reflects current information on HIV/AIDS. The instrument was standardized using a college population, and is deemed appropriate for use with the students at the Faculty of Social Work.

The attitude items include affective responses to HIV/AIDS. Items are measured using a five point Likert type measurement and consist of two sub-scales that include attitudes toward issues, which tap into confidentiality and basic rights, fear of contagion, and attitudes toward persons with the disease as the other sub-scale. Attitudes toward persons taps into subjects' attitudes toward persons with AIDS (Goh, 1993). The attitudinal scales are deemed to have satisfactory content validity, acceptable internal consistency of .86, and test re-test reliability of .74 (Goh, 1993). Questions 1-23 of section I of the survey are taken from the Attitudes toward AIDS Scale. Questions 24-31 were added to the attitudinal section to tap into students views of the social work role with HIV/AIDS, and their comfort level in working with these clients. Two questions were eliminated from Goh's (1993) scale, as it was thought that one might be offensive to social work students, and the other was ambiguously worded.

Items were scored using a range of 5-1 for response categories of Strongly Agree (SA), Agree (A), Neutral (N), Disagree (D), and Strongly Disagree (SD) for positive items, and the reverse was used for scoring negative items, consistent with Goh's method of scoring. The total number of points a respondent received could range from a low of 24 to a high of 120. The higher the score, the more positive and accepting the attitude of the respondent toward HIV/AIDS and persons with the disease. Question 31 was not scored using a five point Likert method of measurement. Instead, respondents were asked to rank their preference with working with specific groups, and a frequency count was conducted to analyze their responses. The questions regarding attitudes toward contact with those with the disease were included in a sub-scale of the attitudes section. The maximum score on questions relating to comfort with the disease are 25, while the minimum was 5. Again, the higher the score, the more positive the attitude toward contact with those with the disease.

Knowledge questions measure what a person knows about HIV/AIDS and include questions 1-22 in Section II. Items use a true-false format and contain no sub-scales. Items tap into knowledge of the prevalence of HIV/AIDS, medical facts about the disease, modes of transmission, misconceptions about HIV/AIDS, and prevention of the disease. The Knowledge Scale was deemed to have satisfactory content validity, and internal consistency with a coefficient of .84. Test re-test reliability for knowledge items is .82 (Goh, 1993).

Items on the knowledge scale were scored by totaling the number of items answered correctly by each respondent, consistent with Goh's (1993) scoring method. Slight modifications and additional knowledge questions were added which changed the maximum number of points a person could obtain on the scale. Possible scores could range from 0-32 and consistent with Goh, the higher the score, the higher the degree of knowledge about HIV/AIDS. Question 19 of the scale was excluded from the survey as this question was not relevant to Canadian legislation for treating HIV/AIDS. Questions 23 and 24 of the knowledge scale were reworded to address the prevalence and incidence of the disease in Canada, rather than in the U.S., which was deemed more relevant to the population of study. Question 16 of the scale (persons who are diagnosed with AIDS will experience symptoms such as swollen lymph nodes, fatigue, fever, nights sweats, and weight loss) was treated as five separate answers, as students may not be aware of all the symptoms of AIDS, but when framed together, would either provide a true or false response which does not accurately reflect their knowledge of all symptoms. Similarly, Question 24 of the survey was scored as five separate questions, in order to establish if students were able to correctly identify all of the groups that are currently experiencing a higher incidence of the disease. The modifications to the scales, although minor, may have slightly affected the reliability coefficients established by Goh (1993), and this represents a limitation of this study.

Measuring social work values.

Selecting an appropriate instrument for measuring students' values was problematic. The review of the literature did not reveal any Canadian instruments for measuring values. Three social work values instruments were located that had been developed within an American context (Abbott, 1988; Howard & Flaitz, 1982; King-Pike, 1994). Each of these instruments were not considered appropriate for use with the population in this study for a number of reasons. The instruments developed by Howard and Flaitz (1982), and Abbott (1988) posed too many questions that were not reflective of the Canadian environment and questions were also outdated, such as "sterilization is an acceptable method of reducing the welfare load", and "capital punishment should not be abolished," (Abbott, 1988, p. 129). Although the questions on both of these scales measured attitudes of social workers to the profession's values, it was thought that many of these questions would not elicit responses from the population in this study that would tap into their true attitudes toward these values, as questions were framed in a manner that elicits the response intended and would be fairly obvious to social work students.

The third instrument (King-Pike, 1994), although current, was eliminated as a possible instrument for measuring values in this study for two reasons. First, the instrument required approximately 50 minutes to complete, which was anticipated to negatively affect the response rate. Second, too many questions would have had to be eliminated or modified in order to reflect the Canadian context, which may have greatly affected the validity and reliability of the instrument (C. King-Pike, personal communication, September 29, 1998).

Given that locating an appropriate instrument was problematic, it was decided during the thesis committee meeting (September, 1998) that the researcher would develop an instrument which measured students' knowledge of social work values, and ability to apply the values when addressing specific issues relevant to HIV/AIDS. In addition to the above reasons, this method was selected as it would allow students to apply the values directly to specific HIV/AIDS situations. Scenarios that reflect an HIV/AIDS context were developed by the student researcher following a review of the literature on social work values, HIV/AIDS and ethics, and in consultation with educators in social work, and experts in social work values from the Faculty of Social Work.

Selection of values relevant to HIV/AIDS.

The selection of values for use in this study naturally led to a review of the literature on HIV/AIDS which encompassed an ethical domain - as ethics flow from the values of the profession (Abbott, 1988). Ethical issues pertinent to HIV/AIDS were identified which operationalized specific values in practice with clients. The literature revealed that although there is an expanding body of social work literature on HIV/AIDS, there is less emphasis on the moral and ethical issues surrounding the disease, and the role that values play in work with HIV/AIDS (Abramson, 1990; Reamer, 1993).

HIV/AIDS has broached new issues that affect the rights of individuals, and the role of social workers in recognizing and upholding these rights (Reamer, 1991, 1993). The ethical dilemmas which surround practice with HIV/AIDS stem from the discrimination and injustices that are experienced by the individuals affected by the disease. Williams and Hopps (1988) identify the social work values which are most challenged by HIV/AIDS to include: the "belief in the primacy of the individual", the "belief in the right to self-determination", the "confidentiality of client information", and the belief in a "fair and equitable distribution of resources and services without discrimination, uninfluenced by race, ethnicity, sexual orientation, or handicapping condition" (p. 49). The literature on social work values in general also cited these values as the values most important, or apparent in the literature. For example, King-Pike (1996) identified confidentiality, self-determination, and social justice as the most frequently cited values in the literature.

Value definitions.

In order to provide a conceptual framework for operationalizing these values, scoring of cases and in the content analysis, the following definitions were developed for each value from a review of the literature:

Confidentiality: keeping information received or observed about a client in confidence; not disclosing information about clients or their families to others, including the clients family, other social workers, professionals (CASW, 1994; Compton & Galaway, 1994; Hancock, 1997; Hepworth & Larson, 1993; King-Pike, 1994). Confidentiality was operationalized in item 2 of the open-ended values, and items 4 and 6 on the forced choice values instrument.

Self-determination: recognition of the right and needs of clients' to freedom in making their own choices and informed decisions; recognizing the client's wishes, desires and motivations as the primary consideration, involving clients in the development of solutions to problems or to promote growth (CASW, 1994; Compton & Galaway, 1994; Hancock, 1997; Hepworth & Larson, 1993; King-Pike, 1994). Item 3 on the open-ended instrument, and items 1 and 3 on the forced choice instrument operationalize the value of self-determination.

Social justice: advocating for the development, equal distribution of and access to resources, services and opportunities for all persons (regardless of race, ethnic background, sex, sexual orientation, language, age, abilities, socio-economic status, political affiliation or national ancestry); identifying and eliminating discrimination; advocating change for individuals, families, the community and society (CASW, 1994; Compton & Galaway, 1994; Hancock, 1997; Hepworth & Larson, 1993; King-Pike, 1994). Item 1 of the open-ended value instrument, and items 2 and 5 of the forced values present ethical situations which reflect the value of social justice.

The value of social justice as defined above, is similar in meaning to the last value identified by Williams and Hopps (1988) although not specifically articulated by them as 'social justice'. The "primacy of the client" was not included as a value in this study, as it was thought to underlie or is a component of the other values. Social workers work 'in the best interests of their clients' regardless of whether the issue concerns confidentiality, the right of the client to make decisions, or in addressing social justice issues.

Development of case scenarios.

Case scenarios were developed based on the issues that surfaced in the literature in relation to the three values of confidentiality, self-determination and social justice. While every attempt was made to ensure that the case scenarios were as clear as possible, and reflected mainly one value as drawn from the literature, the case scenarios are complex, and entail may sub-issues that arise from a particular value dilemma.

In developing case scenarios that realistically reflected work with HIV/AIDS clients, it was identified by the researcher that although a main issue was apparent in the case, it was difficult not to include an underlying issue within each case. For example, item 2 of the confidentiality scale in the open-ended values section primarily addressed confidentiality, however, failure to uphold this value in a practice situation could possibly impact social justice through discrimination of the client should information of him either being a client, or having HIV disease be disclosed. Although question 3 of the open-ended values was framed around self-determination, issues surrounding confidentiality and duty to warn were also apparent.

Validity of the values instrument.

Every attempt was made to ensure the validity of the instrument throughout its use in this study. Validity was built into the questionnaire through the design of the scenarios which were developed with input from experts in areas of social work values, instrumentation, and HIV/AIDS, through pre-testing and clarifying or eliminating the questions which appeared to weakly reflect a value or reflected several values. Refer to Appendix F for a copy of the pre-testing instruction sheet. Finally, a factor analysis was conducted.

Initially, 14 scenarios were developed from a review of the literature on HIV/AIDS, which reflected mainly one of a particular value. Experts in the areas of HIV/AIDS, measurement, and social work values critiqued the instrument for the clarity of the scenarios, their face and content validity. Feedback was given on whether case examples represented or were confounded with more than one value, on the scoring, the answer categories, and whether the values were operationalized within response choices. Twelve scenarios were retained, and either the case description itself, or the answer categories were expanded to allow greater choice (T. Heinonen, personal communication, October 16, 1998) and were clarified for consistency. Based on the feedback of professionals in this area (S. Frankel & S. Grosser, personal communication October 17, 1998) it was thought to be beneficial to include half open-ended items, and half forced choice items. The forced choice questions offered three response categories: a response that upheld the value reflected in each scenario as operationalized by the actions of the social worker in the case example, a response that was neutral, or it was neither wrong, but did not reflect the most appropriate way to handle the situation, or a response that did not uphold the value, as operationalized by the actions of the social worker in each scenario. The open-ended questions were incorporated into the study to provide greater insight into respondents' abilities to address the ethical dilemma in a manner that upheld the professional value. It was also recommended that the respondents be asked to identify the main value inherent in each scenario, after they had provided an answer to the question (S. Frankel, personal communication, October 17, 1998). This method, allowed the researcher to determine if respondents could identify the same value that was mainly reflected in each case example, and address that there may be underlying, less apparent issues within each case scenario.

Factor analysis.

An exploratory factor analysis using Principle Components Analysis was run to establish the validity of the values sections of the survey. A principle components analysis was selected to establish relationships between the variables as it is a method that analyses all the variance in a variable including "its unique variance", and "it is assumed that the test used to assess the variable is perfectly reliable and without error" (Bryman & Cramer, 1997, p. 280). It was anticipated that some of the variables would load according to their conceptualized scales, as the instruments used in this study are the result of the initial attempt to develop scenarios specific to HIV/AIDS.

Social Desirability Bias

Survey research is subject to reactivity (Rubin & Babbie, 1993) therefore several methods were incorporated into the study to address social desirability bias. Questions in the survey were ordered appropriately so as not to influence responses to subsequent questions. The items were carefully worded so that students would be more inclined to answer in a truthful manner, and not provide responses that they think are the ones solicited. The surveys are anonymous, which also assists in promoting honesty in responses. Prior to administering the questionnaires, students were also advised to provide their honest opinion on the surveys, as the purpose of the study was to assess their attitudes and beliefs.

CHAPTER IV

FINDINGS AND DISCUSSION OF POPULATION DESCRIPTIVES AND INDEPENDENT VARIABLES

Introduction

This chapter reports on the results of the individual variables included in the questionnaire and results of the instruments used to measure attitudes, knowledge and values. The report on findings begins with a description of the survey respondents. Statistics presented in the text are supported by tables found in this chapter.

Population Descriptives and Independent Variables

The sample consisted of 134 Bachelor of Social Work (BSW) and Premasters students from both the Fort Garry campus and the Winnipeg Education Center (WEC). The total of 268 surveys were distributed to students at both of these campuses. Approximately 24 surveys were returned incomplete, however ten of these were partially completed except for the values scenarios, and one had incomplete demographic material. These ten surveys were included in the analysis on knowledge and attitudes toward HIV/AIDS, for a response rate of 50%. The response rate for this survey is considered adequate for analysis and reporting of study results (Rubin & Babbie, 1993; Grinnell & Williams, 1990).

The breakdown of respondents in the sample included 33 first year BSW students, 22 second year, and 28 third and fourth year students from the Fort Garry Campus. Nineteen Premasters students from the Fort Garry Campus also participated in the survey. The remaining sample consisted of 14 first year BSW students from WEC, 9 second year students and 9 third and fourth year students. Students from both campuses in the

Bachelors program were grouped together according to their level in the program to form 47 first year students, 31 second year students, and 37 third and fourth year students.

The majority of respondents in the sample (approximately 67%) reported ages that fell in the first two categories used for reporting. Respondents between 17-23 years of age comprised the largest category for respondents at 33.6%, closely followed by 32.1% of respondents who reported ages between 24 and 30. Other respondents reported ages between 31 and 37 (18.5%), and 38 and 44 (9.2%). Only 4.6% reported an age over 45. The age composition of respondents in this study is similar to the age composition reported by Frankel et al. (1992) in their study of University of Manitoba social work students whose reported average age was 30.2. Other studies (Wexler, 1989; Royse et al., 1987) of social work college students have reported ages that are consistent with this study's findings, indicating that the respondents in this study are representative of social work students, at least in terms of their age.

Approximately 80% of the respondents in this study reported an income of less an $20,000 per annum. Just under one fifth of the sample (18.3% of respondents) reported an income between $20,000 and $50,000 per year. Only 1.5% of the respondents reported an income higher than $50,000 per year. Frankel et al. (1992) reported similar findings of income in their sample, with annual personal income between $7,000 and $9,000.

Over one half of the respondents in the survey (53.4%) reported that they did not belong to a specific faith group. This finding differed from the study by Frankel et al. (1992) who reported that 28% of their first sample (n=218) and 31% of their second sample (n=162) specified "none" as a religious preference, in their study of the BSW students (p. 4). The majority of respondents in this study (56.1%) also considered spirituality to be an important part of their lives. Respondents did not necessarily have to belong to a faith group in order to report the presence of spirituality in their lives.

Cultural Background

The variable identifying cultural background was presented to the respondents as an optional, open-ended question in the survey. The majority or 75% of the sample of 134 students opted to provide information on their cultural background. Responses were first reviewed to identify the most commonly reported categories of cultural background. The largest number of respondents (just over 49%) identified their cultural background as Canadian, of European descent which included either German, English, Scottish, or Irish. Respondents who identified themselves as "white Anglo Saxons" were also grouped into this category. Canadian respondents represented a greater portion of the sample in this study than in the study by Frankel et al. (1992).

The second largest group (approximately 26%) of respondents consisted of First Nation persons, or respondents who identified themselves as "Aboriginal." The number of respondents who identified themselves as "Aboriginal" in this study represents an increase from the study by Frankel et al. (1992) where only 14% of respondents identified themselves as Native. The next largest group consisted of respondents who identified a Mennonite background (8% of the sample), followed by respondents with a French Canadian background who consisted of 5% of the sample. The remaining respondents were distributed among the categories of Slavic (Polish or Ukrainian), Asian, Chilean, and Sri Lanken. As cultural background also implies religious affiliation or background, some students chose to identify their religion, with a small percentage of respondents identifying their religious background as Catholic. Refer to Table 1 for a breakdown of these remaining categories.

Educational Descriptives

Over one half of the respondents (58.8%) reported having taken, or were currently enrolled in Introduction to Social Work Practice, the course where students learn about social work values. The majority of the students who have completed this course consisted

Table 1

Population Descriptives

Category	Percent (Frequency)
Age (n = 130)	
17 - 23	32.6 (43)
24 - 30	32.1 (41)
31 - 37	18.5 (24)
38 - 44	9.2 (12)
>45	4.6 (6)
Income (n = 131)	
< 20000	80.2 (105)
20000 - 50000	18.3 (24)
> 50000	1.5 (2)
Religion (n = 131)	
Don't Belong to Faith Group	53.4 (70)
Belong to Faith Group	46.6 (61)
Spirituality (n = 132)	
Not important	43.9 (58)
Important	56.1 (74)
	1.5 (2)
Cultural Background (n = 100)	
Aboriginal	26.0 (26)
Canadian - European	49.0 (49)
French Canadian	5.0 (5)
Canadian - Slavic	4.0 (4)
Asian	4.0 (4)
Mennonite	8.0 (8)
Catholic	2.0 (2)
Chilean	1.0 (1)
Sri Lanken	1.0 (1)

of respondents enrolled in the second (18%) and the third (26%) years of the BSW program (approximately 44% of respondents). Approximately 12% of the Premasters students had completed the course and the majority of first year respondents (approximately 33% of the entire sample or 91% of the first year sample) had not completed the course.

Field placement.

