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An Exploratory-Descriptive Study

of Social Work Students' Ratings

on Scales Testing for

Fear of AIDS and Homophobia

by

K. Russell Kitchen

A Thesis
submitted to the Faculty of Graduate Studies and Research
through the School of Social Work
in partial fulfilment of the requirements
for the Degree of
Master of Social Work
at the University of Windsor

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Abstract

A non-probability sampling of undergraduate and graduate social work students (n=89) enroled at the University of Windsor, Windsor, Ontario, utilizing the Fear of AIDS Scale and Homophobia Scale (Bouton et al., 1987) was carried out in the Winter Session of 1990. The intent was to examine the social work students' fear of AIDS and homophobia ratings as measured by these scales.

Results indicate that the students have a moderate fear of AIDS and a low-moderate level of homophobia. There is a strong positive correlation between the Fear of AIDS Scale's and Homophobia Scale's scoring, but the two scales measure separate factors. Those students who know someone lesbian or gay have lower homophobia scores. Those students who report an understanding of the gay (and lesbian) lifestyle have lower homophobia ratings. Age, gender and educational level had no impact on either fear of AIDS or homophobia.

Discussions and recommendations are offered for the profession of social work, social work education, and individual social workers.

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Acknowledgements

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CHAPTER I

INTRODUCTION

Statement of Purpose

This study proposes to measure the scores of social work students enrolled at the University of Windsor on scales testing for Fear of AIDS and Homophobia as developed by Bouton et al. (1987). These students provide a non-random availability sampling unit. Data collection took place during the Winter Session of 1990 at the University of Windsor. Certain limited demographic variables were added to the questions developed by the authors. Classroom time was utilized to gather the data from the self-administered questionnaire.

The ramifications of AIDS create confusion and misunderstanding (Wishon, 1988; Brody, 1989). Social workers play a vital role in the treatment of AIDS (Krieger, 1988; Wiener, 1986; Geis, Fuller & Rush, 1986). In working with people with AIDS the social worker faces the possibility of occupational hazards including anxiety and fear (Wiener, 1986). The profession of social work is uniquely qualified to study and understand the psychosocial aspects of the AIDS phenomenon by its ability to make assessments at a micro and macro societal level (Stulberg & Buckingham, 1988).

Puritanical and Victorian attitudes permeate western culture (Martin & Vance, 1984). It is considered appropriate to leave sex unseen and unspoken. An obstacle to satisfactory counseling of gay clients is the professional's lack of knowledge about lesbians and gay

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men (Fein & Nuehring. 1981). Lesbians and gay men responding in a survey suggest that their health professional is prejudiced against "homosexuals" (Dardick & Grady, 1980). Social workers exhibit more problems when working with lesbians and gay males than other psychotherapists (Wisniewski & Toomey, 1987; DeCrescenzo, 1984; Davison & Friedman, 1982).

Research Topic

The first case of AIDS in Canada was reported in 1982. The number of persons diagnosed with AIDS has steadily increased. As of April, 1986, 541 persons in Canada had been diagnosed with AIDS (Federal Centre for AIDS, 1989). Nearly half of these persons had died. By April, 1992, the total number diagnosed had increased to 6,116 of which 3,746 had died (Health and Welfare Canada, 1992). To date AIDS has mainly affected adult males in the prime of their life. Gay or bisexual activity accounts for the largest percentage of cases and deaths with 78% and 63% respectively.

AIDS is part of our society. The virus spreads slowly and surely. The cumulative number of cases is growing and will continue to increase, with more equal distribution with respect to age, sex, geography, and means of transmission (Federal Centre for AIDS, 1989). Society has to think of AIDS more in terms of a chronic disease interspersed with acute episodes. Advances in medical procedures for AIDS-related complications which can treat the symptoms but not eradicate the cause. The ramifications of this opportunistic disease have serious

consequences for North America (Boland, Tasker, Evans & Keresztes, 1987). AIDS tends to remain a fatal condition.

AIDS attacks certain high risk groups (Batchelor, 1984). These include gay males, intravenous drug users, and prostitutes. The highest concentration of person with AIDS had been gay males in the early years of this disease. Altman (1986) suggests that the prevalence of AIDS adds to the prejudice directed at gay men because AIDS was first recognized as the "gay plague".

Ten percent of the North American population has been estimated to be potentially lesbians and gay men (Kinsey, Pomeroy & Martin, 1948). Four percent practise exclusive same-sex sexual preference. One in six males have a gay experience between the ages of 16 and 55. An accurate number is difficult to ascertain as most individuals do not reveal their sexual orientation (Berger & Kelly, 1986). Societal reaction to lesbians and gay men varies.

Negative attitudes sanction legal repression of lesbians and gay men (DeCrescenzo, 1984). A non-traditional sexual orientation has long been considered a social corruption that leads to moral decadence (Levitt & Klassen, 1974). Lesbians and gay men experience discrimination in jobs, housing, and medical services (Potter & Darty, 1981). In a culture that values conformity, lesbians and gay men challenge that norm. This desire to conform forces the lesbian and gay male to manage her or his identity to be accepted into the mainstream (Berger & Kelly, 1986).

Until 1973 "homosexuality" was considered a

psychological disturbance (Weinberg & Williams, 1974).
This disorder was in need of a cure. The change in
classification came only as a result of pressure on the
American Psychiatric Association (Morin & Garfinkle,
1978). Some mental health professionals have kept this
outlook (Batchelor, 1984). The recent epidemic of AIDS
creates a new dimension for the value system of
professional social workers (Baumgartner, 1985).

Media coverage of AIDS has tended to strengthen the
association between gay men and disease (Altman, 1986).
The media influences its viewing public, especially the
perpetuation of stereotypes (Myers, 1987). A stereotype
is maintained even when presented with evidence to the
contrary. Attitudes about gay men did shape the early
response to AIDS (Joseph et al., 1984; Altman, 1986;
Batchelor, 1984). Many believe that AIDS is God's just
retribution against gay men.

North American society has difficulty in
acknowledging any sexuality, let alone one that is
considered deviant (Weinberg & Williams, 1974). Canadian
professional social workers, as written into their Code of
Ethics (1983), are asked to address discrimination when
discovered: "the social worker will take reasonable
actions to prevent and eliminate discrimination against
any person or group" (p. 8). The issue of prejudice
against lesbians and gay men is not frequently recognized
by social workers (Berger & Kelly, 1986).

Rationale for study

This paper makes an effort to demonstrate that social

work students exhibit fear of AIDS and homophobia. If
this can be demonstrated, then it behooves social work
educators to address those shortcomings in curricula that
would alleviate the disenfranchisement felt by lesbians
and gay men in any therapeutic interaction with a
professional social worker.

This study hopes to add to recent research literature
on AIDS and homophobia and in part will replicate a
previous study (Bouton et al., 1987). These researchers
developed scales testing for fear of AIDS and homophobia
with a relatively high reliability. The instrument uses a
14 item Fear of AIDS Scale and a seven item Homophobia
Scale that was group administered to social work,
sociology and psychology students at a southern USA
university.

The prevalence of AIDS makes the study timely. AIDS
exacts suffering upon the person with AIDS as well as that
person's family and friends. AIDS is costly, absorbing a
large portion of social welfare spending. AIDS causes an
enormous loss of employable hours. The loss of wages
earned and increased health care cost places a burden on
the fabric of society. The social problems surrounding
AIDS need investigation.

The Federal AIDS Centre (1989) requests research on
methods implementing AIDS education and informative
material about the lesbian and gay lifestyle. A survey by
the Federal AIDS Centre (1988) show that health care staff
express deep conflicts about their moral values when
treating AIDS patients. A request is made for resources
that could assist in meeting needs related to the

lesbian/gay lifestyle and homophobia. Literature is requested on human sexuality and lesbian and gay health concerns in the curricula of health professions.

CHAPTER II

<u>REVIEW OF THE THEORETICAL LITERATURE</u>

A review of the professional literature is needed to relate the research problem or hypothesis to existing theory (Royse, 1991). Relevant material is gained from a comprehensive literature review. A thorough search will help to ground the research question within a theoretical framework. Krathwohl (1965) states that the literature review should achieve five objectives:

1. It demonstrates that the social worker mastered the available and relevant literature.

2. It demonstrates the similarities between the proposed study and past research findings of similar studies.

3. It describes the differences between the proposed investigation and past research findings of similar studies.

4. It discusses how the proposed investigation will contribute to the knowledge-base of the social work profession.

5. It supports and interacts with the conceptual framework by introducing and, together with the conceptual framework, conceptually defines the key variables that are subject of the study.

The following two chapters present conceptual as well as empirical research on fear of AIDS and homophobia, and factors that this researcher considers to be pertinent to the research topic.

This chapter examines: AIDS; fear of AIDS; fear of AIDS and health care; AIDS and gay men (lesbians); AIDS and morality; social work and AIDS; heterosexuality and lesbians/gay; stigma and stereotyping; lesbian/gay stigma and stereotyping; homophobia at a cultural level; homophobia and personal interactions; homophobia and

lesbians/gay men;   and, social work and homophobia.

<u>AIDS</u>

AIDS is an acronym that stands for acquired immune deficiency syndrome. AIDS is a condition that is caused by a virus called the human immunodeficiency virus (HIV) (Federal AIDS Centre, 1989). This virus attacks a person's immune system which in turn renders this individual susceptible to opportunistic diseases that ordinarily would not create problems for that person. But in a body with a suppressed immune system, these opportunistic diseases can be fatal.

Conversion to AIDS is 50% after 10 years of seropositivity (Farmer & Kleinman, 1989). To date, persons with AIDS can expect episodic illnesses as new treatments are developed. AIDS is a physically and emotionally disfiguring condition that usually announces to the public its presence. The condition can be quite visible, thereby stigmatizing the person with AIDS.

<u>Fear of AIDS</u>

AIDS has given rise to anxieties and even fear. Outbreaks of disease threaten a sense of control underlying most forms of social organization (Cullivan, 1991). The cause is seen most often to originate from infected "others". Fear and prejudice of the "plague" affect the providing of empathy and mercy to its victims. A disease which physically affects the most socially stigmatized groups, also affects all of humanity psychosocially.

The mention of AIDS causes people to draw back in

fear (Batchelor, 1984). Underlying at least some of the discrimination, spite, and other inappropriate responses to AIDS is this fear (Farmer & Kleinman, 1989). AIDS reactions include an anxiety over possible contagion and a rejection of the person not only for the disease, but also for the taint of being gay (Furstenberg & Olsen, 1984). There seems to be a need by society for some sort of control over AIDS (Fuller & Geis, 1988). Discrimination against persons with AIDS involves the consideration of consequences that could be justified (Pargetter & Prior, 1987).

Because AIDS is serious and undesirable, non-curable and contagious, it has very serious consequences for the community (Kessler et al., 1988). The AIDS crisis shocks society because it comes at a time when most epidemic diseases are thought to be controllable (Singh, Unnithan & Jones, 1988). In a situation of communal anxiety, locating blame for disease, in effect is a strategy for control (Foege, 1988). Placing blame defines the normal, establishes the boundaries of healthy behavior and appropriate social relationships, and distinguishes the observer from the cause of the fear (Nelkin & Gilman, 1988). This gives cause for social stereotypes and political biases (Bahou & Gralnick, 1989).

Fear of AIDS and Health Care

AIDS elicits fear from health care workers (Friedland, 1989). This involves a fear of how the disease is transmitted. There is a sense of helplessness in the relentless and usually fatal outcome of AIDS

(Weiner, 1986). Persons with AIDS are often viewed as socially unacceptable by the general public and even health care professionals (Gochros, 1988; Macks, 1988).

Physicians with negative emotions and stereotypes attitudes pose a particular threat to humane medical treatment and service delivery to AIDS patients (Alperin & Ritchie, 1989). The person with AIDS is at risk for compromised care because of the fears associated with AIDS (Peloquin, 1990). These fears include death, sin, crime, and the stigma of working with persons with AIDS. Barriers are identified to health care provision for persons with AIDS: contagion, homophobia, confidentiality, and other institutional factors.

The confidentiality of AIDS-related information becomes important in the delivery of social services (Ryan & Rowe, 1988). In a study of home care providers, persons with AIDS are avoided (Novick, 1988). Persons with AIDS are refused ambulance and medical services (Altman, 1986). Gay men report that they have received their diagnosis of AIDS over the phone (Morin, Charles & Malyon, 1984).

Fear of disclosure and condemnation prevents those at risk to contract AIDS from discussing their lifestyle with their health care professional (Dardick & Grady, 1980). Blame for the disease is not placed on the retrovirus, HIV (Epstein, 1988). It is placed on those who are thought to maintain a self-indulgent pattern of behavior that places them at risk.

AIDS and Gay Men (Lesbians)

The emergence of AIDS creates more negative and even

hostile attitudes of gay men (Douglas, Kalman & Kalman, 1985). Gay communities fight off right-wing schemes like the LaRouche Initiative in California which would have allowed mass quarantine (Queen, 1987). Quarantine is a response not only to disease but to the nature of the transmission (Musto, 1986). There are popular demands for a boundary between diseased people and "respectable" persons who hope to remain healthy. Persons with AIDS are judged to share characteristics often invoked in defense of quarantine (Mohr, 1987).

Arguments are offered for peoples's discriminatory treatment of the person with AIDS (Hayry & Hayry, 1987). These include a legal moralism which views AIDS as a mark of behavior. Conservatives and religious fundamentalists view AIDS as a result of gay sexuality, promiscuity, and drug use (Douglas, Kalman & Kalman, 1985; Blendon & Donelan, 1988). Therefore persons with AIDS should deserve punishment and harm. AIDS is linked to the presumed moral defects of the gay community (Epstein, 1988). The media, medical and scientific professions played a significant role in creating the popular early perception that AIDS is an inherently gay disease. Such is this effect that many now hold the view that the gay community is both a moral and medical threat to mainstream society.

Gay men with AIDS are often presumed to fit every rejecting stereotype of "homosexuals" (Tebble, 1986; Macks, 1988). They are generally perceived to be more responsible for their condition than other seriously ill

patients (Triplett & Sugarman, 1987). AIDS is labelled as a sexually transmitted disease (Friedland & Klein, 1987). This stigmatizes those with AIDS and implies that all gay men contact are promiscuous, immoral, and dangerous (Nelkin & Gilman, 1988).

The "gay plague" or "GRID", an acronym for "gay-related immune deficiency" is a moniker that was first given to AIDS (Queen, 1987). AIDS furnishes a pretext for reinserting lesbians and gay men within a symbolic moral drama of pollution versus purity (Seidman & Altman, 1988). AIDS stigmatizes those infected as having a gay disease (Furstenberg & Olson, 1984). There is very little sympathy for person with AIDS because they are considered to be outside of the mainstream of society (Singh, Unnithan & Jones, 1988). The individual and collective terror of this disease leads society to view persons with AIDS as today's lepers, carriers of a modern-day plague, and deserving of God's wrath (Fuller & Geis, 1988).

AIDS and Morality

Society assumes that something about gay behavior is causing AIDS (Katz et al., 1987). AIDS becomes the metaphor for the sin of lesbians and particularly gay men, and the sin of sexual pleasure. Once a plague or threat of plague is linked to a sexual act of any sort, then expectation of divine retribution follows (Poirier, 1988). Stigmatization of the most likely persons to contract AIDS results from the fear not of physical but of moral contagion.

Inherent in this concept is the moralistic condemnation of lesbians and gay men (Pargetter & Prior, 1987). Moral beings who possess the same morally relevant properties should be treated in a morally equivalent manner. It therefore defines sins against nature as any sexual act that does not afford the maximum likelihood of procreation. This prejudice appeals to the most ancient of Christian abhorrences--a promiscuous commitment to sex as a form of pleasure. The recent announcement by the Vatican reiterating that "homosexuality" is considered a sin further brings AIDS under religious condemnation.

The connotation of "innocent" victims given to haemophiliacs and babies born with AIDS implies that gay AIDS patients are guilty (Tebble, 1986). These beliefs give subtle approval to a negative public attitude concerning AIDS. The social dimension and mode of transmission of this disease further compound the problem and generate unprecedented controversy (King, 1989). The slowness to which federal governments are responding to AIDS draws criticisms from the gay community (Joseph et al., 1984; Epstein, 1988). Mandatory testing for AIDS and HIV is suggested (Reamer, 1988). This represents a way to degrade gay men and reaffirm heterosexual supremacy as a sacred value. The socioeconomic ramifications of AIDS give rise to considerations for the abridgement of civil rights for persons with AIDS (Epstein, 1988).

The psychological rejection of gay men is associated with the responsibility for AIDS (Ross, 1988). Therefore, gay men bear "justifiably" the consequences of AIDS

discrimination. Some persons with AIDS describe themselves as hopeless, helpless and out-of-control, anxious, depressed, and miserable. The reasons given for these point directly to discrimination. The association of gay men to AIDS is strengthened. It is possible to speak of "risk groups" rather than "risk behavior" since gay men (and lesbians) are defined solely by their sexual preference (Ross, 1988).

Social work and AIDS

Social workers face dilemmas in working with persons with AIDS (Dunkel & Hatfield, 1986). These include not only the social worker's interactions with the person with AIDS but also with attitudes of friends, family, and colleagues. Countertransference presents particular problems for social workers during interactions with individuals with AIDS. The multiple social, ethical, and medical issues related to AIDS make cooperation between welfare and health care agencies imperative. The profession of social work continues to be instrumental in the development of effective interventions (Furstenberg & Olson, 1984).

The role of social workers in the treatment of AIDS is important (Ryan & Rowe, 1988). The practitioner is trained to make psychosocial assessments and then link clients to available resources. Social workers face many ethical dilemmas while providing services to persons with AIDS. These include: personal conflicts with clients' values and behaviors; colleagues unwilling to serve persons with AIDS; concern over revealing a HIV infected

client's status to her or his sexual partner or health care workers; conflicts with social service agencies that do not provide adequate services; and, concerns over the slow reaction of the social work profession as a whole to the AIDS epidemic (Queen, 1987).

The AIDS epidemic evokes strong personal and professional reactions among health care workers (Macks, 1988). This disease forces workers to face personal feelings and reactions toward gay men, drug addicts, as well as toward issues of sexuality and death. Many countertransference reactions emerge. These include: fear of contagion; denial; discomfort with sex; anger and blaming the victim; blurring ethical and professional boundaries; and, fear of professional inadequacy (Macks, 1988).

The complex issues surrounding AIDS puts those involved in need of some sort of social services (Reamer, 1988). The families, lovers, and friends of people with AIDS often confront the same or similar psychosocial issues as the person with AIDS face (Stulberg & Buckingham, 1988). These issues include: fear of rejection and social isolation; feelings of guilt, shame and anger; denial, both adaptive and maladaptive; and, the physical and emotional devastation resulting from the course of the illness. People with AIDS may become homeless for a variety of reasons (Schietinger, 1988). These include: financial devastation; rejection based on fear of contagion or fear of the dying process; and, homelessness prior to the diagnosis.

Heterosexuality and Lesbians/Gay Men

Heterosexist attitudes impact upon lesbians and gay men. There is a western view that heterosexuality, procreation, and the family unit are the norm (Aguero, Bloch & Byrne, 1984). Anything differing is outside that norm. Individuals are born into a sexual world composed of institutions and legitimations which make their object reality (Plummer, 1975). Some include the family and gender roles which provide routine patterns of sexuality. These provide explicit statements about how people ought to behave sexually. This imagery is drawn from theology, philosophy, history, science, and folk wisdom; all of which serve to justify the existing order, and make it appear "sensible" and "logical" (Law, 1988) .

Arriola (1988) suggests that heterosexual behavior relates to the patriarchal model of society which fosters discrimination against lesbians and gay men. It is argued that heterosexuals' reactions when confronted with a gay-labeled target include three categories: devaluation, avoidance, and aggression (Siegel, 1979).

Myron and Bunch (1975) classify heterosexuality as a function of male supremacy. In order for men to justify exploitation of women (and gay men) and the ability to enforce that exploitation, heterosexuality becomes, not merely an act in relation to impregnation but the dominant ideology. Heterosexual hegemony insures that people think it natural that males and females form a life-long sexual/reproductive unit with the female belonging to the male. Female and male belong together, fit together, and

are basic to nature together.

Male heterosexual identity dichotomizes what it is and not is (Eldridge, 1987). It is perceived as strong and masculine, and not feminine and not gay. The definition of gender role and gender identity is derived in our society from a categorization which depends upon imposition and maintenance of differences between women and men (McConaghy, 1987).

Heterosexual bias characterizes a belief system that values heterosexuality as superior to and or more "natural" than same-sex sexual acts between lesbians or gay men (Morin, 1977). Any behavior pattern that interferes with the status quo is subsumed in the heterosexual value system (Fyfe, 1983). Any sexual deviance outside of the norm is thought of as a sickness. To be a "man" in North American society appears to require hostility toward gay men (Herek, 1986).

Treatises on lesbians and gay men number in the thousands (Schwanberg, 1985). Most prior to 1973 were subjective and speculative rather than scientific and empirical. Lesbians and gay men experience legal sanctions against them and social taboos preclude such empirical research. To defend a stereotyped behavior, especially one lesbian or gay, invites guilt by association (Adam, 1978). Most psychological and psychiatric studies of lesbians and gay men deal with stereotypes. Studies examine mentally disturbed subjects and then generalize their findings to the general lesbian and gay population.

Stigma and stereotyping

Stigma and stereotyping are a means to identify "outsiders". Stigma refers to the taint of disgrace that goes with deviant roles (Spencer, 1985). Social groups create deviance by making the rules. Infractions of these rules constitute deviance, and by applying those rules to particular people and labeling them as outsiders. Stigma involves stereotypic and global interpretations (Hammersmith, 1987). Societies utilize myth to make sense of deviance (Morris, 1985). First, the deviant is identified in terms of characteristics. Secondly, the society prescribes a set of attitudes to be adopted. Thirdly, it generally offers some explanation of the origins of the deviance in question.

People conform to standards of behavior which in turn guide their behavior (Himelfarb & Richardson, 1982). These norms morally bind persons into certain status. Social interactions help define normative boundaries between "our people" and "them" (Spencer, 1985). When the deviance is considered socially unacceptable, it is not normalized, and, then it is likely that society will resort to stigmatization, punishment, segregation, and social control (Moses, 1978). Institutionalization of differences between individuals and between groups creates stereotypes which reduce the full humanity of the individual to a few selected deviant traits (Ferree & Smith, 1979). Stereotyping of minority individuals and groups often leads to severe social limitations and to considerable psychological disempowerment (Rathwell,

1984).

The deviant become a symbol (Lemert, 1972). Deviant behavior dramatizes evil, a reminder of the importance of the rules and the consequences of having violated them. When others decide that a person is designated as non-grata, dangerous, untrustworthy, or morally repugnant, that person then is subjected to rejections and humiliations in interpersonal contacts. It may also include formal action to bring her or him under controls which curtail her or his freedom (Spencer, 1985).

Lesbian/gay stigma and stereotyping

Lesbian/gay stigma and stereotyping places an image upon the target person which identifies her or him with some characteristic. The existence of a "different" sexual orientation is considered an anomaly which threatens the institution of marriage and "one love" (Davis, 1971). It poses a threat to the prevailing systems of classification about gender, family, and sexuality (Law, 1988). Such threats are dealt with by noting the anomaly as deviant, evil, dangerous, heretical, malfunctional, pathological, and sick.

People learn gay stereotypes during early socialization (Spencer, 1985). Interactions with others maintain these "cartoon" images (Myers, 1987). Stereotyping provides information about the "hidden" nature of the gay subculture (Eldridge, 1987). Since same-sex sexual acts are seen as stigmatizing, most lesbians and gay men remain invisible and are thought to be "straight" (Harrison, 1977). This invisibility results

in the continuation of myths and stereotypes. Societal
reactions render the business of becoming a lesbian or gay
a process that is characterized by problems of access,
problems of guilt, and problems of identity.

Negative characteristics associated with gay males
include: dislike of women; effeminacy; the relative
ease with which gay men may be identified; promiscuity;
sado-masochism; cross-dressing; and, the tendency to be
considered either active or passive in sexual behavior
(Plasek & Allard, 1984). The mere presence of an
unconventional sexuality seems to give the sexual content
of life an overwhelming significance (Lavender & Bressler,
1981). Lesbians and gay males gain some legitimacy in
terms of mental health and scientific study, but legal,
political, religious, and popular acceptance lag far
behind (Cabaj, 1988b).

An Overview of Homophobia

The term "homophobia" comes from Weinberg (1972).
Homophobia is defined as the fear felt by heterosexuals
when in near proximity to lesbians and gay men. But it
also means the self-hatred experienced by gay men because
of their sexual orientation. Homophobia suggests a fear
of one's own sex (Rosan, 1978). The disapprobation of
lesbians' and gay men's behavior is a reaction to the
perceived violation of gender norms (Law, 1988). This
helps to preserve the traditional concepts of masculinity
and femininity. Homophobia suggests a sexist requirement
that functions to create a sexual distribution of power
that is implicity hostile to gay men and lesbians (Krayal

& San Giovanni, 1984).

Homophobia at a Cultural Level

Homophobia appears to operate at cultural level, involving in some way, most of society. There are two forms of homophobia according to Hencken (1982): institutional and internalized. Institutional homophobia refers to the reactions that exist at the level of social agencies and social policy which also can be named heterosexism. Internalized homophobia alludes to the responses by the individual. Homophobia has a maximum effect when it engenders guilt and fear among same-sexers themselves (Krayal & San Giovanni, 1984). This internalized homophobia tends to neutralize the perceived threat of the lesbians and gay men to the social order. Homophobia is conceptualized as operating as a form of social control that enforces conventional sex-roles (Nungesser, 1980).

From a cultural perspective homophobia is defined as any belief system which supports negative myths and stereotypes about lesbians and gay males (Morin & Garfinkle, 1978). Discrimination on the basis of sexual orientation is justifiable. The use of language or slang, e.g., "queer" or "fag", is permissible and acceptable (Gramick, 1983). Any belief system which does not value the lesbian or gay lifestyle equally with heterosexual lifestyle is warranted. As a sociopolitical construction, homophobia is transmitted through many of our institutions and social processes (Krayal & San Giovanni, 1984).

Homophobia supports myths and stereotypes about

lesbians and gay men (Morin & Garfinkle, 1978). They are
believed to be set apart from heterosexuals on the basis
of presumed differences in attitudes, appearances, and
behaviors (Plasek & Allard, 1984). Males have more
negative attitudes than females toward lesbians and gay
men (Kite, 1984). Individuals tend to avoid discussions
about sexual orientation (Glenn & Russell, 1986).
Homophobia curbs the range of responses in men so as to
dichotomize between sexes (Klein, 1989).

Homophobia and Personal Interaction

Homophobia causes individuals to react differently.
Hudson and Ricketts (1980) suggest a differentiation
between homophobia and homonegativity. Homonegativity
depicts a multidimensional set of responses involving both
cognitive and affective reactions to individuals who
engage in same-sex sexual acts with issues at the
societal, moral, and or personal levels. Homophobia
relates to more specific reactivity. It represents the
affective or emotional feelings of anxiety, disgust,
aversion, discomfort, and fear that heterosexuals
experience in dealing with lesbians and gay men. This
includes not only close or proximal contact with gay men,
but distal contact as well.

Homophobia encompasses both a cognitive affect and a
behavioral disposition toward gay men (San Miguel &
Millham, 1976). Homophobia is portrayed as an irrational
fear (Messing, Schoenberg & Stephens, 1984; Gramick,
1983). The characterization of hostility toward gay men
in terms of a phobia implies that those attitudes are

based on an unfounded anxiety (Herek, 1986).

Herek (1984) delineates three types of attitudes concerning homophobia: experiential, defensive, and symbolic. The experiential categorizes social reality by one's past interactions with lesbians and gay men. The defensive copes with one's inner conflicts or anxieties by projecting them onto lesbians and gay men. The symbolic expresses abstract ideological concepts that are closely linked to one's notion of self and to one's social network and reference groups.