Respondents were also asked to identify whether they had taken at least one field placement, or were currently enrolled in a field placement, where they apply the values that have been learned through their coursework. Only 36% of respondents in the Bachelor program reported having completed at least one field placement, which consisted of 16% of second year respondents and 26% of the respondents enrolled in the third year of the program. Approximately 58% of students in their Premasters year had taken a field placement. However, 78% of the Premasters respondents had also reported current enrollment in a field placement. The students enrolled in the Premasters program are required to complete only one field placement as part of their degree requirements, therefore, there is some overlap between the respondents who identified themselves as having completed a field placement and those who were currently enrolled in a field placement. The majority of students not enrolled in any field placement consisted of all 47 first year level students in the Bachelors program (36%).

Previous Experience with HIV/AIDS

Over one half of the respondents in this sample (56.1%) reported having prior experience with HIV/AIDS. Table 2 provides a breakdown of the types of experience obtained with the disease. The respondents who identified having previous experience with HIV/AIDS, consisted of approximately 20% who had more than one type of experience with the disease. An interesting aspect of these findings related to the number of students who reported having gained previous experience with HIV/AIDS of a personal nature. Personal experience with the disease ranked the highest (43.2%) among the experience categories and included respondents who gained this experience through a family member who was affected by HIV/AIDS, knowledge of personal acquaintances or 'friends of friends' who had been affected by the disease, or had fiends and family who had worked with the disease. This finding is in contrast to the findings of Frankel et al. (1992) that "many respondents confidently stated that they were relatively unaffected on a personal basis" (p. 52).

Table 2

Experience with AIDS (n=132)

Type of experience	Not Selected	Selected
Overall Experience	43.9 (58)	56.1 (74)
Personal	56.8 (42)	43.2 (32)
Volunteer	66.2 (49)	33.8 (25)
Course	70.3 (52)	29.7 (22)
Professional	82.4 (61)	17.6 (13)
Other Experience	79.7 (59)	20.3 (15)
Knowing someone with HIV/AIDS	67.5 (83)	32.5(40)

The next highest category of experience with HIV/AIDS included respondents who had volunteered with client's in an agency setting. Approximately 34% of respondents had gained their experience through volunteer work. Respondents experience with HIV/AIDS was also gained through course work at the Faculty of Social Work, either through specific HIV/AIDS courses or indirectly through other coursework. Fewer respondents had gained their experience with HIV/AIDS through professional work (17.6%), and through 'other' experiences (20%) which consisted of attending workshops, reading books, or through courses in high school on HIV/AIDS.

Respondents' Level of Interest in HIV/AIDS

Respondents were asked to rank their preference to work in various fields of practice, to determine their professional interest in HIV/AIDS. The response categories were framed in a manner where respondents had to select from fields that were comparable to work with HIV/AIDS, that is, they entail work with stigmatized populations, or were not historically the preferred areas of practice among social workers. Respondents were asked to rank their preference from 1 to 4 out of five categories, however some respondents ranked all five, therefore, the question was coded based on five categories. Table 3 provides a ranking of respondents' choices.

Table 3

Level of Interest in HIV/AIDS (N = 134)

	Choice				
	First	Second	Third	Last	Not Selected
Child Protection	44.8 (60)	16.4 (22)	17.9 (24)	14.9 (20)	5.9 (8)
HIV/AIDS	9.0 (12)	32.8 (44)	30.6 (41)	20.9 (28)	6.7 (9)
Palliative Care	21.6 (29)	14.9 (20)	14.9 (20)	36.6 (49)	11.9 (16)
Perpetrators of Violence	22.4 (30)	17.9 (24)	15.7 (21)	33.6 (45)	10.4 (14)
Sex Offenders	3.7 (5)	8.2 (11)	10.5 (14)	58.9 (79)	18.7 (25)

Respondents were the most willing to work in the field of child protection, a field that most closely identifies with the social work profession. Over 44% of respondents selected this as their first choice, and the least percentage of respondents (14.9%) selected this as their last choice. Respondents were the least willing to work with sex offenders. Fewer that 4% selected this field as their first choice, and over 58% selected this as their last choice. The greatest number of respondents also did not select this as any ranked choice with 18.7% missing cases. Respondents reported that they were willing to work with HIV/AIDS, however, this was selected as their second choice (32.8%), and a close third choice (30.6%). Over 20.9% selected work with HIV/AIDS as their last choice. The least clear categories of choice included work in palliative care, and with perpetrators of violence. The majority of respondents selected work with perpetrators of violence as both their last choice (33.6%), and their first choice (22.4%). Based on areas of professional interest working with stigmatized populations, work with HIV/AIDS, while not the most preferred area of practice for respondents, was not the least preferred area of interest.

Respondents were also asked to select areas of professional interest to them in the demographic section of the survey. Table 4 provides a comparison of their choices. Respondents' preferred area of interests included family violence with over 56.8% of the respondents selecting this as their area of professional interest. Approximately 48% of respondents selected mental health as an area of interest, followed by work in addictions (47%). Respondents were less likely to select work in HIV/AIDS which ranked fourth (40.9%). Although this is in contrast to respondents choice on the attitude variable as reported above, the percentage who selected this area represents 54 students, which is comparable to the 56 students who ranked this as their first and second choice in the attitude variable above, and represents a sizable number of respondents from the total sample who are interested in work with HIV/AIDS. The responses on these two items however, are not consistent, as responses to the attitude item are moderately and negatively correlated ($\underline{r} = -.3362$, $\underline{p} < .000$), indicating that respondents who selected HIV/AIDS as a preference on one item, did not necessarily select this as their preferred area of practice on the second item. This perhaps suggests that out of a group of stigmatized populations, respondents are more willing to select work with HIV/AIDS, but when presented with a broader spectrum of fields of practice, respondents who selected HIV/AIDS previously, were more apt to prefer other areas of work. The least preferred areas of practice included aging (31.8%), vocational rehabilitation (28.8%), and palliative care was the least preferred category of choice with just over 27% of the respondents selecting this field.

The findings with respect to respondents last choice are interesting, as much work with HIV/AIDS entails work with palliative care, or the management and care of individuals who are dying. The cross-tabs procedure was run on these two variables, which revealed a moderate positive correlation of $\underline{r} = .32$ ($\underline{p} < .00018$) between respondents who selected work with HIV/AIDS and palliative care. Thus, there was a tendency for those respondents who selected HIV/AIDS as their area of interest to also select work in palliative care, indicating that respondents who are perhaps most willing to work with HIV/AIDS, are those who are also most willing to work with death and dying.

Table 4

Areas of Preferred Professional Practice (n = 132)

Practice Area	Not Selected	Selected
Addictions	53.0 (70)	47.0 (62)
HIV/AIDS	59.1 (78)	40.9 (54)
Palliative Care	72.7 (96)	27.3 (36)
Mental Health	52.3 (69)	47.7 (63)
Aging	68.2 (90)	31.8 (42)
Vocational Rehabilitation	71.2 (94)	28.8 (38)
Family Violence	43.2 (57)	56.8 (75)

Preparation for Work in HIV/AIDS

Respondents were asked to identify what they believed would adequately prepare students to work with HIV/AIDS in clinical practice. Based on the sample of 134 respondents, 82% chose to answer this open-ended question. Responses were analyzed for themes and categories were constructed according to the educational resources respondents identified. Overall, respondents demonstrated an interest in learning more about HIV/AIDS, as the vast majority of respondents (72.5%) reported that they would be interested in taking a multidisciplinary course on HIV/AIDS, should one be offered.

Learning through existing coursework.

Several respondents provided more than one method of educating students for clinical practice with HIV/AIDS. For example, some respondents identified "exposure through course work and practicum or field work", which were treated as two separate response items. These responses were analyzed and incorporated into more than one category where appropriate. Over 39.5% (49/124) of the response items were categorized into existing coursework which encompassed educating students on HIV/AIDS issues by incorporating discussion and class work into existing courses, such as introductory courses in social work. The focus of education as identified by the respondents, should include educating students of the basic facts, knowledge of the disease (15.3%), counseling of clients and their families (8.3%), examining personal biases and issues regarding discrimination of individuals affected by the disease (5.6%). The remaining percentage (10.3%) was grouped for the less frequently cited areas of education. Refer to Table 5 for a breakdown of the categories of less than 5 percent.

Workshops and speakers.

Approximately 8% of the responses identify that the above issues, should be addressed through specific workshops on HIV/AIDS made available to the students. Respondents were evenly split on identifying learning of these issues though presentations in class by professionals (6.5%) such as physicians, or social workers who work in HIV/AIDS settings. Discussion should include the medical/treatment aspects of the disease, and the situations that social workers are required to address with their clients. Respondents also identified presentations by individuals with HIV disease or AIDS (6.5%) to create awareness and expose students to individuals with the disease.

Learning through direct practice.

Several respondents reported that direct experience or exposure to HIV/AIDS related issues, and individuals with the disease would be beneficial to preparing students to deal with these issues. Experience through practicum or field placements was identified in over 8.8% of responses. Other response items were vague in terms of how students should gain this experience, however, "hands on experience with PWA's" would be

Table 5

Preparation for work in HIV/AIDS (n = 124 response items)

Category of Preparation	Percent/Frequency	
Learning through Existing Coursework	39.5% (total)	
Basic Facts/Knowledge of disease	15.3	(19)
Counseling clients & families	8.3	(10)
Examining biases/discrimination	5.6	(7)
Addressing homophobia	2.4	(3)
Risk of contracting HIV	2.4	(3)
Exploring issues of grief/dying	1.6	(2)
Ethical dilemmas in social work practice	1.6	(2)
Treatment/Medical aspects	< 1	(1)
Impact of Disease	< 1	(1)
Prevention	< 1	(1)
Learning through Required Coursework	7.2	(9)
Create a new course	< 1	(1)
Learning through Workshops/Speakers	21.7% (total)	
Workshops made available to students	8.0	(10)
Seminars by Professionals	6.5	(8)
Speaker with HIV/AIDS	6.5	(8)
Student Presentations	< 1	(1)
Learning through Direct Practice	25% (total)	
Practicum/Field Placement	8.8	(11)
Hands on Experience with PWA's	6.5	(8)
Volunteer Work	5.6	(7)
Field of Focus Course	2.4	(3)
Observing clinical work	1.6	(2)
Research on HIV/AIDS	3.2	(4)

beneficial (6.5%). Approximately 5.6% of the response items included volunteer work at agencies such as Kali Shiva, or Village Clinic, community agencies that provide direct services for HIV/AIDS, to prepare students for clinical work in HIV/AIDS. Less frequently identified response items included observing clinical work with PWA's and obtaining experience through the Field of Focus course offered through the Faculty of

Social Work. Overall, less than 3% of the responses indicated "don't know" in terms of how to prepare students for clinical work with HIV/AIDS.

Based on the responses to this question, respondents appear to have an awareness of the types of education that would prepare them to work with HIV/AIDS issues. Given the range of responses and the number of respondents who chose to answer this question, it appears that respondents possess an interest in learning more about the disease, and were able to identify educational approaches that are consistent with the kinds of skills and knowledge of the disease that would allow for professional work with this population. The content analysis findings of this study are consistent with findings identified by Wexler (1989) in a study of 61 social welfare students, who also identified provision of general information, clinical training/issues, prevention, minority issues, practice issues such as legal/ethical issues, and information on resources to prepare for work with this population. The respondents in the current study however, did not identify provision of information related to specific populations with the disease, nor did they identify information specific to what was happening locally with HIV/AIDS, the two aspects of the disease that respondents were least likely to answer correctly, as was demonstrated on the knowledge items.

Dependent Variables

Respondents' Attitudes Toward HIV/AIDS

The attitudes instrument which measured attitudes toward persons with the disease and the disease, was comprised of 24 questions. Responses to the attitude items were measured using a Likert Scale which ranged from strongly disagree to strongly agree. Items were scored according to the direction of the item, that is, positive responses were assigned a five where appropriate, and negative responses were assigned a 5 where appropriate. The reliability analysis on the attitudes items yielded an alpha of .70, which differed slightly from Goh's (1993) of .86.

Descriptives of dependent variable - attitudes.

The mean score on the attitudes instrument was 101.6 (N - 134), while the median was 103, and the most frequently occurring score or mode was 101. The standard deviation was 7.8. Out of a possible total of 120 points, the minimum was 68, with one case, and the maximum score was 118, with one case. Taken as a whole, attitude scores were very positive; total scores for all respondents were skewed to the left (-1.05), with more respondents receiving higher scores than lower scores. The negatively skewed attitude scores represents that respondents attitudes toward HIV/AIDS are positive, as would be expected from a group of social work students. The higher the attitude score, the more positive a respondent's attitude toward the items reflected in the two scales of the instrument: attitudes toward HIV/AIDS issues, and attitudes toward people with the disease.

Over 90% of respondents answered appropriately or in a manner that reflected positive attitudes toward HIV/AIDS issues and persons with the disease on 10 of the 24 items. Two other items were rated appropriately by at least 89% of the respondents. These findings are consistent with the findings of the study by Frankel et al. (1992) of Bachelor of social work students.

Table 6 presents a breakdown of the distribution of responses. Ranges were calculated for total attitude score one standard deviation above and one standard deviation below the mean. The majority of respondents scored mid-range, with a small percentage scoring either low, or very high.

Although on a whole the attitude scores reflect a positive attitude toward HIV/AIDS issues and individuals with the disease, several items presented varying responses that were not always consistent with the attitudes one would expect from a social worker. The

Table 6

Distribution of Attitude Scores (N = 134)

Score Range	Percent/Frequency
Low Range 68-93	11.9 (16)
Medium Range 94-109	74.6 (100)
High Range 110-118	13.4 (18)

responses to the items with the greatest variability (>.90) were analyzed individually (items 2, 6, 9, 11, 19, and 22). Refer to Table 7 for a breakdown of scores on these items. The items that received the most response variation dealt with issues surrounding confidentiality, such as protecting the names of individuals with the disease, and contact tracing. The right to refuse treating individuals with the disease was also an item with greater response variability, as were items concerning the right's of individuals with the disease, testing and interest in the disease.

Almost 13% of respondents were in disagreement with the statement "the names of individuals with AIDS should be kept confidential in order to protect them against discrimination," and 17.2% were undecided on this issue. Although the majority of respondents (70%) were in agreement with this statement, many respondents were not in agreement, and more were undecided about the issue, indicating that perhaps greater than 13% would not be in agreement over the issue of confidentiality. The negative and undecided response categories of this item were surprising to see, as one would expect that a greater number of respondents would have answered more positively on this question, given that preserving confidentiality and preventing discrimination are fundamental to social work practice.

Table 7

Attitude Items with the Greatest Variability (N = 134)

	Answer Choice				
Item	SD	D	U	A	SA
2. The names of individuals with AIDS should be kept confidential in order to protect them against discrimination.	3.0 (4)	9.7 (13)	17.2 (23)	35.1(47)	5.1(47)
6. A doctor should have the right to decide if he or she wants to treat patients with AIDS.	26.3 (35)	23.3 (31)	27.1 (36)	16.5 (22)	6.8 (9)
9. Children with AIDS should be allowed to attend school with children who don't have AIDS.	3.0 (4)	3.0 (4)	7.5 (10)	29.1 (39)	57.5 (77)
11. Everyone should be tested for HIV infection.	12.7 (17)	23.9 (32)	21.6 (29)	26.1 (35)	15.7 (21)
19. A doctor may inform, without the consent of the AIDS patient, a sexual partner that he or she is at risk of HIV infection.	8.2 (11)	11.9 (16)	32.1 (43)	27.6 (7)	20.1 (27)
22. I often read information about AIDS.	3.0 (4)	20.9 (28)	9.7 (13)	53.0 (71)	13.4 (18)

Note. SD = strongly disagree, D = disagree, U = undecided, A = agree, SA = strongly agree.

The attitudes of respondents were also split on the statement "Everyone should be tested for HIV/AIDS infection." Over 41% of respondents were in agreement with this statement, while 36.6% were in disagreement and 21.6% were undecided. The variability in response to this statement is interesting, as the statement implies mandatory testing. Over half of the respondents were either in agreement with this statement or were undecided, over an issue which runs counter to the belief in the rights of individuals, which social work as a profession champions. Similarly, responses were split over the issue "A doctor may inform, without the consent of the AIDS patient, a sexual partner that he or she is as risk of HIV infection." In Manitoba, there is no current policy on contact tracing that would permit a doctor to breach confidentiality (Manitoba STD Information Line, 1999). One would have expected that social work students would be opposed to this, and they would favor a policy of working with the client, and recognize that it is ultimately the client's choice.

Variability in responses was also demonstrated on the item "A doctor should have the right to decide if he or she wants to treat patients with AIDS." Over 23% of respondents were in agreement with this statement, and 27% were undecided over this issue, indicating that these respondents perhaps recognized a professionals right which may discriminate against individuals with the disease. Respondents were split in their opinion; while 50% of respondents disagreed with the statement, others saw this as a professional choice. Variability was also demonstrated on the item "children with AIDS should be allowed to attend school with children who don't have AIDS." Although the vast majority of respondents (87%) agreed with this statement, 6% disagreed and almost 8% were undecided over this issue. The issue inherent with this item implies that those who were in agreement with the item, did not recognize the inherent discrimination in this practice.

Respondents were also less in agreement on the items concerning funding for the disease. While over 81.2% agreed with the statement "research on AIDS should be a priority for government funding", considerably less (only 52.3%) were in favor of how health care funding has been allocated toward the disease.

Attitudes toward contact with HIV/AIDS.

An important aspect of the attitudes toward HIV/AIDS was identified as social workers comfort in working with individuals with the disease. A small sub-scale was included in the attitude instrument to gauge respondents' comfort level when in contact with individuals with the disease. Five items were scored in the same manner as the other attitude items, with the maximum possible score of 25, and minimum of 5. The reliability analysis yielded an alpha coefficient of .78 on these items. The negative skewness of the scores indicates that overall, respondents demonstrated accepting attitudes toward contact with those with the disease.

Descriptives of dependent variable - comfort.

Based on the 5 items (N = 134), the mean was 21.1, the standard deviation 3.04. The mode was 20, while the median was 21. The minimum score achieved was 12, while the maximum was 21. The frequency distribution of the scores was negatively skewed (-.73) indicating that more respondents received higher scores. The negative skewness indicates that the respondents demonstrated accepting attitudes toward contact with infected individuals.

Table 8 provides a breakdown of the responses to the comfort items. While the majority of respondents (95.5%) recognized that social workers, regardless of field of practice, should be concerned about issues regarding HIV/AIDS, and (62.7%) indicated that if given a choice, they would work with clients who were diagnosed with HIV disease or AIDS, not all demonstrated that they would be comfortable working in settings where they came into contact with individuals with the disease. Based on an item analysis, it appears that the closer the contact with infected individuals, the greater number of respondents who report discomfort. Living in a neighborhood with HIV infected individuals does not appear to bother the majority of respondents. Only a small percentage (3.8) were in disagreement with this item or were undecided on the issue (8%). Similarly, living next door to a person with HIV/AIDS does not appear to be an issue for the majority of respondents. Only 2.2% disagreed with this item, and 2.2% were undecided. Some respondents however, held reservations about their comfort in working in an environment where there was contact with HIV infected clients. Slightly higher numbers of respondents (5.9%) indicated that they would be uncomfortable, while 8.2% were undecided on the issue. In response to the statement "I would experience discomfort sitting next to a person with AIDS" revealed that an even greater number of respondents were uncomfortable with this type of contact. Just under 7% of respondents were in agreement with this item, while over 11% were undecided on this item, indicating that slightly more may experience discomfort with sitting next to a person with AIDS.

Table 8

Comfort Scale Items (N = 134)

	Answer Choice				
Item	SD	D	U	A	SA
23. If I had a choice, I would work with clients who were diagnosed with HIV/AIDS.		86.0(8)	30.8(41)	42.1(56)	21.1(28)
24. I would be comfortable if persons with HIV/AIDS lived in my neighborhood.	[illegible]1)	3.0(4)	8.0(1)	39.1(52)	56.4 (75)
25. I would be comfortable living next door to a person with HIV/AIDS.	.7 (1)	1.5 (2)	2.2 (3)	41.0 (55)	54.5 (73)
26. I would feel comfortable working in an environment where there was contact with HIV infected clients.	.7 (1)	5.2 (7)	8.2 (11)	47.8 (64)	38.1 (51)
27. I would experience discomfort sitting next to a person with AIDS.	50.0(67)	33.6(45)	11.2 (15)	5.2 (5)	1.5 (2)

Note. Items 23 and 24 received .7% or 1 missing response.

Although a small number of respondents indicated that they would be uncomfortable when in contact with individuals with the disease, negative responses to these items demonstrate that not all respondents have positive attitudes toward individuals with the disease, or that they may harbor irrational fears of contagion, even when contact is limited to casual contact. It is evident at least on a small incremental basis, that the closer the contact with someone with the disease, the more some respondents experience discomfort with the disease. Negative attitudes toward, and discomfort in working with these clients can prevent individuals from demonstrating the range of skills and practice behaviors that are required to work with this population.

Respondents' Knowledge of HIV/AIDS

The instrument used to measure respondents' knowledge of HIV/AIDS included a modified form of the scale found in the Attitudes Toward AIDS Scale (Goh, 1993), which consisted of 24 true false questions. Questions 16 and 24 of the modified scale were comprised of 5 sub-questions which were scored individually. Correct questions were coded with a 1, while incorrect responses were coded as 0. The score on the knowledge section of the questionnaire could range from 0 correct, to a possible of 32 points. The score from a reliability analysis yielded an alpha of .30, which differed greatly from that reported by Goh (.84). All of the 134 respondents completed the 32 questions on knowledge of HIV/AIDS.

Descriptives of dependent variables - knowledge.

The mean knowledge score was 26.9, and the standard deviation for scores was 2.1. The median score was 27, while the mode or most frequently occurring score was 26. The lowest score achieved on the knowledge instrument was 20 points, while the maximum was 30 out of 32 possible points. Based on the frequency distribution, the knowledge scores are negatively skewed (skewness -.77) indicating that the majority of respondents received higher scores, with fewer receiving lower scores. Over 79% of respondents received scores of 26 or higher on the instrument. Refer to Table 9 for a breakdown of the knowledge scores.

There were no sub-scales formally identified in the knowledge instrument however, an item analysis revealed that the respondents were more knowledgeable on items that addressed diagnosis and symptoms of the disease (items 4, 7, 9, 11, 16a-e), how the disease was transmitted (items 5,6,8,10, 12, 13, 17, 18, 19), and who can contract the disease (items 1, 3). Almost 100% of the respondents knew that the disease was not limited to homosexuals, and 92.5% were aware that hemophiliacs could get AIDS. Respondents were knowledgeable about the disease in general, and were able to correctly identify the virus that causes AIDS (95%), and over 97% knew that there was no cure for the disease. This finding is consistent with the finding by Frankel et al. (1992) where over 95% of their first sample (n=218) of BSW students knew there was no cure for AIDS. Refer to Table 10 for a breakdown of knowledge items.

The majority of respondents (over 90%) were able to correctly answer items related to the diagnoses and symptoms of the disease. Unlike the study by Frankel et al. (1992), who reported that their first sample were the least knowledgeable about diagnosis of HIV/AIDS, where over 44% did not know if "the incubation period for AIDS was 2 years (p. 19), the respondents in this sample (99%) were able to correctly identify that the AIDS virus could live inside the human body for years before symptoms appeared. The respondents in this study were also able to correctly identify specific symptoms and

Table 9

Distribution of Knowledge Scores

Knowledge Scores	Percent/Frequency (N = 134)	
20	.7	(1)
21	2.2	(3)
22	.7	(1)
23	2.2	(3)
24	5.2	(7)
25	9.0	(12)
26	20.1	(27)
27	18.7	(25)
28	16.4	(22)
29	15.7	(21)
30	9.0	(12)

Table 10

Knowledge Items (N = 134)

Item	Grading Incorrect	 Correct
1. Hemophiliacs can get AIDS.	7.5 (10)	92.5 (124)
2. AIDS is an epidemic.	20.9 (28)	79.1 (106)
3. Only homosexuals can get AIDS.	1.5 (2)	98.5 (132)
4. The virus that causes AIDS is called the Human Immunodeficiency Virus (HIV).	4.5 (6)	95.5 (128)
5. The AIDS virus can remain infectious outside the body for up to 10 days if it is at room temperature.	14.9 (20)	85.1 (114)
6. One can get AIDS by sharing a meal with a person who has AIDS.	2.2 (3)	97.8 (131)
7. People who have AIDS do not develop cancer.	6.7 (9)	93.3 (125)
8. Today, blood supply in hospitals and blood donation centers is screened for the AIDS virus.	2.2 (3)	97.8 (131)
9. Impaired memory, concentration and motor deficits may occur in some AIDS patients.	15.7 (21)	84.3 (113)
10. One can get AIDS by sharing drug needles.	.7 (1)	99.3 (133)
11. The AIDS virus may live in the human body for years before symptoms occur.	.7 (1)	99.3 (133)
12. One can get AIDS from receiving blood or sperm from a donor who has AIDS.	100.0 (134)	0 (0)
13. By using a condom when having sex, one is always safe from contracting AIDS.	11.9 (16)	88.1 (118)
14. The HIV test is a blood test which can tell if a person has AIDS.	65.9 (87)	34.1 (45)
15. There is a cure for AIDS.	3.0 (4)	97.0 (130)
16. Persons who are diagnosed with AIDS will experience symptoms such as:		
swollen lymph nodes	10.4 (14)	89.6 (120)
fatigue	1.5 (2)	98.5 (132)
fever	3.7 (5)	96.3 (129)
night sweats	5.2 (7)	94.8 (127)
weight loss	1.5 (2)	98.5 (132)
17. One can get AIDS by having sexual intercourse with an infected person.	.7 (1)	99.3 (133)
18. AIDS is spread by sneezing, coughing or touching.	2.2 (3)	97.8 (131)
19. One can get AIDS by having sex with someone who uses intravenous drugs.	24.1(2)	5.9 (101)

(table continues)

Table 10 continued

Item	Incorrect	Correct
20. AIDS can be spread by having contact with towels or bed linens used by a person with AIDS.	4.5 (6)	95.5 (128)
21. More women than men have been infected by the AIDS virus.	37.3 (50)	62.7 (84)
22. About 50,000 people in Canada have been infected with HIV.	29.1 (39)	70.9 (95)
23. The majority of funding for HIV/AIDS in Manitoba is provided by the provincial government.	53.0 (71)	47.0 (63)
24. The following groups experience the fastest incidence of HIV infection:		
Heterosexual women who are IV drug users.	38.1 (51)	61.9 (83)
Aboriginal People	49.3 (66)	50.7 (68)
Women who are lesbian	4.5 (6)	95.5 (128)
Men who have sex with men.	70.9 (95)	29.1 (39)
Hemophiliacs	14.9 (20)	85.1 (114)

Note. Item 14 received 1.5 (2) blank responses, and item 19 received .7(1) blank response.

illnesses of the disease such as cancer (over 92% knew that people with AIDS could develop cancer), swollen lymph nodes, fatigue, fever, night sweats and weight loss (over 90%), and 84% were aware that individuals with AIDS could experience impaired memory, concentration and motor deficits. Consistent with the study by Frankel et al., the respondents were less knowledgeable about diagnostic testing. Fewer than 34% of the sample were able to correctly answer the item "the HIV test is a blood test which can tell if a person has AIDS."

Of importance was respondents' ability to correctly identify how the disease was contracted, which has implications for fears surrounding the disease and how one interacts with the individuals who have the disease. Respondents were knowledgeable about how the virus was transmitted. The majority (over 85%) were aware that the AIDS virus could not "remain infectious outside the body for 10 days at room temperature", and over 97% were aware that one could not contract the virus through casual contact such as by sharing a meal with a person with AIDS, and that the AIDS virus was not spread by sneezing, coughing or touching (98%). Respondents were able to correctly identify the activities that are most likely to lead to the spread of the disease, such as through sharing IV drug needles (over 99%), receiving blood or sperm from a donor who has AIDS (100%), the only item on the knowledge instrument that all 134 respondents were able to correctly answer. An interesting finding of respondents' knowledge of transmission of the disease was that while over 99% were able to correctly identify that one could get AIDS by having sexual intercourse with an infected person, only 75% were aware that one could get AIDS by having intercourse with someone who used IV drugs. Perhaps more respondents did not identify this as a means of transmission as they did not believe that this posed a personal risk to them, that is, that they would not have intercourse with someone who used IV drugs. The majority, (approximately 88%) of respondents were aware that one is not always safe from contracting AIDS when using a condom. Respondents' knowledge of how the disease is contracted is consistent with findings of Wiener-Brawerman (1988) whose sample of 406 NASW social workers were able to correctly identify that HIV could not be transmitted by casual contact (85%), and the findings of the study by Frankel et al. (1992), where the majority of their first sample were able to correctly identify answers to transmission questions.

The area of least knowledge was demonstrated on items related to the specific populations who are affected by the disease, the incidence of the disease in Canada, and funding for the disease. Over one third of the sample (37.3%) were not able to correctly identify that more men than women had been infected with the AIDS virus, which is an interesting finding of the study, given that since the start of the epidemic, much emphasis has been placed on the incidence of the disease among men who have sex with men. Less than three quarters (70%) of respondents were aware that about 50,000 people in Canada had been infected with the AIDS virus. Less than one half of the respondents were aware of how the disease was funded, a question of relevance for social workers given their focus on providing resources and supports to clients. Only 47% of respondents were aware that the majority of funding for Manitoba was provided through Manitoba Health.

While over 85% of respondents were able to correctly identify that women who are lesbian have a relatively low incidence of HIV disease, based on how the disease is transmitted, knowledge of other sub-populations was less evident. Only 29% of respondents correctly identified men who have sex with men as a group that is affected significantly by HIV disease in Canada. Approximately 50% of respondents were able to identify that Aboriginal people are a high incidence population. Although more respondents were aware that heterosexual women who are IV drug users are also a high incidence group, only 62% of respondents correctly identified this category. The majority of respondents (over 85%) knew that hemophiliacs no longer experienced a higher incidence of HIV infection, however, 15% did identify this as a high incidence group, despite that 98% of the respondents were aware that the blood supply in hospitals and donation centers was screened for the virus.

Overall, respondents demonstrated to be knowledgeable about the general aspects of the disease such as transmission, symptoms, definition of the disease, however, they were less knowledgeable of the specific facets of the disease that include the sub-populations affected, and funding, information that is relevant to what is happening in Canada and Manitoba with the disease. The deficits in knowledge about the sub-populations affected demonstrated by this sample, are consistent with findings of studies by Wexler (1989) of 61 social work students in the San Francisco Bay area, and the study by Peterson (1992) of 108 NASW social workers who demonstrated similar deficits in knowledge. Knowledge of the prevalence of the disease, and populations who are most affected by HIV disease appears to be an area where students, and professionals are likely to be least knowledgeable.

Respondents' Ability to Apply Social Work Values

Individual methods were used for scoring the forced choice and open-ended values instruments. Responses to open-ended items were reviewed and analyzed for themes, then rated according to conceptualized scales. Individual items on both of these instruments were scored with a 2 for the answer most consistent with the social workers response to the situation that upheld a value, and a 1 for a neutral response. The scoring of 0 was assigned for an answer which clearly violated a value, based on the responses identified by professionals in social work education and social work values to be the response category which least upheld a particular value, or handling of a situation which was not consistent with social work practice. The maximum one could score on both of the values instruments combined was 18, while the minimum was 0.

Table 11 provides a comparison of the social work values descriptives for total scores, and scores on both of the forced choice and open-ended instruments. Based on the total scores, the mean score was 13.90 while the medium was 14 and the mode was 14. The standard deviation was 2.86 and the variance was 8.20. The maximum score obtained on the instruments was 18, while the minimum was 4. Scores were negatively skewed (skewness -1.09), with more respondents realizing higher scores than lower scores. Fewer than 10% of respondents scored less than 10 out of 18 and over 60% of respondents received a score of 14 or better on both values instruments combined.

Table 11

Descriptives of Dependent Variables - Values

	Mean	Standard Deviation	Mode	Median	Variance	Min/Max	Skewness
Values (Total)	13.90	2.86	14	14	8.20	4/18	-1.09
Forced Choice	10.6	1.63	12	11	2.67	4/12	-1.58
Open Ended	3.56	1.52	4	4	2.31	0/6	-.41

Only two items were correctly answered by at least 90% of the respondents, and one question was correctly answered by at least 89% of respondents. The greatest variation in responses was demonstrated on the open-ended questions (Item 3 - self-determination, Item 2 - confidentiality, Item 1 - social justice), as was expected given that respondents had to provide their own response to the scenario. Overall, respondents achieved higher scores on the forced choice values instrument. The data for open-ended questions was slightly negatively skewed (-.41), compared to the scores on the forced choice instrument (skewness -1.58), indicating that a greater number of respondents were able to achieve higher scores on the forced choice instrument. Over 82% of respondents achieved a score of 8 or higher on this instrument.

As a means of understanding respondents' ability to identify and apply social work values to specific HIV/AIDS scenarios, cut-off points were established one standard deviation above the mean, and one standard deviation below the mean. The ranges and score percentages are presented in Table 12. This method was used, as it was thought that the values instruments were not sensitive enough to scoring variations to use the mean as a cut-off (S. Frankel, personal communication, October 17, 1998). The majority of respondents scored high on the values instruments with fewer realizing mid-range scores and a smaller percentage scoring very low between 4-11.

Table 12

Distribution of Total Value Scores (n = 128)

Score Range	Percent/Frequency
Low Range 4-11	16.5 (21)
Medium Range 12-14	39.0 (50)
High Range 15-18	44.5 (57)

Content Analysis of Open-Ended Values

The open-ended instrument consisted of three scales, which included social justice, confidentiality and self-determination, one item per scale. Respondents were asked to read the scenario, then respond to the scenario using their professional opinion as a social worker. They were then asked to identify the main dilemma or social work value apparent in each scenario. The latter answer was used to gauge whether respondents were able to correctly identify the main issue or value, then provide a description of how they would handle the situation, which was scored separate from the identified value. If their response upheld the value, they were assigned a 2, or, if they partially addressed the issue, but did not handle it in the most appropriate manner, they were assigned a 1. If their response violated the value, or was contrary to professional expectations of how a social worker would address the situation, they were assigned a 0. The main value identified by professionals in social work education and values, and masters students, was used as a reference for gauging respondents answers to the values items.

Table 13 provides the score allocation for each item on the open-ended items. Enclosed in Table 14 is a breakdown of frequency and percentages of the respondents who were able to identify the correct value, and the total frequency and percentage of those who in addition to identifying the correct value, also upheld that value.

Table 13

Content Analysis of Open-Ended Values Item Distribution (n = 124)

		Grading	
Value	Incorrect	Neutral	Correct
Social Justice	21.0 (26)	3.2 (4)	75.8 (94)
Confidentiality	21.0 (26)	12.1 (15)	66.9 (83)
Self-determination	66.1 (82)	12.9 (16)	21.0 (26)

Item 1: social justice.