Homophobic attitudes invoke certain anxieties (Gramick, 1983). These include attraction to the same-sex in oneself, conversion to lesbianism or being gay, and, extinction of the human race. These beliefs reinforce the social disapproval and stigmatization that lesbians and gay men receive (Tebble, 1986). There is a belief that lesbians and gay men are a threat to others (Plasek & Allard, 1984). There is a fear that legalization will lead to wholesale practice of lesbianism or being gay. Interactions of the general public strongly influence these homophobic attitudes (Pagtolun-An & Clair, 1986).

Homophobia and Lesbians/Gay men

Lesbians and gay men struggle against the effects of homophobia (Fein & Nuehring, 1981). They try to maintain self-respect and a reputable public image. Patterns of adjusting accomplish the construction of a manageable social reality. Societal attitudes about deviant behavior shape reactions which in turn mould the stigmatized (Steffensmeier & Steffensmeier, 1974). This devaluation

tends to force lesbian and gay men into a subculture and
out of the public eye (Albro & Tully, 1979). The
advancement of AIDS has brought a homophobic backlash
(Batchelor, 1984; Altman, 1986).

Social work and homophobia

Social workers are part of a society in which
homophobia is widespread and prevalent (Tully & Albro,
1979). The social worker is not oblivious to viewing
lesbians and gay men in terms of myths, stereotypes, and
the effects of traditional discrimination. Social work as
a profession impacts upon homophobia whether consciously
or unconsciously.

Social work has some of its roots profoundly affected
by psychoanalytic thought and some social workers
incorporate psychoanalytic concepts into their practice
orientation (Cornett & Hudson, 1984). Lesbian and gay
behavior has been viewed by this paradigm (and by some
social workers) as causing personal problems. Same-sex
sexual preference is seen as an individual phenomenon and
as a result of a person's psychological disturbance.

The sense of awkwardness, defensiveness, and
distancing by social workers leads to a sense of rejection
felt by gay clients (Hammersmith, 1987). Of particular
concern is same-sexed client-therapist interaction
(Tievsky, 1988). Counselors express significantly more
personal anxiety with respect to same-sexed lesbian and
gay clients (Millham, San Miguel & Kellogg, 1976). These
factors in combination with the AIDS epidemic create a
special problem for gay males (Tebble, 1986; Dunkel &

Hatfield, 1986).

One of the major obstacles to satisfactory counseling with lesbians and gay men is the professional's lack of practical knowledge about lesbians and gay men (Fein & Nuehring, 1981; Dunkel & Hatfield, 1986; Tievsky, 1988). Most social workers receive minimal training in sexuality counseling (Shernoff, 1988). Some social workers are uncomfortable discussing sexual matters with their clients. Those who reveal their sexual orientation to their health professional are more satisfied with their relationship (Dardick & Grady, 1980). Client-therapist similarity has special significance for gay men (Rochlin, 1982).

Homophobia is reinforced by certain professional experts (Steffensmeier & Steffensmeier, 1974). Homophobic attitudes of mental health professionals make therapy counter-productive (DeCrescenzo, 1984). Some therapists feel threatened by a lesbian or gay client (Morin, 1977; Hopcke, 1990). Gay men receive more serious clinical diagnoses than heterosexuals (Davison & Friedman, 1982). Sexual orientation has a profound impact on the lesbian's or gay's life which is not taken into account in the provision of social work services (Messing, Schoenberg & Stephens, 1984). Homophobia both in the therapist and in the client creates problems for client-therapist interactions (Cabaj, 1988a).

Rudolf (1989) reports three factors that have negative effects on therapists' attitudes toward and counseling lesbians and gay men. These factors include:

current conservative political ideology; the return to fundamental religiosity; and, the appearance of AIDS. Lesbians and gay men report dissatisfaction with their therapy, negative prejudicial attitudes, and a lack of understanding of lesbianism or being gay by their counselors. Brown (1989) states that homophobia which leads to negative attitudes toward lesbians and gay men by therapists is always present. Isay (1985) suggests that the therapists' internalized social values interferes with the proper conduct of any client-therapist interaction with lesbians or gay men by causing the therapist to be unable to convey an appropriate positive regard for the client or to maintain therapeutic neutrality.

Summary

AIDS tends to be a fatal condition caused by a variety of opportunistic infections or diseases. AIDS invokes anxiety and fear reactions from individuals including social workers. Persons with AIDS have received compromised health care services apparently because of their condition. There was an early association with AIDS to it being a "gay disease". AIDS is viewed as a result of gay sexuality, promiscuity, and drug use. There seems to be a need to place blame for this disease during a perceived "plague". AIDS has placed a focus on the method of transmission of the virus thus identifying "at risk" actors. This has allowed an increase in the stigma and stereotyping against gay men (and lesbians).

There is a view that heterosexuality is considered normal and lesbianism or being gay a "sickness".

Homophobia is a reaction to a perceived threat that lesbians and gay men are a threat to traditional sex roles and the "natural order" to procreate. Homophobia appears to be firmly entrenched in the fabric of society and social workers are part of that society.

This author maintains that the negative attitudes about lesbians and gay males are considered acceptable, or at the least, tolerated by most individuals in western society. This devaluation is part of an underlying homophobic attitude that is learned during the socialization process. The early association of AIDS to the gay community only further serves to add to this devaluation. Social work professionals cannot be immune to the negativity and stereotypes that lesbians and gay men receive. Homophobia reinforces this negativity.

CHAPTER III

REVIEW OF THE EMPIRICAL RESEARCH LITERATURE

The following review of empirical studies is intended
to illustrate how previous researchers have measured the
following concepts: that fear of AIDS may be prevalent
among social workers and mental health professionals;
that lesbians and gay men are devalued at societal level;
and, that social workers are influenced by homophobia as
reflected at a cultural level.

This chapter will examine the following: fear of
AIDS; fear of AIDS among college students; social work
and fear of AIDS; homophobia; homophobia among
university students; homophobia and personal interaction;
homophobia and gender; social work and homophobia; and,
the Fear of AIDS Scale and Homophobia Scale.

Fear of AIDS

A number of studies have examined the concept "Fear
of AIDS". Blendon and Donelan (1988) conducted a survey
($\underline{n}$=1185) of American attitudes about AIDS. Sixty-two
percent see the AIDS epidemic as leading to increased
discrimination against those with the virus or active
disease. Eighty-one percent see the control of AIDS as
requiring some loss of individual privacy. Twenty-nine
percent favor a tatoo for persons who test positive for
the disease (a figure that has doubled since 1985).
Thirty-nine percent state that they would support the
rights of employers to fire workers who have AIDS.
Thirty-three percent report that they would take their
child out of school to avoid contact with a classmate with

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AIDS. Forty percent believe that those with AIDS should not be allowed to live in their neighborhood. The survey shows that intolerance persists even when people understand that they are at very low risk of being infected.

Johnson (1987) searched for factors related to intolerance of person with AIDS. Three hundred and seventy-one residents of Muncie, Indiana were randomly selected by a standard random-digit dialing technique to be interviewed over the phone during the fall of 1985. Factors measured included: basic demographic items such as age, sex, race, marital status, income and education; general life satisfaction or happiness, and satisfaction with specific aspects of life such as finances, neighborhood, job, marriage, and health; attitudes about abortion. divorce and women in the workplace; self-perceived political ideology; self-esteem; support for school prayer; religious factors of denomination preference, extent of church attendance, the belief that every word of the Bible is true, and a perception that America has not recognized the contributions of Christian fundamentalists; and, toleration of AIDS. The findings indicate that 61.3% reported that a child with AIDS should not be allowed to attend classes. Forty-nine percent state that a law should be made to prohibit people with AIDS from working in close contact with other people. The most important factor having led to an intolerance of person with AIDS is a political/religious variable.

"Fear of AIDS" has also been linked to homophobia.

Dupras, Levy, Samson and Tessier (1989) randomly sampled adults about their perceptions of AIDS. Four hundred and seven individuals responded to a random telephone dialing survey interview. The authors used a scale that examined attitudes toward lesbians and gay men, and four scales on attitudes towards AIDS developed by the researchers. A stepwise regression analysis (homophobia, exclusion, condemnation, information, and level of education) shows that negative perceptions of lesbians and gay men is the main explanatory variable for attitudes of condemnation and for the exclusion of a person with AIDS. A negative attitude about AIDS is best predicted when there is a negative attitude about homophobia. Individuals are less concerned about AIDS and extramarital affairs than AIDS and gay men.

St. Lawrence, Husfeldt, Kelly, Hood and Smith (1990) conducted an experiment to determine empirically whether stigma is associated with AIDS, to identify the nature of social and attitudinal beliefs about AIDS patients, and, to explore possible relationships between negative attitudes toward AIDS and attitudes related to AIDS patients' sexual preference. Three hundred undergraduates were randomly assigned to one of four vignettes about "Mark", identical in all but two respects. A name is given to Mark's disease (AIDS vs. leukemia) and the name of Mark's romantic partner (Robert or Roberta). Each participant read a single vignette which describes a heterosexual or gay male diagnosed with AIDS or leukemia. This experimental research design factored for type of

disease and sexual preference. The subjects filled out a
questionnaire that included a prejudicial evaluation
scale, an interpersonal attraction inventory, and, a
social interaction scale developed by the authors. The
results indicate that AIDS patients are seen as being more
responsible for their illness, less deserving of sympathy,
more deserving of their illness, more deserving to die, to
be quarantined, to lose their jobs, and regarded as people
whom the world would be better off without. Gay men are
evaluated, independent of the disease description, as more
negative than heterosexuals. The gay AIDS patient is
considered more responsible for and more deserving of his
illness than any other group. Subjects are less willing
to interact socially with AIDS patients than leukemia
patients.

Fear of AIDS Among College Students

Studies have examined fear of AIDS among college
students. Triplett and Sugarman (1987) examined 116
college students for the causes of negative reactions to
AIDS patients. The authors hypothesized that a person
with AIDS would be perceived as less interactionally
desirable than victims of other diseases, and also that a
person with AIDS would be seen as more personally
responsible for their disease. Of primary importance is
the question of whether the gay male with AIDS is held to
be more personally responsible than heterosexuals. The
question of whether gay men with AIDS are seen as being
less attractive and less interactionally desirable than
heterosexual patients was also asked. Hypothetical case

descriptions were presented on eight victims who varied systematically on their sexual preference and diagnosis (AIDS/ genital herpes/ serum hepatitis / Legionnaire's disease). A four-group one-way ANOVA was performed on the seriousness measure in order to check the diagnosis manipulation. The results show that AIDS is seen as the most serious disease. Gay men are seen as more responsible for their disease than heterosexuals for any disease diagnosis, especially AIDS. Subjects perceive heterosexuals as more interactionally desirable than gay men with AIDS.

Winslow, Rumbaudt and Hwang (1990) studied 563 college students responses on scales testing for AIDS-phobia, fear of getting AIDS or the AIDS virus from casual contact when compared to a random telephone cross-sectional sample of 1002 adults in California. The researchers hypothesized that AIDS-phobia is directly related to sentiment in favor of reporting HIV seropositive individuals to local health authorities. It is also hypothesized that AIDS phobia is directly related to a proquarantine sentiment. The instrument included the Index of Homophobia (Hudson & Ricketts, 1980) and a 34-item AIDS-phobia scale developed by the authors which has a Cronbach's alpha reliability of .835. The findings show that 27% of the students favor, 30% of the students are undecided, and 71.7% of the public favor a proquarantine (of persons with AIDS) sentiment. Male respondents have a high degree of homophobia especially when considering a proquarantine attitude.

Social work and AIDS

AIDS presents unique issues for the social work profession (Furstenberg & Olson, 1984). Individual and societal responses impact upon practitioners and human service organizations. Eight major countertransference issues are identified by social workers working with persons with AIDS (Dunkel & Hatfield, 1985). These include: fear of dying or death; fear of the unknown; fear of contagion; denial of helplessness; anger; over-identification; and, the need for professional omnipotence.

Social work and fear of AIDS

There have been a few studies that have studied for effects of AIDS on social work students and practitioners. Royse, Dhooper and Hatch (1987) studied undergraduate and graduate social work students' (n=219) attitudes toward persons with AIDS. In this exploratory-descriptive study that utilizes a nonrandom availability sample, three scales were developed. The Knowledge of AIDS Scale has a Cronbach alpha reliability rating of .66. The Fear Scale has an alpha rating of .67. The Empathy Scale has an alpha rating of .71. The researchers used multiple regression to examine for effects of variables. The results suggest that the respondents are fearful of AIDS irrespective of age, sex, race, and educational status. A greater knowledge of AIDS is associated with greater empathy of persons with AIDS. Greater knowledge and greater empathy are associated with a lower fear of AIDS.

Practicing social workers (n=128) were also examined

for their attitudes toward persons with AIDS (Dhooper,
Royse & Tran, 1987/88). Thirty-seven percent score high
on the Fear of AIDS Scale. Thirty percent score high on
the Social Distance Scale. Thirty-two percent score low
on the Empathy Scale. Thirty percent disagree that
lesbians and gay men have an acceptable lifestyle.
Seventy-one percent who disagree with this condition are
in the category representing the most fear of AIDS. Those
social workers who are most fearful are less empathetic
with a person with AIDS and would have the greatest social
distance needs. Eighty percent of the participants report
that if they were a hospital social worker they would
refuse the assignment of a patient with AIDS, whereas 11%
indicate a willingness, and nine percent were undecided.

In a different survey, social workers ($\underline{n}$=264) were
surveyed to examine the extent to which they expressed
comfort in working with persons with AIDS (Wiener &
Siegel, 1990). Social workers from 12 major hospitals in
three large urban areas were randomly mailed the
questionnaire that contained one of two vignettes. One
scenario has a gay AIDS patient and the other a male
haemophiliac with AIDS. The instrument includes the Index
of Attitudes toward Homosexuality (Hudson & Ricketts,
1980), and scales developed by the authors. These scales
were created to assess the subjects' level of comfort when
interacting with AIDS patients, knowledge about the
disease, and, negative moral attitudes toward persons with
AIDS. Cronbach alpha demonstrate that the comfort and
fear scales have reliabilities of .83, that the negative

attitudes toward persons with AIDS has an alpha of .77, and, that the knowledge of AIDS scale has an alpha of .45. The respondents express more anger and less sympathy for gay men with AIDS than haemophiliacs with AIDS. High ratings of homophobia, fear of contagion, and negative moral attitudes are indicative of negative attitudes of persons with AIDS. Sixty percent of the subjects state that they would be "not very likely" or "not at all likely" to apply for a position in which the principal responsibilities includes provision of services to a large number of persons with AIDS. Sixty-eight percent have not sought an opportunity to work with an AIDS patient. Sixteen percent are unsure and two percent believe they could get AIDS in the course of providing services to a person with AIDS. Thirty-two percent feel moderate to extreme anxiety about providing services to the gay man described in the vignette. Eighteen percent of the participants agree that they feel more negative about gay men since the AIDS crisis. Forty-one percent disagree that "homosexuality is a natural expression of love and affection". Scores on the homophobia scale are found to be negatively associated with the subjects comfort in working with a person with AIDS. A majority of the respondents who have a greater knowledge of AIDS report significantly higher levels of comfort in provision of social work services to patients with AIDS, less fear of contracting AIDS from the AIDS patients, and, tend to be less homophobic.