Respondents scored higher on the question related to social justice, with over 75% correctly identifying the value, and the majority of these respondents upholding the value (71%). Correct answers or those assigned a 2, consisted of responses such as "reject the report/advocate for enhanced benefits for all" or "advocate for equality/report discriminates." Approximately 3.2% identified a neutral response to handling the situation, which either identified that the proposal discriminates, or that individuals should have the same worth, however, respondents did not specify how to address the situation, or take action to address the issue. Neutral scores were also assigned to responses of "deny enhanced benefits to all." Approximately 21% did not uphold the value, or were not able to apply the value. Responses which were scored 'incorrect' included answers such as "talk to the supervisor to see if the proposal is OK," or those that supported the report as is, as well as responses indicating "don't know" and those left blank. Refer to Table 15 for a breakdown of response categories for each value item.

Table 14

Percentage of Values Identified and Upheld (n = 124)

Value	Value Identified Percent/Frequency	Value Upheld Percent/Frequency
Social Justice	79 (98)	71 (89)
Confidentiality	83 (103)	73.4 (91)
Self-determination	24.2 (30)	15.3 (19)

Item 2: confidentiality.

Respondents violated confidentiality when the identified main value was 'honesty' and 'professionalism.' The content analysis of responses revealed that 66% of respondents were able to answer the question in a manner that upheld the value. Responses that were deemed to have upheld the value included answers which specified that Anne, the social worker in the scenario, should not disclose any information that would allow the supervisor to directly, or to infer, that the client was in fact a client, or of his medical condition. Responses such as "Anne should not disclose that he is a client to the supervisor - she should keep her answer vague or say he is just an acquaintance," were scored with a two. Approximately 21.8% either violated the value, or the value was not applied to the situation. Responses that violated the value included those that would allow the supervisor to infer - that is, by saying "I can't tell you because it is confidential, or "tell the supervisor how you know the client." The former response was scored as incorrect, as the supervisor may conclude that Anne knows this candidate from the clinic where she volunteers, and he is a client. Answers left blank or "don't know" responses were scored with a zero as well. Approximately 12% provided a neutral response which was assigned to answers that indicated that the supervisor did not have a right to know this information, or simply that "Anne should not tell", without providing any explanation for how they would specifically deal with the situation. The greatest number of respondents (83%) were able to articulate the value of confidentiality with 73.4% identifying the value, also upholding the value when addressing the situation.

Item 3: self-determination.

The question which appears to have been most problematic for respondents was item 3, self-determination. Over 66% of respondents were not able to correctly answer this question. Few respondents (15.3%) could identify the value and uphold this value when responding to the scenario.

Approximately 21% upheld the value of self-determination with responses that encompassed providing the client with further information, but also recognized that ultimately it was the client's decision. Approximately 13% provided a neutral response, which was scored according to answers where the respondent wanted to provide more information to the client, that may or may not lead him to change his mind. Over

Table 15

Summary of Response Items

Upholds Value	Neutral	Violates Value
Social Justice		
Reject report/ discriminates	Deny enhanced benefits	Report rewards responsible behavior.
Challenge report	Report discriminates	Support report as is
Advocate for enhanced benefits for everyone	Not a valid report	There should be enhanced benefits for occupational HIV
Advocate for equality of treatment.		Talk to supervisor about current policies
Provide access to same resources		Do nothing
Confidentiality		
Client has right to confidentiality/say he is just an acquaintance	Don't disclose private information.	Be honest and tell the truth
The supervisor does not have a right to know/say he is just a friend	It's not the supervisors business	Say that you know him from the clinic, but don't say he has HIV disease
Do not disclose that he has HIV or that he attends the clinic/say that you know him from the community	Protect his confidentiality	Tell the supervisor that you can't say, as it's confidential
		He's a client
Don't disclose confidential information/say he just said 'Hi'		Don't say, it's up to the client to tell

(table continues)

Table 15- continued
Self-Determination

Upholds Value	Neutral	Violates Value
Respect the client's decision, it is his choice	Provide him with more information	Encourage him to tell
Review pro's and con's of his decision, but ultimately it is up to him to decide	Discuss the ramifications of his decision	Strongly urge him to tell
Respect the client's choice, but stress the importance of safe sex	Respect his decision, but keep it open with the hope that he will eventually tell	Tell him to disclose or end the relationship with his partner
Disagree with the client, but respect that it is his decision to make	Support his decision, but encourage open communication	Tell him that his partner has a right to know and he should be honest
Make sure the client understands his decision, but it's his choice	Provide more information	Tell him he is placing his partner at risk
Don't judge his decision, go over it with him and support it	Have him role play with you to review his partners possible responses	Tell him that honesty is important in an relationship
		Tell him that you cannot support his decision
		Tell him that his partner has a right to self determination
		Make him aware of the importance of the information he is hiding
		Tell him that he is putting his partners life at risk
		Other
		Tell him that either he tells or as a social worker, you are professionally obligated to tell

66% could not apply the value of self-determination, or through their handling of the situation, did not address this value. Responses that indicated that the social worker should do what is necessary to strongly encourage the client to change his mind, such as by informing him that if "he did not tell, then the social worker would inform his partner" were scored with a zero, as this clearly violates the value of self-determination.

Forced Choice Values

Respondents demonstrated stronger performance on the forced choice values instrument, with a greater percentage of respondents scoring correctly on each of the six items. The greatest percentage of incorrect responses were found on value 6 which dealt with confidentiality (13.7% incorrect responses), and item 3 which dealt with self-determination (11.9% incorrect responses). Table 16 provides a breakdown of item scores for the three value scales.

Items 1 and 3: self-determination.

The majority of respondents (86.5%) were able to correctly answer item 1 , and over 65% of respondents answered item 3. The greater percentage of respondents selected the neutral response in item 3 (over 23%), whereas, only 8% selected the neutral response in item 1. Incorrect responses on both items were minimal, with 5.6% for item 1, and 12% for item 3. Overall, respondents upheld the value of self-determination as the majority (well over 50%) selected the response category which most strongly supported the value.

Items 2 and 5: social justice.

Based on the high percentages of correct responses- over 90% of respondents correctly answered item 2 and over 89% correctly answered item 5, the vast majority of respondents upheld the value of social justice. Only 3.2% selected the incorrect response in item 2, and 4% selected the incorrect response in item 5, or the response categories which least upheld the value in each item.

Items 4 and 6: confidentiality.

Respondents performed well on the confidentiality scale, thus upholding the value on both items. Almost 93% of respondents correctly answered item 4, and approximately 83% of respondents correctly answered item 6. In both scenarios, respondents recognized the clients' right to confidentiality as the most appropriate method of handling the situation. Only a small percentage, 1.6% on item 4, and 13.7% on item 6 selected the response category which least upheld the value of confidentiality.

Table 16

Forced Choice Values Distribution (n = 126)

Value/Item	Incorrect	Grading Neutral	Correct
Self-determination			
Item 1	5.6 (7)	7.9 (10)	86.5 (109)
Item 3	11.9 (15)	23.0 (29)	65.1 (82)
Social Justice			
Item 2	3.2 (4)	5.6 (7)	91.3 (115)
Item 5	4.0 (5)	6.4 (8)	89.6 (112)
Confidentiality			
Item 4	1.6 (2)	5.6 (7)	92.8 (116)
Item 6	13.7 (17)	4.0 (5)	82.3 (102)

Note. Item 5 for social justice is missing <1(1) response. Item 4 is missing <1(1) and item 6 is missing 7.9 (10) for confidentiality.

Discussion of Values Performance

Based on the total value score, respondents appeared to have an ability to identify and uphold a particular value, given a specific situation. Respondents demonstrated an ability to handle specific HIV/AIDS related scenarios in a manner that meets professional expectations, or is consistent with professional social work practice. Over 90% of respondents were able to correctly identify the appropriate response on the forced choice items on two questions, and 89.6% of respondents were able to correctly answer one forced choice item. Responses to the open-ended values however, demonstrate the complexity of handling situations that arise in social work practice with clients. The variation in response to identifying a main value, particularly evident in item three, and having to identify how to address a scenario in the absence of provided answer choices, illustrated the difficulty of this task for many respondents. Given that the majority of respondents were not able to correctly identify item 3 or handle the presented situation without violating a particular value, it appears that identifying values and applying these values to specific HIV/AIDS related situations is problematic. The respondents who are able to identify a social work value, tended to respond in a manner that upheld that value, with few having first identified the correct value, then violating the value which was particularly evident in items 1 and 2. Consistent with the literature on social work values, confidentiality presented as the value most respondents were able to identify. Self-determination, however, was the least clearly identified value, and also the value least upheld by respondents. Knowing the social work values in a manner where either respondents are able to articulate or define, demonstrates greater ability to handle HIV/AIDS related situations in a manner that is consistent with professional expectations.

Presenting open-ended case scenarios required respondents to identify the main issue or problem however, as the case scenarios presented possible dilemmas which impacts the worker's decision making, underlying issues or sub-issues also required consideration. The amount of variation in responses indicated that respondents were able to identify a range of issues in each scenario. However, ability to identify the main issue in each scenario, such as preserving confidentiality, addressing discriminatory practices, or upholding the clients right to self-determination was not always evident. For example, some respondents identified honesty as an important social work value in response to item 2. These respondents tended to believe that informing the supervisor was more important than maintaining client confidentiality over an issue that did not have any relevance to the supervisor. It was apparent that these respondents recognized this as a dilemma between maintaining professionalism, being honest with the supervisor, or upholding the client's right to confidentiality. However, maintaining confidentiality is an important aspect of professionalism, and should be upheld as violating the value in this case could lead to repercussions for the client.

Some respondents were able to identify a particular value, however in handling the situation, violated another value or sub-issue, which they may not have been able to identify as operating within the scenario. In the case of item 3 on self-determination, few respondents, although presented with an issue regarding a client's decision, recognized that the client who is not incapacitated or threatening to harm his partner, had a right to make a decision and that the social worker's role was to ensure that it was an informed decision, and contract with the client to practice safe sex. Many respondents saw this as an issue regarding confidentiality and safety, and the method of handling this situation was to inform the client that either he tell his partner, or they would be required to do so. By informing the client's partner, the worker has not acknowledged the client's right to make a decision, and has also violated the value of confidentiality. The manner in which situations such as these are handled and prioritized, clearly have implications for work with clients. Given the demonstrated complexities surrounding these scenarios, it is not always readily apparent how a situation should be handled in a manner that respects the client and yet does not jeopardize another, which has implications for how potential social workers are educationally prepared to deal with situations that arise through practice with clients with HIV/AIDS.

Summary

This chapter presented a description of the respondents background and interests. An overview of the dependent variables has highlighted the areas where further preparation is required for work with HIV/AIDS. Responses on the values instruments have demonstrated the difficulties in handling the issues relevant to HIV/AIDS, and how social work values are operationalized in practice situations with these clients.

CHAPTER V

ANALYSIS OF RESEARCH QUESTIONS

Introduction

The following chapter reports on the results of relationships between the dependent and independent variables used in this study. All anticipated relationships between these variables were found to be supported. The validity and reliability findings of the values instruments are also reported in this chapter.

Research Question I

Will respondents with more positive or accepting attitudes towards HIV/AIDS identify more strongly with core professional social work values?

It was anticipated that the respondents who possess more positive or accepting attitudes toward those with the disease would also more strongly support social work values, or would tend to uphold social work values when applying a particular value to an HIV/AIDS based scenario. Attitudes toward HIV/AIDS, treated as a dependent variable, and social work value scores, treated as the independent variable, were analyzed using a Pearson's r which revealed a significant relationship between these two variables ($r = .2670$, $p = .002$). Attitudes and values were weakly and significantly associated. The positive relationship between these two variables indicates that slightly higher performance on the attitudes instrument was associated with higher performance on the values instrument. Based on these findings, it appears that these two variables are related and answers the research question, that generally respondents who can uphold a social work value when applying it to an HIV/AIDS related scenario, have more positive attitudes towards the disease and individuals with the disease.

Limited studies are available by which to compare the findings of this study on the relationship between social work values and attitudes toward HIV/AIDS. Studies by Wexler (1989) and Frankel et al. (1992) reported positive attitudes of social work students that were consistent with social work values however, the findings of this study offer statistical evidence that these two variables are at least related.

Comfort level was significantly related to both attitudes and values. There was a strong positive relationship between comfort when in contact with HIV/AIDS and respondents' attitudes toward the disease ($r = .67$, $p = .000$). This finding is consistent with that of Wiener-Brawerman (1988) whose sample of 406 NASW social workers revealed that positive moral attitudes toward persons with AIDS was associated with significantly higher levels of comfort.

Increases in comfort when in contact with HIV/AIDS were also associated with increases in value scores, although the relationship between these variables was weaker ($r = .2464$, $p = .005$). When controlling for attitudes toward contact with HIV/AIDS, the relationship between attitudes toward HIV/AIDS in general and values changed significantly ($r = .1414$, $p = .113$), which suggests that comfort level explains the relationship between attitudes and values. Based on these statistical outcomes, it appears that respondents' attitudes toward contact with individuals with the disease is an important factor in understanding the relationship between respondents' values, and their attitudes in general toward the disease.

Variables related to attitudes toward HIV/AIDS.

Based on the anticipated relationship between social work values and attitudes toward HIV/AIDS, it was originally questioned whether respondents either in their completing year of the program, or those who had taken or were currently enrolled in the values course, or had taken at least one field placement would possess more accepting attitudes toward those with the disease. Higher scores on the attitudes test would result as these respondents would more strongly support the values of the profession. The only variable determined to be significantly related to attitudes was social work values, as above. There were no significant relationships between attitude scores and the values course (*t* = .84, *p* = .403, d.f. = 129), enrollment in a field placement (*t*= .34, *p* =.733, d.f. = 130), nor was a significant relationship established between attitudes and completion of a field placement (*t* = .49, *p* = .628, d.f. = 130).

Variables related to social work values.

The variables of 'enrollment in a field placement', 'having taken a field placement', 'year in program', and 'enrollment in the values course' were analyzed with total value scores. Social work values were not significantly related to any of these independent variables based on calculated *t*-tests (enrollment in field placement: *t* = .10, *p* = .923, d.f. = 125; completed field placement: *t* = .42, *p* = .677, d.f. = 125; values course: *t* = 1.88, *p* = .062, d.f. = 124). Using a one-way anova with Sheffe's test did not reveal any significant differences in learning of values across program year at *p* < .05. Using a general factorial anova for these variables revealed a significant main effect for taking a course in social work values (*F* (1, 118) = 9.22, *p* = .004) and for having taken a field placement, (*F* (1, 45) = 4.52, *p* = .039). The main effects of these two variables provides support for how values are learned, given that learning of values occurs in the course, and application of those values is learned in a field placement setting.

The demonstrated relationships between attitudes toward the disease, and social work values, as well as the role of taking the values course and field placement in this study, supports the assumption put forth in Wexler's (1989) study of social welfare students' attitudes toward the disease, that positive attitudes "suggests the success of social work education in socializing students to the profession (p. 146).

Research Question II — Do respondents with more positive or accepting attitudes toward those with HIV/AIDS also possess greater knowledge of the disease?

Knowledge of HIV/AIDS.

The social work respondents who demonstrated positive attitudes toward those with the disease also demonstrated a greater understanding of HIV/AIDS. The results of a correlational analysis using Pearson's Product Moment Correlation, excluding cases pairwise, revealed that there was a positive moderate relationship between these two variables that was significant (r=.3816, p = .000). Respondents who possess a greater understanding of the disease, tend to have more positive attitudes toward the disease, and toward individuals with the disease. This finding is supported by other studies on HIV/AIDS by Dhooper et al. (1988), Frankel et al. (1992), Royse et al. (1987), Shi et al. (1993) and Wexler (1989).

The combined sub-score of attitudinal items which measured respondents' comfort with contact with HIV/AIDS was analyzed with knowledge and revealed a weak relationship. The respondents who possess a better understanding of the disease were more comfortable with coming into contact with someone with the disease (r = .2961, p = .001), than those with less knowledge of HIV/AIDS. This finding is consistent with results reported by Wiener and Siegel (1990), and Gillman (1991).

Research Question 3: — What additional variables are related to attitudes toward HIV/AIDS, core professional social work values and knowledge of the disease?

Attitudes and Additional Variables

Experience with HIV/AIDS.

Student's t-tests were performed on attitude scores to examine whether any significant differences existed for the variable 'experience with HIV/AIDS'. The results of a t-test revealed that a significant difference existed for attitude scores between individuals with prior experience with HIV/AIDS and those without this experience ($t = 4.53$, $p = .000$, d.f. = 130). Respondents who possess experience with HIV/AIDS tended to score moderately higher on the attitudes toward AIDS measure, based on the association between these two variables ($r=.37919$, $p = .00001$).

Breaking experience with HIV/AIDS into experience gained through coursework, personal experience and volunteer work, a significant difference was found between the respondents who possessed volunteer experience, and respondents without this experience ($t = 2.68$, $p = .009$, d.f. = 72). The results of a correlational analysis revealed that volunteer experience was associated with a moderate increase in attitude scores ($r = .3014$, $p = .00906$). Consistent with the research on HIV/AIDS, the findings of this study support the associations between the role of experience with HIV/AIDS, at least through volunteer work, and more accepting attitudes toward individuals with the disease. Gillman (1991) demonstrated similar results in her study of NASW members with experience working with HIV/AIDS, who expressed less negative attitudes toward individuals with the disease, and individuals at risk of becoming HIV positive.

Knowing someone with the disease.

The variable 'knowing someone with the disease' was also found to be significantly related to attitudes toward HIV/AIDS and individuals with the disease ($t = 3.66$, $p = .000$, d.f. = 121). There was a positive correlation between these two variables, indicating that individuals who have gained exposure to the disease through knowing someone with HIV/AIDS tend to have moderately higher scores on the attitudes measure ($r=.316$, $p =$

.00037). The relationship between these two variables offers further support that individuals who have previous experience with the disease, generally, have more positive or accepting attitudes toward the disease and individuals with the disease.