Homophobia and Counseling

There have been many empirical studies about
homophobia and counseling. Rudolph (1988) finds that the
counseling profession holds divergent opinions regarding
the acceptability of lesbians and gay men. As many as
one-third in many samples express negative attitudes about
lesbians and gay men. There seems to be a belief at one
and the same time, in the psychological health and
potential pathology of lesbians and gay men. There is a
belief in the ability of lesbians and gay men to fully
function in any situation, and yet to be hampered in their
performance in certain positions by the very fact of their
sexual orientation. There is also the belief that the
locus of the lesbians' and gay men' problems to be both
internal and societal.

Homophobia Among University Students

Many studies examine homophobia among university
students. Some of the research looks at the impact of
gender and other personal characteristics. Personal
interaction with lesbians and gay men is also a factor in
determining whether an individual is likely to be
homophobic. Davison & Friedman (1982) asked psychology
students for their clinical assessment of a man who has
extramarital affairs. The subjects ($\underline{n}$=235) received
characteristics and behaviors indicative of a
psychological problem identical to both hypothetical
situations. Results show that when the man is described
as having gay involvements, he is more likely to receive a
diagnosis of sexual deviation or his nonsexual diagnosis

is justified on the basis of sexual orientation, and more likely to construe his sexuality as important in the etiology of his nonsexual psychological problems. The subjects also are more interested in obtaining information about the patient's sexuality, or feminine or masculine feelings, as being important in the etiology of the patient's problems than those who hear of heterosexual affairs.

Jackson & Sullivan (1989) studied university students' ($\underline{n}$=131) evaluation of lesbian, gay and heterosexual applicants to a graduate program. The subjects were told that the researchers were interested in how the nature and quality of information about graduate school applicants influenced the evaluation of the applicants. The lesbian or gay applicant received more negative reviews and fewer expected success in both the graduate program and their careers. It suggests that negative affect predicts evaluations of lesbians and gay men but not heterosexuals.

Istvan (1983) studied 110 female and 102 male undergraduates' perceptions that lesbians and gay men were obsessed with sex. The targets were evaluated with regard to likeability, work partner desirability, intelligence, morality, adjustment, and along dimensions that assessed perceptions of sexuality. The results show that exclusive heterosexuals were seen as more likeable, moral, and well-adjusted than all persons with any lesbian or gay experience.

Page and Yee (1985) studied undergraduate students

(n=85) enroled at the University of Windsor, Windsor, Ontario for their stereotypes of lesbians and gay men. Thirty subjects were asked to construct a profile of a "male homosexual"; 27 profiled the "lesbian"; and, 28 profiled a "normal, healthy adult". The findings suggest that gay men are viewed unfavorably and significantly different from the "normality" when compared to the "normal adult". Male gender nonconformity is viewed more seriously than female nonconformity. This nonconformity is viewed as a personal maladjustment. Lesbians and gay men were profiled by both sexes in a largely negative fashion.

Kite and Deaux (1986) assessed university students (n=206) for their beliefs about characteristics of lesbians, gay men and heterosexuals. The results suggest that gay men are perceived to have characteristics of female heterosexuals. Lesbians are believed to be similar to male heterosexuals. The results support a bipolar model of gender stereotyping that devalues any sexual nonconformity and encourages homophobia.

Sigelman, Howell, Cornell, Cutright and Dewey (1991) studied male university students (n=116) for their perception of associating with a gay person. The stimulus person was deliberately endowed with both positive and negative, and masculine and feminine stereotyped interests and behaviors so that respondents could, depending on their inclinations, attribute either gay or heterosexual tendencies to the target. Forty-seven percent of the respondents report purely negative answers. The results

suggest that the gay "labeled" student is seen as having significantly stronger gay tendencies than the other three stimulus targets. Subjects with high negative attitudes toward gay men perceive more gay tendencies in the stimulus target than those with a more tolerant attitude. All subjects view the gay stimulus individual to be significantly less mentally healthy than other stimulus targets.

Hudson and Ricketts (1980) developed a homophobia scale (Index of Homophobia) by utilizing 300 students from social work, sociology and psychology. The subjects volunteered in this nonrandom purposive sample. The IHP has a coefficient alpha of .901. The results indicate that 55% of the respondents scored in the homophobic range. Seven percent have a high grade homophobic scores. Better educated people are more tolerant of alternative lifestyles and hence less homophobic.

Young and Whertvine (1982) examined 190 heterosexual college students on attitudes toward lesbians' and gay men' behavior. The findings suggest that generally negative attitudes are expressed about lesbians and gay men and their sexual behaviors. Males declare more negativity than females.

Millham, San Miguel and Kellogg (1976) examined undergraduate students' attitudes about lesbians and gay men. Thirty-eight items were generated which reflect a wide spectrum of opinions concerning lesbians and gay males. These include statements of emotional reaction to lesbians and gay men, their status under the law, their

mental health, acceptance of various behavior stereotypes,
and moral-ethical aspects of lesbians and gay men.
Demographic data on religious preferences, ethnic
background, geographic background, marital status, and
previous exposure to a lesbian or gay friend or relative
was obtained. The results suggest that males have a
higher personal anxiety of gay males than females. Having
a lesbian or gay friend or relative results in
significantly lower personal anxiety, less advocation of
repression, and lower moral reprobation scores in
describing both lesbians and gay men.

Homophobia and Personal Interaction

Some studies have examined individual's interactions
with lesbians and gay men. Lance (1987) studied 51
university students for the effects of interactions with
lesbian and gay males on attitudes toward them. The
author suggests that lesbians and gay men represent a
threat to strongly sex-typed perceptions of acceptable
male and female behavior. These include: lesbians and
gay men suffer from gender confusion; and, lesbians and
gay males adopt patterns of the other sex. Two classes in
a human sexuality course were given the Index of
Homophobia Scale (Hudson & Ricketts, 1980). One class
completed the questionnaire prior to a three hour session
of exposure and interaction with a self-identified lesbian
or gay male. The second class filled out the
questionnaire after the three hour session of exposure and
interaction with a self-identified lesbian or gay male.
The results suggest that an interaction with a lesbian or

gay male lead to a reduction in discomfort with lesbians and gay men. Eighty-two percent of those subjects who interacted with lesbians and gay males prior to answering the questionnaire express low to moderate discomfort with lesbians or gay men. Sixty-two percent of those students who completed the survey prior to the interaction with the lesbians and gay males express a high degree of discomfort with lesbians and gay men.

Whitley (1990) studied the relationship of heterosexuals' attributions for the causes of homosexuality to attitudes toward lesbians and gay men. One hundred ninety-three female and 173 introductory psychology students participated in this group administered questionnaire. Same-sexed groups of 10 to 25 were randomly assigned one of two versions of the questionnaire which either refers to a lesbian or gay male as the stimulus person. The researchers used a 2 (Sex of respondent) X 2 (Sex of target person) between subjects design. The results suggest that those individuals who were less conservative, who were older, and who held less traditional sex role beliefs hold less negative attitudes toward lesbians and gay men. Less negative attitudes are also associated with a more stereotypically masculine behavior pattern. Heterosexuals' attitudes toward same-sexed lesbians and gay males are more negative than those toward the opposite-sex lesbian or gay male. Heterosexuals who knew a gay person have a more positive attitude toward lesbians and gay men than those who did not.

In a Solomon Four-Group Experimental Design 92
volunteer college students were studied for their
attitudes toward lesbians and gay men (Pagtolun-An &
Clair, 1986). The subjects were randomly assigned to one
of the four groups. The Index of Homophobia Scale (IHP)
(Hudson & Ricketts, 1980) was utilized. Both the
experimental and control groups were administered the IHP
as a pre- and post-test. The two remaining groups
received only a post-test survey. The independent
variable was positive social interaction with a lesbians
and gay men. The dependent variable was the degree of
homophobia. The experimental treatment consisted of a gay
male having positive interaction with the experimental
group. This included that individual playing the role of
a guest speaker for the class and answering questions
about lesbians and gay males. The post-test was
administered after this interaction. The findings
indicate that positive interactions with the gay male have
a positive effect on changing negative behavior or
stereotypes concerning lesbians and gay men. Females hold
lower negative scores than males of lesbians and gay
males. Subjects who have prior associations with lesbians
and gay men hold lower ratings on the IHP.

Homophobia and Gender

Homophobia seems to be affected by gender. Sex
differences in reactions to lesbians and gay men were
examined by Steffensmeier and Steffensmeier (1974). Two
hundred and five undergraduates responded to a social
distance scale exploring for their attitudes. The major

variables studied were the sex of the stimulus target, sex of the reactor, and acceptance of two commonly held stereotypes: perceived danger and psychological disturbance. Two questionnaires were randomly distributed to the students. One questionnaire with a gay male target, and the other a lesbian target. A ten-item social distance scale to which Guttman scaling criteria were applied was used to measure rejection of the lesbian and gay male. More than two-thirds of the sample agree with the stereotype characterizing lesbians and gay men as psychologically disturbed. Thirty-eight percent of the respondents think a gay male is dangerous. A primary factor determining rejection is the extent to which the lesbian and gay behavior is considered "sick" and "dangerous". Gay men are more likely to be rejected than lesbians. Male subjects are more rejecting of lesbians and gay males than were female subjects.

Gentry (1987) studied social distancing from heterosexual females and males and lesbians and gay males by 201 undergraduates. The participants were randomly given a questionnaire with either a lesbian or gay stimulus target. The subjects report a higher degree of discomfort toward same-sex lesbian or gay male than toward opposite-sex lesbian or gay male. Social distancing is positively correlated with the frequency of religious participation. Having a lesbian or gay friend is associated with higher levels of social contact with that person. The gay male is associated with being sick, dangerous, sinful, effeminate, and mentally ill. The

author suggests that these reactions are a function of stereotyping. The content of the stereotype is critical for the understanding the social distancing from lesbians and gay men. The stigmatization of and negative sanctions against lesbians and gay men in society at large are such that any expression of feeling among and between men is perceived as effeminate and taboo.

Social work and homophobia

A number of recent studies have confirmed that homophobia is a problem that can effect the provision of services by social workers. Wisniewski & Toomey (1987) studied social worker's (n=77) homophobia. The researchers mailed a questionnaire that contained the Index of Attitudes toward Homosexuality (IAH) (Hudson & Ricketts, 1980) and a scale which measured cynicism, intolerance or ambiguity, conformity, and anti-intellectual attitudes. One third of the participants expressed homophobic attitudes. The study was explained in a cover letter as an assessment of differences among social workers in how male clients with either a heterosexual or gay preference are perceived. The authors hoped to assess whether social workers evaluate gay or heterosexual males differently based on information provided in a case history. Twenty-five percent of the respondents score on the IAH in the low-grade homophobic range. High-grade homophobics represent 6.5% of the sample. The results also indicate that two measures of authoritarianism explain a small but significant portion of the variance in IAH scores for social workers when a

stepwise multiple regression analysis is completed with the participants' scores on the IAH as the dependent variable.

In another study mental health professionals ($\underline{n}=140$) were surveyed for the attitudes toward lesbians and gay men (DeCrescenzo, 1984). In addition to 23 demographic variables, this exploratory-descriptive research design included measures to assess three distinct aspects of homophobia: stereotypic thinking; lesbians and gay men as psychopathological; and, "general" homophobia. Participants were asked to rate their own sexual orientation on the Kinsey Scale (1948). Results indicate that social workers achieved the highest homophobia scores when compared to other mental health professionals. Those who identified as exclusively heterosexual perceived lesbians and gay male in more stereotypic terms. Those who knew a lesbian or gay male held less homophobic attitudes than those who did not know a lesbian or gay male.

Having a communication problem is significantly associated with the inability of the lesbian or gay client being able to discuss her or his sexual orientation with her or his therapist (Dardick & Grady, 1980). Six hundred and twenty-two individuals responded to a mailed questionnaire that included: background demographics; sexual behavior in the last year; degree of openness about sexual orientation; utilization of health professionals during the past year; openness with health professionals and their sexual orientation and attitude

toward lesbians and gay men as perceived by respondent;
respondent's preference for health professionals of a
particular sexual orientation; and, medical care
including patient satisfaction, perceptions of competence,
ease of communication, screening (of men) for venereal
disease, and treatment (of women) for vaginitis. The
findings found that only 63% of the men shared their
sexual orientation with their health professional. Only
49% of the women shared this information with their
primary health professional. Whereas six percent of the
men stated that they would not divulge their sexual
orientation under any circumstances, 10% of the women were
in this category. Those who explicitly revealed their
lesbian/gay status to their primary health professional
were much more satisfied with that person. Twenty-five
percent of respondents indicated that there were things
they would like to discuss with their primary health
professional but did not for some reason. Thirty-two
percent of the respondents had a communication problem
with their health professional where they felt they could
not discuss openly their sexual orientation. Twenty-seven
percent stated that they felt that they had dealt with a
health professional who was prejudiced against lesbians
and gay men. Twenty-one percent think that their current
health professional was not supportive of lesbians and gay
males.

The Fear of AIDS Scale and Homophobia Scale

A study by Bouton et al. (1987) examined the
connection between AIDS and homophobia. The Fear of AIDS

Scale was developed. The researcher generated about 40 items then pared these down to 20. This was administered to group of 90 freshmen introductory psychology students who acted as judges. Three different orders of the 20 items was utilized to avoid order bias. An 11-point scale was used to rate the degree to which each statement expressed a fear of AIDS.

A low rating indicates that the item reflected little fear of AIDS, and a high rating indicates a high fear of AIDS. Median and semi-interquartile range of the ratings by the 90 judges were found for each item. Statements were included in the Fear of AIDS Scale only if their medians had fallen outside of the middle range of possible values and if their variabilities were relatively low. An equal number of positive and negative statement were selected, seven of each.

The authors also developed the Homophobia Scale (1987). An initial sample of 30 statements about lesbians and gay men was developed. A final list of 18 items remained after preliminary culling. Again three different orders of statements were used to reduce the possibility of position bias. The judges rated the items by using an 11-point scale to reflect the presence or absence of homophobic statements.

Inclusion in the Homophobia Scale (1987) required: a median rating falling outside of the middle range of possible values; a relatively low degree of variability; and, approximately equal number of positive and negative items. Three positive and four negative statement were

chosen.

The authors then tested 528 students (258 females and 266 males) at the University of Texas at Austin. The different items from the two scales were randomly placed in the questionnaire. A Likert-type coding system was utilized. The scales were administered to groups of approximately 50 students. At least one female and one male experimenter were in attendance at each application of the instrument. Three other scales were also included in this group-administered survey. These scales includes an 11-item Irrational Behavior Change scale, a 11-item Rational Behavior Change scale, and, a 17-item Knowledge of AIDS test. Subjects were asked for their age, grade point average, political and religious affiliation, sorority or fraternity involvement, number of opposite partners, and acquaintance with lesbians and gay men.

This process was repeated using an alternate questionnaire that utilized a different order of the same statements. The response that was given by this second observation of the dependent variable was used to estimate the reliabilities of the two scales and was also used in factor analyses of the scales. The Fear of AIDS Scale has seven positive questions where the answer "strongly agree" represents little or no fear of AIDS. There are also seven negative questions where the answer "strongly agree" represents a fear of AIDS. The Homophobia Scale has three positive questions where the answer "strongly agree" represents little or no homophobia. There is also four negative questions where the answer "strongly agree"

represents a homophobic response.

The researchers hypothesized that if only a single attitude or factor underlay the two scales, then fear of AIDS and homophobia would be highly correlated. If the two attitudes were independent on one another then at least two attitudes would be measured by the two scales and the correlation between the two scales would be relatively low.

The results indicate that the two scales were reliable. The Fear of AIDS Scale and the Homophobia Scale were found to have Cronbach alpha reliabilities of .80 and .89, respectively. The correlation between the two scales is .55. Although the scales were significantly related (p < .001), the amount of variance shared between the two is only about 30%. Comparisons between males and females were made. Males were more homophobic than females.

A factor analysis was computed on each of the two scales to identify those attitudes measured by the two scales. Three factors emerge from this analysis of the Fear of AIDS Scale which seem to be measuring three different variables. These include: a fear of contact factor; a question of public health; and, a personal fear of contracting AIDS. One factor on this analysis of the Homophobia Scale emerges. This factor is an attitude toward lesbians and gay men. The data suggested that the attitudes measured by the two scales were independent of one another and did not represent a single underlying attitude.

The scores from the Fear of AIDS Scale were analyzed

according to the background variables (Bouton et al., 1989). Conservative respondents are more fearful of AIDS than are liberal respondents. Protestant religious groups tended to be more fearful of AIDS than are other groups. Members of sororities and fraternities were more fearful of AIDS than were nonmembers. Number of sex partners of the opposite sex was found to be positively related to fear of AIDS. Acquaintance with lesbians and gay men was negatively related to fear of AIDS.

The scores from the Homophobia Scale were also analyzed by the background characteristics. Conservatives were more homophobic than liberals. Frequency of church attendance and religious affiliation was related to homophobia. Sorority and fraternity members were found to be more fearful of lesbians and gay men than nonmembers. Homophobia was negatively correlated with acquaintance with lesbians and gay men. The authors summarized by stating that the person who would tend to be most fearful of AIDS and most homophobic would be a conservative, church-attending Protestant who belonged to a sorority or fraternity but who did not know any lesbians or gay males.

Other researchers have also developed scales testing for fear of AIDS and homophobia. McDevitt, Sheehan, Lennon and Ambrosio (1990) designed the AIDS Phobia Scale and the Homophobia Scale. The researchers were able to develop a 14 item AIDS scale and a 21-item homophobia scale after culling and rating. Both scales equalled or exceeded a Cronbach alpha of .89. The instrument was group-administered to 733 university students. The

results indicated that AIDS phobia and homophobia scales were highly associated. Men reported more fear of AIDS and homophobia than women.

Summary

AIDS invokes many fears but particularly one of contagion even when people know they have a low risk factor for infection. Much of the research on this concept was obtained by surveying college and university students. Results show that there is a need to socially distance oneself from a person with AIDS. Those with AIDS are perceived to be responsible for their affliction, particularly the gay male with AIDS. Included in these studies, social work students and practitioners have responded to questionnaires about AIDS. Both have exhibited fear of AIDS regardless of age, sex, race, or educational status. AIDS is having a major impact upon social service delivery and social workers have been profoundly influenced by AIDS, some negatively.

Many studies have demonstrated a strong positive correlation between fear of AIDS and homophobia. The advance of AIDS has brought a backlash of repressive attitudes toward gay men even by social workers. Gay males are perceived to be more responsible for their condition than other seriously ill patients. In studies on homophobia and therapist interaction with lesbians and gay men, these clients report strained therapeutic relations. Lesbians and gay men report that they feel that they cannot report their sexual orientation for fear of reprisals or discrimination. Homophobia appears to be

related to gender stereotyping and required of males. Males tend to be more homophobic than females. Some studies have demonstrated that up to one third of the sample of social workers express homophobic attitudes.

Bouton et al. (1987) developed the Fear of AIDS Scale and the Homophobia Scale. They have alpha reliability coefficients of .80 and .89 respectively. Other researchers have attempted to develop scales testing for the same concepts.

CHAPTER IV

RESEARCH METHODOLOGY

The conceptual framework is considered a frame of reference that serves to guide the study (Grinnell, 1985). A research of relevant literature helps to identify independent and dependent variables as well as to predict relationships among them. The appropriateness of the research as well as its reliability and validity can be scrutinized (APA, 1988).

The Research Methodology will set forth: the classification of the research design; the research questions; the concepts; the operational definitions; purpose of the study; the setting; the population; the sample; the research design; the instruments; data collection; methods of data analysis; and, the limitations of the study.

Classification of the Research Design

This study is an example of an exploratory-descriptive study. Tripodi, Fellin and Meyer (1983) suggest that exploratory-descriptive studies are those studies which seek to describe a particular phenomenon (p. 40). Further, exploratory studies help to familiarize a researcher with a concept so as to formulate research questions and stimulate future research efforts. Royse (1991) states that exploratory surveys provide beginning information so that more rigorous studies can be implemented (p. 103).

Research Questions.

General research questions develop from the prior

components of the proposal (Grinnell, 1985, p.452). These help to identify the specific aspects of the topic to be studied. These should help to define in terms of the perspective and definitions provided by the literature review and conceptual framework. The research design and conceptual framework are given substance by the following questions:

1. Do social work students have a fear of AIDS?
2. Are social work students homophobic?
3. If a social work student knows a person with AIDS, will she or he express less fear of AIDS?
4. If a social work student knows a gay person, will she or he express less homophobia?
5. If a social work student expresses a knowledge of lesbians and gay men or the gay lifestyle, will she or he express less homophobia?
6. Will age, gender or educational status have an impact on fear of AIDS and homophobia scores?

The Concepts

The following concepts have been formulated according to ideas obtained in the review of the literature.

Lesbian or gay male denotes those individuals who recognize that they have tendencies for engaging in same-sex sexual acts, or, who have a self-image and self-concept as being lesbian or gay.

AIDS is the acronym for acquired immunodeficiency syndrome and, for the purposes of this study, includes those who test positive for the human immunodeficiency virus (HIV). AIDS classifies as a condition that is the

result of the Human Immunodeficiency Virus (HIV). The presence of HIV causes the immune system of an individual to malfunction which allows the invasion of opportunistic diseases against which the individual's body has no defense, and tends to result in that person's death.

Fear of AIDS is an anxiety invoking reaction to the nature and etiology of AIDS.

Homophobia is a fear or intolerance of lesbians and gay men.

Gay lifestyle is the social network of friends, commercial establishments, and support groups that attract the lesbian and gay community.

Knowledge of the gay lifestyle refers to the self-perceived level of information a person believes she or he knows about the lesbian and gay subculture and practices.

Knowing someone who AIDS refers to the self-report of the research participant, answering whether she or he knows someone with AIDS.

Operational Definitions

Operational definitions allow the researcher to specify the devices that will be used to measure variables (Weinbach & Grinnell, 1987). The meaning of variables must be clarified by reducing them to observable and measurable dimensions. Operationalization attaches meanings to the different values of the variables.

Social work students are those individuals who have been accepted into the School of Social Work at the University of Windsor, Windsor, Ontario. This School is recognized by the Canadian Association of Schools of

Social Work as an accredited educational institution. The students meet criteria as stated in the University of Windsor calendar (1988).

Fear of AIDS score is obtained by using the Fear of AIDS Scale (Bouton et al., 1987).

Homophobia score is obtained by using the Homophobia Scale (Bouton et al., 1987).

Prior association with a person with AIDS is determined by the self-report of this concept by the respondents.

Prior association with gay men (and lesbians) is determined by the self-report of this concept by the participants.

Understanding the gay lifestyle is determined by the self-report of this concept by the respondents.

Knowing someone who has AIDS is determined by the self-report of this question by the participants.

Purpose of the study

This study examines social work students' scores on scales testing for fear of AIDS and homophobia. It is conjectured that fear of AIDS and homophobia will have an effect upon any client/therapist interaction that these students may encounter with a person with AIDS or who is lesbian or gay.

The setting

The setting was the University of Windsor, Windsor, Ontario. Classroom time was utilized for application of the instruments.

The population

The population represents the total set from which the individuals of the study are chosen (Grinnell, 1985). The totality of persons for this research design is the social work students who are enroled in the School of Social Work at the University of Windsor, either in the Bachelor of Social Work program, or the Master of Social Work program. The enrolment for the undergraduate class was 123. The enrolment for the graduate class was 25. This provides an N of 148.

The sample

The students offer a finite population at the School of Social Work, University of Windsor. The sample represents an example of non-random availability sampling (Grinnell, 1985). These procedures are used when the probability of inclusion in the sample is unknown and is usually different for each person or unit in the sample. Grinnell (1985) states that nonprobability samples are suited to exploratory studies where investigators are merely interested in obtaining as much unique data on a research question as possible.

Research Design

Research designs are logical strategies for planning research procedures and providing evidence for the development of knowledge (Grinnell, 1985). Levels of desired knowledge are identified. Criteria for establishing knowledge is specified.

This study is an example of a non-random availability sample survey research method. The group-administered

survey is chosen because of its benefits. Grinnell (1985)
notes the advantages of survey research that include:
acquisition of the largest number of participants in the
shortest amount of time; standardized wording; greater
assurance of anonymity; and, the researcher's ability to
come in contact with the study's population.

The disadvantages of survey research is noted to
include: a lack of flexibility in question format, which
prevents varying the items or probing (as is possible in
interviewing); high potential for low response rate;
and, the use of written responses only where nonverbal
behavior and other characteristics cannot be documented
(Bailey, 1978).

The Instruments

The Fear of AIDS Scale and Homophobia Scale developed
by Bouton et al. (1987) is used in this study. The Fear
of AIDS Scale has 14 items, seven of which are positive
and seven which are negative. A response of "strongly
agree" on a positive item is coded as a numerical value of
zero (0) that represents little fear of AIDS. On a
negative item, a "strongly agree" receive a numerical
coding of four (4) that represents a fear of AIDS. The
Homophobia Scale has seven items, four of which are
negative and three which are positive. On a positive
item, a "strongly agree" is coded numerically as zero (0)
which represents little or no homophobia. A response of
"strongly agree" on a negative item is coded with a
numerical value of four (4) that represents a homophobic
attitude. The Fear of AIDS Scale and the Homophobia Scale

have Cronbach alpha reliabilities of .80 and .89 respectively.

The subjects were also asked to give their age, sex, whether she or he has an understanding or knowledge of the gay lifestyle, whether she or he knows someone who is lesbian or gay, whether she or he associates with that person on a regular basis, and, whether she or he knows someone with AIDS. The items from the Fear of AIDS and Homophobia Scales were alternated at random to place positive and negative back-to-back items as best possible so as not to have a flow or either negative or positive items.

Data Collection

The instruments were applied after obtaining permission from the School of Social Work at the University of Windsor. Classroom time was utilized for all subjects. Group-administration of this questionnaire was used to increase the response rate. The subjects were informed that their participation was voluntary and anonymous prior to passing out the questionnaire. The participants signed consent forms, acknowledging that they understood that they were participating in a voluntary study, and that the results would be make available through the School of Social Work when the study was completed.

Methods of Data Analysis

The data was analyzed by utilizing The Statistical Package for the Social Sciences (SPSS-PC). Descriptive statistics, i.e., frequency tables and percentages, was

used. Bivariate analysis is presented as cross-tabulations. Reliability coefficients for the two scales, factor analysis, and correlations are presented.

Limitations

This study can be generalized only to the students who are enroled in the School of Social Work at the University of Windsor. The population for this study is not meant to be representative of all social work students registered in social work programs elsewhere. The distributional curves for the sample cannot be obtained from other schools to determine representativeness of this study's sample.

Another limitation may be the "Hawthorne Effect", or the fact that the students knew that they were being "studied", and therefore may give socially desirable answers. This would seem to be relevant since the implication or undertone of the instrument certainly goes against basic social work ethics and questions the value system of the student.

Summary

This study is an example of an exploratory-descriptive research design. The research questions were posited, centering around the students' fear of AIDS and homophobia. There are six research questions in all. The research questions and concepts were defined by the literature review. The purpose of the study was to examine social work students fear of AIDS and homophobia scores by utilizing scales testing for these issues. The subjects were social work undergraduate and graduates

students enroled in the School of Social Work at the University of Windsor, Windsor, Ontario. Limitations for the study can be that the participants gave socially desirable answers and that the results can only be generalized to the population studied.