Attitudes and descriptive factors.

The relationships between attitudes and religion, spirituality, age, income, year in program, type of program, cultural background, and interest in HIV/AIDS were also explored. Whether respondents identified with spirituality did not result in significant differences in attitude scores (t = .67, p = .503, d.f. = 130). The variable 'religion' resulted in significant differences in attitude scores (t = 3.23, p = .002, d.f. = 129). An inverse relationship was found to exist between attitude scores and individuals who identified belonging to a specific faith group (r = - .273, p = .00159). The inverse relationship between attitudes toward HIV/AIDS and belonging to a specific faith group or religion has been supported in other attitudinal studies of HIV/AIDS. Frankel et al. (1992) demonstrated this relationship in their study of BSW students, where identifying oneself as "Christian" was significantly related to less appropriate attitudes. The inverse relationship between religion and negative attitudes toward HIV/AIDS has been attributed to the perceived connection between AIDS and homosexuality, and belief supported by many churches that some homosexual lifestyles are immoral (Frankel et al., 1992).

Significant differences resulted in attitude scores between individuals who are interested and those who revealed they were not interested in taking coursework related to HIV/AIDS (t = 3.01, p = .003, d.f. = 128). These two variables were found to be weakly and positively correlated (r = .25690, p = .003). Respondents who also selected HIV/AIDS as an area of professional interest realized significantly different attitude scores from the respondents who did not select HIV/AIDS as an area of professional interest (t = 4.66, p = .000, d.f. = 130).

One way ANOVA's were calculated to determine whether any differences existed in attitude scores across income levels, age groups, year in program and for cultural background. Significant differences were found to exist for attitude scores and income. The results of Tukey's HSD ($\underline{p} < .05$) revealed that respondents who identified their income as \$50,000 or greater per annum ($\underline{M} = 85$), had scores on the attitudes questions which differed significantly from respondents with income levels below \$20,000 per year ($\underline{M} = 97.35$) and respondents with incomes between 20,000 - 50,000 per year ($\underline{M} = 97.7$). An inverse relationship was determined between scores on the attitude measure and a reported income over \$50,000 per annum ($\underline{r} = -.2195$, $\underline{p} = .01178$). Generally, the higher the income the lower the score however, this finding should be interpreted with caution, given the small number of respondents who identified having an income of greater that \$50,000 per annum. No significant differences were demonstrated for attitude scores with respect to age ($\underline{F}$ (4, 128) = .5587, $\underline{p} = .6931$), year in program for either of the Fort Garry campus, or WEC ($\underline{F}$ (4, 128) = .0203, $\underline{p} = .9961$) or for cultural background ($\underline{F}$ (5, 95) = 1.117, $\underline{p} = .3572$). Similarly, Frankel et al. (1992) did not determine any significant findings for age and cultural background with respect to attitudes.

Attitudes toward contact with HIV/AIDS

The sub-scale of the attitudes instrument that measured comfort when in contact with HIV/AIDS was explored with additional descriptive variables.

Experience with HIV/AIDS.

Experience obtained through volunteer work with HIV/AIDS was the only variable from all three experience variables that resulted in a significant difference in comfort scores ($\underline{t} = 3.41$, $\underline{p} = .001$, d.f. = 72). Increased comfort with contact with HIV/AIDS was positively and moderately associated with volunteer work ($\underline{r} = .37295$, $\underline{p} = .001$). This finding is consistent with Wiener-Brawerman's (1988) finding on higher levels of comfort and previous work experience with the disease.

Interest in HIV/AIDS.

The results of a Student's t-test (excluding cases analysis by analysis) revealed significant differences in comfort level with contact with HIV/AIDS between individuals who identified HIV/AIDS as a field of interest and the respondents with no professional interest in the disease ($t = 4.92$, $p = .000$, d.f. = 130). The correlation between these two variables is moderate ($r = .3961$, $p = .00000$), suggesting that those who selected HIV/AIDS as an area of professional interest tended to score higher on comfort when in contact with HIV/AIDS.

Demographic variables

Comfort with HIV/AIDS was also found to significantly correlate with whether respondents' identified with a specific faith group ($t = 2.19$, $p = .03$, d.f. = 129). Belonging to a specific faith group was weakly and negatively correlated with comfort ($r = -.1895$, $p = .03015$). The variable 'spirituality' was not determined to be related to differences in level of comfort with HIV/AIDS ($t = .23$, $p = .819$, d.f. = 130). One way Anovas with Sheffe's Test ($p < .50$) did not reveal any significant differences for age, however, consistent with the findings for income and attitudes in general, respondents who reported higher levels of income over $50,000 per annum ($M = 17.5$) tended to report lower comfort when in contact with HIV/AIDS than did the respondents who identified incomes below $20,000 per year ($M = 25.7$) or between $20,000 and $50,000 per annum ($M = 25.9$). Again, this finding should be interpreted with caution, given the relatively few numbers of respondents who identified having an income greater than $50,000 per year.

Social Work Values and Additional Variables

Social work values were not significantly associated with knowledge of the disease ($r = .117$, $p = .190$). Sheffe's test ($p < .05$) did not reveal any significant relationships between social work values and age, income level or across cultural background. Similarly, t-tests did not reveal any significant differences in values scores for religion ($t = .62$, $p = .537$, d.f. = 124), spirituality ($t = .02$, $p = .981$, d.f. = 125), experience with HIV ($t = .23$, $p = .822$, d.f. = 125), knowing someone with the disease ($t = 1.11$, $p = .267$, d.f. = 117), and professional interest in the disease ($t = .01$, $p = .993$, d.f. = 125). Social work values scores were also not related to any other descriptive variable such as experience with HIV/AIDS, personal experience with HIV/AIDS, or interest in the disease at an alpha level of .05.

Knowledge and Additional Variables

Personal experience.

Student's t-tests were calculated to determine if any significant differences between knowledge scores, treated as a dependent, interval level variable, and independent nominal variables existed. Two tailed tests of significance were conducted, excluding cases analysis by analysis. The calculated t-test revealed no significant differences in knowledge scores between respondents who identified having previous experience with HIV/AIDS, and the respondents without previous experience with the disease ($t = 1.83$, $p = .069$, d.f. = 130). Experience obtained through coursework, personal experience, or experience obtained through volunteer work were explored with knowledge of the disease. No significant differences in knowledge scores were demonstrated between respondents who had taken courses and respondents without previous coursework ($t = .42$, $p = .677$, d.f. = 72), nor between respondents who had personal experience with the disease and respondents without personal experience ($t = 1.09$, $p = .280$, d.f. = 72).

Respondents with volunteer experience did not demonstrate significant differences in knowledge compared with respondents without previous volunteer experience (t= .95, p = .345, d.f. = 72). The instrument used to measure respondent's understanding of the disease may not have tapped into the types of knowledge that one with more experience with the disease may hold. Thus, a more discriminating test may have determined a significant relationship between these variables. The findings of this study are in contrast to those reported in studies by Gillman (1991), who determined a significant relationship between knowledge of the disease and training on HIV/AIDS issues. Similarly, Frankel et al. (1992) reported a weak, but significant relationship between personal experience with the disease and knowledge scores, from their first sample of BSW students.

The variable 'knowing someone with the disease' was also tested with knowledge scores to determine whether any significant difference existed between respondents who knew someone with the disease and respondents without this experience. The calculated t-test revealed that any difference between the two groups only approached significance (t = 1.93, p = .056, d.f. = 121). Similarly, no significant differences were revealed between respondents who belong to a faith group and respondents who did not report a religious affiliation (t = 1.35, p = .180, d.f. = 129). In addition, the knowledge scores of respondents who identified spirituality to be important in their lives and the respondents who did not, were not significantly different (t = 1.04, p = .300, d.f. = 130). The finding on religion differed from that reported by Frankel et al. (1992), who determined significant differences on the knowledge definition sub-scale between Anglican and Catholic respondents.

Interest in HIV/AIDS.

Significant differences in knowledge scores were revealed between individuals who were interested in taking the multi-disciplinary course in HIV/AIDS, and the respondents who did not have an interest in taking this course (t = 2.62, p = .01, d.f. = 128). Interest in coursework on HIV/AIDS was determined to be weakly and positively associated with knowledge scores ($r = .22594$, $p<.00974$).

Knowledge of HIV/AIDS and descriptive variables.

One-way ANOVA's were calculated to examine differences in knowledge scores for year in program, cultural background, age and income (independent variables). No significant differences were found for respondents at any level of the BSW or Premasters programs ($F(3, 129) = .9291$, $p = .4288$), nor were any significant differences in knowledge scores revealed across cultural background ($F(5,95) = 2.24$, $p = .057$). The findings regarding knowledge, cultural background and income are consistent with findings reported by Frankel et al. (1992).

Social Work Values Instruments: Validity and Reliability Findings

Several methods were undertaken to address the validity and reliability concerns of the values instruments. The findings of methods used to address the validity of the instrument, through pre-testing, content analysis of respondents' identified values, and a factor analysis are reported. Issues concerning the reliability of the instruments are also addressed.

Pre-Testing

The values instruments were pre-tested on a group of 5 social work masters students, who assessed the questionnaire for its face and content validity, clarity of the questions, and the time it had taken them to complete the values section of the survey. The students who volunteered to pre-test the questionnaire were provided with the definitions of the social work values, and asked to identify the value, or values inherent in each scenario. Questions were graded according to whether a case example strongly reflected a particular value, may have reflected a value, or weakly reflected a value. The five masters students were also asked to provide an open-ended answer to the open-ended case scenarios, and the forced choice case scenarios. Their answer choices were used to support or clarify the grading of the instrument.

The time for completion of pre-testing the values instruments varied from approximately 20 minutes to one hour. As time was considered a factor in the overall response rate for completion of questionnaires, three of the weaker open-ended questions were eliminated from the final instrument, as it was thought that it would take respondents too long to complete the surveys, and thus would negatively affect the response rate. The decision to eliminate questions was considered carefully with eliminating the variability of the instrument.

Minor modifications were made to item 1 on the open-ended instrument to enhance its face validity. Other minor modifications were made to the wording of the remaining scenarios to enhance their clarity, or validity. Overall, the pre-test results provided support for the face and content validity of the instruments, with the main value identified as the intended value in each scenario, which primarily was strongly reflected, and to a lesser extent, may have been reflected. Only three items out of the total of nine were identified by one pre-test subject to include a second possible value or underlying issue in the scenario.

Content Analysis Findings

The total of 126 respondents completed the open-ended values instrument. Respondents were asked following completion of each scenario, to identify the main value or dilemma in each scenario as a method of establishing validity for both of the open-ended and forced choice instruments (S. Frankel, personal communication, October 17, 1998).

The value definitions were used to code respondents' identification of the main value or issue in each scenario. Respondents were not expected to identify the exact name of the value that was used in this study. Few were able to articulate the value names of self-determination or social justice, however, the majority of respondents were able to identify 'confidentiality', which is consistent with the literature on social work values

(King-Pike, 1996). The values of social justice and self-determination were coded as such based on parts of their definitions. Respondents identified the main value using descriptive phrases of the value definitions which referenced a particular value. For example, phrases such as "should not discriminate", "equal access to resources" and "advocacy for social change" are reflective of the value of social justice, and are phrases that comprise the definition of this value.

Open-Ended Findings

The majority of respondents were able to correctly identify the main value inherent in both of items one and two, which deal with social justice and confidentiality, respectively. Greater variability, however, was demonstrated on item three, which deals with self-determination. Appendix G provides a listing of the value items in each scale.

Social justice.

The majority of respondents were able to identify the main value for Item 1 on the open-ended values instrument as social justice. Refer to Table 17 for a breakdown of responses for social justice. Almost 75% of respondents referred to social justice in their answer. Approximately 8% of respondents identified issues that may or may not have represented a social work value. Three respondents identified "confidentiality" as the main value inherent in the scenario however, in this item, confidentiality reflects an underlying issue, and a technicality with respect to the scenario, as greater support is identified for social justice as a main value. The response "best interest of the client" (2%) is not necessarily a value per se, but operates within each value to guide practice behaviors. Other responses such as "empathy" (2%), "providing care for job related dangers", and "how one feels toward individuals with AIDS" (each less than 1%) do not comprise social work values. Approximately 9.5% did not know the value, and 8% left the question blank.

Table 17

Response Categories for Open-Ended Value Items (n=126)

Social Justice Item 1 Identified Value	Count
Equality	41
Discrimination	14
Equal Access to resources	8
Moral Judgments/Victim Blaming	8
Equal Value and Worth	7
Advocacy for Social Change	5
Equal Rights/Human Rights	2
Egalitarianism	3
Fairness	3
Social Justice	2
Humanitarianism	1
Other:	
Empathy	2
Best interest of client	2
Confidentiality/Privacy	3
Freedom of Choice	1
Providing Care for Job Related Dangers	1
How one feels toward Individuals with AIDS	1
Don't Know	12
Blank	10

Confidentiality.

The least variability in responses was demonstrated for item two, where the main value inherent in the scenario was confidentiality. Refer to Table 18 for the breakdown of confidentiality responses. Over 80% of respondents identified the value as confidentiality, with 3% identifying "privacy", a related principle. Other identified values included "self-determination" (1%), and "respect" which underlies social work values in general. Approximately 5.4% of respondents identified "honesty" as the main social work value. Other responses that did not encompass a particular social work value included understanding and empathy. Approximately 3% of respondents were not able to identify the main value, and 6% left the question blank.

Table 18

Response Categories for Open-Ended Value Items (n=128)

Confidentiality Item 2: Identified Value:	Count
Confidentiality	100
Privacy	3
Other:	
Honesty	7
Self-determination	2
Professionalism	1
Respect	1
Empathy	1
Understanding	1
Don't Know	4
Blank	8

Self-determination.

Approximately 21% of the respondents surveyed were able to correctly identify the main value as 'self determination', or identified phrases that described this value, such as "autonomy", "respect for the client's choice" and 'empowerment/making an informed decision.' Table 19 provides a breakdown of these responses. Approximately 43% identified the main value as one concerning confidentiality verses the duty to warn the partner which represents an underlying issue. Approximately 3.5% of respondents identified the issue of "confidentiality vs. the client's intent to harm," however, the scenario did not reflect any intent of the client to harm his partner. "Fairness", "ethics", "harm to self or others," "honesty," and "keeping the situation open" were also identified. "Fully informed consent" was also identified as a main value (less than 1%), however, it was identified with respect to the partners' right, and the client's rights were not addressed. Approximately 10% could not identify the main value, and 18.25% left the question blank.

Table 19

Response Categories for Open-Ended Value Items (n=126)

Self Determination Item 3 Identified Value Categories:	Count
Self determination	19
Autonomy	5
Empowerment/Making an Informed Decision	1
Non - judgment/respect	5
Other:	
Confidentiality	14
Confidentiality vs. Duty to Warn	13
Safety/Rights of Partner	1
Protection of Life	20
Confidentiality vs. Client's Intent to Harm	1
Fairness	1
Ethics	2
Feedback	1
Harm to self or others	1
Fully informed consent	1
Keeping the situation open	1
Honesty	4
Blank	23
Don't Know	13

Forced Choice Instrument

The content analysis of the 128 completed cases of the forced choice values instrument provided support for the validity of this measure. The content analysis of the forced choice items resulted in less categories, and greater use of the value word itself compared to the open-ended items. Less categories may have resulted, as the provided answer categories operationalized the value reflected in each item, which may have provided respondents with a clearer sense of the issue inherent in each scenario. Refer to Appendix H for a listing of value items for this instrument.

Social justice.

Social justice was operationalized in questions 2 and 5. Only a small percentage of 122 respondents (3%) were able to identify the name of the value as social justice, however, the majority of the respondents (61%) used terms and phrases which defined the value and supported the validity of this item. Less than 1% of respondents identified the value as self-determination, and a small percentage (3%) identified "best interest of the client." Approximately 25% did not identify the value, and 4% identified that they did not know the value. Refer to Table 20 for a breakdown of responses to the social justice items.

The findings of item 5, provide support for social justice, the value inherent in this item, however greater variation in responses was evident in this item than in item 2. Over 50% of the respondents identified the inherent value in this item with terms such as 'advocacy' (20%), 'education/advocacy' (10%), 'rights' (5%), 'equality' (7.4%), 'equality of access' (4%), and 'preventing discrimination' (5%), which share the same meaning as social justice. Less than 3% identified the value inherent in the scenario as another value, such as self-determination or confidentiality. "Support" (6.5%) and "best interest of the client" (4%) were identified, however these define the actions that entail social work practice. 'Ethics' was used to describe the situation (less than 1%). Although not a value, the respondent understood that the situation had to do with 'ethics' which operationalize values. Other identified non-values included "empathy", "cooperation", and "conflict of interest" (each less than 1%).

Self-determination.