CHAPTER V

DATA ANALYSIS

The data was analyzed by using descriptive
statistics, cross-tabulations, reliability coefficients of
the two scales, factor analysis, and correlations. This
was accomplished by using SPSS-PC.

Age and Gender of Social Work Students

This section examines the age and gender of the
social work students. Table 5.1 displays the age and
gender of the social work students. The mean age for the
sample is 26.91 years. The minimum and maximum age are 21
and 48 respectively.

Female students represent 79.8% of the sample.
Undergraduate females account for 69.7% of the
respondents. Graduate female students represent 10.1%.
The mean age for females is 26.38.

Male students account for 20.2% of the sample. There
is an equal distribution of men in both undergraduate and
graduate programs with nine students in each respectively.
The mean age for males is 29.

The largest age grouping (21-22) accounts for 34.9%
of the participants and are all undergraduates,
predominantly female (30.4%). The mean age for
undergraduates is 25.97 while the graduates' mean age is
30.61.

Table 5.1
Age and gender of social work students

| Age | Undergraduate | | Graduate | |
| | Female | Male | Female | Male |
	f	f	f	f
21-22	27	4		
23-24	11	2	3	2
25-30	13	1	3	2
31-40	7	1	2	5
> 40	4	1	1	
Total	62	9	9	9

$\underline{n}$=89 $\underline{M}$=26.91 $\underline{SD}$=6.936

Social Work Students' Awareness of the Gay Lifestyles or Persons with AIDS

Social work students were asked for their awareness of the gay lifestyles or persons with AIDS. The social work students were asked the question: "Do you feel that you have an understanding or knowledge of homosexual or gay lifestyle?" Twenty-five percent of the subjects report that they feel that they have an understanding of the gay lifestyle. The majority of participants (66.3%) state that they "somewhat" have a knowledge of the gay lifestyle. Only 7.9% respond that they did not have an understanding of the gay lifestyle.

The students responded to the question: "Do you know anyone who is homosexual / gay?" Those who responded

affirmatively account for 74.1% of the participants, leaving 25.8% who do not know someone gay.

The participants were asked the question: "If yes, do you associate with this person on a regular basis?" Only 13.5% state that they associate with this person "often", while 36% do so on a "sometimes" basis. Twenty-seven percent respond that they associate "not often" with this (gay) person.

The social work students were asked the question: "Do you know someone with AIDS?" Students who know someone with AIDS represent 28.1% of the sample. Those who do not account for 71.9%.

Results of the Fear of AIDS Scale

This section reports the results of the Fear of AIDS Scale. Table 5.2 illustrates the Fear of AIDS items as well as the ranked means. The scores are obtained by totalling the responses to 14 items: 1, 3, 5, 7, 9, 11, 12, 14, and 16 through 21. There are seven negative items and seven positive items. Scores on the positive items were coded from a range of "0=strongly agree" to "4=strongly disagree". Negative items were reversed coded, i.e., "0=strongly disagree" ranging to "4=strongly agree" which were coded at the time of analysis.

The one item that has the highest mean (3.22) is item 18 which asks whether the disease is not being recognized as a serious health problem. This concern is also indicated by items 21 (M=2.55) and 11 (M=2.31). The item that reveals the second highest level of anxiety about AIDS is item 9 (M=2.71) which pertains to whether the subject would still have sex with a person with AIDS.

Table 5.2
The Items and Ranked Means of the Fear of AIDS Scale

Item	M	SD
18: Compared to other public health problems, I think AIDS is a very minor problem.	3.22	.93
9: If I found out that my lover had AIDS, I would still have sex with him/her.	2.71	1.16
21: The seriousness of AIDS is greatly overblown by the media.	2.55	1.24
11: AIDS will become a severe and widespread epidemic.	2.31	.92
1: If I found out a friend or lover had AIDS I would be afraid to kiss him/her.	1.62	1.05
7: A centralized file containing the names of all people known to have the AIDS virus should be created.	1.12	.74
3: I am afraid I will catch AIDS.	1.11	1.13
16: I believe public officials when they say AIDS cannot be transmitted through casual contact.	1.03	.88
5: I would object to sending my non-infected child to school which had a child who has AIDS.	.92	.89
17: I am worried about catching AIDS in a public restroom.	.81	.89
12: Even if a friend had AIDS, I wouldn't mind touching him/her?	.76	.74
20: AIDS children should be allowed to attend school.	.69	.91
19: If I found out a friend had AIDS, I would be afraid to hug her/him?	.55	.74
14: I wouldn't mind being in the same room with a friend who had AIDS.	.46	.57

* Note: Positive items were scored "0=strongly agree" and "4=strongly disagree". Negative items were scored "4=strongly agree" and "0=strongly disagree". Positive items numbers: 9, 12, 14, 16, 18, 20, and 21.

Table 5.3 illustrates the scores of students on the Fear of AIDS Scale. The mean score is 19.876 which falls into the low-moderate range of fear of AIDS. The range of scores is 30 with a minimum of 7 and a maximum of 37.

Ther₋ is little difference between female and male social work students' scores on the Fear of AIDS Scale. The mean score for females is 19.68 with a standard deviation of 6.06. The mean score for males is 20.67 with a standard deviation of 6.98.

There appears to be a difference between the undergraduate and graduate scores on the Fear of AIDS Scale. The undergraduate class had higher ratings. The mean score for undergraduates is 20.89 with a standard deviation of 6.03. The mean score for graduates is 15.89 with a standard deviation of 5.48.

Students who score in the low range, which represents a low fear of AIDS reaction, account for 6.8% of the ·ample. Those in the low-moderate range represent 59.5%. Th·· moderate range accounts for 32.5% of the students' sco₋ ·s.

Table 5.3
Social work students' scores on the Fear of AIDS Scale.

Score	Rating	Undergraduate f	Graduate f
0-10	low	3	3
11-22	low-moderate	40	13
23-34	moderate	27	2
35-46	moderate-high	1	
47 >	high		
	Total	71	18

n=89   M=19.876   SD=6.228

Results of the Homophobia Scale

The Homophobia Scale is used to obtain scores of the
social work students' attitudes concerning homophobia.
There are seven items in this instrument: items 2, 4, 6,
8, 10, 13, and, 15.   There are three positive and four
negative items. Table 5.4 displays these items. Positive
items were coded ranging from "0=strongly agree" to
"4=strongly disagree". Negative items were reversed
coded, i.e., "4=strongly agree" ranging to "0=strongly
disagree".

Table 5.4 displays the ranked means of responses of
students to the Homophobia Scale. It is interesting that
the two items (#4 and #2; M=1.02 and M=1.01 respectively)
with the highest means present lesbians and gay men in a
positive light. While the homophobia ratings appear to be

low, the concept of lesbians and gay males as equals in a heterosexual-dominated society appears to be difficult to accept. In the study by Wiener and Siegel (1990) of practicing social workers, 41% disagree that "homosexuality is a natural expression of love and affection".

Social work students seem to think that being lesbian or gay is not a reason to deny that person their civil rights as indicated in item 6 which has the lowest ranked item mean.

Table 5.4
The Items and Ranked Means of the Homophobia Scale

Item	M	SD
4: Homosexuals are just as moral as heterosexuals.	1.02	.90
2: Homosexuals contribute positively to society.	1.01	.91
15: Homosexuality is a sin	1.00	1.01
',: Homosexuality is disgusting	.99	.90
13: Homosexuals corrupt young people.	.71	.77
8: Homosexuality should be against the law.	.56	.78
6: Homosexuals should have equal civil rights.	.49	.68

* Note: Positive items were scored "0=strongly agree" and "4=strongly disagree". Negative items were score "4=strongly agree" and "0=strongly disagree". Positive items: 2, 4, and 6.

Table 5.5 displays the students' ratings on the Homophobia Scale. The mean is 5.79 with a standard deviation of 4.47. The mean falls in the low-moderate range. The median is six. The range of 21 occurs between a minimum of zero and a maximum of 21.

The mean for females is 5.62 with a standard deviation of 4.26. The mean for males is 6.44 with a standard deviation of 5.29.

The mean for undergraduates is 6.65 with a standard deviation of 4.42. The mean for graduates is 2.39 with a standard deviation of 2.75.

Those who have a low rating on this scale account for 39.3% of the sample. Social work students in the low-moderate range represent 42.7%. Those in the moderate range account for 13.5%. Those who score in the moderate-high and high ranges represent 3.4% and 1.1% respectively. The majority (82.0%) of social work students score in the low-moderate or low range. Eighteen percent hold a moderate or higher homophobia response.

These results differ from Wiesniewski and Toomey (1987) where one third of the sample of social workers express homophobic attitudes. In a study of social workers by Dhooper, Royse and Tran (1987/88), 30% disagree that lesbians and gay men have an acceptable lifestyle. Forty-one percent of a study of hospital social workers disagree that "homosexuality" is a natural expression of love and affection (Wiener & Siegel, 1990).

Table 5.5
Social work students' scores on the Homophobia Scale.

Score	Rating	Undergraduate f	Graduate f
0- 4	low	21	14
5- 9	low-moderate	34	4
10-14	moderate	12	
15-19	moderate-high	3	
20 >	high	1	
	Total	71	18

n=89   M=5.787   SD=4.471

Correlational Analysis

Coefficients that measure the strength of the relationship are generally called measures of association or correlation. In this study, Pearson's product moment correlation coefficient (r) is used for calculating correlations.

Table 5.6 illustrates the correlation coefficients of various variables and the Fear of AIDS and Homophobia Scales. There appears to be no association between the age and sex of the subjects with either of the two scales. There is a strong negative association between knowing a lesbian or gay male and the Homophobia scale scores. If a subject knows someone who is lesbian or gay then that person has a tendency to have a lower homophobia score.

There is also a strong negative association between when a subject associates more often with a gay person on both the scales. This results in less fear of AIDS and a lower Homophobia rating when the subject associates with a lesbian or gay male more often than not. There is a moderate negative association on both scales when the participant expresses an understanding of the gay lifestyle. The more a respondent states that she or he has this understanding results in less fear of AIDS and less homophobia.

There is a strong negative association between education level and fear of AIDS and homophobia. The more educated individual exhibits less fear of AIDS and less homophobia.

There is a strong positive correlation between the Fear of AIDS Scale and the Homophobia Scale as indicated by an r value of positive .54 ($p<.001$). As scores on the Fear of AIDS Scale tend to go higher so do the scores on the Homophobia Scale. Seventy-one percent of those respondents who disagree with the gay (and lesbian) lifestyle are in the category representing the most fear of AIDS in a study by Dhooper, Royse and Tran (1987/88). Eighteen percent of the study of social workers by Wiener and Siegel (1990) state that they feel more negative about gay men since the AIDS crisis. High ratings of homophobia, fear of contagion, and negative moral attitudes are indicative of negative attitudes of persons with AIDS.

Table 5.6
Variable Correlations with Fear of AIDS Scale and
Homophobia Scale

Variable	Fear of AIDS Rating (n=89)	Homophobia Rating (n=89)
Education level	-.3242 p=.002	-.3848 p=.000
Age	-.1647 p=.123	-.1553 p=.146
Sex	.0642 p=.550	.0745 p=.488
Knowing gay	-.1610 p=.132	-.3459 p=.001
Associating with gay	-.3366 p=.001	-.3817 p=.000
Understanding gay lifestyle	-.2564 p=.015	-.2270 p=.032
Knowing person with AIDS	-.0279 p=.795	-.0712 p=.507

* Note: Two-tailed probability significance levels

Table 5.7 displays the comparison of the study's
variables to the means of the Fear of AIDS Scale and the
Homophobia Scale. There is no significant difference on
the Fear of AIDS Scale for females and males, X^2(11, N
= 89) = 11.42, p<.41. Females and males have no
significant differences in scores on the Homophobia Scale,
X^2(5, N = 89) = 8.42, p<.13. This differs from previous
studies that state males tend to be more homophobic than
females (Young & Whertvine, 1982; Pagtolun-An & Clair,
1986), although the number of males in this study (n=18)

is small.

There is no significant difference at an educational level for fear of AIDS, $X^2(11, \underline{N} = 89) = 5.11$, $\underline{p} < .93$. There is no significant difference for the Homophobia Scale for educational level, $X^2(5, \underline{N} = 89) = 1.70$, $\underline{p} < .89$. As noted in the correlation analysis, there is a strong negative association for both scales where graduate students demonstrate less fear of AIDS and less homophobia.

There is no significant difference whether a subject knows a person with AIDS or not on the Fear of AIDS Scale, $X^2(11, \underline{N} = 89) = 16.68$, $\underline{p} < .12$, and, the Homophobia Scale, $X^2(5, \underline{N} = 89) = 1.29$, $\underline{p} < .94$. Royse, Dhooper and Hatch (1987) in their study of social work students note that a greater knowledge of AIDS and greater empathy is associated with lower fear of AIDS.

There is no significant difference whether a participant knows someone gay or not on the Fear of AIDS Scale, $X^2(11, \underline{N} = 89) = 8.94$, $\underline{p} < .63$. There is a significant difference when a subject knows someone gay and the Homophobia Scale, $X^2(5, \underline{N} = 89) = 18.30$, $\underline{p} < .003$. This is noted in the literature (DeCrescenzo, 1984; Gentry, 1987; Whitley, 1990; Pagtolun-An & Clair, 1986; Millham, San Miguel & Kellogg, 1976).

There is no significant difference when a respondent states an understanding of the gay lifestyle and the Fear of AIDS Scale, $X^2(22, \underline{N} = 89) = 32.54$, $\underline{p} < .07$. When a participant states she/he has an understanding of the gay lifestyle and the Homophobia Scale there is a significant

difference. $X^2(10, \underline{N} = 89) = 18.83$, $\underline{p}<.04$.