Variability in responses was also demonstrated for items 1 and 3 which dealt with self-determination. The majority of respondents for both items however, were able to use terms and phrases that represented the meaning of self-determination, or identify the value itself (item 1 30%, item 3 22%) which supported the validity of both of these items. Terms were used consistently across both of these items which reflected the meaning of self-determination such as "respect/support for the client's decision" (item 1 40%, item 3 15%), "autonomy" (item 1 4%, item 3, 9%). Greater variation was demonstrated in item 3 as more respondents identified underlying issues such as "prevention of HIV" (10%), "protection of unborn child" (5.8%), "honesty" (1.6%) and "empathy" (1.6%), for example. Overall support however, for the validity of self-determination was demonstrated for both items (73% for item 1, 47.5% for item 3). Although item 3 had a smaller percentage of respondents identifying the value as self-

Table 20

Forced choice Values

Social Justice

Item 2: (n= 121)		Item 5: (n = 122)	
Identified Value	Count	Identified Value	Count
Equality	32	Advocacy	24
Advocacy (advocacy for change)	15	Education/Advocacy	12
Preventing Discrimination/Educating	11	Equality	9
Equal Rights	9	Rights	6
Social Justice	4	Preventing Discrimination	6
Worth	3	Equal Access	5
Empowerment	1		
Other:		Other:	
Self-Determination	1	Self-Determination	2
Best Interest of the Client	4	Confidentiality	1
Integration	2	Support	8
Cooperation	1	Best Interest of Client	5
Safety	1	Humanism	1
Empathy	1	Quality of Life	1
		Empathy	1
Blank	31	Ethics	1
		Cooperation	1
Don't Know	5	Conflict of Interest	1
Don't Know	7		
		Blank	31

determination, the greater percentage of responses supported this value, as opposed to another construct. Refer to Table 21 for a breakdown of responses for these items.

Table 21

Forced choice Values

Self-Determination Item 1	(n = 126)	Item 3	(n = 120)
Identified Value	Count	Identified Value	Count
Self-Determination	37	Self-Determination	26
Respect/support for Client's Decision	50	Autonomy	11
Autonomy	5	Support/Respect Client's Decision	9
		Right to choose	9
Other:		Provide with further information	1
Protection of Life	8	Self Actualization	1
Respect for Human Life	1		
Quality of Life	1	Other:	
Hope	1		
Personal Feelings	1	Prevention of HIV	12
Blank	18	Protection of Unborn Child	7
Don't Know	4	Honesty	2
		Empathy	2
		Quality of Life	1
		Ethics	1
		Blank	29
		Don't Know	9

Confidentiality.

Items 4 and 6 which reflect confidentiality contained the least variability in identified value categories. Refer to Table 22 for confidentiality responses. The majority of respondents (over 81% for item 4, and 60% for item 6) were able to identify the value of "confidentiality" as reflected in each item. Approximately 4% identified "privacy" for item 4, a related concept to confidentiality. Only 2.3% of respondents reported that they did not know the value, and 12.5% of respondents did not identify any value.

Table 22

Forced Choice Values

Confidentiality: Item 4	(n=128)	Item 6	(n= 122)
Identified Value	Count	Identified Value	Count
Confidentiality	104	Confidentiality	73
Privacy	5	Privacy	1
Blank	16	Other:	
Don't Know	3		
		Confidentiality vs.	
		Duty to Warn	4
		Safety	12
		Prevention of HIV	3
		Integrity	1
		Work with Client's Fears	1
		Don't Know	6
		Blank	21

The categories identified for item 6 were less homogenous than those identified for item 4. Although the majority of respondents identified "confidentiality", or a related concept of "privacy", approximately 15.5% identified a safety issue such as duty to warn, safety, or prevention of HIV, which represent underlying issues in the scenario. Few respondents (5%) identified not knowing the value, and 17% left it blank.

Although some items presented with a degree of variability in response categories, the majority of respondents identified the value, or value meaning which was the intended value in each item, supporting the overall validity of both the forced choice and open-ended value instruments.

Reliability

The scoring of the open-ended value items, and coding of identified values was addressed through a review of each item on two separate occasions. The second review followed discussion of scoring and coding procedures with the primary advisor of this thesis. Recommendations of the primary advisor were implemented on the second review, which resulted in minor changes in the scoring procedure and interpretation of some of the responses to the values items. This method was deemed sufficient for the interpretation and coding of the data, as the open-ended responses were fairly concise, and categorization was relatively unproblematic.

Establishing the internal consistency of the instruments was more problematic. Parallel forms reliability was not possible to establish, given that the open-ended measure did not represent a parallel form of the forced choice measure. Using an alpha coefficient to establish the reliability of the forced choice instrument was also not practical, given that there were too few items per scale to provide for a reliable analysis. The reliability coefficient for the forced choice items was alpha = .34 ($\underline{n}$ cases = 124, $\underline{n}$ items = 6).

Factor Analysis

An exploratory factor analysis was conducted on the six forced choice items, and three open-ended items, following the content analysis and scoring of respondents' answers. Principle components analysis was selected for the analysis as it is more sensitive to all the variance in a score, including error and specific variance (Bryman & Cramer, 1997). The number of cases ($\underline{n}$=126) met the criteria for a principle components analysis, and the number of variables contained in each conceptualized scale also met the minimum criteria of three items (Bryman & Cramer, 1997). Correlational analysis of the items revealed that some were weakly correlated, and the relationship between these variables was significant at less than $\underline{p}$<.05., therefore, the principle components analysis was conducted. Three factors were retained with an Eigenvalue greater than 1, and were rotated using Varimax. The primary loadings were examined, and revealed that some of the items that were thought to conceptually represent the same scale loaded together, however, it is difficult to interpret the scale that the items in fact represent. Refer to Table 23 which lists the factors and their loadings.

Table 23

Rotated Factor Matrix

	Factor		
Value /Item	1	2	3
Confidentiality 4	.84	.03	.01
Confidentiality 6	.35	.32	-.19
Confidentiality 2	.14	-.10	.67
Self-Determination 1	.05	.62	.26
Self-Determination 3	.09	.73	.04
Self-Determination 3	-.08	.69	-.16
Social Justice 2	-.18	-.00	.59
Social Justice 5	.79	-.01	.11
Social Justice 1	.09	.14	.68

The first factor consists of confidentiality items 4 (.84), and to a lesser extent item 6 (.34 and the open-ended item 2 , .14). Using a minimal criterion for an item loading of .30, the last confidentiality item would not load on this factor. Factor 2 loads more consistently with all three self-determination items, item 1 (.60), item 3 (.73), and the open-ended item 3 (.67). Factor 3 consists of one confidentiality item (item 2, .67) which loaded weakly into Factor 1, and two social justice items, item 2 (.60), and the open-ended value item 1 (.68). The third social justice item (item 5, .78) loads better into Factor 1. Based on these initial findings, further clarification of the values scenarios is needed to address the validity of the instruments. Further development of additional items for the individual scales is also needed in order to increase the variability and enhance the interpretation and validity of the values instruments.

Summary

This chapter has presented the significant findings on relationships between the variables of attitudes, social work values, and knowledge of HIV/AIDS. The findings of some of these significant relationships are supported by the findings of other studies on social workers' attitudes toward the disease. Findings of the validity and reliability of the social work values instruments have also been reported in this chapter.

CHAPTER VI

INTERPRETATION AND IMPLICATIONS OF FINDINGS
SUMMARY AND CONCLUSIONS

Introduction

This study examined several variables related to attitudes toward HIV/AIDS and the role of social work values in educationally preparing respondents to work with individuals with this disease. The study explored the attitudes of 134 Bachelor of Social Work and Premasters students toward HIV/AIDS, and whether these potential social workers could identify and apply values to HIV/AIDS practice situations in a manner that upholds a value and is consistent with professional social work practice. Interpretations and discussion of the usefulness of these findings are presented in this chapter, along with implications for future research and the study's limitations.

Summary and Interpretation of Findings

Dependent Variables

Respondents' overall attitudes toward the disease including their attitudes toward individuals with the disease and towards contact with infected individuals, was positive or accepting, as was expected from a group of social workers. The greatest variation in responses to attitudes toward the disease and those with the disease however, was demonstrated on items that one would anticipate social work respondents would largely support. These issues regarded the rights of individuals with the disease, and included issues surrounding confidentiality, mandatory testing, and discrimination. Slightly higher numbers of respondents reported that they would be uncomfortable when contact with infected individuals became closer in distance, such as sitting next to someone with the disease. The reported discomfort of these respondents when in contact with the disease suggests that some may harbor irrational fears of contagion.

Respondents also appeared to be able to apply a social work value to a HIV/AIDS practice situation based on the scores on the values instruments, although many respondents were not always able to identify the main value at work in each scenario. Respondents demonstrated more difficulty in addressing a scenario when they were presented with an open-ended answer, than when they were provided with responses and had to choose from among a response that most upheld a value, a neutral response, or one that violated the value. Furthermore, respondents demonstrated the difficulty in prioritizing issues that needed to be addressed when handling situations. Their answers identified that it is difficult for some to handle situations in a manner that upholds values, when faced with competing ethical issues. Respondents who were able to correctly identify the main value in each scenario, either through the definition, or through articulating that value, were most likely to uphold the value when addressing the situation presented. This last point speaks to how learning of values, or ability to recognize and identify values is significant to how ethical dilemmas are addressed and has implications for how potential social workers are educationally prepared to deal with ethical situations in their work with HIV/AIDS.

The respondents in this study also demonstrated to be knowledgeable about HIV/AIDS, based on the findings reported in Chapter 4 of this thesis. The results of this study revealed the areas where respondents were likely to be least knowledgeable which included information regarding the incidence of the disease, the sub-populations most affected by the disease both locally and throughout Canada, and knowledge of resources for HIV/AIDS. These deficits are consistent with those identified in other studies of social work students and social workers (Peterson, 1992; Wexler, 1989).

Significant Findings

Several research questions were stipulated with respect to the role of these dependent variables and their relationships. Trends and patterns in the data are discussed in the subsequent paragraphs, and interpretations and conclusions are drawn from the findings on attitudes, social work values, and knowledge. Refer to Table 24 for a summary of the significant findings.

Attitudes and related variables.

Initially it was questioned whether respondents who demonstrated higher positive attitudes toward HIV/AIDS in general, would apply values in a manner more consistent with social work, and would have greater knowledge of the disease. Respondents' attitudes were measured toward the disease, and toward contact with infected individuals. Those with more accepting attitudes overall, tended to identify more strongly with the professional core social work values. Respondents who tended to demonstrated a positive attitude toward individuals with the disease also demonstrated a higher level of comfort when in contact with infected individuals. The sub-scale of the attitudes instrument on contact with infected individuals explained the relationship between attitudes in general toward those with the disease and social work values. The respondents who demonstrated more accepting attitudes toward contact with infected individuals, also demonstrated a tendency to apply values more consistently with professional expectations, and more accepting attitudes toward those with the disease. This finding suggests that comfort level is of significance to how the social work respondents in this study applied values to practice situations with HIV/AIDS, and in how they view individuals with the disease. While one's attitude toward contact with the disease does not necessarily speak to how they acquire values, it is related to how the social work respondents in this study applied those values to practice situations with HIV/AIDS, and their attitudes toward persons with the disease. One possible explanation for these relationships is that individuals who are likely to harbor less irrational fears of the disease, may also be less likely to judge those with the disease or view them in a negative manner, which is reflected in how they applied values to practice situations.

Table 24

Summary of Significant Findings

Dependent Variable	Independent Variable	Direction of Relationship	Significance of Relationship (r)
Attitudes	Knowledge	+	.3816
	Experience with HIV/AIDS	+	.379
	Volunteer Experience	+	.3014
	Knowing someone	+	.316
	Social Work Values	+	.2767
	Professional Interest	+	.378
	Religion	-	.273
Attitudes toward contact with infected individuals (sub-scale)	Attitudes	+	.67
	Values	+	.2464
	Experience (Volunteer)	+	.373
	Knowing someone with HIV/AIDS	+	.370
	Interest in HIV/AIDS	+	.396
	Knowledge	+	.29
	Religion	-	.185
Social Work Values	Field Placement		F (1,45) = 4.52
	Values Course		F (1, 118) = 9.22
Knowledge	Interest in Coursework	+	.257

Note. All relationships were significant at $p < .05$.

Respondents with more accepting attitudes were also more likely to have a greater understanding of the disease, volunteer or have personal experience, know someone with the disease, and possess a professional interest in working with HIV/AIDS. The plausible explanation for these relationships is that the respondents with more accepting attitudes toward the disease avail themselves to opportunities where they have exposure to HIV/AIDS, or to learn about the disease. It is equally plausible however, that respondents with greater knowledge of the disease have a better understanding of the facts surrounding the disease, or through experience, are less likely to view the disease in a negative manner. Interest in taking coursework in HIV/AIDS and professional interest in the disease were variables that were also associated with more accepting attitudes toward the disease. The respondents who identified with a particular religious affiliation however, tended to demonstrate less accepting attitudes.

Social work values.

Two additional variables produced significant findings with regard to social work values. Having taken a values course and a field placement produced main effects which speak to the role of both of these variables in learning of values. The values course and field placement were the only two variables associated with learning of values that produced significant findings, and although limited, these findings have implications for how respondents learn values in their social work education.

Knowledge of HIV/AIDS.

The respondents who demonstrated a greater understanding of the disease also tended to have an interest in HIV/AIDS coursework. Although the respondents who have experience with the disease are likely to report more positive attitudes toward HIV/AIDS, interestingly enough, these respondents do not necessarily have a greater understanding of the disease. These respondents however, had also not necessarily taken coursework in HIV/AIDS. Perhaps the respondents who demonstrated an interest in HIV/AIDS coursework were more receptive to information on HIV/AIDS presented through various mediums, which provides one possible explanation for greater understanding of the disease. Professional interest in the disease was not related to understanding of the disease.

Conclusions and Implications of the Study

The results of this study offer findings which identify some of the factors that are significantly related to attitudes. This study identified the relationship between attitudes and values, and the significance of attitudes toward contact with infected individuals. The findings related to social work values offer insight into how social work students can be prepared educationally to deal with practice situations related to HIV/AIDS in a manner consistent with the expectations of the profession, and have implications for social work practice with these clients.

This study also demonstrated the significance of other factors that are related to accepting attitudes toward the disease, and attitudes toward contact with those with the disease. In summary, the most important factors related to attitudes toward HIV/AIDS were identified as attitudes toward contact with infected individuals, social work values, volunteer experience, knowing someone with the disease and professional interest in the disease, and to a lesser extent, knowledge of the facts surrounding HIV/AIDS. Religion was also found to be an important characteristic of respondents that was negatively associated with attitudes. Each of these variables has implications for how students are prepared educationally for professional social work practice with HIV/AIDS.

Attitudes toward contact with infected individuals.

Respondents' comfort level has implications for how social workers are educationally prepared to deal with HIV/AIDS practice situations. The literature on HIV/AIDS identified that effective social work practice with clients can only occur when social work practitioners do not allow their biases and discomfort with the disease to interfere with their work. How can one be effective at addressing the issues surrounding stigma and isolation of those with the disease when they have fears of casual contact with infected persons? This is particularly relevant when the social work role has been carved out in the literature as one which shapes appropriate responses to the problems surrounding the disease.

The positive associations between comfort and the variables that have provided opportunity for contact with HIV/AIDS and their positive correlates with attitudes have implications for addressing social work students' fears of the disease. Approaches where social work students have an opportunity for direct contact with those with the disease, could be effective for addressing their discomfort, and misconceptions that are held about individuals with the disease. The respondents in this study demonstrated insight into how some of these concerns could be addressed. Approaches such as bringing in speakers with HIV disease or AIDS to share their personal experiences, through volunteer work, or through integrating work with HIV/AIDS through field placements or the field of focus course, are methods for overcoming some of the anxiety or fear surrounding contact with infected individuals. Integration of more personal contact with the disease through the core social work curriculum is an area that should be potentially explored.

Attitudes toward HIV/AIDS and social work values.

The attitudes instrument identified issues relevant to HIV/AIDS that demonstrated mixed opinions from the respondents in this study. Issues which impact the rights of infected individuals such as confidentiality, contact tracing, mandatory testing, professionals' right to refuse treating an infected person, and denying infected individuals access to opportunities, are relevant to social work practice with HIV/AIDS. These areas reveal issues that social work students should potentially explore in class discussions. As many of these issues regard policy work which can potentially impact individuals with the disease, greater opportunity for students to discuss and clarify issues and values around these items should be integrated and explored in their policy courses.

The associations between social work values and attitudes toward the disease, suggests that ways in which respondents can learn and incorporate values into their belief system are significant to HIV/AIDS education. The variables which were identified as significant to social work education, such as the course where respondents learn values, and having taken a field placement where respondents learn to apply values to practice situations, speaks to the importance of these variables in not only learning of values, but for preparation for work with HIV/AIDS. Incorporating HIV/AIDS material directly into coursework where learning of values occurs would provide opportunities to clarify values and attitudes toward HIV/AIDS, would introduce students to practice situations with HIV/AIDS and define and solidify the social work role with the disease.

The incorporation of HIV/AIDS related scenarios in this study also revealed that many of the respondents demonstrated difficulties in handling ethical dilemmas. Prioritizing practice principles and values that pertain to ethical decision making with clients was not always readily apparent in this study. This finding suggests that learning of values should also incorporate situations where students have opportunities to work with complex practice situations where they are faced with ethical dilemmas. How do social workers handle situations where inherent or systemic policies or practices can lead to discrimination of individuals with the disease? How do they work with clients who do not want to disclose their HIV status to others who may be affected by their disease? Should a social worker support a person who wants to end their treatment? These present just some of the conflicts surrounding HIV/AIDS that are not easily answered. The implications of this study suggest that learning of values should incorporate greater discussion around these situations. Opportunities to operationalize these values through discussion in class settings would allow for greater understanding of the issues relevant to HIV/AIDS, as well as discussion of the affects of decision making around ethical dilemmas with these clients.

Many respondents also identified on their surveys that they were not aware of their "legal responsibility" to an HIV/AIDS client. Learning of values around HIV/AIDS should also incorporate information regarding the legal responsibilities of social workers. The level of discrimination that has resulted from breaching confidentiality, contact tracing, and issues surrounding right to die, are of particular relevance to work with HIV/AIDS. Integrating policy information of local laws and the legal responsibilities of the profession in course work is an area that should be potentially explored more fully.