Table 5.7
Comparison of Variables to Means of Fear of AIDS Scale and
Homophobia Scale

Variable	Fear of AIDS	Homophobia
	$\underline{n}$=89 $\underline{M}$=19.88	$\underline{n}$=89 $\underline{M}$=5.79
Female student (n=71)	M=19.68	M=5.62
Male student (n=18)	M=20.67	M=6.44
Undergraduate student (n=71)	M=20.89	M=6.65
Graduate student (n=18)	M=15.89	M=2.39
Not knowing person with AIDS (n=64)	M=19.98	M=5.98
Knowing person with AIDS (n=25)	M=19.60	M=5.28
Not knowing someone gay (n=21)	M=21.90	M=8.62
Knowing someone gay (n=68)	M=19.29	M=4.91
Not understanding gay men (n= 7)	M=25.71	M=9.71
Understanding gay men (n=82)	M=19.39	M=5.45

* Note the variable, "associating with someone gay", was not included because results were identical to "knowing someone gay" variable

Reliability Analysis

Research instruments report their reliabilities in a way that resembles a correlation coefficient (Royse, 1991). This is the extent to which an instrument is reliable by being consistent in its measurement of a particular construct (Atherton & Klemmack, 1982). What is needed is similar results under similar circumstances. Internal consistency can be measured by utilizing Cronbach's alpha, or the coefficient alpha. In this a value of "0" signifies low internal consistency and "1" high indicates internal consistency.

Table 5.8 illustrates the reliability analysis of the Fear of AIDS Scale for this study. Bouton et al. (1987) report that the Fear of AIDS Scale has an alpha reliability of .80. The reliability analysis on the Fear of AIDS Scale for this sample gives an alpha reliability of .74 which suggests a modest reliability. If item 11 is deleted the alpha is .76. This is not indicated since the increase in correlation coefficient is small, and that the difference from this application of the scale and the Bouton et al. (1987) study may be due to subject variability and not an indication that item 11 represents some other factor. The deletion of any item will not improve the internal consistency of the research instrument, i.e., it appears the inclusion of the items will maintain instrument reliability.

Table 5.8
<u>Reliability Analysis of Fear of AIDS Scale</u>

	With Item Deleted		Corrected Item Total	Alpha If Item
Item	<u>M</u>	Variance	Correlation	Deleted
1. Kissing/AIDS	18.26	30.95	.58	.70
3. Catching AIDS	18.76	34.27	.24	.74
5. Child/school	18.96	33.32	.45	.71
7. AIDS file	18.75	37.42	.09	.75
9. Sex/AIDS	17.17	33.94	.26	.74
11. AIDS epidemic	17.56	37.70	.02	.76
12. Touching/AIDS	19.11	34.03	.49	.71
14. Same room/AIDS	19.42	34.68	.57	.71
16. Casual contact	18.84	33.20	.47	.71
17. Public restroom	19.07	33.22	.57	.70
18. Minor problem	16.65	35.16	.25	.74
19. Hugging friend	19.33	33.18	.60	.70
20. Children/school	19.19	33.38	.43	.72
21. Seriousness	17.33	34.20	.21	.75

Table 5.9 displays the reliability analysis for the
Homophobia Scale for this study. Bouton et al. (1987)
report an alpha reliability of .89 for the Homophobia
Scale. A reliability analysis of this application of the
scale reveals an alpha reliability of .8665 which is
comparable to the authors. When item 6 is deleted the
alpha is .8725. There would be no rationale for deleting
this item as the application of this scale for this sample
nearly replicated the Bouton et al. (1987) coefficient.
The internal consistency of this instrument has been
maintained with this application and no item can be

deleted to make it a more reliable research instrument.

Table 5.9
Reliability Analysis of Homophobia Scale

Item	With Item Deleted		Corrected Item Total Correlaticn	Alpha If Item Deleted
	M	Variance		
2. Positivity	4.78	14.54	.67	.84
4. Morality	4.76	14.16	.74	.83
6. Civil rights	5.29	17.16	.42	.87
8. Outlawing	5.22	16.04	.53	.86
10. Disgusting	4.80	14.39	.70	.84
13. Corruption	5.08	14.80	.77	.83
15. Sin	4.79	13.99	.66	.85

Rotated Factor Matrix Analysis of Fear of AIDS Scale and Homophobia Scale Items

The rotated factor matrix is used to maximize high correlation and to minimize low correlation (Tabachnick & Fidell, 1989). Higher correlation is associated with higher factor loading.

As noted by the first factor in this study's factor analysis, it is similar to the Fear of Contact factor in Bouton et al. (1987). The highest factor loadings occur in items: 1, 5, 12, 14, 17, 19, and 20 (see Table 5.2, p.61). These items account for 31.1% of the variance. As with the authors, the subject matter common to these items appears to be in the degree of close personal contact. Bouton et al. (1987) called this factor the Fear of Contact. The only difference between this study and the

Bouton et al. (1987) study was item 17, "I am worried about catching AIDS in a public washroom", and the authors' study included item 7, "A centralized file containing the names of all people known to have the AIDS virus should be created". This instrument does also seem to measure a Fear of Contact or contagion factor.

Factor 3 appears to be an intimacy dimension with items: 1, 9, and 16, where the subjects appear to have difficulties with kissing or having sex with a person with AIDS. This factor accounts for 7.9% of the variance.

Factor 4 seems to be a concern about public welfare. Items 11 and 18 account for 6.3% of the variance. This compares to the Bouton et al. (1987) Public Health factor which included these two items as well as item 21, "The seriousness of AIDS is greatly overblown by the media".

Factor 5 appears to have concerns about keeping a public file and catching AIDS. Items 3 and 7 account for 5.6% of the variance. Factor 6 seems to be related to questions about AIDS not being taken seriously by public officials. Items 18 and 21 represent 4.8% of the variance.

Factor 2 relates entirely to the Homophobia Scale (see Table 5.4, p. 64). This compares directly to the Bouton et al. (1987) study in which a factor analysis found only the Homophobia Scale items. This gives evidence to the fact that the two scales are measuring two separate dimensions and not the same underlying factor.

Summary

Both undergraduate and graduate social work students

expressed low to moderate fear of AIDS and homophobia
scores. Those students who know someone lesbian or gay
have lower homophobia scores. Those participants who
report an understanding of the gay lifestyle express lower
homophobia scores. Those students who associate with a
lesbian or gay male have lower homophobia ratings than
those who do not. Those students who knew someone with
AIDS did not have lower scores on the Fear of AIDS Scale
compared to those who did not. This seems to further
reiterate a fear of contagion factor re: AIDS.

This author also posits that homophobia impacts upon
fear of AIDS. Although there is a strong positive
correlation between the two scales in this study as well
as Bouton et al. (1987), the scales examine two separate
concepts. Other studies have found a strong association
of these two attitudes (McDevitt et al., 1990; Dupras et
al., 1989; St. Lawrence et al., 1990; Winslow et al.,
1990). In most of these cases, the gay person with AIDS
is viewed as more personally responsible for the
contraction of the virus than "straight" persons with
AIDS, and more deserving of their fate. The gay person
with AIDS is "guilty" of their sexual behavior while there
are "innocent" persons with AIDS.

CHAPTER VI

DISCUSSION AND RECOMMENDATIONS

This chapter presents the discussion and recommendations for this research study. Recommendations are offered for the profession of social work, social work education, and individual social workers. Also offered are future research suggestions.

Discussion of Research Questions

The purpose of this study is to evaluate social work students' scores on scales testing for fear of AIDS and homophobia. The research questions for the study are:

1. Do social work students have a fear of AIDS?

2. Are social work students homophobic?

3. If a social work student knows a person with AIDS, will she or he express less fear of AIDS?

4. If a social work student knows a gay person, will she or he express less homophobia?

5. If a social work student expresses a knowledge of lesbians and gay men or the gay lifestyle, will she or he express less homophobia?

6. Will age, gender or educational status have an impact on fear of AIDS and homophobia scores?

Do social work students have a fear of AIDS?

While the majority (59.5%) of the students express scores in the low-moderate range, 32.5% still have a moderate fear of AIDS. Only 6.8% of the study score in the low range. There is obviously some concern about AIDS in this sample by approximately one-third of the sample. What portent this would have for these students during any

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interaction on a professional level with a person with AIDS can only be surmised. In the study of social work students' attitudes toward persons with AIDS (Royse, Dhooper & Hatch, 1987), respondents were fearful of AIDS irrespective of age, sex, race, and educational status. Are social work students homophobic?

Those students who express a low homophobia score represent 39.3% of the sample. Scores in the low-moderate range account for 42.7% of the respondents. Eighteen percent express a moderate or higher homophobia rating. Although 18% is a small portion of the participants, this still should present concern to anyone engaging in a helping profession. Even those in the low-moderate range should present a concern to social work educators that these students could have homophobic stereotypes and attitudes, and have the potential to express them, possibly during future professional interactions. One third of the participants in a study of social workers exhibit homophobic attitudes (Wisniewski & Toomey, 1987). If a social work student knows a person with AIDS, will she or he express less fear of AIDS?

It is interesting that even if a student knows someone who has AIDS ($n=25$), there is little difference in the means for Fear of AIDS scores (and Homophobia). While there is a difference, it is not statistically significant. As noted in the factor analysis, there is a fear of contact that appears to be underlying this fear of AIDS. As noted in the literature, there is a fear of contagion when confronted with a person with AIDS (Dunkel

& Hatfield, 1986). Greater knowledge of AIDS and greater
empathy by social work students for a person with AIDS
were associated with a lower fear of AIDS (Royse, Dhooper
& Hatch, 1987). A greater knowledge of AIDS by hospital
social workers resulted in significantly higher levels of
comfort in provision of services to persons with AIDS
(Weiner & Siegel, 1990).

If a social work student knows a gay person, will she or
he express less homophobia?

There is a statistical difference when a subject
knows someone who is lesbian or gay on the Homophobia
Scale than when a subject does not. This is supported in
the correlation analysis which illustrates a strong
negative association on this variable. If a respondent
knows a person who is lesbian or gay male, then the
resulting homophobia score tends to be lower. Various
studies report that social workers who know a lesbian or
gay person hold less homophobic attitudes (DeCreszenzo,
1984; Gentry, 1987; Whitley, 1990; Pagtolun-An & Clair,
1986; Millham, San Miguel & Kellogg, 1976).

If a social work student expresses a knowledge of lesbians
and gay men or the gay lifestyle, will she or he express
less homophobia?

There is a statistical significance in whether a
participant who reports an understanding of lesbians and
gay men will express less homophobia. This is supported
by the correlation analysis which shows a negative
association between a stated understanding of the gay
lifestyle and less homophobia, i.e., the more a respondent

reports an understanding tends to result in less homophobia. In Lance's study (1987) of lesbian/gay issues on university students as instructed by either a lesbian or gay professional, those students who received this instruction reported less homophobia that those who did not.

Will age, gender or educational status have an impact on fear of AIDS and homophobia scores?

With this study's sample, there appears to be no impact of age or gender on the scores of the Fear of AIDS Scale and Homophobia Scale. This differs from the research of Royse, Dhooper and Hatch (1987) which suggest that social work students were fearful of AIDS regardless of age or gender.

There is a strong negative correlation between educational status and the scores of the Fear of AIDS Scale and Homophobia Scale. The graduate student has less fear of AIDS and lower homophobia ratings than the undergraduate student. In the study by Royse, Dhooper and Hatch (1987), education status had no bearing on the fear of AIDS. Hudson and Ricketts (1980) found that better educated people were more tolerant of alternative lifestyles and less homophobic.

Recommendations

Fear of AIDS

The documentation of AIDS-related anxieties is noted in the literature. Social workers' problems in interacting with persons with AIDS are also prevalent and this should be considered a priority by the profession and

addressed by social work educators.

The need to locate blame for AIDS is associated with attitudinal, affective, and behavioral discrimination (Ross, 1988). Social workers play a vital role in the provision of social services to persons with AIDS (and who are HIV positive). In working with people with AIDS, social workers face the possibility of occupational stress, fear, anxiety, frustration, anger, prejudice, and profound feelings of sadness and loss (Wiener, 1986). While the social worker faces these problems, the person with AIDS confronts a multitude of psychosocial stressors that would overwhelm a healthy individual. The degree of stress she or he experiences as a stigmatized and isolated individual cannot be overestimated by anyone involved in counseling with her or him.

The worst of the AIDS epidemic has not yet arrived, and planning and provision measures remain inadequate (Friedland, 1989). AIDS causes extreme demands on social workers because: AIDS tends to be relentless and fatal; affects adults in the prime of their lives; fear of contagion; and, working with persons who are considered socially unacceptable. The social worker must deal with feelings of helplessness in the face of such a life threat. The therapist faces the reality of the client's pessimism and sense of doom (Brody, 1989). The person with AIDS when diagnosed, encounters even stronger homophobic reactions and discreditation (Sandstrom, 1990). An especially troublesome form of stigmatization occurs when the person with AIDS is rejected by friends and

family members (Kowalewski, 1988). A few are even shunned
by gay friends, thus becoming "doubly stigmatized". The
person with AIDS does not need to face this discrimination
from her or his social worker.

Individuals personally threatened by AIDS should be
treated with humanity and dignity. They have not been
afforded that right by their social workers on occasion as
noted in the literature. In a national survey about
knowledge of AIDS, social workers answered less that 50%
of the questions correctly (Peterson, 1991). The
profession of social work as a whole has been slow to
respond to AIDS (Stulberg & Buckingham, 1988).

The AIDS crisis is forcing social workers and clients
alike to face up to their sexual identities (Gochros,
1988). As long as their is no vaccine for AIDS, there is
no risk-free strategy for its prevention. Most social
workers receive minimal training in sexuality counseling
and therefore are uncomfortable discussing sexual matters
with clients (Shernoff, 1988). Individual and societa
responses to this illness (and to lesbians and gay males)
create issues for social work practice that are both
unique to AIDS and exemplary of cultural issues in all
mental and health care practices (Furstenberg & Olsen,
1984). In working with persons with AIDS, social workers
must cope not only with their interactions with the
client, but with problems with human service agencies,
attitudes of friends and families, as well as
countertransference (Dunkel & Hatfield, 1986).

As part of their professional obligation, social

workers must work actively to identify the concerns of
specific cultural and minority groups. especially for the
marginalized groups associated with AIDS (Lockhart &
Wodarski, 1989). AIDS-related anxiety and stigma is a
problem for all of society, not just social work. It
imposes severe hardships on the people who are its
targets, and it ultimately interferes with treating and
preventing HIV infection. By attacking AIDS-related
anxiety and stigma, the social work profession can create
a social climate conducive to rational, effective, and
compassionate response to this epidemic.

It behooves social workers to become actively
involved in the discourse and debate about institutional
and agency policies related to AIDS. Social workers offer
a special and essential perspective; one that
simultaneously examines clinical, programmatic, policy,
and ethical implications (Reamer, 1988). The needs of the
person with AIDS is balanced against the needs of the
community, yet it is the former's that should take
precedent, thus incorporating basic social work values.

Those social workers who have a knowledge of AIDS
exhibit less fear of AIDS (Wiener & Siegel, 1990). To
effectively interact with clients with AIDS, social
workers need instruction about AIDS, and attitudes toward
persons with AIDS which are consistent with the values of
the social work profession. The social work role at the
micro and macro level re: AIDS is to reduce client
victimization, develop coping skills for clients, and
reduce public hysteria and negative attitudes toward

persons with AIDS through education and advocacy. But the social worker must first learn what the complex issues surrounding AIDS are before any effective dissemination.

It is then contingent upon social work educators to incorporate AIDS-related courses in social work curricula (Canadian Schools of Social Work Education, 1988). A pro-active, responsible and changed stance about AIDS in relation to all forms of social work training was recommended to the National Planning Committee of the Canadian Social of Social Work Education in October of 1988. In essence, this implies a recognition that AIDS/HIV issues, whether in relation to policy development, interventions, community resource mobilization or research should influence school curriculum and other social work training programs in the most fundamental way, and thus reflect the ethical tradition of the social work profession.

The following recommendations are offered:

1. The profession of social work and social work educators must take an active role in combating AIDS and HIV infection by advocating for increase federal spending for: HIV education; the establishments of systems of care for persons with AIDS; increased social benefits to provide adequate financial support and subsidized housing; and, to establish studies of sexual behavior to assist in design of education and public health programs, and to establish databases of sexual knowledge, attitudes and practices.

2. Social work education must incorporate curriculum

about HIV and AIDS. Transmission routes for HIV must
be taught and safer-sex counseling must become part
of the social workers repertoire. Psychosocial
ramifications of HIV/AIDS must be examined and
considered, not only for the person with AIDS, but
also for the social worker.

3.   Courses in human sexuality must become mandatory for
social work education. Western society has a
difficulty in discussing openly any sexuality without
apparently adding stereotypes. Social work education
needs to dispel these myths and stereotypes.

In short, the profession of social work must become
an advocate for persons with HIV/AIDS. The baseless,
unfounded and unrealistic fears of individuals, including
social workers re: AIDS, must be removed. Intolerance for
persons with AIDS even persists when people understand
that they are at very low risk of being infected with AIDS
(Blendon & Donelan, 1988). Public education alone is not
enough to prevent discrimination of persons with HIV or
AIDS. Those afflicted must bear the burden of societal
hostility at a time when they are most in need of social
support.

A diagnosis of AIDS may reveal an individual's sexual
preference, thereby going from the "discreditable" to the
"discredited" (Goffman, 1963). The stigma attached to
AIDS layers upon pre-existing stigma of gay men (and
lesbians). All of these tasks have in common the goals of
minimizing the negative impact of AIDS and of mobilizing
the resources of individuals and institutions to deal with

AIDS. Social workers must examine and bring into
consciousness their own attitudes, beliefs and feelings,
and the ways these affect their responses to persons with
AIDS.

Homophobia

Social workers are part of a culture that
discriminates against lesbians and gay males. Homophobia
appears to be an acceptable reaction toward those with a
different sexual preference. This stigma complicates
delivery of appropriate, ethical, and sound mental health
treatment (Messing, Schoenberg & Stephens, 1984). The
effects of traditional discrimination prevents an
comprehensive client assessment by the social worker, thus
hindering effective delivery of social services. It
should be the responsibility of social workers to examine
their attitudes toward lesbians and gay men. But this
does not happen where such an action can be accompanied by
"courtesy stigma" (Goffman, 1963), or the stigma attached
to defending a "discredited" group.

Social workers report that their opinion of gay males
has negatively changed since the advance of AIDS (Dhooper,
Royse & Tran, 1987/88). AIDS furnishes a pretext for
reinserting "homosexuality" within a moral drama of
pollution versus purity (Seidman & Altman, 1988). The
literature presents a strong correlation between fear of
AIDS and homophobia, as well as indicated by the results
of this study. There is a need to place blame during
epidemics. Gay males were the first recognized actors in
this era of AIDS. There is pervasive stereotyping of gay

men (and lesbians) as being "immoral", "sick", and "promiscuous". The identification of AIDS as sexually transmitted further identifies gay men to what is considered a repulsive act by the majority of society-- same-sex sexual acts.

It appears that social workers who know someone lesbian or gay hold less homophobic attitudes than those who do not. Presentations about lesbians and gay males, including interactions by lesbian and gay instructors, has led to more positive attitudes about lesbians and gay men. There is a lack of solid research in the area of counselor values (Seymour, 1982). The value systems of social workers can be questioned when many studies reflect as much as one third of the study's sample express a homophobic attitude.

Theory and research concerning sexual orientation is restricted in its scope and influenced by the lack of clear and widely accepted definitions of terms like "bisexual", "heterosexual",and "homosexual" (Klein, Sepekoff & Wolf, 1985). The problem with lesbianism or being gay is that it can be held against someone without her or him knowing it. The taint of the research question may hinder those from conducting studies of this topic. But homophobia can only be confronted by understanding it in order to combat it.

It can only be hoped that social workers would respond to lesbians and gay males in an informed, sensitive manner. This appears not to be occurring. Many lesbians and gay men report that they feel their social

workers have a homophobic attitude (Davison & Friedman, 1982). Homophobia can be confronted in at least three ways: the social worker exploring her or his own history; learning the facts about sexual orientation; and, getting to know lesbians and gay males (Messing, Schoenberg & Stephens, 1984).

To be effective in working with lesbians and gay men, social workers must become knowledgeable of and comfortable with lesbian and gay sexuality. Social workers must recognize that a heterosexist society (one governed by both heterosexual and sexist norms) has shaped their perceptions of sexual orientation (Potter & Darty, 1981). Gender stereotypes can act as barriers to effective work with lesbians and gay men by dictating assumptions about a client's sexual orientation (Eldridge, 1987). Assessment of the lesbian and gay client's needs for professional help requires a lesbian/gay consciousness and familiarity with current resources and events in the lesbian/gay community (Rochlin, 1982).

Any change in homophobic attitudes must come at the personal level because human sexuality is so intensely personal. At the individual level each social worker should examine their beliefs about sexuality. She or he can accomplish this by educating herself or himself by attending workshops and seminars, and by reading the professional literature. Individual agencies can provide this instruction by the encouragement of its social workers. Social workers need to create a non-threatening atmosphere in which clients can begin to talk about their

sexual orientation without fear of prejudice, derision, or embarrassment.

The list of interventions to combat homophobia is beyond the scope of this study. Social work is valued as an enabling profession that "starts where the client is" and proceeds in an unbiased, non-judgemental manner. Advocacy should be at the crux of an effort to eradicate homophobia, at least in the social work profession. Institutionalized and internalized homophobia affects social workers and lesbian/gay clients alike.

The following recommendations are offered:

Social Work Education:

1. Courses on human sexuality must be made mandatory and include a reconciliation or acceptance that lesbianism and being gay is a normal and enduring component of some people's lives (Hammersmith, 1987).

2. Specific seminars or workshops about lesbianism and being gay presented by lesbians and gay men. This is done in an effort to "undo" popular myths, stereotypes, and dehumanizing attitudes about lesbians and gay men. This is also offered as an opportunity to present lesbians and gay men as positive role models.

Social Work Profession:

3. A commitment by the profession to confront the discrimination directed against individuals because of their sexual orientation. This can be accomplished by providing: impetus for research in human sexuality; a bureau of speakers that can

present lesbianism and being gay in a proactive and positive manner;   and, lobbying efforts to institute legislative reform that makes discrimination based on sexual orientation illegal.

Social Workers:

In an effort to combat homophobia, the individual social worker must attempt to do the following:

4. Evaluate personal feelings, attitudes and beliefs about lesbians and gay men.

5. Accept the lesbian or gay client as a member of an oppressed minority, not as a pathological entity.

6. Become educated about lesbianism and being gay--do not believe myths and stereotypes.

7. Become familiar with the lesbian and gay community in her or his area. Every community has a lesbian/gay subculture.

8. Act as an advocate for the lesbian or gay client and help others become better educated about lesbianism and being gay.

9. Be aware that not every lesbian or gay accepts their sexuality, and may be having difficulties balancing their lives with the mores of society-at-large.

10. Know resources within the community that will provide a support system for lesbians and gay men.

11. Realize that lesbian or gay individuals or couples with problems are like any other individuals or couples and may need appropriate counseling or other services.

12. Become at ease when talking to lesbians and gay men

about sexual matters.

Homophobia appears to be engrained in the fabric of our society. Striving to eradicate homophobia is consistent with the core social work values as embodied in the Code of Ethics. In countering an oppressive and destructive force and by providing quality services, social workers can engage in exemplary social work practice. This effort can begin at the social work educational level.

Future Research

One of the functions of exploratory-descriptive research is to provide impetus for further research (Royse, 1991). It would seem that this research effort has demonstrated that some social work students have anxiety about AIDS, and could have the potential to be influenced by homophobia.

If this researcher were to do anything different, it would be to include case vignettes about a gay person with AIDS when compared to a haemophiliac with AIDS. The use of a case study may tend to somewhat reduce any "halo effect" of the participants to give socially desirable answers. Rather than having the students fill out the questionnaires without a vignette may increase their potential to give "desired" answers. The use of vignettes may be a method of circumventing this Hawthorn Effect.

A research effort to demonstrate the efficacy of AIDS instruction is important. A pre- and post-test research design followed by a post-post-test could help illustrate the importance of AIDS-related curriculum in social work

· education. A similar research design could also be done
to demonstrate the importance of presenting lesbian and
gay lifestyle information by lesbian or gay instructors.

APPENDIX A

Letter of Authorization to Use

Fear of AIDS Scale

and

Homophobia Scale

APPENDIX B

Study Instrument

THIS QUESTIONNAIRE IS ANONYMOUS. PLEASE ANSWER ALL QUESTIONS.

AGE: (please give your age)

PLEASE CIRCLE YOUR MOST CORRECT RESPONSE

SEX: FEMALE   MALE

A.   Do you feel that you have an understanding or knowledge of the homosexual or gay lifestyle?

YES   SOMEWHAT   NO

B.   Do you know anyone who is homosexual / gay?

YES   NO

C.   If yes, do you associate with this person on a regular basis?

OFTEN   SOMETIMES   NOT OFTEN

D.   Do you know someone who has AIDS?

YES   NO

1.   If I found out a friend or lover had AIDS I would be afraid to kiss him/her.

strongly agree   agree   undecided   disagree   strongly disagree

2.   Homosexuals contribute positively to society.

strongly agree   agree   undecided   disagree   strongly disagree

3.   I am afraid I will catch AIDS.

strongly agree   agree   undecided   disagree   strongly disagree

4.   Homosexuals are just as moral as heterosexuals.

strongly agree   agree   undecided   disagree   strongly disagree

5.   I would object to sending my non-infected child to school which
         had a child who has AIDS.

strongly agree   agree   undecided   disagree   strongly disagree

6.   Homosexuals should have equal civil rights.

strongly agree   agree   undecided   disagree   strongly disagree

7.   A centralized file containing the names of all people known to
         have the AIDS virus should be created.

strongly agree   agree   undecided   disagree   strongly disagree

8.   Homosexuality should be against the law.

strongly agree   agree   undecided   disagree   strongly disagree

9.   If I found that my lover had AIDS, I would still have sex with
         him/her.

strongly agree   agree   undecided   disagree   strongly disagree

10.   Homosexuality is disgusting.

strongly agree   agree   undecided   disagree   strongly disagree

11.   AIDS will become a severe and widespread epidemic.

strongly agree   agree   undecided   disagree   strongly disagree

12.   Even if a friend had AIDS, I wouldn't mind touching him/her.

strongly agree   agree   undecided   disagree   strongly disagree

13.   Homosexual corrupt young people.

strongly agree   agree   undecided   disagree   strongly disagree

14.   1 wouldn't mind being in the same room with a friend who had AIDS.

strongly agree   agree   undecided   disagree   strongly disagree

15.   Homosexuality is a sin.

strongly agree   agree   undecided   disagree   strongly disagree

16.   I believe public officials when they say AIDS cannot be
        transmitted through casual contact.

strongly agree   agree   undecided   disagree   strongly disagree

17.   I am worried about catching AIDS in a public restroom.

strongly agree   agree   undecided   disagree   strongly disagree

18.   Compared with other public health problems, I think AIDS is a very
        minor problem.

strongly agree   agree   undecided   disagree   strongly disagree

19.   If I found out a friend had AIDS, I would be afraid to hug
        her/him.

strongly agree   agree   undecided   disagree   strongly disagree

20.   AIDS children should be allowed to attend school.

strongly agree   agree   undecided   disagree   strongly disagree

21.   The seriousness of AIDS is greatly overblown by the media.

strongly agree   agree   undecided   disagree   strongly disagree

APPENDIX C

Consent Form

CONSENT FORM

I, Kim Kitchen, am conducting research into attitudes concerning Acquired Immune Deficiency Syndrome (AIDS) and homophobia.

Your participation is voluntary. Any involvement will remain anonymous. I do request that you complete this questionnaire. The timeliness of the research subject is important and needed.

Research results can be obtained by contacting the School of Social Work at the University of Windsor, Windsor, Ontario.

_____

I, _____, hereby state that I
             (please print)
have read this prospectus and understand its content. I understand that my participation is voluntary and that I cannot be identified to the questionnaire I complete.

Signed: _____

Date: _____

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Vita Auctoris

K. Russell Kitchen was born on July 24, 1952, in South Porcupine, Ontario. He moved to Windsor with his family in 1952. He attended King Edward Public School and graduated in 1966, and Walkerville Collegiate Institute from 1966 to 1971. In 1989, he received his Bachelor of Social Work from the University of Windsor's School of Social Work. He entered the Master of Social Work program at the University of Windsor in 1989, and expects to graduate in 1992.