Finally, the respondents who identified belonging to a specific faith group tended to demonstrate less positive attitudes toward the disease, and a preference for greater distance from those with the disease. This finding has implications for how social work education can address more negative attitudes that may be influenced by a particular religious ideology. Provision of information that addresses the moral undertones of the disease, or clarification of personal and professional values in coursework would provide opportunities for students to address some of the biases or negative beliefs surrounding the disease.

Understanding of HIV/AIDS.

The findings of this study suggest that those with a greater understanding of the disease will have more accepting attitudes and less preference for social distance when in contact with the disease. Social work education that provides information on the disease to students has implications for both attitudes and comfort with the disease. This study also has implications for the types of information that would be useful for increasing knowledge of HIV/AIDS. While the respondents in this study were knowledgeable about the facts related to transmission of the disease, treatment and diagnosis, they were less knowledgeable about the affect of the disease on minorities, and funding for the disease. These are important areas which have direct relevance to social work practice with clients. Given the mandate of the profession, and that many of the respondents in this study will have an opportunity to interact with these clients in a professional manner, knowledge of the basic facts represents a starting place for understanding the disease and how to best assist these clients. Social work education which goes beyond provision of the basic facts surrounding the disease provides an avenue for students to acquire further understanding of the disease that more readily impacts clinical and policy work, in addition to addressing some of the negative beliefs and level of discomfort held by some.

Strengths, and Limitations of the Research

There are several strengths and limitations of this research. It was identified that the method of research employed in this study had several strengths. First, survey research made it possible to reach a large portion of the student population and gather a large amount of data on many different constructs. The use of a survey provided greater flexibility than other methods of research and enhanced the flexibility in the analysis of the data. The Faculty of Social Work has students from varying cultural backgrounds who may use English as a second language. Surveys provided them with greater flexibility in completing the surveys, as respondents could complete the surveys in their own time. The use of survey research also enhanced the measurement of concepts, as concepts had to be clearly defined, and the constructs and questions incorporated into this study were developed in a manner that was applicable to all respondents. Survey research also facilitated reliability in that the results did not rest on observations alone. Furthermore, the surveys also promoted honesty through anonymity which was necessary for this type of research as it touched on sensitive issues.

While the above points represent strengths of survey research, they also contributed to several weaknesses. The surveys did not allow for respondents to share in great length their personal experiences with the disease, as most of the questions were closed-ended. A further limitation stemmed from the method of data collection which may have introduced a response bias toward individuals with positive attitudes toward the disease. Although a large number of the sample population were involved with work in HIV/AIDS, which suggests that these respondents were in some way more inclined to participate in the research, the majority of the student body (268 out of 291 students enrolled in the BSW and Premasters programs) were provided with an opportunity to participate of which 50% chose to be a part of the research. This response rate was identified as constituting an adequate sample (Rubin & Babbie, 1993, Grinnell & Williams, 1990). Furthermore, the findings of this study are consistent with those reported by Frankel et al. (1992) who employed a larger sample (218 students in their first sample) in their study. While there is no reason to believe that the results of this study cannot be generalized to the student body as a whole, and to other schools of social work, further study would be necessary to investigate the attitudes and values of other social workers across the country.

Another limitation of this study stems from the instrument used to measure knowledge of the disease. Respondents' performance on the knowledge instrument demonstrated that the majority possessed an understanding of the disease. The results of the knowledge scores in this study also demonstrated that the test was not very discriminating. This is reflected in the fact that almost 70% of the sample achieved scores within the moderate to high cut-off ranges, indicating that the test either was too easy, or that these respondents knew all about the disease. It was anticipated that social work students would have a higher level of knowledge about the disease, given that from the start of education in their discipline they are taught to have an awareness of their biases, and enhanced sensitivity to issues that are of concern. This may have influenced their performance on this instrument, which may account for the low reliability rating reported on this sample in Chapter 4, compared to that reported by Goh (1993). While the analysis of co-relations of knowledge with other variables in this study does provide significant findings, incorporating information that would present students in this faculty with a more challenging assessment of their knowledge may provide for more meaningful results.

A further limitation of this study entails the findings of the principle components analysis of the values instruments. The low loadings on the factors indicate that further work is required to develop the existing scenarios, and additional items to increase the variability of the instrument. The development of scenarios that measure values as they apply to HIV/AIDS has proved to be a difficult process, as the challenges that HIV/AIDS presents to social workers are complex with many underlying issues. Use of scenarios such as these also involves the perceptions of respondents, which is a factor limiting the validity of the instruments.

The last limitation of this research stems from how values were operationalized in this study. Although this study demonstrated that the majority of respondents could apply values to HIV/AIDS practice situations, it does not guarantee that these respondents will behave in the same manner if confronted with similar situations in actual practice settings. Given the limitations of measuring actual practice behaviors through observation, the use of this measure was an effective method for capturing some information on respondents' behavior in practice settings.

Implications for Future Research

This exploratory study provided a basis for understanding potential social workers' attitudes, knowledge and values and also revealed several issues and opportunities for further research. These opportunities have implications for both social work education, and social work practice with clients.

Although this study did reveal that respondents could identify and apply values to practice situations, and there are certain characteristics of these students associated with higher values performance in relation to a HIV/AIDS situation, it was not the focus of this study to determine how students acquire values in social work education. This research only touched on areas that were thought to be related to learning of values. The literature on social work values identifies that learning of values is a complex and not thoroughly understood process. In order to more fully understanding the role that values play in relation to practice behaviors with clients, and the attitudes of professional social workers toward stigmatized populations, further investigation is necessary to understand how values are acquired, and the impact that social work education has on values.

Social workers and social work students' attitudes have not been an area of study that has been well investigated in the current literature on HIV/AIDS. As this was an exploratory study, the focus of this research was not to establish cause and effect or to determine whether comfort causes one to have a positive attitude or whether a positive attitude leads one to be more comfortable with HIV/AIDS. Identifying the variables that influence attitudes is an area that can be more fully examined and researched through use of experimental design or more rigorous controls. Further studies that evaluate the effects of comfort, and learning of social work values would allow for greater understanding of our professional preparation to work with HIV/AIDS.

Closing Statement

This exploratory study identified the relationships between attitudes, values, knowledge, and additional factors that are related to HIV/AIDS. Based on the findings of this study, it appears that social work students who possess the least negative attitudes toward HIV/AIDS are those who are more comfortable with contact with the disease, are knowledgeable about the disease, probably have volunteered or have personal experience with the disease, and have a professional interest in working with the disease. These students also possess values that more highly reflect the values of the social work profession and are not likely to identify with a specific faith group or religion. Thus, these characteristics have implications for how students in the program learn about the disease, and are educationally prepared for work in this area.

The majority of respondents in this study held appropriate attitudes, knowledge and understanding of values, however, they also demonstrated that further learning and preparation is required to fully understand and fulfill the social work role with HIV/AIDS. The literature has outlined a clear mandate for the role that social work should play in the HIV/AIDS epidemic. Consistent with this mandate, it is important that all social workers, and potential social workers, examine their personal values and beliefs, and reinforce positive attitudes toward those with the disease. It is identified in the literature, that "until AIDS is looked at in the same way as other life threatening diseases, society will be inhibited from developing policies and practices that will stem the disease and provide for humane treatment of persons suffering from or at risk of AIDS" (Doka, 1997, p. xiv). This personal examination of values and beliefs, and taking a proactive approach in our future work as social workers, are steps toward addressing the negative perceptions, attitudes and inequities that have surrounded individuals with this disease. It is hoped that this exploratory study will provide a basis for future HIV/AIDS related research at the Faculty of Social Work, to enhance both, our understanding of HIV/AIDS, and our professional role with the disease.

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Appendices

Appendix A

List of Terms

(Sources: Canadian AIDS Society, 1998; Rathus et al, 1997).

Acquired Immunodeficiency Syndrome (AIDS): Condition caused by the human immunodeficiency virus that destroys the immune system so that the body is stripped of its ability to fight life-threatening diseases.

Human Immunodeficiency Virus (HIV): Sexually transmitted virus that destroys white blood cells in the immune system, leaving the body vulnerable to life threatening illnesses.

Homophobia: The negative attitudes and feelings toward gay people, which include intolerance, hatred, and fear.

Opportunistic Infections: The diseases that occur when the immune system is weakened and unable to fight them.

Kaposi's Sarcoma (KS): Type of opportunistic disease that results when the immune system fails. KS is a form of cancer of the capillaries characteristic of lesions that appear of the feet, legs, or soft palate of the mouth and in the internal organs.

Pneumocystis Carinii Pneumonia (PCP): Pneumonia caused by a fungus that grows in the lungs of people infected with HIV disease.

Wasting Syndrome: Severe weight loss which can result in the loss of healthy muscle mass and can occur in the absence of other infections.

Appendix B

A Study of Student' Values, Attitudes, and Knowledge About HIV/AIDS: Participant Information Sheet

Dear Fellow Student:

I am an MSW student at the Faculty of Social Work, University of Manitoba and I am conducting a study which explores the nature of student preparation at the Faculty of Social Work for dealing with issues surrounding the HIV/AIDS. I am interested in exploring the relationship between Values, Attitudes and Knowledge of HIV/AIDS. The proposal for this study has been approved by my thesis committee, the Ethics Review Committee at the Faculty of Social Work, and Don Fuchs, Dean.

Your participation in this study is voluntary. As a respondent in this study, you will be required to share information related to your beliefs and knowledge about HIV/AIDS, as well as social work values. Your involvement in this study requires an approximate thirty (30) minute time commitment and there is no financial cost for involvement in this study. This study and your decision to participate in the study will not affect your course grades or academic standing at the University of Manitoba.

Involvement in this study is also anonymous: you are asked not to provide your name or other information that would allow you to be personally identified. The information obtained by students will be aggregated, therefore, there is no way that responses of individual students can be identified in the study. As a respondent in this study, you can withdraw your participation in this research at any time prior to completing the questionnaires or during the completion of the questionnaires.

Completion of this masters thesis is under the direct supervision of Dr. Laura Taylor and Prof. Sharon Taylor Henley at the Faculty of Social Work, and Dr. John Schallow of the Faculty of Psychology.

Susan Podolsky-Scarth

____________________ Date____________________

Appendix C

Survey Research on HIV/AIDS and Social Work Values:
Pre-test Participant Information Form

Dear Fellow Masters Students:

I am presently working on my thesis for completion of the Masters in Social Work Program at the University of Manitoba. I am working with Dr. Laura Taylor who is my primary advisor, as well as Professor Sharon Taylor Henley at the Faculty of Social Work, and Dr. John Schallow from the Faculty of Psychology (Clinical) at the University of Manitoba.

My thesis consists of survey research exploring the Bachelor of Social Work and premasters students' attitudes toward HIV and AIDS, and the social work values. For this research, I have prepared a survey which taps into various constructs related to HIV/AIDS, as well as social work values. I am in need of some assistance in pre-testing this survey on its face, content, and construct validity, and assessing it for ambiguous, or double barreled questions that the respondents in this survey may find confusing.

I will be asking several masters students to fill out a questionnaire and assess it for its validity and clarity. These students will be provided with a copy of the survey, a sheet containing instructions for the pre-test, definitions of the constructs that I have included in the survey, as well as an envelope to store the survey. It will take approximately one hour to complete this pre-test, which can be done at a time of your convenience, and in the setting of your choice. There is no financial cost to you for completing this survey. Your names as subjects in this research will be held confidentially. Any suggested changes will be incorporated into the original questionnaire, however these will be anonymous, and will not be reported in the findings of this study. I hope to begin this study by mid October, 1998.

Thank you for taking the time to consider this request.

Susan Podolsky-Scarth, MSW Student.

Appendix D

Survey Research on HIV/AIDS and Social Work Values:
Pre-test Participant Consent Form

In signing this consent form, I __________________________________, am giving my consent to participate in a pre-test of a survey that will be used in a study which explores the relationship between Bachelor of Social Work and Pre-Masters students' attitudes toward the Human Immunodefiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS) and Social Work Values. This study is for completion of the requirements of a Master of Social Work Degree by Susan Podolsky-Scarth and the proposal for this study has been approved by her thesis committee, the Dean of Social Work, as well as by the Ethic Review Committee at the Faculty of Social Work.

I understand that my participation is voluntary, and my involvement in this study will require approximately one hour to assess the survey on its face, content, construct validity, and for ambiguous or double barreled questions. I understand that I can complete this pre-test at a time of my convenience, in my chosen setting and that there is no financial cost to me for my involvement in this study. I understand that my participation in this pre-test will not affect my academic standing at the University of Manitoba.

The results of this study and the survey itself will be published, however, it will be identified in the study that the survey was pre-tested by a group of masters students at the Faculty of Social Work, University of Manitoba. I understand that my involvement in this pre-test is confidential and no information will be published that will reveal my personal identity. I understand that my input into the questionnaire is anonymous, and will not be reported in the findings of this research. As a subject in this study, I can withdraw my participation in this research at any time by notifying Susan Podolsky-Scarth.

Completion of this masters thesis is under the direct supervision of Dr. Laura Taylor and Prof. Sharon Taylor-Henley at the Faculty of Social Work, and Dr. John Schallow of the Faculty of Psychology (Clinical). I understand that I can contact Susan Podolsky -Scarth if I have any questions about the survey or study, or should I wish to obtain the results of this study.

I agree to participate in this study freely.

____________________ _________________________

Date Respondent's Signature

____

Researcher's Signature

Appendix E

When filling out this questionnaire, please answer all of the questions in each section. Do not skip any questions unless they are specified as 'optional'.

Section I:

In this section, please read each question, then respond to the following items on a 5 point rating scale. Circle (SA) if you strongly agree, (A) if you agree, (UD) if you are undecided, (D) if you disagree, or (SD) if you strongly disagree with each statement. There are no right or wrong answers to these questions as it is your opinion that is important in this study.

1. There is no need for the average person to become concerned about AIDS.	SD	D	UD	A	SA
2. The names of individuals with AIDS should be kept confidential in order to protect them against discrimination.	SD	D	UD	A	SA
3. If it is meant to be that I get AIDS, there is nothing I can do to prevent getting the disease.	SD	D	UD	A	SA
4. More government funds should be spent on providing support services for people with AIDS.	SD	D	UD	A	SA
5. I would avoid having contact with persons who have AIDS.	SD	D	UD	A	SA
6. A doctor should have the right to decide if he or she wants to treat patients with AIDS.	SD	D	UD	A	SA
7. I would feel embarrassed if one of my family members had AIDS.	SD	D	UD	A	SA
8. It's important to exercise safety precautions in one's sex behaviors in order to prevent AIDS.	SD	D	UD	A	SA
9. Children with AIDS should be allowed to attend school with children who don't have AIDS.	SD	D	UD	A	SA
10. There should be separate public facilities (i.e. rest room toilets) for people with AIDS.	SD	D	UD	A	SA
11. Everyone should be tested for HIV/AIDS infection.	SD	D	UD	A	SA
12. AIDS is the omnipotent's way of punishing homosexuals.	SD	D	UD	A	SA

13. Everybody should know something about HIV/AIDS. SD D UD A SA

14. Reckless intravenous drug users should change their drug use habits in order to prevent AIDS. SD D UD A SA

15. An employee who has AIDS should not be allowed to work. SD D UD A SA

16. I have great sympathy for people who suffer from AIDS or AIDS related dementia. SD D UD A SA

17. Knowing more about HIV/AIDS will cause less fear about the disease. SD D UD A SA

18. Children should be educated about AIDS to protect them through their lives. SD D UD A SA

19. A doctor may inform, without the consent of the AIDS patient, a sexual partner that he or she is as risk of HIV infection. SD D UD A SA

20. AIDS can be prevented by taking proper procedures. SD D UD A SA

21. Research on AIDS should be a priority for government funding. SD D UD A SA

22. I often read information about AIDS. SD D UD A SA

23. There should be separate public facilities (i.e. rest room toilets) for people with AIDS. SD D UD A SA

24. If I had a choice, I would work with clients who were diagnosed with HIV/AIDS. SD D UD A SA

25. I would be comfortable if persons with HIV/AIDS lived in my neighborhood. SD D UD A SA

26. I would be comfortable living next door to a person with HIV/AIDS. SD D UD A SA

27. I would feel comfortable working in an environment where there was contact with HIV infected clients. SD D UD A SA

28. I would experience discomfort sitting next to a person with AIDS. SD D UD A SA

29. Only social workers who work in health care settings or those who work with HIV/AIDS clients directly should be concerned with HIV/AIDS issues. SD D UD A SA

30. HIV/AIDS has received considerable government funding. Do you feel that other health care issues have suffered as a result of how funding has been allocated?	SD	D	UD	A	SA

If you believe that other areas in healthcare have suffered, please specify what other areas should receive more financial support.

____

____

____

31. Social work involves practice with many different groups of people. For the following question, please rank your preference for working in the various practice areas. Mark your preference, with (1) for
your first preference and (4) for your least preferred area of practice.

____ child protection.

____ counseling perpetrators of violence.

____ HIV/AIDS.

____ probation with sexual offenders.

____ palliative care.

Please turn the page

Section II:

This section requires you to answer some factual questions on HIV/AIDS. Please read the following questions, and answer the items as true or false. Circle T if you believe the statement is True and F if you believe it is False.

1. Hemophiliacs can get AIDS.	T	F
2. AIDS is an epidemic.	T	F
3. Only homosexuals get AIDS.	T	F
4. The virus that causes AIDS is called the Human Immunodeficiency Virus (HIV)	T	F
5. The AIDS virus can remain infectious outside the body for up to ten days if it is at room temperature.	T	F
6. One can get AIDS by sharing a meal with a person who has AIDS.	T	F
7. People who have AIDS do not develop cancer.	T	F
8. Today, blood supply in hospitals and blood donation centers is screened for the AIDS virus.	T	F
9. Impaired memory and concentration and motor deficits may occur in some AIDS patients.	T	F
10. One can get AIDS by sharing drug needles.	T	F
11. The AIDS virus may live in the human body for years before symptoms appear.	T	F
12. One can get AIDS from receiving blood or sperm from a donor who has AIDS.	T	F
13. By using a condom when having sex, one is always safe from contracting AIDS.	T	F
14. The HIV test is a blood test which can tell if a person has AIDS.	T	F
15. There is a cure for AIDS.	T	F

16. Persons who are diagnosed with AIDS will experience symptoms such as:		
- swollen lymph nodes,	T	F
- fatigue,	T	F
- fever,	T	F
- night sweats	T	F
- weight loss.	T	F
17. One can get AIDS by having sexual intercourse with an infected person.	T	F
18. AIDS is spread by sneezing, coughing or touching.	T	F
19. One can get AIDS by having sex with someone who uses intravenous drugs.	T	F
20. AIDS can be spread by having contact with towels or bed linens used by a person with AIDS.	T	F
21. More women than men have been infected by the AIDS virus.	T	F
22. About 50,000 people in Canada have been infected with HIV.	T	F
23. The majority of funding for HIV/AIDS in Manitoba is provided by the provincial government.	T	F

For question 24, please put an 'X' in the space beside the group(s) you believe best answer(s) the question.

24. Which of the following groups experience the fastest rising incidence (number of new cases within a twelve month period) of HIV disease? Please indicate the group (s) with an 'X'.

____ heterosexual women who are IV drug users.

____ women who are lesbian

____ hemophiliacs

____ aboriginal people.

____ men who have sex with men

Section III:

This section of the questionnaire requires you to read several case scenarios. Read each scenario carefully. Following each scenario, you will be asked to respond to "what action should be taken by the social worker in this situation?" Please respond to this question in one or two lines. When answering these questions, your professional opinion as a social worker is the standard you should use. Each scenario contains enough information for you to decide how the social worker should respond. Base your answer on the information that is provided. Once you have responded to the scenario, please identify the main social work value inherent in each item. Each scenario should not take you more than 1-2 minutes to complete.

Case scenarios:

1. Steve, a social worker in a large community agency was asked to review a report that proposed allowing individuals who contract HIV in health care occupations to receive enhanced benefits under the employer's insurance plan. Individuals who contract HIV through unprotected sexual intercourse or IV drug use would have access to existing benefits under the plan, but not enhanced benefits. Steve must respond to the report.

What action should be taken by the social worker in this scenario?

____

____

What value is inherent in this scenario? ________________________

2. Anne is a counselor in an addictions facility and volunteers at an HIV/AIDS clinic two nights a week. She discovers that one of the clients who has been receiving counseling at the clinic for a diagnosis of HIV infection has applied for a job at the addictions facility. Prior to his interview with Anne's supervisor, the client says hello to Anne in passing. Later, Anne's supervisor asks her how she knows the candidate.

What action should be taken by Anne, the social worker in this scenario?

____

____

What value is inherent in this scenario? ________________________

3. Jane is a social worker who has been working with Tom, a 20 year old gay man. Tom has found out that he is HIV positive, and he has been working with Jane for several weeks to explore whether he should tell his partner, who is not HIV positive. Tom is knowledgeable about HIV and usually practices safe sex. Tom feels that he has explored his decision and its potential impact on his relationship with his partner. Tom has told Jane that he has decided that he does not want to tell his partner about his HIV status. He would like Jane to provide him with some feedback on his decision.

What action should be taken by the social worker in this scenario?

What value is inherent in this scenario? ______________________________

Please turn the page

Section IV:

In this section, please read the following case scenarios and the actions that are provided under each scenario. Circle the answer (either the action itself or the corresponding number to that action) which you believe best reflects how the social worker in each scenario should handle the situation. After you have selected an answer choice from the response categories, please identify what social work value is inherent in the scenario. When answering these questions, your professional opinion as a social worker is the standard you should use for choosing an answer. Each scenario contains enough information for you to decide how the social worker should respond. Base your answer on the information that is provided. Each scenario should not take you more than 1-2 minutes to complete.

Case Scenarios:

1. Terry is a social worker who works with terminally ill AIDS patients. She has been working with Bob, an adult client who has been suffering with AIDS related illnesses for the last six years. Terry and Bob have been working extensively to explore issues around his decision to terminate his treatment. Bob is fully aware that he will be severely jeopardizing his health. Bob has considered his decision carefully, has discussed this with his family, and has decided to terminate the treatment. Would you advise Terry to:

1 - Tell Bob that she will support his decision at this point.

2 - Tell Bob to work with her for a few more sessions and try to convince him to change his mind.

3 - Tell Bob that she could not work with him anymore and refer him to someone else.

What value is inherent in this scenario? ______________________________

2. Christine, a school social worker has learned that some of the parents in the community are upset that a child who was diagnosed as HIV positive would be attending classes. In order to allay the concerns of these parents, the school proposed that the child could attend classes at the school, but would not be allowed to participate in certain activities such as physical education, or organized sports which are supervised. Participation in these activities would not pose a risk to other students, but the school feels this is a reasonable precaution. Christine has been working with the parents and is aware that they are upset with the school's proposed plan that would not allow their child to participate in all activities. They feel the plan is unfair as it treats their child differently. Would you advise Christine to:

1 - Suggest that the parents find another school.

2 - Actively work with the school to change the proposed plan for one that allows full integration.

3 - Suggest to the parents that the plan is the best they can expect the school can do.

What value is inherent in this scenario? ______________________________

3. Linda is a social worker who works in a family therapy center. She has been working with Maria, a client who has tested HIV positive, and her husband Jim. Maria and Jim both want a baby, however, they have been having difficulty in deciding whether to start a family. Both Maria and Jim have been aware of Maria's HIV status for two years. Maria has been taking HIV medications. She had discussed this issue with her physician, who has advised her that there is some risk, even while being on the medication, that HIV may be passed to her baby, but there are precautions that can be taken to try to prevent this. They had explored adoption for a considerable amount of time, however, they had decided that this was not an option for them. After lengthily consideration they had informed Linda that they had decided to have a baby. Would you advise Linda to:

1 - Tell Maria and Jim that you support their decision to try to have a baby.

2 - Tell Maria and Jim that you cannot work with them anymore, and refer them to someone else.

3 - Advise Maria and Jim to avoid pregnancy because of the risk of HIV transmission to a developing fetus, and try to convince them to explore adoption further.

What value is inherent in this scenario?______________________________

4. Cheryl is a social worker in a local community hospital who provides counseling to some of the students who are working at the hospital as part of their degree requirements. She has been counseling a medical intern, Ron, who has been having difficulty coping with his recent diagnosis of HIV infection. Cheryl had received a phone call from Ron's clinical supervisor who was aware that Ron was seeking counseling with her, and was concerned about his performance in the internship program. During the conversation, the clinical supervisor inquired if Ron was sick. Would you advise Cheryl to:

1 - Agree with the clinical supervisor that there is something wrong, but do not disclose the details of the case.

2 - Explain that she is not at liberty to discuss Ron's situation with the clinical supervisor, without a release of information from Ron, and suggest that he talk to Ron directly.

3 - Explain to the clinical supervisor that Ron has been diagnosed with HIV infection and is having difficulty coping.

What value is inherent in this scenario? ______________________________

5. Jerry is a social worker who works with AIDS patients. He has recently learned that the residents in a neighborhood are organizing to take action against a proposal for a residential hospice in their neighborhood for patients who have AIDS. There are limited residential supports and if implemented, this would be the first residential AIDS facility in this part of the community. Several of Jerry's clients would be potential referrals to such a facility. Would you advise Jerry to:

1- Suggest that the hospice be centered in another neighborhood.

2 - Remain passive to the residents organizing against the hospice.

3 - Actively work with the residents to have the AIDS hospice established in the neighborhood.

What value is inherent in this scenario? ______________________________

6. Mary is a social worker at a local clinic that is known for its work with HIV/AIDS. Mary has been encouraging Pat, a client to inform her husband, Ed, of her HIV status, and to abstain from unsafe sexual activity with him. As of their last session, Mary was aware that Pat had not informed her husband of her HIV status. One afternoon, prior to seeing Pat, Mary was contacted by Pat's husband who asked if there was anything that he should be concerned about. Would you advise Mary to:

1 - Tell him that everyone should practice safe sex

2 - Tell him that he should be concerned.

3 - Tell Pat's husband that you are not at liberty to discuss Pat with him directly and advise him to speak with Pat.

What value is inherent in this scenario? ____________________________

Please turn the page

Section V:

As a participant in this study, I would like to find out more about you. Please put an X or check mark in the appropriate box following each question. Please answer all of the demographic questions, unless they are specified as optional.

1. Program BSW _____ Premasters _____

Year in program:
First _____
Second _____
Third/Fourth _____

2. Age: (please specify your age)
17-23 _____
24-30 _____
31-37 _____
38-44 _____
45-on _____

3. Income: please specify your income:

Below 20,000 per year _____
20,000-50,000 per year _____
50,000 and up per year _____

4. Are you a member of a faith group?
Yes _____
No _____

5. Does spirituality represent a large part of your life?
Yes _____
No _____

6. Have you taken Introduction to Social Work Practice (47.314 or 47.405 for premasters students)?
Yes _____
No _____

7. Have you taken at least one Field Placement (47.315 , 47.312, or 47.412)?
Yes _____
No _____

Are you currently enrolled in a Field Placement?
Yes _____
No _____

8. Do you have prior experience with HIV/AIDS issues?

Yes _____
No _____

If "YES" please specify in what way you gained this experience:

_____ course work
_____ volunteer work
_____ professional experience
_____ personal experience
_____ other (Please specify)

9. Please check off the area(s) of professional interest to you:

child protection ______
HIV/AIDS ______
palliative care ______
aging ______
addictions ______
vocational rehabilitation ______
mental health ______
family violence ______

10. What do you think would adequately prepare students to deal with HIV/AIDS related issues in clinical practice ?

____
____
____
____
____

11. Would you be interested in taking a multidisciplinary course on HIV/AIDS at the University of Manitoba as part of your degree requirements?

Yes _____
No _____

Questions 12 and 13 are optional:

12. What is your cultural background? ______________________________

13. Do you know someone who is HIV positive or has AIDS?

Yes _____
No _____

If "YES" Is this person male or female? Please circle. Male Female

Please include your comments with respect to completing this questionnaire:

____

____

____

____

____

____

THANK YOU FOR YOUR PARTICIPATION IN THIS SURVEY.

Appendix F

Instruction Sheet For Pre-Testing

Dear Masters Student:

Your participation in this study on Social Work values and attitudes toward HIV/AIDS is greatly appreciated. I have enclosed a copy of the questionnaire for your reference, along with definitions of the three values that I have selected to use in this study. Please review the sections of the questionnaire that address Social Work Values (Section III and IV). Please assess these questions for the following:

1) Clarity of instructions.

2) Clarity of each scenario (i.e. well worded, not enough information, too much information).

3) The overall face validity of the values section, face, content and construct validity of each scenario, based on the following definitions of each value (Hancock, 1997; CASW, 1994; Hepworth & Larson, 1993; Compton & Galaway, 1994):

1) Confidentiality: keeping information received or observed about a client in confidence; not disclosing information about clients or their families to others, including the clients family, other social workers, professionals, etc., unless the social worker has obtained informed consent from the client, the information involves a threat of harm to self or others, or the client is a minor.

2) Self-determination: recognition of the right and needs of client's to freedom in making their own choices and decisions; recognizing the client's wishes, desires and motivations as the primary consideration, except when the client is a child, and/or lacks the capacity to make an informed decision; involving clients in the development of solutions to problems or to promote growth.

3). Social Justice: advocating for the development, equal distribution of and access to resources, services and opportunities for all persons (regardless of race, ethnic background, sex, sexual orientation, language, age, abilities, socio-economic status, political affiliation or national ancestry); identifying and eliminating discrimination; advocating change for individuals, families, the community and society.

Instructions for pre-test:

Please follow these directions carefully for assessing the values scale:

1) Each scenario was developed to reflect a particular value. Please read each scenario and the response categories carefully, as these reflect which value is measured by that scenario.

2) After you have read each scenario, determine what value you believe it is measuring (confidentiality, self determination, social justice). Refer back to the definitions of the values if necessary.

3) Rate each scenario according to whether you believe it

strongly reflects that value

may reflect that value

weakly reflects that value.

Write in the line under each scenario the value you feel the scenario is measuring, and whether it strongly, may or weakly reflects that value.

4) If you believe a scenario may reflect more than one value, or you are uncertain of the value that the scenario is measuring, use your best judgment to select a value, and please note that this situation was confusing and name the value (if you believe that it represents possibly another value) in the margin by that scenario.

5) If you feel that a scenario is clear and reflects a particular value, please answer the question in Section III (What action should be taken by the social worker in each scenario?), or circle the response item (Section IV) that you feel is the 'best' answer - meaning that the social worker acts in a manner that upholds that value. Your responses will assist me in my analysis of the data.

If you have time, please revisit values that you may have had difficulty assessing.

7) Once you have completed this task, please place the questionnaire in the envelope, seal the envelope and return it to the Social Work General Office in the drop box with my name on it, or to my student mailbox under 'S'. Do not sign your name, or provide any information on the envelope or questionnaire that would allow you to be personally identified.

Thank you for your input, time, and assistance with this questionnaire?

Appendix G

Open Ended Value Items

Social Justice

Item 1:
Steve, a social worker in a large community agency was asked to review a report that proposed allowing individuals who contract HIV in health care occupations to receive enhanced benefits under the employer's insurance plan. Individuals who contract HIV through unprotected sexual intercourse or IV drug use would have access to existing benefits under the plan, but not enhanced benefits. Steve must respond to the report.

Confidentiality:

Item 2:
Anne is a counselor in an addictions facility and volunteers at an HIV/AIDS clinic two nights a week. She discovers that one of the clients who has been receiving counseling at the clinic for a diagnosis of HIV infection has applied for a job at the addictions facility. Prior to his interview with Anne's supervisor, the client says hello to Anne in passing. Later, Anne's supervisor asks her how she knows the candidate.

Self Determination

Item 3:
Jane is a social worker who has been working with Tom, a 20 year old gay man. Tom has found out that he is HIV positive, and he has been working with Jane for several weeks to explore whether he should tell his partner, who is not HIV positive. Tom is knowledgeable about HIV and usually practices safe sex. Tom feels that he has explored his decision and its potential impact on his relationship with his partner. Tom has told Jane that he has decided that he does not want to tell his partner about his HIV status. He would like Jane to provide him with some feedback on his decision.

Appendix H

Forced Choice Value Items

Social Justice

Item 2:

Christine, a school social worker has learned that some of the parents in the community are upset that a child who was diagnosed as HIV positive would be attending classes. In order to allay the concerns of these parents, the school proposed that the child could attend classes at the school, but would not be allowed to participate in certain activities such as physical education, or organized sports which are supervised. Participation in these activities would not pose a risk to other students, but the school feels this is a reasonable precaution. Christine has been working with the parents and is aware that they are upset with the school's proposed plan that would not allow their child to participate in all activities. They feel the plan is unfair as it treats their child differently. Would you advise Christine to:

Item 5:

Jerry is a social worker who works with AIDS patients. He has recently learned that the residents in a neighborhood are organizing to take action against a proposal for a residential hospice in their neighborhood for patients who have AIDS. There are limited residential supports and if implemented, this would be the first residential AIDS facility in this part of the community. Several of Jerry's clients would be potential referrals to such a facility. Would you advise Jerry to:

Confidentiality

Item 4:

Cheryl is a social worker in a local community hospital who provides counseling to some of the students who are working at the hospital as part of their degree requirements. She has been counseling a medical intern, Ron, who has been having difficulty coping with his recent diagnosis of HIV infection. Cheryl had received a phone call from Ron's clinical supervisor who was aware that Ron was seeking counseling with her, and was concerned about his performance in the internship program. During the conversation, the clinical supervisor inquired if Ron was sick.

Item 6:

Mary is a social worker at a local clinic that is known for its work with HIV/AIDS. Mary has been encouraging Pat, a client to inform her husband, Ed, of her HIV status, and to abstain from unsafe sexual activity with him. As of their last session, Mary was aware that Pat had not informed her husband of her HIV status. One afternoon, prior to seeing Pat, Mary was contacted by Pat's husband who asked if there was anything that he should be concerned about. Would you advise Mary to:

Self Determination

Item 1:

Terry is a social worker who works with terminally ill AIDS patients. She has been working with Bob, an adult client who has been suffering with AIDS related illnesses for the last six years. Terry and Bob have been working extensively to explore issues around his decision to terminate his treatment. Bob is fully aware that he will be severely jeopardizing his health. Bob has considered his decision carefully, has discussed this with his family, and has decided to terminate the treatment. Would you advise Terry to:

Item 3:

Linda is a social worker who works in a family therapy center. She has been working with Maria, a client who has tested HIV positive, and her husband Jim. Maria and Jim both want a baby, however, they have been having difficulty in deciding whether to start a family. Both Maria and Jim have been aware of Maria's HIV status for two years. Maria has been taking HIV medications. She had discussed this issue with her physician, who has advised her that there is some risk, even while being on the medication, that HIV may be passed to her baby, but there are precautions that can be taken to try to prevent this. They had explored adoption for a considerable amount of time , however, they had decided that this was not an option for them. After lengthily consideration they had informed Linda that they had decided to have a baby. Would you advise Linda to: