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Sydney Alan. Strom

University of Windsor

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TOWARD AN UNDERSTANDING OF THE SOCIALIZATION
OF NURSING STUDENTS: A MULTI-DIMENSIONAL ANALYSIS
WITH ACQUIRED IMMUNE DEFICIENCY SYNDROME AS A FOCUS

BY:

SYDNEY ALAN STRON

A Thesis
Submitted to the Faculty of Graduate Studies
and Research through the Department of Sociology
and Anthropology in Partial Fulfillment of the
Requirements for the Degree of
Master of Arts
at the University of Windsor
Windsor, Ontario, Canada
1990
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Abstract

This research examines the socialization experiences of first year nursing students using the "problematic" case of AIDS as a focus. An emphasis is placed on the influences of structures other than the institutions of the hospital and university in the social construction of AIDS for these students such as the family, friends and the media.

Building on the work of Becker, Geer, Hughes and Strauss (1961), Merton, Reader and Kendall (1957), Simpson (1967), Schutz and Luckmann (1973) and Berger and Luckmann (1966), this research demonstrates that a purely structuralist explanation of the socialization process fails to recognize the complex interactive experiences of students, and how these experiences impact on the socialization process.

The conclusions from this research suggest that the socialization of nursing students into their profession requires the presence of certain structural elements for this process to be successful. However, the success of the process is inextricably connected to the interactive experiences of students with others in both the institutional and lay world in which they are situated.
Dedication

Dedicated to J.D., whose support and encouragement made this project possible.
Acknowledgements

A project such as this is never the sole creation of one individual, but rather relies on the support, expertise and talents of a great many people. I would like to take this opportunity to give proper credit to those who have helped this project reach fruition.

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Due to my mechanical ineptitude, Cézanne Charlebois' involvement in the programming of 5.0 was also contributory to the final product, and to her I am also very grateful.

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INTRODUCTION

At the closing of the 1970's, an international epidemic broke out. It first appeared in Africa, and then made its way to the North American continent, bringing with it fear in proportions not witnessed since the great plagues. As the death toll rose, it became apparent that certain groups - homosexuals, intravenous drug users and haemophiliacs - seemed to be at higher risk than others of contracting this deadly disease - Acquired Immune Deficiency Syndrome, or AIDS.

The medical impact of AIDS on these groups has been defined as a breakdown in the person's immune system, rendering it helpless to fight off a variety of infections usually leading to death.

The social impact of AIDS on these groups is ambiguous, and is further complicated by the fact that this impact is derivative both of the fear of contagion and of the identification of certain "deviant" groups, especially homosexuals and intravenous drug users, with this disease. Many reports have suggested that the impact on those afflicted with AIDS has been very destructive.

The social impact of AIDS has been very destructive. Due to the paucity of knowledge about the disease before 1984, the disease became sensationalized in the media. Further excitement occurred when health care professionals made statements about the syndrome without
sufficient scientific data to support their findings (Salisbury, 1986: 14)

Medical assertions concerning AIDS made over the past few years have contributed to, and complicated the issue of, attitudes our society holds towards AIDS and homosexuality, and have serious implications for AIDS patients concerning their medical care.

These medical assertions have resulted in a hysterical public reaction, escalating to the extent where people with AIDS have been ostracized because of the public's fear of contracting the disease (Salisbury, 1986: 14). Although in certain ways the hysterical public reaction toward AIDS is similar to the flu epidemic of 1912, where it was reported that people would rather cross the street rather than walk past the house of a flu victim, the fear of AIDS goes beyond this, in part based on the stigma that has been attached to those with the virus and the association of their lifestyles with it. According to a study conducted by Young (1988), 64% of the nurses surveyed had negative feelings toward homosexuals with AIDS.

It was therefore thought to be germane to look at those individuals who will be working and coming into close contact with AIDS patients, in this case, student nurses. Of interest was the process of professionalization as it shapes the individual's view of the world and how this specifically related to his or her attitudes toward AIDS and homosexuality.
On the institutional level in the university setting, student nurses are engaged in the process of resocialization into a profession. Embodied in this process are new ways of viewing the world as well as views of how the individual now fits into it. In short, nursing students begin to see their role in society from a different vantage point - through the eyes of a nurse. Although these student nurses bring with them a particular view of the world, or a specific "social reality" which they have internalized in the course of their primary and general secondary socialization, they begin their professional socialization as blank sheets on which the occupation will write. The occupation sets out to define role expectations for its members in a variety of situations, so that the member understands what behaviour is normative.

The emergence of AIDS poses some very interesting occupational problems for the nurse, as well as for the institution itself, the hospital, or university, in that there is a great deal of conflicting information being transmitted by the scientific community. It is at the individual level of the student nurse that these conflicts become realized, where "knowledge" is expressed as an attitude and corresponding behaviour - which connects the nurse to the prospective AIDS patient.

The initial interest for this research was generated from an interactive interview the author conducted with a
former volunteer of the AIDS Committee of Windsor, who stated that many people with AIDS are discriminated against by both physicians and nurses in their attempts to get treatment. This aspect of discrimination was confirmed in the research of Douglas, Kalman and Kalman (1985), who found that prejudicial attitudes toward homosexuals among health care professionals in a hospital setting were real and that 10% of their staff responded with "strongly agree" when asked "whether or not homosexuals were getting what they deserve in the contraction of AIDS". As further anecdotal support, one individual stated that many physicians will not treat AIDS patients, that homosexual patients who have been admitted to the hospital have complained that the contact with nurses is kept to a minimum and that they are not treated with the level of dignity accorded to other terminal patients. (Interview with former volunteer of the AIDS Committee of Windsor, November, 1988).
LITERATURE REVIEW

This review of the literature will include two major sections, a review of pure theory on the macro and micro levels of analysis, and a review of empirical research. It will begin with a brief overview of the domain in which this research is situated: the socialization of individuals into occupations generally, and into professions specifically, highlighting the professional socialization of nursing students, utilizing a structural functionalist framework.

Attention will then turn to a review of empirical studies based on these theoretical premises from general theory, in the socialization of both nursing students and other associated professionals, commencing with an assessment of both the strength and weaknesses of research conducted to date.

Evolving from the inability of past research on the macro level to explain how socialization occurs, why variation exists in the process of professional socialization, and what this variability looks like on the individual level, the theoretical focus will shift, to address the actions, meaning systems and interpretations of individuals within the profession of nursing on a micro level of analysis, using both symbolic interactionism and phenomenology as theoretical premises.
Finally, the last section in this review will deal with empirical research that has been conducted in the areas of homophobia and AIDS as it relates to the nursing profession.

Review of Theoretical Literature:
Socialization Theory

Pavalko (1971) has stated that socialization is one of the most central features to the field of sociology, both from the viewpoint of the child, as well as from the viewpoint of the adult and the adult’s secondary or occupational socialization. The term 'socialization' has been defined in numerous ways by a variety of scholars. Elkin (1960: 4) states that socialization is "the process by which someone learns the ways of a given society or social group well enough so that he can function in it." A different emphasis is given by Child (1954) who sees socialization as "the whole process by which an individual born with behavioral potentialities of enormously wide range - is led to develop actual behaviour which is confined within a much narrower range - the range of what is customary and acceptable for him according to the standards of his group" (Childs, 1954: 655). Merton, Reader and Kendall (1957: 287) have a somewhat more specific definition for the term 'socialization' as they refer to it as "the process by which people selectively acquire the values and attitudes, the interests, skills and knowledge - in short,
the culture - current in the groups of which they are, or seek to become, a member." It refers to the learning of roles. These definitions of the process of socialization may be somewhat different in small ways from each other, none the less, they all imply that the process itself involves the learning of specific behaviour, roles and norms of a given culture, whether this is the culture of an occupation or the culture that one is born into, so that the member can become a functioning entity at some acceptable level of competence.

This does not assume that primary socialization which occurs through significant others during childhood and secondary, usually involving an institution or organization, are the same. The major difference between primary and secondary socialization is that in the former, the individual is learning appropriate role behaviour and norms for the first time, often referred to as starting out as a "tabula rasa", whereas in the latter, the individual has presumably already been socialized into the larger culture and must now be socialized to fit into the specific norms and culture of an organization.

Adult socialization must be approached with a recognition that the process frequently involves, in addition to the learning of new roles and norms, the unlearning or relinquishing of old norms and roles, the extension of old ones, and the possibility of holding conflicting norms and occupying conflicting roles (Pavalko 1971: 83).
Recognition of the fact that adult socialization brings with it the possibility of old norms, values and roles coming into conflict with the new ones, as suggested by Pavalko (1971), is of particular interest to the present study, where it may be hypothesized that the first year student nurse may find the culture of nursing in some ways incongruent with the culture that they were first socialized into, particularly as it relates to some of the moral implications that surround the issue of AIDS.

Pavalko (1971) states that one of the important aspects of adult socialization is that of anticipatory socialization. This is possible as a result of the fact that human beings are able to imagine being in the role of another through the manipulation of symbols, or are able to imagine being a member of a group that they do not presently belong. This has often been referred to in social psychology or symbolic interactionism as "role-playing". Anticipatory socialization is uniquely different from other types of socialization in that the individual is able to play the role of the socializer, as well as the role of socializee. This is possible as a result of the fact that one not need be a member of a group to imagine being a member and the roles and norms that would follow. Anticipatory socialization is largely based on assumptions that the individual has about the group or organization that one aspires to be a member of. In some instances, depending on
the actual type of exposure they have had to the group itself, these assumptions may be an accurate view of the culture, however in other cases, the assumptions may be unrealistic entirely.

There are many factors that have been shown to enhance both the amount, as well as the kind of anticipatory socialization, that one undergoes prior to formal training one receives upon entering an occupation or profession. Pavalko (1971) states that one important influence that affects anticipatory socialization is the availability of role models such as parents, relatives and close friends in the occupation one seeks to enter. For the young adult wanting to enter the field of nursing, having a member of their family already in the profession enables them to get a clearer picture of what the profession appears to be like. Anticipatory socialization does not only occur prior to admittance to formal training, but rather, is an ongoing process that the individual engages in throughout their training. For the student nurse, the impact of reference others in the hospital, such as R.N's and other nurses, no doubt impacts on the type and amount of anticipatory socialization that student nurses go through.

The notion of reference groups or reference others comes out of the symbolic interactionist literature associated with Cooley, Dewey and Mead. This perspective has illuminated the fact that much of human behaviour is as a
result of the way that individuals take into account the expectations of others in social environments through the act of role-playing (Pavalko, 1971:87). The concept of reference groups becomes very useful when one attempts to understand the occupational socialization process. In the stage of anticipatory socialization the individual, aspiring to become a member of a particular group, uses the members of that group as reference others by which to judge and evaluate himself/herself. In formal training, the members of the occupation become a normative reference group, as they set the standards the neophyte must aspire to. When the process of occupational socialization is complete, the socializee has taken the views, values and behaviours of the occupation as his or her own, and now sees the world through professional eyes.

Socialization to Work

When we refer to the socialization to work we are generally making reference to the changes that individuals undergo on the social, psychological and skill levels within this process.

Most of the theory written on the socialization to work contends that it is the nature of the work and the contingencies of the workplace that contribute to our understanding of the process of socialization, rather than the attributes that the socializee brings with them to the
experience, which suggests a structural functionalist perspective.

In very general terms, the socialization to work consists of three phases. Firstly, the incumbent must acquire the knowledge and skills necessary to meet the tasks set forth by the occupational role. Secondly, they must learn the subculture of the occupation they have chosen in what Chen and Regan (1985: 63) have called "learning the ropes or codes of conduct that are shared among one's fellow workmates". Lastly, the incumbent experiences a transformation of identity, when the occupational role and the norms, values and skills of the occupation have become internalized (Chen and Regan, 1985).

Richard Hall (1975: 12) identifies two major structural properties that distinguish contemporary work from those conditions that characterized work in earlier years.

The skills and social relationships of modern occupations are not just those that are learned as one becomes socialized into adulthood. Instead, they are specific to the occupation, often are not transferable to other occupations and in the case of social relationships, are not transferable if the location of the occupation shifts.

The second distinguishing characteristic of modern occupations cited by Hall is that "they are carried out in organizational settings".

Organizational employment in the modern era represents a majority of the overall total labour force picture. In fact, even those professions that place a high emphasis on
individual skills such as the professions of law and medicine more often than not take place in organizational settings such as law offices or medical clinics (Hall, 1975).

The Nature of Occupations

It is not at all surprising that so much attention has been given within the field of sociology to the study of work and occupations and the socialization one undergoes when embarking upon a career, given the fact that work constitutes a major focus of our lives. There are numerous definitions for the concept 'occupation', however Hall's (1975) conceptualization seems to summarize the basic properties of what the literature suggests that an occupation involves:

An occupation is the social role performed by adult members of society that directly and/or indirectly yields social and financial consequences and that constitutes a major focus in the life of an adult (Hall, 1975: 6).

It is clear that an occupation is not simply a means that enables individuals to meet their economic needs, but in essence also defines who they are and gives them a perspective through which they view the social world. Everett Hughes, according to Hall, views the occupation as a part of the individual, rather than just a set of activities that they go through. He states:

An occupation, in essence, is not some particular set of activities; it is the part of an individual in any ongoing set of activities (Everett Hughes, 1965, cited in Hall, 1975: 5).
What is particularly salient in Hughes' conceptualization, is the emphasis on the social relationships surrounding an occupation rather than the economic factors that exist in occupations. It is with this in mind than we may begin to see peoples occupation not only explaining what it is they do, but more importantly, who they are and how they view the social world.

Professions

Given the fact that this research specifically will be examining the socialization of nursing students into the profession of nursing, it would be germane to have a theoretical framework for what is meant exactly by the term "profession" before delving any further into the matter.

When one speaks of the professions, the term "status" quickly comes to mind. Although not all professions are regarded as being "high status" occupations, generally, as a result of the highly specialized nature of the skills involved, the nature of the power professionals exert over others, and the social strata that becoming a professional enables the member to aspire to, the professions are generally regarded in the literature as higher status occupations than those requiring less formal training and fewer specialized skills.

Although there are a variety of interpretations for the professional model, certain properties are present in most characterizations. Properties such as the presence of an
intellectual technique that are acquired through specialized training are generally regarded in the literature on occupations as properties of professionalism. In addition to the above, professions perform services in society that are unavailable to the laity (Hall, 1975). The distinction made concerning an "intellectual technique" specifically refers to not only an application of knowledge, but according to Hall also implies a theoretically oriented approach.

Ernest Greenwood (1957) has suggested five major professional attributes. The first attribute is the presence of systematic theory, which he states can be both intellectual and practical. A second major attribute of professions is professional authority. It is through this, that the professional can dictate what is good or bad for the client, and establishes for the client a belief that the professional will make the correct judgement in matters affecting him/her.

The third attribute cited by Greenwood are the formal and informal sanctions of the community toward the profession and its powers and privileges. The formal approval manifests itself in the manner in which the profession is given the power to determine the appropriate character and curriculum of the training process.

Another attribute that distinguishes professions from other types of occupations is the formal and informal code of ethics which specifies the appropriate behaviour of the
professional toward clients and other professionals. Deviations from the professional code of ethics are handled formally and informally, through the removal from professional associations, censure, and the ostracism of the member from interaction systems.

The final attribute Greenwood refers to is the professional culture which is connected to the norms governing membership in professional associations, organizations that are qualified to provide training, and the language and symbols of the profession. These symbols and language have meaning only to those on the inside, and are a way of demarcating the professional social world and the social world outside. Within some of the broad definitions of the occupational category profession, it is generally agreed that the greater the development of a professional culture, the greater the social distance between the profession and lay world.

Although Greenwood clearly outlines some of the structural characteristics that distinguish professions from that of other occupations, Edward Gross offers further insight into the attitudinal properties that demarcate individuals in professions from other types of occupational membership. One of the central characteristics according to Gross (1958: 78) that distinguishes a professional from other occupational members is the high degree of personal involvement. It is through this personal involvement that
clients believe that the professional is acting in their best interests, and hence, place themselves in the professional's care. In addition to personal involvement, is the recognition that the professional is committed to his/her art, rather than simply viewing his/her professional membership as "a means to an end". Gross notes that the professional is not supposed to be interested in sordid money (Gross, 1958). Implied in this conception is the basic premise that the professional is thought to be one who would work simply for the intrinsic rewards of the occupation.

An additional attitudinal characteristic that has been identified in professional circles is the close ties with colleagues and the importance of membership in professional associations. In the words of Gross:

This close identification is a source of attitudes governing his own orientations as well a source of control over his behaviour (Gross, 1958, cited in Hall, 1975: 75).

Supplementary to characteristics that are manifested on the individual level, Gross offers some further structural characteristics of professions that have been recognized elsewhere in the literature.

Gross views professions as dealing with an unstandardized product, where knowledge is applied to solving particular problems, each of which, though unique, fits into the theoretical body of knowledge. The base for power is clearly connected to the knowledge base, where the
client being mostly ignorant in the field of the professional's competence, must trust the professional's judgement regarding his situation. In a larger sense, this lack of knowledge is also witnessed in the wider community which, as a result of its ignorance, must give the professional the right to make decisions in important areas of life (Hall, 1975: 75).

The final structural characteristic that Gross has identified as being connected to professions, is that the service being provided is one that is usually essential to the health or welfare of the individual and of society. Turning to the process of becoming a professional Goode (1960) has suggested that the student of a profession undergoes a more rigorous and far-reaching adult socialization than students from other occupational types. Professional training not only takes considerably more time than training in other occupations, but also involves socialization into the appropriate attitudes and behaviours prescribed by the profession. The end result, it has been suggested, is an attitudinal consensus reached by all those within the profession. This consensus being recognized as "the hallmark" of professions (Goode, cited in Hall, 1975: 76).

The final characteristic which has often been cited as a associated trait of professions is that typically they are "terminal occupations" for the members (Goode, 1960). In
part due to the investment of both time and money and the
amount of specialization required to attain professional
status, most professionals remain in the profession for the
duration of their careers (Hall, 1975).

Having discussed some of the theoretical assumptions
that pervade the literature concerning the socialization to
work as well as briefly outlining some of the principles
generally accepted on the sociology of occupations, and the
characteristics that demarcate professions from other types
of occupations, one can now discuss some of the relevant
studies which specifically focus on the socialization of
professionals and attempt to connect empirical data with the
theoretical principles previously outlined.

Review of Research on Socialization in Professions

Among the first studies to analyze the process of
professional socialization in a medical milieu were Merton,
Reader and Kendall's (1957) "The Student Physician" and
Becker, Geer, Hughes and Strauss' (1961) "Boys in White".
Both of these works looked in depth at the transformation
that one undergoes in the process of medical training,
however their interpretations of the occupational
socialization processes are markedly different. Merton's
study (chapter on socialization by Mary Jean Huntington)
stated that by the fourth year of medical training, students
are beginning to view themselves as doctors, largely brought
about by the interactions they have had up to this point
with patients. By virtue of the patients defining and responding to these students as doctors, the students have already started to internalize this role as real for them.

While less than one-third of the first and second-year medical students reported that they thought of themselves primarily as doctors rather than students, 59 percent of the third-year students did so, and this increased to 83 percent of the fourth-year students (Huntington, in Merton, 1957: 180).

Merton's interpretation of the socialization process of medical students is not held by Becker who states that the system of which the fourth year student is a participant will not allow for this type of self-evaluation, as the doctors are continually reminding the student of their subordinate role, and there is a constant denial of responsibility from the physicians toward the student. Becker identified shifts in student values during their tenure at medical school, which has been supported later in the work of Simpson (1967) studying the socialization patterns of nursing students. Becker states that the medical student starts out his/her training with a strong sense of idealism, dedication and high purpose. This emphasis by the student on these values soon becomes replaced with an emphasis on tasks, where just getting through becomes of utmost importance. Many scholars, who have written about this transition between the idealistic stage and the task oriented stage, have referred to it as a transition from idealism to cynicism, an evaluation with which Becker does
not agree. Becker's analysis seems to suggest that although the student leaves behind a sense of naive idealism, it becomes replaced with a more mature one.

Samuel Bloom (1965), in reviewing some of the work that had been conducted up to that point on the socialization process that occurs in medical school (primarily based on the works of Merton and Becker), identified some of the conflicting interpretations of the process. Some of these have already been discussed, especially whether or not the neophyte medical student actually begins to role-play doctor during their training or not, but of particular interest is the conflicting interpretation that has been given to the importance of the institution on the completeness of the socialization process. One view holds that the training that the student receives during medical school socializes them to the extent that upon graduation they can move directly into full fledged participation in the profession. The contrasting view maintains that although the institution gives the student a minimum amount of competency, these skills must be augmented by the profession itself upon graduation.

In the area of the socialization of nursing students a number of studies have been conducted (Lurie, 1981; Warner and Jones, 1981; Simpson, 1967; Estok, 1977; Watson, 1981; McCain, 1985; and Brief, Van Sell, Aldag and Melone, 1979). These studies are similar in their emphasis on socialization
theory as the central principle for explaining the processual nature of becoming a nurse, however their specific foci are quite different. A number of these studies do not venture beyond the theoretical sphere (e.g., McCain, 1985 and Estok, 1977), where the focus is a discussion of various theories of socialization rather than on an empirical demonstration of them. Other studies examined the specific type of education nursing students receive as the determining factor for such things as role stress later on (Brief et al., 1979), the conflict of the socialization experience versus role content later on (Lurie, 1981), and finally the role of the educational experience for the profession of nursing (Watson, 1981). In addition to the research that has been conducted on either theoretical models for the socialization process or the role of the institution on this process, others have looked at the individual characteristics or backgrounds of the socializee as a determinant of the socialization experience (Warner and Jones, 1981).

For the purposes of the present study, the research conducted by Ida Harper Simpson "Patterns of Socialization into Professions: The Case of Student Nurses" (1967) was particularly useful in that this research attempted to connect issues existing on a theoretical level with empirical cases.
Simpson (1967), utilizing propositions put forward by both Piaget and Mead, suggests that not unlike childhood socialization, adult socialization takes place in a series of phases, with each phase building upon the previous one. This is supported by the work of Genevieve Rogge-Meyer (1960) who found that beginning students preferred work that involved dealing with patients on a one-to-one basis. This preference often became replaced with the desire to involve themselves with more technical aspects of their jobs and/or administrative tasks dealing with patients as a member of a team rather than working strictly on a one-to-one basis.

Simpson's data were obtained in a new four-year collegiate school of nursing attached to a teaching hospital. At the time of the study, the school was three years old and contained 57 freshmen, 21 sophomores and 17 juniors. Data were obtained through observation in the hospital, interviews and questionnaires.

This paper shows that socialization of an adult into an occupational role also involves a sequential process (Simpson, 1967: 47).

According to Simpson, socialization into a profession occurs in three phases. In the first phase, the individual shifts their attention from the broad socially defined goals that led them to choose the profession in the first place to the goal of proficiency in work related tasks (Simpson, 1967: 47). During the second phase, significant others within the work environment become the main reference group,
and finally in the third phase, the individual internalizes the values of the occupational group and adapts its behaviour (Simpson, 1967: 47).

According to Simpson (1967), during the first phase of socialization for nursing students there is a strong emphasis placed by the student on serving and helping those who are suffering, in what Rogge-Meyer (1960) labelled the "ministering angel" phase.

Without exception our student nurses said that their main reason for choosing nursing as a career had been the wish to be of service to suffering people (Simpson, 1967: 48).

As students begin to realize the emphasis that the institution places on the acquisition of skills, this initial emphasis is replaced with a concern for the mastering of skills necessary in nursing practice.

Thus, the initial socialization phase involves at least a temporary suspension of the role conception the student brought to the training situation and the learning of a new role emphasizing quite different concerns (Favalko, 1971: 94).

The second phase in the socialization process for nursing students involves the development of a new reference group within the training environment. The students' initial orientation toward patients is replaced with an orientation toward others in their work environment - fellow nursing students, nurses and physicians. This shift in the importance of others in the hospital environment from
patient to the technical virtuosity of other nurses and physicians can be seen in the following:

Freshmen sometimes expressed shock at what they regarded as doctors' callous disregard of patients' feelings. Juniors, in contrast, frequently discussed their experiences in working with different doctors and nurses; they were interested in the technical virtuosity of the nurses and in the doctors' prestige standing in the hospital (Simpson, 1979: 51).

Phase three is an intensification of the second phase. Professional values and norms replace old values and norms and are now the base for evaluating others as well as themselves. The socialization cycle is complete when professional values are fully internalized (Pavalko, 1971). Simpson states that in her own estimation, socialization rarely is complete by the end of training, but actually becomes completed when the profession has accepted the member into the profession (Simpson, 1979).

There have been a number of other studies suggesting a developmental process of occupational socialization, which involve changes in students' values and attitudes as they progress through their educational experiences (Brown, Swift and Oberman, 1974; May and Ilardi, 1970; Psathas, 1968; Warner and Jones, 1981; and McCain, 1985).

One of the most cited studies in the area of the socialization of nursing students is George Psathas' study "The Fate of Idealism in Nursing School" (1968), which is similar to the work of Becker and Geer (1961) on the
socialization experiences of medical students referred to earlier in this review. In the Psathas' study, expressions of idealism, optimism, and realism were viewed as situationally specific attitudes whose degree of intensity and expression vary with the role relationships in which the student nurse is involved. Using an instrument called the Role Projective Test (RPT), which was a series of slides depicting a variety of different scenarios that take place in a hospital setting, students were instructed to write a brief story about each picture using their imagination to describe (1) what led up to the situation (2) what is happening, and (3) what will be the outcome.

Using data from the stories of both freshmen and seniors it was concluded that seniors showed a marked increase of negativism in their depiction of how the stories ended indicating what Psathas (1968: 62) termed a loss of "idealism".

These results in general show that in a variety of role relationships and situations depicted in the Role Projective Test, freshmen express a degree of idealism and optimism which is not found among seniors.

Although not detailing how the freshman student begins from a state of idealism and optimism and moves to one of negativism, Psathas' work does lend support to the work of Simpson in suggesting that there is a series of stages that the nursing student moves through in their occupational socialization.
In a similar vein, W. Theodore May and Robert L. Ilardi (1970) also attempted to measure attitudinal changes that might take place in a nursing programme using a University of Tennessee school of Nursing as the population to be studied. The instrument used was the Allport-Vernon-Lindzey Study of Values (A-V-L), and was used to measure demographic variables, personality variables, nursing attitude variables, personal attitude variables, values and on-the-job performance on a longitudinal basis. Three groups of students were tested four different times over the course of their nursing education, in the fall for the first three tests, and in May upon graduation for the last test. There were six values that were measured: theoretical (value orientation towards truth), economic (value interests in what is useful), aesthetic (highest orientation towards form and harmony), social (value of love and people), political (primarily power-orientation), and religious (values unity in the world).

The results of this study showed that there was a significant decrease in mean scores on the religious value scale and an increase on the aesthetic value scale. Although the relative rankings of the value categories remained relatively stable over a four year period, within each category significant shifts upward and downward did occur. These researchers suggest that there was a significant shift in values that took place as a result of an academically
successful college experience. This study adds to the significant body of literature suggesting attitudinal changes that take place in the course of the occupational socialization of nursing students.

McCain (1985) attempted to test the Cohen (1981) model of professional socialization, which proposed that there are four developmental stages that nursing students move through during the course of occupational socialization: unilateral dependence, negative/independence, dependence/mutuality and interdependence. In general, McCain was not able to conclude that students do move through these developmental stages in the fashion suggested by Cohen (1981). However with regard to the first stage (unilateral dependence) it was concluded that beginning students were more dependent than were graduating students (McCain, 1985: 183). Also of interest, it was concluded that there is a positive relationship between maturity as measured by age and the stages of professional socialization such that, independent of their level of enrolment, older students evidence higher stages of socialization than do younger students (McCain, 1985: 183).

Although research on a developmental model for professional socialization as suggested by Cohen (1981) and tested by McCain (1985) is paramount to understanding the nature of professional socialization, this study paid little attention to the entry phase, or the cross-over from layperson to beginning student nurse.
Although the volume of research suggesting a shift of values and attitudinal changes that occur during the course of occupational socialization for nursing students is vast, there are those researchers who do not hold this view. One such study by Virginia Olesen and Fred Davis (1966), suggests that in general values held by first year nursing students remain constant throughout their tenure within the university. Having previously carried out a study on the images of nursing among baccalaureate students at the University of California School of Nursing, they conducted a follow up report on these same students two years later, to determine whether or not there had been any significant changes in attitudes towards, and images of, nursing at the completion of their degrees. In the original study, several dimensions of change were addressed: the attributes by which students characterize nursing, and whether such attributes were viewed as important to the self, the amount of consensus students reach among themselves regarding what they see in nursing and what they view as important to the self, and the amount of consonance students achieve within themselves between what they see in nursing and what they consider important to the self. The results of their initial study suggested that by the end of the first year in a nursing programme, students began to characterize nursing in terms of certain advanced professional images of the field e.g., "originality and creativity" and "frequent innovation"
in the solution of problems". Over the course of the year, in general, although not as much as predicted, they began to relinquish layman-type images of the field such as "dedicated service to humanity" and "moving ritual and ceremony". These students began to think of the advanced professional images of nursing as important to the self and they did not reach greater overall consensus among themselves about those attributes which characterize nursing, or those attributes which are viewed as important to the self. And finally, they did not achieve greater consonance within themselves between what they saw in nursing and what they valued for themselves (Olesen and Davis, 1966: 151).

For the follow up study, to investigate whether or not there had been any significant changes in occupational imagery or modifications to the original images, they administered the same questionnaire to sixty-five graduating students who had participated in their original study. Within this questionnaire was a 19 item checklist which sought to elicit from them their images of nursing. For each item the student was to signify (1) whether it corresponded to her (sic) image of nursing and (2), whether it was important to her personally. The 19 item checklist was grouped into six image clusters labelled laymen images, traditional images, professional images, advanced professional images, and bureaucratic images.
The results of the follow up study indicated that in the area of layman's images of nursing, three years of professional education had not altered these images significantly. In the second cluster, students had moved away from viewing nursing in accordance with certain traditional professional images. The two areas where change was most noticed in opposite directions were in advanced professional images and bureaucratic images. The significant increase in attributions of such advanced professional images such as "originality and creativity" and "frequent innovation" were attributed to the increasing importance given to these areas by the faculty, obviously influencing the perceptions of the students. Not surprisingly, at the opposite extreme, attributions of the profession being seen as bureaucratic were given significantly less emphasis over the course of their education.

The authors state in the discussion section of their paper that although much emphasis has been given by sociologists to the effect that professional socialization has on homogenizing the outlook of students towards their intended profession, students by and large did not radically alter their perceptions of nursing or of what they valued for themselves. Nor did they achieve greater over-all consensus among themselves or consonance within themselves in these respects (Olesen and Davis, 1966: 155-156).
In reviewing the vast literature on occupational socialization, considerable attention has been paid to the concepts of role conflict and role strain.

Brief et al. (1979) have identified role conflict as when individuals are required to play roles that conflict with their value systems, or to play two or more roles that conflict with each other (Brief et al., 1979). In their study "Anticipatory Socialization and Role Stress among Registered Nurses" these researchers looked at the impact of specific types of nursing education (conceptualized as the anticipatory stage of the socialization process) on role stress experiences on the job (Brief et al., 1979). Although it is of importance to understand the relationship between the type of nursing education one undergoes and the effect this may have on role conflict and role strain upon admittance to the occupation upon graduation, the conflict that occurs during the entry phase of one's nursing education has largely been ignored in the literature. Although AIDS is not necessarily a unique case within the profession of nursing (there are some who might argue that it is), it would be useful to better understand how AIDS and the moral implications attached to it may be a source of role conflict for those wishing to enter the profession of nursing, in addition to being problematic from the viewpoint of the profession itself. It is at the point of entry into a professional school where the personal values and norms that
have been passed on by an individual's primary group and his/her culture in general would most likely come into conflict with the new values and ideals proposed by the profession to which he/she would like to become a member.

One of the few studies that attempted to explain the processes of occupational socialization on a micro level, taking into account the interactive experience of the individual, was Donald Light's (1980) study entitled "Becoming Psychiatrists – The Professional Transformation of Self". Light suggests that partly due to the era in which occupational socialization theory emerged (in the late 1950's) the individual has been portrayed as a passive being on which the system or organization acts as a socializer. Light has suggested that to fully understand the process of occupational socialization, one must not only understand the structural features of the institution and its role as socializer, but also the interpretive characteristics of the individual being socialized (Light, 1980: 309).

In fact, professional socialization centers on the discrepancy between the properties which recruits bring with them or attribute to the program and the properties of the setting which those in charge have organized.

Light states that for a lengthy period of time social researchers were almost exclusively using survey research methods in attempts to understand a variety of social phenomena. This particular research method is effective in
studying certain types of social phenomena but may also result in a great deal of information loss in other areas.

Martin Trow once cogently argued that 'the problem under investigation properly dictates the methods of investigation'. This is not what was happening at the University of Chicago, where the survey method was used almost exclusively for an extraordinarily wide range of problems (Light, 1980: 356).

It was with the desire to enhance his ability to uncover the socialization process of psychiatric students that Light turned to a more qualitative approach in his study.

It is not hard to accept at least on a general level the hypothesis that there are oblique stages or phases that an individual moves through during the course of their occupational socialization, if only by the fact that this has been supported in much of the literature written on the subject. It is difficult however to accept a "complete socialization" theory simply by the fact that although in a general code of ethics for nursing, all people are to be treated with dignity and support, there still exists a certain amount of prejudicial behaviour in the nursing profession as witnessed by the literature on AIDS in the health community (Douglas, Kalman and Kalman, 1985).

The human person, regardless of race, creed, colour, social class or health status, is of incalculable worth, and commands reverence and respect (Canadian Nurses Association Code of Ethics, 1980).
How does one account for the apparent discrepancy between what has been written on the process of occupational socialization and the internalization of values, norms and beliefs, and empirical evidence suggesting that values not espoused by the profession of nursing are none the less still held by those in practice?

In summary, although there has been a great deal of research conducted on socialization theory, both in general terms as well as specifically focusing on the occupational socialization of nursing students, little has been done on the entry phase into a professional school for the student nurse. In addition, although studies conducted on the process of socialization on a macro level are substantial, it was felt that it would be beneficial to study the socialization process for nursing on a micro level as suggested by Light (1980).

The general structural properties of the professional socialization process have been, for the most part, substantiated at least in part by empirical research conducted to date, however, there still remains a void with regard to why the process of professional socialization does not achieve the same results with all participants, and what this variability looks like on the level of the individual actor. In addition, although we gain a certain amount of insight into the structural components necessary for professional socialization to occur, there is an implied
assumption that the process itself is unproblematic and that socialization exists as an "objective" phenomenon independent of the "subjective" experiences of the individual.

By virtue of this problem, the remaining discussion on theoretical premises that guided the methodological approach taken, and were necessary to address these problems, will elaborate sociological approaches that attempt to explain the nature of social reality on the level of the individual actor, and the individual in society.

Symbolic Interactionism

One of the basic foundations for Symbolic Interactionism is that the social world is perceived to be constructed out of a shared symbolic universe by individuals using shared symbols in concrete situations (Douglas, 1980). There is an emphasis placed on the way that individuals are taught by significant others who share symbols which lead to common patterns of action. The actions of individuals in society can only be understood in terms of the meanings that have been attached to acts and social acts that occur during face to face interaction. Reality for the individual occurs during interaction, where meanings are modified through an interpretive process (Blumer, 1969).

Understanding then that actors respond to objects on the basis of meaning which occur during interaction, it must be also understood that people do not act in relation to
objects in their world in a haphazard way, but rather, act toward objects in specific ways based on their definition of the situation. Hewitt (1984: 142) has detailed this process as:

The definition of the situation may be thought of as an overall grasp of the nature of a particular setting, the activities that have taken place there are seen as likely to occur again, the objects to be taken into account, and the roles represented.

The roles that people represent or their situated roles and their definition of the situation is reflexive. By their definition of the situation, they are able to determine their own and others' roles, and conversely by knowing or identifying their and others' roles they can come to define the situation. These concepts as they apply to the present research are useful in determining how nursing students view themselves in the social role of "nurse" given the other role relationships they are engaged in and their definitions of the situations.

According to Stebbins (1975: 7) there are two types of situations; the objective situation, which is comprised of the "immediate social and physical surroundings and the current physiological and psychological state of the actor," and the subjective situation, which is comprised of "those elements of the objective situation seen by the actor to affect any of his action orientations and must, therefore, be given meaning before he can act."
Thus, it is with the understanding that individuals act in relation to the meaning of objects during social interaction, and that this meaning is imparted by the individual based on their objective and subjective definitions of the situation that we can attempt to analyze how nursing students come to perceive and construct a social reality of AIDS for themselves.

**Phenomenology and the Sociology of Knowledge**

Building on some of the theoretical concepts offered by symbolic interactionism, primarily the fact that social life is inextricably bound in the interactions that human beings have with one another, the remainder of this discussion concerning theoretical frames of reference that shaped the present research will address the perspectives offered by both phenomenology and a sociology of knowledge approach.

Alfred Schutz, one of the main voices in phenomenological inquiry, sees the meaning that every individual gives to the situation of prime importance, as this meaning determines the definition of the situation for that individual. In defining the situation, individuals draw upon stocks of knowledge, a recipe that the individual uses to interpret their conduct. Wallace and Wolf (1986: 235) state that "Schutz views individuals as constructing a world by using the typifications (or ideal types) passed on to them by their social group."
In addition to this definition of the situation imparted by the individual, the meaning of the situation may be shared by others in the interaction. Schutz refers to this as the *reciprocity of perspectives* (Wallace and Wolf, 1986: 236). In these situations, people act on the assumption that people in the interaction are sharing their perception of the situation, or have a "reciprocity of perspectives." It is through this cognition that others share our definition of the situation, that we can have certain taken for granted assumptions about a given situation. It is these "taken for granted" assumptions traditionally ignored in positivistic sociology that become the central concern for the phenomenologist.

One of the goals of phenomenology is to "be true to the phenomenon", that is to describe that which is given in experience, that which you and others experience, that which appears to be the case (Roche, 1973: 1).

Phenomenological sociology rejects the idea inherent in those sociological approaches that adopt the natural science paradigm, that the social world constitutes an object world that we can study independent of the meaning that its members have of it.

With respect to the current research, this implies that in studying the socialization process of nursing students, it is essential to understand the meaning that this process
has for the students, for to ignore this, would be accepting the process as part of the object world.

Phenomenology sees the social world as a world that is constructed from human activity, interpretation and intention, as a subject world (Smart, 1976: 75). For the phenomenologist, the social world is seen as a linguistic and cognitive world, and the role of the social scientist is to describe the processes by which this world is constructed. One of the main areas of interest that phenomenology has raised in part by its critique of positivism, is the fact that there are certain "taken for granted assumptions" in social life that have been traditionally treated as if they exist as objective fact. In the past, these "taken for granted assumptions" have been viewed almost as if they could not be any other way, rather than acknowledging that by the fact that these assumptions are social in nature, they are constituted through the meanings that individuals attach to them and can take any form that is socially agreed upon.

Although Schutz was not really concerned with phenomenology as it relates to sociology, his work on the a priori structure of the world in which sociological inquiry is embedded is extremely valuable for understanding the assumptions that sociology traditionally has held. Schutz attempted to theorize precisely how the life-world was
constructed for both the "expert" and the "laymen", making no clear distinction between the two.

For Schutz, the "everyday world" or the "common sense" world does not exist just in the mind of the individual, but rather this world is intersubjective in nature, with each person taking for granted that the world for one individual assumes the same world for others. Not only is the social world intersubjective according to Schutz, but so is the natural world, for it is through the mediation of the social processes that the natural world takes on meaning. Hence, there is no clear distinction between the two. Reality is then experienced by the individual as objective, with little distinction made between the natural and the social world. The salient issue becomes how the natural world is apprehended by the individual, for the objects themselves are not intuitively understood, but the individual first must have internalized a lower-order meaning stratum from which the natural things are experienced as cultural objects. This meaning stratum becomes "reality" only when coupled with events, objects or facts in the world, and conversely the objects, events, or facts only become real because of their meaningfulness (Smart, 1976: 96). To put this simply, the individual does not respond to either physical or social phenomena intuitively, but rather is socialized to recognize the meaning that is culturally given to these objects. Reality according to Schutz is not
homogeneous, rather there are multiple realities that exist depending upon a person's social location and his/her life experience. Schutz refers to these orders of reality as finite provinces of meaning. These provinces of meaning are finite as a result of the fact that they are manifested by the unity of a lived experience (Smart, 1976: 97).

It can be seen that Schutz's conception of finite provinces of meaning becomes very useful when analyzing the "realities" of those students engaged in the process of becoming a nurse, and how this relates to AIDS. The "realities" of AIDS for those in the nursing profession might be markedly different from the "realities" of the layperson, as a result of the fact that AIDS takes on a different meaning dependent upon one's life experiences and social location. Of still greater significance to the immediate research is the proposition that the occupation of "nurse", by virtue of the life experience and social location of the subjects, may be markedly different as well. These multiple realitics, one might suggest, would be further complicated by the onset of a "socially ambiguous disease". The social ambiguity of this disease crosses boundaries that permeate such essential social structures as the family, further complicating for these students the situational role of nurse.

Peter Berger and Thomas Luckmann (1966) attempted to unite the processes of reality construction on both the
micro and macro levels in their work "The Social Construction of Reality", and, starting from a conceptual framework put forth by Schutz, attempted to formulate specifically how knowledge is apprehended by the individual in society as real, and how a shared reality becomes both objectively factual and subjectively meaningful for the individual. In this work Berger and Luckmann take a sociology of knowledge approach, and focus on the processes by which any body of knowledge comes to be socially accepted as reality. By construction they mean the process whereby people are actively engaged in creating their social world through their interactions with others; a shared reality that is experienced as objectively factual and subjectively meaningful. The subjective aspect of reality addresses the fact that reality is personally meaningful to the individual. By objective they are referring to the social order, or the institutional world, which they also view as a human product (Wallace and Wolf, 1986: 254).

If one situates these concepts offered by Schutz into the current research, it can be seen that the objectification of "client" or "patient" occurs over time, with roles understood as if they are separate from the situational experience that reoccurs every time that interaction between client-nurse happens. This is accomplished through the institutional world defining for
the student what a client "is" and what a nurse "is", and how these two roles are supposed to mesh together.

For Berger and Luckmann, the central concern becomes the process by which that which is subjectively meaningful for the individual becomes objective facticity. In order for this process to take place there must be a dialectic for reality construction which they label externalization, objectivation, and internalization. The first "moment" in this dialectical process, externalization, refers to the fact that individuals actively create their own social worlds. Social order comes about from both past human activity, and it exists only as a result of the fact that the individual continues to create it. Externalization then has two elements, the fact that new reality is actively constructed, and that individuals maintain an old reality by continuing to produce it through their interactions. Objectivation refers to the fact that individuals apprehend their everyday life as an ordered prearranged reality that seems to impinge upon them, rather than one that they can control. Language is the means by which objects are so designated.

The language used in everyday life continuously provides me with the necessary objectifications and posits the order within which these make sense and within which everyday life has meaning for me (Berger and Luckmann, 1967: 22).
The third phase in this dialectical process is that of internalization, a type of socialization by which the institutional order becomes solidified. Berger and Luckmann differentiate between two types of socialization that are necessary for internalization of the institutional order, primary, and secondary. Primary socialization refers to the socialization that the individual receives from significant others during their childhood, and the values and norms that are transmitted from these significant others to the child. Secondary socialization is any subsequent process that inducts an already socialized individual into new worlds, as in the case of the student nurse being socialized into the world of nursing. Secondary socialization concerns the acquisition of more specific knowledge and corresponding roles, and usually takes place under the auspices of specialized agencies, like modern educational institutions (Wallace and Wolf, 1986: 257).

An individual is not born a member of society, he/she must be socialized to become one. This is initially accomplished through the process of primary socialization. The beginning of this process is internalization. This is begun with the realization of an objective event as expressing meaning, that is, that another's subjective experience becomes subjectively meaningful to oneself. That is not to say that the subjective experience is experienced by one person the same way that it is meaningful to another,
as there is always the possibility of misinterpretation. In any event, one's own subjectivity is objectively available to others, and becomes meaningful to them. Internalization is the first basis for understanding one's fellow human beings, and secondly, the beginning to the apprehension that the world is a meaningful social reality.

This apprehension of the socially meaningful world does not occur in isolation for the individual, but rather begins with what Berger and Luckmann refer to as the "taking over" the world in which others already live. This process is brought about, and initiated through the process of socialization. Primary socialization is the first socialization that a child receives, and it is through this process that the individual is introduced and assimilated into society. Secondary socialization is any subsequent socialization that inducts an already socialized individual into new sectors of society.

Primary socialization is the most important process that an individual goes through in terms of making the objective world subjectively meaningful to them, and secondary socialization resembles that of primary socialization in its structure. All individuals are born into a social structure, with significant others in it. The definition of reality based on their social location are imposed, and through this imposition, this presentation of the social world becomes that of the child. In other words,
how the parents or significant others present the world to
the child, and the child's role and position in it, become
meaningful to the child.

The significant others who mediate this
world to him modify it in the course of
mediating it. They select aspects of it
in accordance with their own location in
the social structure, and also by virtue
of their individual, biographically
rooted idiosyncrasies (Berger and

As Berger and Luckmann state, it is possible to have not
only a different world presented as meaningful to the lower
class child and the upper class child, but two lower class
neighbours may also present a different world based on their
idiosyncratic tendencies to their children.

The process of primary socialization goes much beyond
just the cognitive aspects of learning "what the world is
all about", as this process is highly charged emotionally.
The child takes on the significant others' roles and
attitudes, and internalizes them and makes them his/her own.
The self is a reflected entity, reflecting the attitudes
first taken by significant others toward it, and the
individual becomes what he/she is addressed by his/her
significant others. This is not a one-sided process, but
rather a dialectical one where the child takes on the
identification of others and a self-identification, between
objectively assigned and subjectively appropriated identity.
The child learns that they are what they are called (I am

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Syd Strom). Every name implies a nomenclature, which in turn implies a social location.

Primary socialization initiates the progressive abstraction from the roles and attitudes of specific others, to roles and attitudes in general. This might be compared to Mead's progression of moving from taking the role of the other, in specific terms, to taking the role of the generalized other. The child learns that not only is certain behaviour not acceptable by him/her to the significant others, but is also unacceptable to others in general. The formation of the generalized other means that the individual now identifies not only with concrete others but with a generality of others, that is with society (Berger and Luckmann, 1966: 133).

The formation within the child's consciousness of the generalized other marks a decisive phase in the child's socialization process. It is at this point that the child has internalized the objective reality of society, and at the same time has internalized a subjective coherent identity. According to Berger and Luckmann, when the child has internalized the generalized other, there becomes a symmetrical relationship between objective and subjective reality. Language is the principle facilitator for the subjective to the objective, and vice versa.

In primary socialization there is no problem of identification, as the child has no choice of significant
others. Since the child has no choice in the selection of those significant others responsible for their primary socialization, the child's identification with those significant others is quasi-automatic. Resulting from this his/her internalization of their particular reality is also quasi-automatic. For the child then, the world of his/her significant others becomes THE world.

The one content feature of primary socialization that is universal is the internalization of language.

Finally, the last aspect of primary socialization that is of great importance is the internalization of at least the rudiments of the legitimating apparatus; the child learns "why" the programs are what they are.

One must be brave because one wants to become a real man; one must perform the rituals because otherwise the gods will be angry; one must be loyal to the chief because only if one does will the gods support one in times of danger; and so on (Berger and Luckmann, 1966: 135).

The character of primary socialization is also affected by the stock of knowledge to be transmitted, and this varies depending on one's social location. An upper class child may learn about the facts of life at an age when a lower class boy has learned the rudiments of abortion technique (Berger and Luckmann 1966 :137).

Primary socialization ends when the child has internalized the concept of the generalized other. At this point they can become an effective member of society and be
in the possession of a subjective self. Socialization is never total or complete, and Berger and Luckmann turn their attention to how the reality internalized in primary socialization is maintained in consciousness, and secondly, how further socialization (secondary) in the later development of the individual takes place.

It is conceivable to think of a society where no further socialization is necessary after the primary, however such a society would necessarily have to be characterized as a society with a very simple stock of knowledge (Berger and Luckmann, 1966). They state however that there is no society without some type of division of labour, and therefore, some social distribution of knowledge. As this is the case, secondary socialization becomes necessary.

Secondary socialization is the internalization of institutional or institutional-based subworlds. The extent and character of secondary socialization is largely based on the extent of the division of labour and the concomitant social distribution of knowledge. The type of knowledge that is socially distributed in secondary socialization is a "specific" type of knowledge rather than a knowledge that is centrally shared by the members of a given society. Secondary socialization requires the acquisition of role-specific vocabularies, which are transmitted by
institutional means that structure the interpretations and conduct within an institutional area.

The subworlds internalized in secondary socialization are generally seen as only partial realities in contrast to the realities presented to the individual during their primary socialization. As it was stated earlier on, primary socialization cannot take place in an emotionally empty arena, that is, the child must relate emotionally to the significant others in charge of his/her socialization. This is not the case in secondary socialization. There only need be a certain amount of mutual identification involved for those participating in the secondary socialization in order for it to be effective. One must love one's mother, but not one's teacher (Berger and Luckmann, 1966: 141).

Occasionally after the primary socialization process has been completed, a crisis may arise during secondary socialization, as the subworld of the institution presents a reality to the individual that is in many ways incongruent to THE reality that was presented to them during their primary socialization. The role relationships that are characteristic of secondary socialization are considered to be anonymous when compared to the emotional content of the relationships characterized during primary socialization. The teacher of sociology, could in fact be any teacher of sociology, although each teacher will differ in their idiosyncratic behaviour. The most important aspect of
secondary socialization is to bestow on the contents of what is learned in secondary socialization much less subjective inevitability than the contents of the primary socialization process. It is as a result of this emphasis, that the knowledge generated during the secondary socialization process is much more easily bracketed (that is, the subjective sense that these internalizations are real is more fugitive) (Berger and Luckmann, 1966: 142). The individual is able to establish a distance between his total self and its reality on the one hand, and the role-specific partial self and its reality on the other hand.

It is these distinctions made by Berger and Luckmann that offer insight into the importance of reality construction during primary socialization, which makes the objective world subjectively meaningful to the child, and how this world later becomes translated during the secondary process of professional socialization. This primary/secondary socialization dialectic is ignored in the positivistic position on professional socialization. This lack of regard by positivists underscores the importance of this dialectical process and presumes that reality is fixed.

The efforts of the institution to displace some of the values that earlier became subjectively meaningful and objectified for these students, become very difficult due to the relatively "fixed" reality presented to the child during their primary socialization. This is possible as a result of
the child's identification with those significant others who interact with them during primary socialization. Although the structuralist conception of professional socialization does recognize conflict that may occur during re-socialization into a profession, witnessed by literature on role conflict, it is only through an examination of propositions offered by phenomenology and the sociology of knowledge of Berger and Luckmann that one begins to realize just how problematic the process really is. Of greater importance than simply the recognition of the problematic nature of secondary socialization, is the illumination of why, and how, secondary socialization becomes problematic. This is essential in understanding how the individual nurse establishes a "reality" of AIDS, and what this means on the level of client care.

Maintenance and Transformation of Subjective Reality

Since socialization is never totally complete, and the contents it internalizes face continuing threats to their subjective reality, every viable society must have procedures for reality maintenance to ensure a symmetry between the objective and subjective realities.

The internalization of those things that one encounters during primary socialization are for the most part permanent features of the individual's view of the social world. However, the same is not true for those things that are internalized during secondary socialization, as the
individual does not internalize them to the same degree. They are subject to influence from other sources. This point is central to the hypothesis that although the institution of university and hospital attempt to re-socialize these students into the sub-world of nursing and its language and meanings, they are not impervious to disruptions of "reality" transformation from the organizational environment in the form of alternate realities presented by friends and significant others in the students' families, with these realities more deeply rooted in their consciousness. As Berger and Luckmann state, this is because the reality apprehended during secondary socialization is less deeply rooted in our consciousness, and thus more susceptible to displacement. The reality of everyday life maintains itself by being embodied in routines, this being the essence of internalization. In addition, reality as we enact it in our daily lives is an ongoing procedure that is re-affirmed through our conversations with others. During this process of reality maintenance, the person distinguishes between those significant others, and those others that are on the periphery. Both those significant others, and those peripheral others serve to maintain the social world as objective facticity.

In terms of the maintenance of a subjective identity, both the significant others, as well as those others that one interacts with peripherally, serve to reinforce the
subjective reality for the individual. The significant others in the individual's life are the principal agents for the maintenance of his/her subjective reality, and the less significant others act as a sort of chorus. The relation between the significant others and the chorus in reality maintenance is a dialectical one, that is, they interact with each other as well as with the subjective reality they seek to confirm (Berger and Luckmann, 1966: 151).

The most important vehicle for reality maintenance is conversation. It is through conversation that the individual maintains, modifies, and reconstructs his/her subjective reality. The feature of conversation as a reality maintainer, is implicit rather than explicit. The casualness of conversation is possible because it refers to the routines of a taken-for-granted world. The loss of casualness, signals a threat to this taken-for-granted world.

In summation, Phenomenology offers an opposing view from the positivistic notion that there are such things as "social facts" that exist outside of the individual experience. Contrary to the simplistic positivist view of professional socialization, the process is not merely a "production line", where individuals leave the influences of primary socialization "at the door" when they begin secondary socialization, rather, there is an ongoing dialectical process that occurs in the construction of a
subjectively meaningful and objectified world that evolves through interaction.

In light of the current research, it would be insufficient to simply look at structural factors in attempting to explain the socialization process of becoming a nurse. One must end up on the level of the individual, and how reality is maintained as meaningful for him/her, if there is to be any further insight into why variability exists in this process and what the variability looks like on the level of the individual actor.

Social constructionism, specifically the work of Berger and Luckmann (1967), becomes useful in the attempt to understand how realities of AIDS have been transmitted through society, and to understand the processes by which those individuals, specifically student nurses, construct what for them becomes a subjectively meaningful and objectively facticical reality of AIDS. The emergence of Acquired Immune Deficiency Syndrome (AIDS) within North American society and the stigma that has been attached to certain groups who have contracted this virus in substantial numbers begs a social constructionist explanation for how the knowledge of AIDS has been transmitted throughout society, and how this has shaped the emerging realities of AIDS for the individual.
Susan Sontag has observed the importance of illness - especially cancer - as metaphors, with illness given a particular moral stigma when related to an activity of a group of people otherwise disapproved of (Weeks, 1985:46).

As Adam (1989) suggests in his article "The state, public policy, and AIDS discourse", AIDS came onto the scene unexpectedly, but it was given significant meaning by the already highly charged political and ideological arena that placed AIDS on the historical stage (Adam, 1989: 1).

AIDS is something of a "pure case" in the social construction of disease, having arrived as an unknown and unanticipated phenomenon at the site of some of the deepest anxieties of western civilization, namely, sex and death.

Although AIDS does exist in a physical (symptomatic) form - a breakdown of the immune system for a large percentage of those with HIV - the ways that society reacts to AIDS as well as those individuals with it, has been socially constructed in a historical context.

Sexuality is a fertile source of moral panic, arousing intimate questions about personal identity, and touching on crucial social boundaries. The erotic acts as a crossover point for a number of tensions whose origins are elsewhere: of class, moral acceptability and medical definition (Weeks, 1985: 44).

Indeed, outside of the symptoms of AIDS, the label "acquired immune deficiency syndrome" has been socially constructed as well. It is a fallacy if we view the "taken for granted assumptions" associated with AIDS as not in
themselves problematic. It might even be posited by some that the inability of federal governments to expediently allocate the necessary funds for research on AIDS can be traced to the connection of the virus with certain "deviant" groups primarily homosexual men and intravenous drug users.

Phenomenology offers the social scientist a new way of conducting research, as well, it challenges the researcher to examine the everyday world in which we are all situated as being a world that we cannot take for granted.

On an "empirical" level, given the fact that nursing students might at some point be responsible for the care of persons with AIDS, it would seem logical to attempt to explicate how these nursing students make sense of the information they have received from peers, the institution, and their significant others in constructing what for them becomes a reality of AIDS.

**AIDS/ Homophobia**

In the last five years a great deal has been written about the impact of AIDS on various groups – most notably the homosexual population, which one of the highest risk groups for the contraction of this virus (Salisbury, 1986; Messing, Schoenberg, Stephens, 1984; Douglas, Kalman, Kalman, 1985; Cummings, Rapaport, Cummings, 1985; Rayside and Bowler, 1988).
The literature about AIDS and attitudes toward homosexuality is diverse, with a variety of different foci. A brief summary of the areas that have been investigated now follows to give the reader an overview of the research that has been conducted to date. Following this summary, a critical review of the literature written about the impact of AIDS on a variety of populations will be undertaken.

Work has been done concerning a student population's knowledge of AIDS (Edwards and Aldige' Hiday, 1987) using the students enroled in an introductory psychology course as a sample. Turnbull and Brown (1977) looked at students' reactions and attitudes to slides of homosexual and heterosexual behaviour. There have also been public opinion polls conducted on various populations' attitudes about AIDS (Singer, Rogers and Corcoran, 1987).

Some of the literature is more specifically focused. For instance, Messing, Schoenberg and Stephens (1984) discuss the role of social workers in combating homophobia in a hospital setting; Salisbury (1986) discusses the psychosocial impact of AIDS on health care professionals and patients with AIDS. Similarly, Cummings, Rapaport and Cummings (1986) investigate psychiatric staff responses to AIDS. Douglas, Kalman and Kalman (1985) measured the level of homophobia found in a hospital setting using the IHP scale developed by Hudson and Ricketts (1980); and lastly, Pleck, O'Donnell, O'Donnell and Snarey (1988) in a survey of
237 hospital workers studied AIDS-Phobia, AIDS-Contact and AIDS-Stress at a major inpatient-care facility.

Other researchers (Hudson and Ricketts, 1980; Gentry, 1986) have focused on the development of scales and indices to measure homophobia as such, with Gentry using social distance as a measurement, and Hudson and Ricketts developing a questionnaire as an index of homophobia. Additional researchers such as Rayside and Bowler (1988) focused their research on a more macro level of analysis, looking at the liberalization of attitudes toward homosexuality as an expression of the trend of public acceptance on equal rights for minority groups.

The research that has been conducted on AIDS/Homophobia can be broken down into four major areas: student attitudes and knowledge of AIDS and/or homosexuality, public opinion polls concerning issues connected to AIDS, AIDS as a factor in a variety of health care situations and the development of scales to measure homophobia. Having peripherally discussed the general foci of the research conducted on AIDS/Homophobia, a detailed description of the studies and their results will now follow.

Dougls, Kalman and Kalman (1985) state that the current epidemic of Acquired Immune Deficiency Syndrome has had a great impact on public attitudes toward homosexuals. This has led to many instances of overt discrimination, social ostracism, and even the deprivation of various rights
such as housing, employment, transportation, and funeral services. They state further that there have been numerous anecdotal reports of prejudicial attitudes and behaviour toward homosexual AIDS patients among health professionals. In some medical centers, AIDS has been nicknamed "WOG" (wrath of God) (Douglas, Kalman and Kalman, 1985: 1309). Prejudicial behaviours toward PWA's (persons with AIDS) were also found in a study by Kelly (1988) who stated that nurses react with much more attitudinal negativity toward a patient identified as having AIDS than toward a patient with leukaemia. A similar pattern of stigma was expressed for persons identified as homosexual regardless of their illness (Kelly, 1988: 78-83). In support of the findings of the aforementioned studies, Pleck et al. (1988) showed that negative attitudes in a major inpatient-care facility were prevalent towards PWA's and that the major predictor of AIDS-Phobia was AIDS-Contact with those persons having the least amount of contact holding the most negative attitudes toward people with AIDS. They concluded that AIDS-phobic attitudes and AIDS-contact could be interpreted as predicting each other. As well, AIDS- stress was predicted by low contact with AIDS and AIDS-phobic attitudes. Their findings indicated that although only a small minority of the staff reported strongly negative attitudes toward AIDS patients, five & agreed that "AIDS is God's punishment for immorality", 16% acknowledged that AIDS patients morally
offend them, and a further 16.9% said they would discontinue a relationship with an acquaintance who developed AIDS (Pleck et al., 1988: 44).

Reports such as these suggest that the AIDS epidemic has activated underlying anxieties about homosexuality, not simply a fear of contagion. Many homosexual patients believe this reemergence of homophobia has adversely affected their medical care (Douglas et al., 1985 : 1309). The issue of activation of underlying anxieties about homosexuality is challenged by Rayside and Bowler (1988), who state that there has been a liberalization of attitudes concerning the rights of minority groups in recent years, including those of homosexuals. They do feel, however, that although the public's position on the principle of equality for homosexuals has received more support recently, strong moral disapproval still persists. It appears that while people in general support more liberalized policies toward homosexuals in a variety of arenas, when it comes to personal feelings, the fears that they have held traditionally still prevail. This might be manifested in the area of health care, where institutional policy concerning the treatment of homosexuals exists on one level and the carrying out of those policies exists on yet another, the two not necessarily being in harmony. With the number of AIDS patients being admitted to hospitals increasing, this will be an even more relevant issue in the future than it is presently.
According to Hudson and Ricketts (1980) there were thirty-one reports of attitudinal studies done in this area between the years 1971–1978, including those of Dunbar, Brown, and Amoroso (1973); Leavitt and Klassan (1974); and Millham, San Miguel, and Kellogg (1976).

Hudson and Ricketts state that most of the negative attitudes reported in these studies toward homosexuality have been presented as "homophobia", even though they state that there are no distinctions made between intellectual attitudes and affective responses toward gay people. They have proposed that the entire domain of anti-gay responses be categorized as "homonegativism", with the affective dimensions of personal responses being the dimension called "homophobia" (Hudson and Ricketts, 1980: 358). This statement has been supported elsewhere in the literature, where Gentry (1986: 75) also suggests that measurement of attitudes toward homosexuals often appear multidimensional in that they combine questions regarding a respondent's opinion about homosexuality with questions regarding a respondent's feelings about homosexuality. Gentry states that such an approach fails to distinguish between individual's cognitive evaluation and affective response.

This makes a great deal of sense, in so far as the statement that what people "think", and what people may "feel", may be two distinct things. This interpretation is supported by the work of Rayside and Bowler (1988), who

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state that increased support given to the rights of homosexuals is usually accompanied by serious reservations about how universally such principles ought to be applied, and even more serious moral reservations about homosexuality itself (Rayside and Bowler, 1988: 653). In such sensitive areas as attitudes toward homosexuals, it is possible to assume that people can make "objective" judgments concerning homosexuals in response to questions on a cognitive level but that different questions put on an affective level may get entirely different responses altogether, indicating the opposite of the cognitive responses.

Gentry (1986), in establishing a scale for "homophobia" similar to Hudson and Ricketts (1980), defines homophobia as "the dread of being in close quarters with homosexuals". From this definition Gentry then designed a scale for homophobia using Guttman scaling to measure social distance.

Other researchers studying the attitudes toward homosexuality have attempted to incorporate into their methodology more than one measure for homophobia. Turnbull and Brown (1977) looked at the relationship between attitudes toward male and female homosexuality and subjects' reactions to slides of various explicit sexual activities (including homosexuality, lesbianism, heterosexuality and group sex). This particular study examined the attitudes toward male and female homosexuality separately to determine whether or not there would be any significant attitudinal
differences in these two groups. Thirty-four males and thirty-one females were divided into those opposed to homosexuality (anti-H) and those not opposed (H-neutral) on the basis of attitude scale scores. The results showed that the anti-H subjects of both sexes rated the slides as more pornographic and evaluated them more negatively than the H-neutral subjects. Females rated them more negatively than males, while males rated all but the male themes (male nude, masturbation, homosexual) more sexually arousing than did females. Males reacted more negatively to the male themes than to the comparable female themes. Female subjects showed no such difference (Turnbull, Brown, 1977: 68).

Although the research generated thus far has alerted us to the realm of attitudes towards AIDS and the attitudes toward homosexuality/homophobia, further in-depth research is needed to examine the impact of homophobia on the treatment and care of homosexual AIDS patients. This may be accomplished in part by attempting to explain how the occupational process of becoming a nurse impacts on the already existing attitudes and behaviours emanating from "common" knowledge to reshape these attitudes and behaviours to fit the occupational definition of "nurse".
METHODOLOGY

Questionnaire Design and Interview Method

This study employed both qualitative as well as quantitative data collection techniques, qualitative, in the form of interactive interviews, and quantitative, in the form of a replicated questionnaire measuring homophobia designed by Walter Hudson and Wendell Ricketts (1980). The justification for using both methods came out of the desire for accuracy in attempting to explain a given phenomenon, in this case the entry phase of the socialization process for nursing, and how this might be correlated to homophobia within this population.

Both qualitative and quantitative methods of data collection are useful individually, based on the topic being studied, for each method has certain strengths for measuring a variety of phenomena. The strengths of a quantitative methodology are: greater replicability and generalizability to a larger population. Conversely, qualitative methods facilitate: greater flexibility to adapt to changing conditions, a greater degree of depth, and an openness to the interview situation and the context (Babbie, 1986). Qualitative and quantitative methods not only have their strengths and weaknesses, they complement each other perfectly (Babbie, 1986). The rationale for utilizing both of these methods was primarily motivated by the ability to
have a complementary set of data that could be compared to the main source of data utilized in this research, namely qualitative, collected from the interview situation. It was felt that based on the topic being discussed during the interview, the reality of treating AIDS patients within a hypothetical situation that there might be a desire on the part of the subject to answer questions presented in a "acceptable" fashion rather than be completely honest. With this in mind, it was decided that it would be beneficial to have a complementary set of data for each subject that could be compared to the data that emerged from the interviews. Ultimately the addition of the quantitative data would be used to validate the findings from the interviews. Finally, it was felt that the ability to compare levels of homophobia within this nursing student population with levels obtained using this same instrument within a hospital setting (Douglas, Kalman and Kalman, 1985) would be of value in determining the consistency of homophobic attitudes within a health care context. It was hypothesized that perhaps homophobic behaviour and attitudes might exist in the population under investigation based on the fact that, during the initial phases of socialization, the "public" attitudes which these students bring with them to the socialization experience may have not yet been modified to the institutional ways of viewing the problems associated with AIDS or the treatment of PWA's.
Qualitative methodology

The first method used was an interactive or focused interview. This type of interview was felt to be the most useful in attempting to have the subjects evaluate for the researcher their personal feelings and perceptions concerning a sensitive topic, specifically their perceptions of AIDS as it related to their forthcoming career in nursing. Given the theoretical premises of this research, that of social constructionism, symbolic interactionism and phenomenology, the focused or interactive interview method was deemed to be the most successful at uncovering the meaning systems of the subject. Although this research was undertaken with certain theoretical assumptions about the impact of various groups or individuals, and the role of the institution (the school of nursing) on the individual's attitudes and values, the main interest was in discovering what these forces look like on the micro level. This interest ultimately lent itself to a focused approach. Although embarking upon any type of social research with theoretical assumptions may be somewhat incompatible with a Social Constructionist approach, in that they believe in "bracketing" assumptions, as Murphy and Pilotta (1983: 49) state:

The interview is a form of inquiry in which data is collected based upon embedded presuppositions and expectations of the evaluator and the respondent. The presuppositions may be
based upon everyday common sense or formal theoretical assumptions.

The focused interview technique uses topics and hypotheses selected in advance, however the actual questions are not specified in advance (Merton, Fiske and Kendall, 1956). In the interview situation the researcher attempted to explore with the subjects how they have synthesized all the information they have been given from a variety of sources on their role as prospective nurse as it relates to AIDS and the treatment of PWA's using hypothetical nursing situations dealing with PWA's as a facilitator.

The interactive interview allowed the researcher to explore areas of concern with the subject while at the same time gave the researcher the flexibility to spontaneously probe certain areas of relevance for the subjects during the interview. This type of interview technique also freed the subject from feeling as though they were being questioned, and helped to facilitate communication between the researcher and the subject, as information flowed in both directions.

In the focused interview questions are also open-ended, to provide flexibility and allow for unanticipated responses. But in addition the focused interview allows flexibility in terms of questions asked. Since questions are not written in advance they may be tailored to probe avenues of exploration that seem to be yielding information relevant for the hypothesis or topic being studied (Babbie, 1982: 201).

quantitative methodology

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The second method of data collection utilized in this research was purely descriptive, a measurement of homophobia in this sample using a Likert type scale, replicated from the "index of homophobia" (IHP) developed by Walter W. Hudson and Wendell A. Ricketts (1980). The IHP is a 25 item summated category partition scale with a score range from 0 to 100. People who have a low fear of being in close quarters with homosexual men or women tend to have low IHP scores; those with a high fear tend to obtain much higher scores (Hudson and Ricketts, 1980). A range or score of 0 to 25 is considered "high grade non-homophobic", and those who score between 25 and 50 are considered "low grade non-homophobic". Scores between 50 and 75 are classified as "low grade homophobic", and those who score 75 and over are regarded as "high grade homophobic" (Hudson and Ricketts, 1980). The relevant questions are item 11 to 35 in the second section of the questionnaire located in the appendix.

In order to score the IHP, it is necessary to reverse-score all of the negatively worded items so that a score of five equals one, four equals two, two equals four, one equals five and a score of three remains the same. The questions that were reverse-scored are: 13, 14, 15, 17, 18, 20, 21, 22, 23, 25, 27, 29, 32.

In addition to the questions that were related to homophobia from the Hudson and Ricketts scale, questions were also included that related to AIDS in general taken
from "Attitudes Towards and Knowledge of AIDS" by Andrew Edwards and Virginia Aldige' Hiday (1987). These questions also utilized a Likert type scale. The questions that were included in this study were selected on the basis that they were measuring attitudes not previously measured in the scale by Hudson and Ricketts. In addition, these questions were included as well for the reason that this scale was used on a student population originally, and the ability to compare results between their student population and this study's population was felt to be important. In so far as the population in the study by Edwards and Aldige' Hiday consisted of students enroled in introductory psychology, it was hypothesized that students enroled in the school of nursing might have a more technical knowledge of AIDS based on their field. The questions that were used in this study are questions one through ten in the present questionnaire located in the appendix. The questions that were reverse scored were: one, two, seven, nine and ten. The maximum score on these questions, reflecting a positive attitude is 50 and the minimum score, reflecting a negative attitude, is ten.

Demographic variables that were measured were chosen on the basis that they might have some influence on the attitudes that are held regarding AIDS and homophobia. The variables considered were: sex, year of study in the university, marital status, SES (operationalized by father's
occupation, mother's occupation, and total family income), ethnicity (operationalized by where parents were born), and religion. Marital status was broken down to include as many different response categories as possible.

Finally, questions 34 to 38 were constructed as attitude measures to differentiate attitudes of nurses toward various risk groups. It was hypothesized from a review of the literature that on the basis of moral feelings, those nurses with low IHP scores might show less discrimination toward patients concerning their method of contraction of the virus than nurses with high IHP scores.

Procedure

The first step in the interview construction was to determine a set number of procedures that first year nursing students would most likely have studied. By discussing a standard set of nursing procedures with each subject, it could be determined whether or not all subjects had a uniform education. This hopefully, would enable the researcher at a later date to eliminate the type and amount of education the subjects received as a possible confounding variable in the social construction of AIDS for these student nurses. These procedures were taken from the introductory nursing textbook (Potter and Perry, 1985) these students actually used during the year, and were reviewed by the external reader for this research, Professor Janet Rosenbaum from the School of Nursing at the University of
Windsor. Once the procedures had been established (there were thirteen in total), they were then classified into domains or classifications of types of procedures and ranked in order of their potential for evoking anxiety based on certain theoretical assumptions. The theoretical considerations for this ranking were: potential for the risk of exposure to the virus during the procedure, and sensitive types of procedures involving the genitalia of the client or other possible difficulties for the student nurse. For example, under the domain of "promoting comfort and safety" it was thought that tepid sponging (sponging down a client to bring down temperature) would be theoretically less problematic for the student nurse than male perineal care (the washing of the male scrotum and anal region). In ordinary circumstances the washing of the male genitalia by a female nursing student might invoke anxiety initially as a result of the sexual connotations. The same procedure carried out on a PWA might cause additional anxiety based on the fact that the initial difficulty still exists, but is compounded by the possible anxiety of caring for a PWA and the perceptions of risk, real or not.

AIDS was chosen as a topic for discussion during the interviews based on the hypothesis that with all the attention AIDS has received in the media over the last ten years, these students would most likely have received some exposure to the problems and dilemmas associated with AIDS.
It was also hypothesized that the institution, the School of Nursing, as an agent of socialization would be in the initial process of moulding the ideals and values of the student to fit the ideology of the profession of nursing. AIDS as a moral issue was felt to be useful in determining what amount of socialization first year nurses might have been exposed to, and whether or not the socialization they had received was in any way incongruent to their own personal beliefs and values concerning AIDS and the treatment of AIDS patients. Subjects were solicited through a presentation given by the researcher in one of the introductory nursing classes. The general topic for the research was presented to them, and they were requested to sign up as volunteers. Once the list of volunteers had been completed, they were contacted at their homes by phone and a suitable meeting time was set up. It was decided that for the purposes of neutrality that the best location for the interviews would be in the sociology department at the university. Due to the fact that some of the students would be starting their clinical training immediately upon their completion of the semester, and others had a two week lay-off, interviews were scheduled whenever possible at a convenient time for the subject. Although the initial goal for subject participation was twenty, due to the fact that participation was purely voluntary, the researcher had little control over the eventual number of students that did
decide to participate. In the end, thirteen students signed up to participate, however two listed telephone numbers that were not in service, reducing the final sample to eleven subjects.

Once the interview date had been established, the subject was met in the department at the designated time and taken to the room where the interview was to take place (the small groups laboratory). Subjects were asked whether or not they would object to the interview being taped and there were no objections. They were informed of the confidentiality of all information that was discussed during the interview, at which point the interview commenced.

Subjects were handed a set of procedures reproduced from the textbook by Potter and Perry which they could view during the course of the interview. Each procedure was discussed with each subject and they were asked whether or not they had studied and practised the procedure. Once this had been established, they were then asked whether or not they had any specific difficulties with the procedure. Finally for each procedure, they were asked to imagine carrying out the same procedure on a client who had AIDS, and if they might find anything concerning the procedure under these hypothetical circumstance problematic. Wherever it was deemed necessary, probes were used to elaborate on any information given or to elicit possible information not given. In addition, at opportune moments during the
interviews, probes were used to extract information about potential theoretical sources of influence that were thought to play some part in the construction of AIDS for the individual, determined prior to the carrying out of the research. All subjects were asked to discuss the same procedures in the same order during the interviews.

Although the procedures that were included in the interview situation were reviewed by the external reader for this research, as the interviews evolved it was soon discovered that three of the procedures were beyond the level that these students were at, and once this had been established with each subject, the procedure was skipped over. For purposes of clarity the procedures that were skipped were: oral medication (#7), subcutaneous-intramuscular injections (#9) and mouth to mouth resuscitation (#12).

At the end of the last procedure subjects were asked whether or not they could think of any other influence that might have helped shape their perceptions of AIDS as it related to the career they were about to embark upon. In some cases, this uncovered details that were missed during the actual discussion of the various procedures. Lastly, subjects were asked whether or not they had decided on an area of nursing that they might specialize in upon completion of their education. The interviews lasted between
forty-five minutes to one hour and fifteen minutes in length.

Finally, at the completion of the interview each subject was requested to fill out a short questionnaire and upon its completion the interview was complete. As a method to increase the number of subjects that were participating in the research, subjects were asked whether or not they knew of anyone else in first year that might be interested in participating in the research. This snowball technique enlisted one new subject to the research bringing the original number from ten to eleven subjects in total.

Sample

The sample in this study came about through a convenience sampling technique and consisted of eleven subjects, ten were female and one was male. All subjects were in their first year in a four year nursing programme at the University of Windsor, School of Nursing. In that the interviews were carried out at the end of the school year and that the clinical instruction in the hospital was set up in two two-week periods, some of the subjects had already completed their clinicals for the year and others were still in progress. To protect the anonymity of the one male subject, all references in the interviews refer to the subjects as female.
Reliability and Validity

As mentioned before, although the procedures that were used during the interview were discussed with the external reader for this research prior to embarking upon the interviews, it was discovered that as the interviews proceeded, certain procedures had not made their way into the curriculum during the first year of study, and therefore, although each subject was asked about them, they were eventually skipped over during the interviews. All other procedures used during the interview had been studied by all subjects, and in most cases had been practised in the hospital or lab by most of the subjects. As a result of this uniformity concerning the procedures used, it was felt that however the subjects envisioned the carrying out of these procedures on PWA's, the differences between subjects perceptions could not be attributed to the uncertainty of the procedures themselves and therefore had to be accounted for from other sources. It was therefore felt that the interview as a measure for the construction of AIDS as a source of uncertainty during the entry phase of the socialization process was valid. There was some difference in the degree of comprehension between subjects about how they might perceive the imaginary scenario of performing these procedures on a PWA. However, since the basis of this research concerns itself with the social construction of
AIDS from a variety of different stocks of knowledge, this difference in degree of comprehension was expected.

Due to the fact that the population in this study consisted of a small sample from the total population, there is the chance that as a result of the fact that the general topic for the research was discussed during the solicitation process for volunteers that only those who were comfortable with the general issue of AIDS volunteered. If this were the case, the validity of the information extracted from the interviews might be challenged. However, it is felt that this was not the case, partly due to the fact that the issues presented to the introductory class were peripheral enough that it would not discourage those who were either uncomfortable with the issue of AIDS or those who were homophobic.

The Index of Homophobia (IHP) by Hudson and Ricketts (1980) was used based on the fact that the authors had tested their scale sufficiently and have shown that it is an excellent scale in terms of its measurement characteristics (Hudson and Ricketts, 1980). In addition the authors have shown this scale to have good construct as well as good factorial validity. For these reasons the scale as it appeared in its original form was used as the measure for homophobia. In addition to its strength of reliability and validity, this scale was also deemed appropriate based on the fact that it included both the affective as well as the
cognitive aspects of homophobia, a distinction left out of many of the scales that supposedly measure homophobia.

Similarly, the questions taken from the scale constructed by Aldige 'Hiday and Edwards (1987) were shown to have good construct as well as content validity.

Finally, the remaining five questions used in this questionnaire, although not pre-tested in advance, were included to hopefully discriminate between attitudes held by respondents regarding perceptions on the method of contraction of the virus.
**Procedures used During Interviews:**

<table>
<thead>
<tr>
<th>Procedures</th>
<th>S1</th>
<th>S2</th>
<th>S3</th>
<th>S4</th>
<th>S5</th>
<th>S6</th>
<th>S7</th>
<th>S8</th>
<th>S9</th>
<th>S10</th>
<th>S11</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assist sit pos.</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
</tr>
<tr>
<td>Bed to chair</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
</tr>
<tr>
<td>R.O.M. excercise</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
</tr>
<tr>
<td>Tepid sponging</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
</tr>
<tr>
<td>Bed bath</td>
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<td>yes</td>
<td>yes</td>
<td>yes</td>
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<td>yes</td>
<td>yes</td>
<td>yes</td>
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<td>yes</td>
</tr>
<tr>
<td>Perineal care</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
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</tr>
<tr>
<td>Oral medication</td>
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<td>no</td>
<td>no</td>
<td>no</td>
<td>no</td>
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</tr>
<tr>
<td>Rectal suppos.</td>
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<td>no</td>
<td>no</td>
<td>no</td>
<td>no</td>
<td>no</td>
<td>no</td>
<td>no</td>
<td>no</td>
</tr>
<tr>
<td>Removing stool</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
</tr>
<tr>
<td>Enema</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
</tr>
<tr>
<td>Mouth to mouth</td>
<td>no</td>
<td>no</td>
<td>no</td>
<td>no</td>
<td>no</td>
<td>no</td>
<td>no</td>
<td>no</td>
<td>no</td>
<td>no</td>
<td>no</td>
</tr>
<tr>
<td>Specimen collect.</td>
<td>yes</td>
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<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
</tr>
</tbody>
</table>

* S = Studied  
P = Practised
DATA ANALYSIS

Qualitative

The method for coding the information or data extracted from the interviews for the purposes of analysis was as follows: prior to the commencement of the interviews, theoretical influences felt to be significant in the individual's construction of AIDS were detailed. These areas of influence included: primary group, the institution (including professors, textbooks and journals), peer group within the school, practising nurses in the hospital, the media (including television, magazines and newspapers), and friends outside of nursing. These influences on the individual became the derived categories in the construction of AIDS for the student. Each area of influence was given a colour code, and once the interviews were transcribed, the author reviewed each interview and colour coded responses as they fit into the appropriate category. As a result of the fact that individuals often take for granted where they might have received information or opinions that have shaped their perceptions on a given topic, or the fact that information often comes from numerous sources, it was often necessary during the interview to specifically ask where the subject felt they got certain information from. As the following quote illustrates, when asked whether or not performing the first procedure (assisting the client to a
sitting position) would be difficult on a PWA subject #1 states:

S: Well, no I don't think so... the only thing, like if they had any open sores or anything like that, then maybe I'd take the precautions ah, you know to have gloves on or stuff... or if um, they were at the stage where they can catch things...

I: Um how do you know about things like that, about the infection, where have you gotten that information?

S: Well when we (students) were at Grace hospital they um showed us a film um I forget, it's like on universal precautions they're trying to get into the hospital now like for everybody... they're trying to start this here because like a lot of places think you should be gowned, gloved and... (interview #1)

As a result of the probe used during this segment of the interview, it was determined that the subject considered the hospital, specifically a film that she saw at the hospital on universal care, to be the source for her information. In recognition of this, this particular segment was coded in the colour designated for the influence of the hospital. In another case, when asked about where the information on using gloves for a particular procedure came from this subject responded in the following manner:

I: Where do you get, um I'm interested in knowing where you get information like using gloves, is this something that you learned in school?

S: Yes, oh yes.

I: Like you've had lectures on it?

S: I had a client who had active herpes that I had to give care to.

I: This is in the hospital?

S: Yes, and so I was familiar, I think I was probably the only one in the group that had a patient like that, so I had to use gloves whenever I did anything with her. (Interview #2)
In this particular example, the subject had received information on the use of gloves from her education within the university, however she had also synthesized practical experience on the care of a patient with active herpes into the imaginary scenario of carrying out a particular procedure on a client with AIDS. This segment of the interview was coded using both the influence of the institution, as well as the influence of the hospital in her construction of the possibility of caring for a PWA.

Each interview was coded in the same fashion, however at certain points in the interviews, responses given did not fit the theoretical areas of the derived categories, and a new category had to be created. These new categories became in the analysis the extracted categories for the construction of AIDS for the student nurse. As the following case demonstrates, the respondent constructed a particular view of AIDS as it relates to nursing from a source other than those considered in the derived categories.

\[ I: \] When you mention things like double gloving, where do you know about, like where do you have the practice of gloving in the first place?

\[ S: \] We learn that in clinical, like in the lab.

\[ I: \] At the university?

\[ S: \] Yeah, but not double gloving. The reason I know about double gloving is, and I'll be the first to admit, back when AIDS was becoming a big deal so to speak in the media, I had some friends who were homosexual, and had kissed, kissed them you know, hi how are you, and kissed them, and I became very paranoid about that so I wanted to see...it's probably crazy I know, but I was thinking of getting pregnant with him (pointing to her son), so I went to the health unit and I asked to be tested for the virus. I was
tested, and I was really intrigued to see the procedure that they went through when they took my blood sample for testing for the virus, and they double gloved. (Interview #3)

The categories that emerged or were extracted from the interviews were the following: first aid course, prior education (other degrees), community health services, life saving classes, donating blood, prior jobs and attending an AIDS seminar.

Coding Difficulties

Although it would have been preferable to have not encountered any difficulties in the coding of the qualitative data, this was not the case. In attempting to uncover the variety of sources of information that each individual utilized to construct the imaginary scenario of caring for a PWA, it was not always possible to recover where certain information they utilized came from. In addition, it was difficult when attempting to keep the interview as interactive as possible to interrupt the flow of information with leading types of questions. Part of the interactive process involves the researcher becoming involved with the topic at hand, and it is not always possible to remain as focused as one might like to. As a result of this, certain bits of information were volunteered without any probes on the author's part to try and find out the source of the information. Further, often even after probing for sources, the respondent could not exactly trace where the information came from. It was thought that rather
than interject my own biases and preconceived notions, it would be better to just acknowledge that I was uncertain what sources of information they might be drawing from.

Quantitative:

The demographic information received from the questionnaires was tabulated and placed in frequency distributions, see tables #2 through #8. Although the demographic data were not expected to produce any significant revelations about the subjects and their perceptions of AIDS, it was thought to be useful to have a certain amount of background information on each subject.
<table>
<thead>
<tr>
<th>Table 1 Procedures Used During Interviews</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>S1</strong></td>
</tr>
<tr>
<td>Assist sit pos. S: yes</td>
</tr>
<tr>
<td>P: yes</td>
</tr>
<tr>
<td>Bed to chair S: yes</td>
</tr>
<tr>
<td>P: yes</td>
</tr>
<tr>
<td>R.O.M. exercise S: yes</td>
</tr>
<tr>
<td>P: yes</td>
</tr>
<tr>
<td>Tepid sponging S: yes</td>
</tr>
<tr>
<td>P: yes</td>
</tr>
<tr>
<td>Bed bath S: yes</td>
</tr>
<tr>
<td>P: yes</td>
</tr>
<tr>
<td>Perineal care S: yes</td>
</tr>
<tr>
<td>P: yes</td>
</tr>
<tr>
<td>Oral medication S: no</td>
</tr>
<tr>
<td>P: no</td>
</tr>
<tr>
<td>Rectal suppos. S: yes</td>
</tr>
<tr>
<td>P: yes</td>
</tr>
<tr>
<td>Injections S: no</td>
</tr>
<tr>
<td>P: no</td>
</tr>
<tr>
<td>Removing stool S: yes</td>
</tr>
<tr>
<td>P: no</td>
</tr>
<tr>
<td>Enema S: yes</td>
</tr>
<tr>
<td>P: yes</td>
</tr>
<tr>
<td>Mouth to mouth S: no</td>
</tr>
<tr>
<td>P: no</td>
</tr>
<tr>
<td>Specimen collect. S: yes</td>
</tr>
<tr>
<td>P: yes</td>
</tr>
</tbody>
</table>

*S: Studied  
P: Practised*
QUANTITATIVE FINDINGS

Table 1  Procedures used during interviews

As Table 1 demonstrates, the subjects all had the same educational experience. In the case of procedures #7, #9, and #12, none of the subjects had either studied or practised these procedures. As a result of this fact, during the interviews once this was identified, the procedure was skipped over. In a few cases there was a small discrepancy in the practice of certain procedures, where some of the subjects had not carried out certain procedures, e.g., removing stool digitally was not done by Subject 1, S4, S5, S7 and S9; giving an enema, by S2, S6, S8 and S11; and specimen collection, by S2, S5, S6, S9 and S11. Although these subjects had not actually carried out these procedures, their knowledge of them was enough to imagine carrying out the procedures on a FWA. In certain cases the subject may have not carried out a particular procedure but had watched it being performed.

I:  Okay, um, that's good. The second procedure is administering an enema.

S:  We've learned the various procedures for this. Uh, I've seen a fleet enema given but not an enema like this one. (Interview #8)

The general purpose of this table is to demonstrate that although the subjects in this study all received the same education, and had relatively the same experience with the procedures used during the interview, their perceptions
of these procedures as they related to AIDS were significantly different in certain ways, this the result of a variety of influences that subjects had been exposed to and their interpretation of those experiences. Of particular interest to this research was the degree of uncertainty that many of these first year nurses displayed when trying to imagine any difficulties they might have encountering a PWA during the carrying out of one of these procedures.

In some cases, students might try to utilize past experience with caring for a patient who had some other type of awkward or uncomfortable illness and try to relate their feelings from that experience to the imaginary scenario of AIDS. In other instances some students openly admitted to not being able to predict how they might react in the presence of someone with AIDS who was in their care. As the following quote demonstrates the difference between knowledge and experience can be quite substantial when confronted with what one "knows" about AIDS and how one might "feel" taking care of a PWA:

*I don't know, see it's difficult cause (because) like I told you, I haven't seen anything like that (referring to open lesions) so I don't know how I'd react. It's different when you read about something and you talk about something and when you're actually there and doing it. It's very different and you might react differently. (Interview #10)*

Once it had been established with subjects whether or not they had studied and carried out the procedure, an attempt was then made to find out whether or not the procedure itself presented any problems or difficulties for
them. This was considered important in so far as it was desirable to separate the difficulties of the procedure from the possible difficulties of carrying this procedure out on a person with AIDS. Although it was thought at the outset that some of these procedures would most likely be problematic for some of the subjects, particularly those procedures connoting sexual undertones e.g., cleaning of the male perineal area, with very few exceptions the subjects had very few difficulties with the procedures as a whole.

I:  Okay, was there anything in the procedure itself that you found difficult or problematic?

S:  I didn't find it a pleasant procedure, but no, I didn't find it difficult or... (Interview #6)

In another case, when asked about the same procedure, male perineal care subject#4 responded in the following way.

I:  Okay, is there anything in this procedure itself, that you found difficult?

S:  At first it was hard to do, I found it really awkward doing it, uhmm like now I do it and don't think too much about it, but it still feels a little awkward.

This is not to suggest that the procedures in total were not at all problematic for some of the nursing students. As it was expected, some of the students either implied that they were worried about forgetting some of the proper steps in the procedure or were initially uncomfortable at seeing a client naked for the first time as an example. When one student was asked about any problems she might have had in doing a bed bath she responded in the following way:
R: The only thing uh, that a lot of us felt at first with steps of the body exposed, how am I going to react. Like this is someone else's body, am I going to be nervous, am I going to giggle, am I going to go red and black? (Interview #8).

Table 2 Occupations

<table>
<thead>
<tr>
<th>Father</th>
<th>Mother</th>
</tr>
</thead>
<tbody>
<tr>
<td>Managerial</td>
<td>1</td>
</tr>
<tr>
<td>Skilled Technical</td>
<td>2</td>
</tr>
<tr>
<td>Professional</td>
<td>2</td>
</tr>
<tr>
<td>Factory Worker</td>
<td>1</td>
</tr>
<tr>
<td>Business Person</td>
<td>1</td>
</tr>
<tr>
<td>Farmer</td>
<td>1</td>
</tr>
<tr>
<td>Clerk</td>
<td>1</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
</tr>
<tr>
<td>Retired</td>
<td>1</td>
</tr>
<tr>
<td>Homemaker</td>
<td>5</td>
</tr>
<tr>
<td>Computer Programmer</td>
<td>1</td>
</tr>
<tr>
<td>Secretary</td>
<td>2</td>
</tr>
<tr>
<td>Nurse</td>
<td>1</td>
</tr>
<tr>
<td>Real Estate Agent</td>
<td>1</td>
</tr>
</tbody>
</table>

Table 2 shows the distribution of occupations for both the mothers and fathers of respondents. In looking at the data shown in the table, there appears to be fair representation of occupational backgrounds for the respondents' fathers, with only the categories of skilled technical and professional containing more than one entry in
those cells. The same is not true for the mothers of the respondents, where 45% of the mothers worked in the home, with the remaining percentage of the mothers occupying a variety of positions in the workforce.

Table 3  Country of Parents' Origin

<table>
<thead>
<tr>
<th></th>
<th>Father</th>
<th>Mother</th>
</tr>
</thead>
<tbody>
<tr>
<td>Canada</td>
<td>8</td>
<td>9</td>
</tr>
<tr>
<td>Lebanon</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>England</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

As Table 3 indicates, the majority of the respondents' parents were born in Canada, 72% of the fathers and 81% of the mothers, with the remaining number either born in Lebanon or England. Although the cultural background of the respondents whose parents were born in Canada and England are in many ways similar, e.g., customs and norms, the norms and customs found in Lebanon may well be markedly differentiated from our own.

It is therefore interesting to note that the highest score on the index of homophobia scale (IHP) was from the respondent whose parents were born in Lebanon, reaching 70. This score translates as low-grade homophobic, however it is only five points out of the range for high-grade homophobic 75-100. The next closest score in the sample was a score of 61.
Table 4 Marital Status

<table>
<thead>
<tr>
<th>Status</th>
<th>Number</th>
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</thead>
<tbody>
<tr>
<td>Single</td>
<td>6</td>
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<tr>
<td>Married</td>
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<tr>
<td>Separated</td>
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<tr>
<td>Widowed</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
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</tbody>
</table>

The above table indicated that 54% of the sample or six of the respondents were single, 36% or four were married and .09% or one of the respondents were divorced. None of the sample fell into any of the remaining categories. Although the results of the IHP (Index of homophobia) will be discussed at length in a table to follow, the marital status of the respondents as it relates to the homophobic scale showed no apparent pattern. Of the six cases or 54% of the sample that was scored as low-grade homophobic, four of the students were single, one was married and one was divorced. Conversely, of the five or 45% of the sample that were scored as low-grade non-homophobic, two were single and three were married. Although it is difficult to make any generalizations about such a small sample, on a purely
descriptive level it appears that the level of homophobia of the respondents as measured by the IHP was spread over the marital categories of those who were married, single and divorced.

\textbf{Table 5} Number of Children

<table>
<thead>
<tr>
<th>Number of Children</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
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</tr>
<tr>
<td>One</td>
<td>1</td>
</tr>
<tr>
<td>Two</td>
<td></td>
</tr>
<tr>
<td>Three</td>
<td>3</td>
</tr>
</tbody>
</table>

The above table showed that of the 11 respondents, 63% or seven of the individuals had no children, .09% or one had one child, and 27% or three had three children. Although at the outset of this study, the fact of having children was thought to perhaps play a small role in the individuals perceptions and feelings about AIDS, this turned out to be a rather interesting variable in how the student nurses viewed themselves vis-a-vis the perceived risks of caring for a PWA.

As the following quote demonstrates, there appears to be a distinction made among nurses between those who have children and those who do not. Those with children perhaps feel more concerned about the likelihood of contracting AIDS on the job as a result of wanting to protect their children.
Table 6  Religion

Protestant    4
Catholic      5
Jewish
Greek Orthodox
Jehovah Witness
Muslim
Hindu
Sikh
Other
None          2

Table 6 shows the distribution of the sample according to religion. It was found that 45% of the sample stated their religion as Catholic, 36% were Protestant, and the remainder listed no religion for themselves. It is difficult to assess the impact that religious beliefs might have on attitudes toward AIDS, in so far as questions were not included that might discriminate between the degrees of religiosity on the part of the subjects. Of those who were scored in the 50-75 range of the IHP scale (low-grade homophobic), 50% or three were Catholic and 50% or three
were Protestant. Those who were scored in the 25-50 range on the IHP scale (low-grade non-homophobic) 20% or one listed Protestant as their religious background, 40% or two were Catholics, and 40% or two had no religious affiliation.

**Table 7** Parents' Combined Annual Income

<table>
<thead>
<tr>
<th>Income Range</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
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<tr>
<td>Between 20,000-29,000</td>
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</tr>
<tr>
<td>Between 30,000-49,000</td>
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</tr>
<tr>
<td>Between 50,000-69,000</td>
<td>2</td>
</tr>
<tr>
<td>70,000 or more</td>
<td>4</td>
</tr>
<tr>
<td>Don't know</td>
<td>4</td>
</tr>
</tbody>
</table>

Table 7 shows the distribution of the sample according to the parents' combined total income. There were no subjects whose family income fell into the cells at either extreme. Most of the subjects come from middle income backgrounds.

**Table 8** Sex of Respondent

<table>
<thead>
<tr>
<th>Sex</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
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</tr>
<tr>
<td>Female</td>
<td>10</td>
</tr>
</tbody>
</table>

Table 8 shows that the majority of subjects, 10 out of eleven subjects, were female. This is not surprising given
the fact that the profession until very recently, was predominantly female.

The Index of Homophobia

As will be recalled from the methodology chapter, specifically the quantitative section, the Index of Homophobia (Hudson and Ricketts, 1980) is a 25 item summated category partition scale with a score range from 0 to 100. People who have a low fear of being in close quarters with homosexual men or women tend to have low IHP scores; those with a high fear tend to obtain much higher scores (Hudson and Ricketts, 1980). A range or score of 0 to 25 is considered "high grade non-homophbic", and those who score between 25 and 50 are considered "low grade non-homophbic". Scores between 50 and 75 are classified as "low grade homophobic", and those who score 75 and over are regarded as "high grade homophobic" (Hudson and Ricketts, 1980).

<table>
<thead>
<tr>
<th>Table 9 Levels of Homophobia</th>
<th>Cases</th>
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<tr>
<td>Range 0-25</td>
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<td>Range 25-50</td>
<td>5</td>
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<td>Range 50-75</td>
<td>6</td>
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<td>Range 75-100</td>
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As Table 9 indicates, all subjects placed in the middle categories of low grade non-homophbic, to low grade
homophobic. The majority of subjects were "low grade homophobic", with slightly more than half falling into this category.

In order to understand what exactly these categories mean, it is necessary to examine some of the attitudinal tendencies of people in these groups with the view to how they answered some of the questions in the scale.

An analysis of the findings show that those in the "low grade homophobic" category showed consistent response patterns to the following questions:

**Low Grade Homophobic**

17. *I would feel comfortable if a member of my sex made an advance toward me.*

Five of the six subjects answered this question with "strongly disagree", with one choosing "disagree" as a response.

19. *I would feel disappointed if I learned that my child was homosexual.*

Five of six subjects answered this question with "agree", with one subject choosing "neither agree or disagree".

25. *If a member of my sex made an advance toward me I would be offended.*

Four subjects answered this with "agree", with the remaining two subjects choosing "strongly agree" as their response patterns.

27. *I would feel uncomfortable if I leaned that my spouse or partner was attracted to members of his or her sex.*
Five subjects answered with "strongly agree", with the remaining one choosing "agree" as a response.

32. I would feel comfortable if I learned that my best friend of my sex was homosexual.

Five subjects answered this question with "disagree" with the remaining one choosing "agree" as their response.

By comparison, those in the "low grade non-homophobic" category showed consistent responses to the following questions:

Low Grade Non-Homophobic

13. I would feel uncomfortable if I learned that my neighbour was homosexual.

All subjects answered this question with "strongly disagree".

20. I would feel nervous being in a group of homosexuals.

Four subjects answered this with "disagree", with the remaining one answering "neither agree or disagree".

27. I would feel uncomfortable if I learned that my spouse or partner was attracted to members of his or her sex.

Four subjects answered with "agree", with the remaining subject answering "strongly agree".

This question produced the same type of response pattern as in the low grade homophobic category, with differences being demonstrated in degree. Those in the low grade homophobic category more often chose "strongly agree"
than "agree" as their response category. This was the opposite for those in the low grade non-homophobic category.

28. *I would feel at ease talking with a homosexual person at a party.*

Five subjects answered with "strongly agree", with one choosing "agree" as their response.

**Comparing the Two Groups**

Looking at some of the differences in attitudes that were expressed in the answering of certain questions, we can get a clearer picture of what attitudes seem to distinguish these two groups from each other.

When asked about attitudes they would have regarding having a neighbour that was a homosexual, those in the low grade homophobic category were more likely to express discomfort about this scenario than those in the low grade non-homophobic category.

When asked about their level of comfort in being seen in a gay bar, the attitudes of both groups expressed the same level of discomfort, with the low grade homophobic group expressing slightly more discomfort.

Those people in the low grade homophobic group expressed greater disappointment in the idea of finding out their child was gay than those in the other group. There was a marked difference in how the question regarding "being nervous in a group of homosexuals" was answered. Those in the low grade homophobic group were more likely to express
nervousness than those in the other group. Similarly, those in the low grade homophobic group were more likely to express discomfort at the idea of "talking to a homosexual at a party" than those in the low grade non-homophobic group.

The question regarding "walking through a predominantly gay section of town" evoked a more neutral response from the low grade non-homophobic group than it the homophobic group. They chose "strongly disagree" or "disagree" to respond to whether or not they would feel comfortable.

Having a best friend of the same sex who was homosexual was more likely to evoke feelings of discomfort in the homophobic group than it was in the other group, although there were two subjects in the low grade non-homophobic group who expressed extreme discomfort as well.

Lastly, working close with a female homosexual evoked greater discomfort from the low grade homophobic group than it did with the other group, who stated equally that they would feel either comfortable or very comfortable in this situation.

This questionnaire is useful in highlighting certain attitudinal tendencies of the subjects, however it does not explain how these tendencies might translate into actual behaviour. One might argue that answering a question about their feelings on finding out that their child was a homosexual might have no connection to the way they view
their role as a caregiver. In order to understand the connection that this scale might have to behaviour displayed in a nursing context, it is necessary to connect AIDS with issues that the nurse might face in a hospital setting, and have the nurse discuss any feelings he/she might have in this area.
QUALITATIVE FINDINGS

The qualitative findings were analyzed in terms of the derived categories that came out of the review of literature on socialization. These categories were: the family, peer group and fellow students, the media and the institution.

The remaining categories were extracted from the interviews themselves and are entitled, "other sources in the construction of AIDS". The reporting of the data follow these headings.

The Family

As was stated earlier in the review of the literature, one of the most profound influences on the value systems that the students bring with them to the secondary socialization experience is the family. Many integral values human beings live by and believe in, such as the importance of work, religion, honesty, love, compassion, belief in the family and benevolence, are imparted to the child from significant others in the family at a very early age, and in many, if not all cases, remain as part of the child's own value system for the rest of his/her life. Even as he/she matures and enter the working world as bona fide adults, the support and encouragement of their families still remains important.
With the above in mind, this research was undertaken with the prediction that the family would most likely have a significant influence in the construction of the reality of AIDS for the student nurse. Because AIDS is such a volatile issue in the media, connected to some very strong moral pedagogies primarily passed on to the student from the family, it was hypothesized that the respondents would have engaged in some type of discussion with members of their families concerning the moral aspects of AIDS as well as personal concern for the nurse in the hospital setting.

**AIDS as a Non-Issue**

Certain categories of responses emerged during the interviews with regard to the feelings of family members concerning the respondent being in the field of nursing and the potential risk of infection from the virus. When asked how her husband or other family members felt about her going into a profession that potentially might have to deal with AIDS, subject #6 responded in the following manner:

**S:** Actually he (husband) is pretty happy about my going into nursing, but as of AIDS, we've never discussed anything. As far as I'm concerned I really don't think that it's an issue.

**I:** What about any other family member, have you talked about this with any other family member?

**S:** They're just glad I'm in it. None of them have really had any doubts or see anything wrong with it or me catching anything. They haven't really discussed it with me. (Interview #6)

Similar types of responses emerged from two other interviews, where the family had not discussed with the
subject any concern about the potential risk of contraction of the virus in the hospital setting.

Anticipatory Socialization - Family Support

As was discussed earlier in the review of socialization theory, one important factor that influences anticipatory socialization is the availability of role models such as parents, relatives and close friends in the occupation one seeks to enter (Pavalko, 1971). This was the case for two of the respondents in this study. One subject when asked whether or not she had any conversations with members of her family on her role as a nurse as it related to the potential risks, she responded this way:

S:  Well I have a sister-in-law who is a nurse and I once had a discussion with her about it, and she said how it is, especially since it is so confidential and the nursing staff is not necessarily aware that the person has AIDS like that's a problem.

I:  Um, hum.

S:  Yes, because of confidentiality that sometimes they are not aware...like she works in an operating room where there is blood and stuff like that so they take the precautions that the person has AIDS under all circumstances because they can't be too sure, and I think if she can work in an atmosphere like that and she is just fine... Like I'm sure she stuck herself and cut herself a number of times and I think maybe I don't worry about it enough, but it seems to me that all the cases I've heard, um if a person just sticks himself once or twice nothing happens, so maybe it is not something we know that we should be getting all hysterical about, maybe it takes more than that. There is people who have had relationships and haven't gotten anything so maybe it's not as contagious...(Interview #2)

The above interview demonstrates how a member of the family being in the profession that she aspires to join has influenced the subject's own perceptions of possible risks of the contraction of HIV, as well as gaining "insider" information on how practising nurses deal with any potential threat of the virus. The only other case where the subject
had relatives in the related field did not disclose such information. In fact she stated that no one in her family had influenced her in choosing nursing as a profession.

**AIDS as a Concern**

The majority of the subjects indicated that in some form or another, members of their family, e.g., husband, parents and siblings, had voiced concern over their welfare within a health care setting and this concern was founded in the fear of the contraction of AIDS. The following interview demonstrated the general type of response given, when asked about conversations they may have had with members of their family regarding concern voiced by family members about AIDS:

I: Okay, um I want to ask you, you're still in first year, how does your family...have you ever discussed anything in regards to AIDS with...going into nursing with your family?

S: Yeah I did, my husband. He's more afraid of it than I am. (laugh)

I: Well you're the expert. You're the one with the technical knowledge...um what sort of fears does he have?

S: Well the basic fear...he was afraid of me catching, getting AIDS somehow and bringing it home and him having to deal with it.

I: What sorts of things were you able to say to him that might, you know make him feel a little more comfortable?

S: That we were taught that we were to wear gloves and gowns um, when there was possibility of us coming into contact with any type of virus um, well it didn't help much for AIDS but I had my hepatitis shot. Hepatitis can be just as deadly as AIDS and I had my hepatitis shot and it's...just a lot of comforting and um you know some...he was more stressed out about it at the beginning of the year and I told him, I let him know if I was working with an AIDS patient and it would be my decision whether or not I wanted to work with an AIDS patient. (Interview #5)

A similar response emerged in the second interview where the subject refers to her husband's fears about her working
in an environment and profession where AIDS might be prevalent:

I: Okay, have you ever had any opportunity to discuss any of either of these procedures as it relates to AIDS or AIDS in general with fellow students?

S: We touched on that a little bit at school. My husband expressed a lot of fears to me but not in any great detail.

I: In terms of your husband, um in terms of your own risk of infection?

S: Yeah, uh huh.

I: He has, he is obviously worried for your own safety, is that it?

S: Uh huh.

I: How do you feel about it, I mean, do you feel...we are bombarded with a lot of information, you obviously have a lot more knowledge...specific information than I would because of the profession you chose, um what sorts of things would you say to your husband that might alleviate some of his anxiety?

S: Well I just tell him that I take precautions and not to worry because the only way it can be spread is through bodily fluids and so far I haven’t been using any needles or anything like that, I haven’t even had an AIDS patient. But he just prefers that I don’t even say anything to him, he says just pretend that if I have a patient like that...he doesn’t want to know anything about it, you know, so we just leave it at that. (Interview #2)

Some of the fear that was expressed from the subject’s family was not directed by a spouse, but similar responses came from other subjects concerning fear about their own welfare from other family members. Five subjects out of eleven expressed fear on the part of some member of their family with regards to them being in a profession at the forefront of dealing with the AIDS crisis. One subject stated that her parents’ fears, although unfounded, were as a result of them being foreign and that regardless of the information that she might provide them, that they were not ready to listen to the facts.
Support of Family

The final type of response pattern that emerged during the interviews on the part of some member of the subject's family toward the subject as it related to potential risk of contraction of the AIDS virus was that of support. This support was demonstrated in a variety of ways from parents encouraging the student to take a course on AIDS, to the parents expressing pride in their child for choosing the profession of nursing as a career. When asked how her parents might feel about her doing mouth to mouth resuscitation on a person who might have HIV, subject #4 responded by saying:

I: How do your parents feel about, like for example you took this course at St. John's Ambulance. Have they ever talked about anything to do with the risk of doing something like mouth to mouth?

S: Not really, they've taken the course too, and I don't know, I think...they really haven't said anything so I think they'd want to do the same thing (give the mouth to mouth even if there might be a risk). (Interview #4)

Four subjects out of eleven had some type of supportive behaviour shown by some member of their family towards them working in an environment that might be perceived to be potentially dangerous. It appears that supportive behaviour came most often in the form of verbal encouragement by some member of the family. One subject had actually discussed the threat of AIDS to her and her husband's lives, and she had actually been tested for the virus:

I: Have you talked to, I mean do you have friends outside of nursing who you talk to about anything to do with your role in the hospital...AIDS and the prevalence of AIDS...society and so on?

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S: Not to actually sit down and discuss it no. Um my husband and I talk about it sometimes but it's not really applicable to us. I don't think, because we are both fidelity loving (monogamous) I hope. He seems to be and I know I am so. You know we talk about, we've talked about it ...when I was concerned about AIDS and I got tested and stuff like that, but as for in the hospital I haven't seen a whole heck of a lot of it, and to be quite honest I don't think I've seen people with AIDS in clinical practice so far. (Interview #3)

The support from her husband came in his own behaviour toward AIDS as well as through discussions she had had with him on the subject. The subject's husband was in management with a company that had dealings with various hospitals, and he was faced with having to deal with AIDS in his own business as the subject states:

S: Its funny, talking about AIDS, my husband used to be the manager for Company X, and back in '85 some of his people would not go into the rooms of clients that they knew had AIDS because they were afraid that they would catch it just by being in the room with them. My husband had to go in himself.

I: When was this that this took place?

S: This was like '85-'86 and they would not... they said uh-uh I have kids, I am not prepared to risk my life. I'm not going in there...I don't have to, I'm not going to put myself in danger. And I said to my husband "that's stupid". He went into the hospital and made sure that they had service. (Interview #3)

Religion as a Family Value

As it was stated in the introduction to this section, the family is one of the primary vehicles for values to be transmitted from one generation to the next. Although it was not a significant feature of the discussions on the influence of the family, religious beliefs were brought up by one subject as it pertained to the possible contraction of the virus in a work setting. It might be assumed that the value of religion was something transmitted to this individual from her family. She responded the following way
when asked about her family's feelings on her being in nursing:

I: That's a good profession for that. Uhm, Well that brings me to another question, uhm I guess if you had to identify any profession that's been in the forefront in dealing with AIDS and treating AIDS, not so much in Windsor, but in big cities like San Francisco, New York, there would probably be nurses. How does your family feel about you going into a profession that might, that might be, that might expose you to having to work with someone with AIDS, have they ever said anything to you?

S: No uhm my parents are proud of me to go in for nursing. We haven't really discussed it but it doesn't worry me, because I feel that if I do it properly and if I protect myself properly then I shouldn't get it. If there is an odd case like by chance that I get it, I just have to believe that God purposes my time and if it's meant to be it's meant to be but I feel that if I'm careful and if I know its an AIDS patient and I have nothing really to worry about.

I: okay

S: And if you worry I think if you get yourself all nervous, you make more mistakes. So you can't be nervous. And you have to think, you have to think well he's a human being you can't treat him like something else because he or she has AIDS. (Interview #11)

This same subject brought up God later on during the interview when asked about any other influences that may have shaped her perceptions of AIDS. She felt that:

S: Um not really. I think we're taught to just take the person holistically, and we um, when you first see your patient you're supposed to respect them individually and treat each one differently for their individuality. but um, I guess I'm not scared of it because I feel that if it's time to die that's the way God planned it, so I can't be scared. I can't always be turning my back wondering like when, or did I really deserve this because when it happens, then if I'm careful I shouldn't have to worry about it. But it really bothers me though, the way people treat AIDS people. Like I mean they may be homosexuals, they may be heterosexuals, maybe a completely innocent victims of something else but just because they are different from us, I don't think they should be degraded. We may not agree with them, but AIDS is a very lonely dying death because no one wants to be with them, and I'm not there to stay with them, I'm there to help them. I want my clients to die peacefully. (Interview #11)

Summary of Findings

Although when probed during the interviews most subjects indicated some form of discussion occurring in the past with one or more members of their family, ranging from their
spouses to their parents and siblings, the issue of AIDS within the family context was not as significant as hypothesized. There was no mention of any anti-homosexual feelings by either the respondent or their families, although a number of subjects made it clear that they were aware of the associations commonly made between AIDS and "deviant" groups through their conversations about others. The types of interactions subjects had with their families and significant others ranged from the topic of AIDS not being discussed at all (3 subjects), to fear and anxiety expressed by the family (5 subjects). In addition, four out of the eleven subjects in the study indicated that in some form or another their families or significant others had shown support for them choosing their prospective profession.

One subject referred to her own belief in God as a factor for her lack of fear concerning her own risk for contraction of the virus and appeared to be comforted by this.

Lastly, two of the subjects had family members in the profession of nursing, with one subject gaining "inside" information about AIDS through conversations she had with a family member and the other subject indicating that her relatives within nursing had no influence on her perceptions of AIDS as it relates to nursing directly.
Peer Group and Fellow Students

It was hypothesized that the topic of AIDS would be of importance in the working lives of the nursing students and their fellow classmates, and somewhat less so, in the nursing student's peer group outside of the university. This assumption was based on the notion that as emerging professionals, nursing students might have discussed, at least peripherally, some of the health risks of the disease, including modes of transmission, as well as its basic epidemiology.

By comparison to fellow classmates, although the issue of AIDS was thought be important within the student's peer group outside of the University, the concern was envisaged to be more general in nature and of a lesser magnitude.

The findings on the influence of friends both in and out of the university setting in the social construction of AIDS show that, contrary to the general hypothesis, seven out of eleven subjects had not talked about AIDS with classmates. In fact, the topic was more prevalent within the subject's peer group outside of the University, where only three of eleven interviewees claimed to have not had any conversations on the topic.

AIDS as a Non-Issue

The following quote illustrates the most common response pattern when subjects were asked about any discussions they might have had concerning AIDS with other nursing students:
S: Not really, no we don't really discuss that. (Interview #5)

Another response demonstrates the similarity of experiences within the university setting for students. Being asked to recall any scenarios she had encountered, the subject responded:

S: No, not... nothing specific I can't really recall anything specific.
    no. (Interview #2)

Similar responses were given by five others who claimed that the topic of AIDS "never" came up or that "nothing specific" was discussed.

The topic of AIDS was more prevalent in the subject's peer group outside of the university, although three subjects claimed that AIDS and issues associated with it had not been discussed with their peers. Essentially, the character of these responses was the same as those made by fellow nursing students. However, although AIDS was not discussed by three of the nurses with their peer groups, other issues in nursing were. A common theme of their conversations was other aspects of nursing, such as the availability of jobs, or the difficulty of putting in the long hours that a nurse does. In other words, subject #9 states when asked about conversations she may have had with friends:

S: If anything, they said why'd you pick nursing because it's so much hard work!
    (laughs)

I: (laughs)

S: That's why they said it. But um, not really with an AIDS patient because you hear of it around here but like if we lived like as you say in Los Angeles or Toronto.
Like if I was in London and working at Western Hospital or something like that, you know, it would be different there because you'd see a lot more of it and you'd talk a lot more about it, but here, I'm not really thinking of AIDS right now. (Interview #9)

Distancing

One of the common themes that emerged during the interviews was a notion of distancing. What is meant by distancing is simply that the issue of AIDS was not thought to be significant in their lives. This response was based on certain perceptions they had such as, "like if I was in London and working at Western, you know it would be different there", "we're not in that part of nursing I guess yet", or that "I plan to nurse in Chatham, and there are only a few cases of AIDS there".

Although this distancing was expressed in different forms, it appeared nevertheless as a common thread throughout the interviews. As the quote in the preceding section illustrates, the subject thinks that: if she were working in Los Angeles or Toronto, or even in London, Ontario, the threat of AIDS would perhaps generate more conversations about potential dangers on the job, but seems to feel somewhat insulated in Windsor where she doesn't see much evidence of it.

This conception of distancing can be seen in the following interview as well, where the subject places the issue of AIDS into the future rather than in the present since as students they have not yet come into contact with a
PWA during their clinical experience, as shown in the following exchange:

\textbf{I:} \textit{Can you recall at all during this past year having any discussions with fellow classmates about any of these procedures that we talked about, these... of AIDS and AIDS in terms of "gee I wonder what would happen if we were doing this", or have you ever been...?}

\textbf{S:} \textit{We discussed it but we didn't go into detail, it was just like they'd be as cautious as I am, but right now since they haven't come into contact with it, they are not as worried about it yet. (Interview #6) }

Further evidence of this distancing can be seen in another interview, where again the issue of AIDS in the workplace has not made an impact, although the subject recognizes AIDS as something she may have to deal with at some point:

\textbf{S:} \textit{The thing is it was just kind of brought up you know in that orientation, then ah we talk about it afterwards or something... you see we really haven't had to... you know we're not in that part of nursing I guess yet that we really know, cause most of the people are 80 and above [laughing] and I don't think that they... you know [that they would have AIDS] and so we're really not that concerned about it right now, but it's something I guess we should have, you know we face, and we hope that the hospital and um their policies, they're dealing with it and I guess nurses are allowed if they don't want to work with a person that has AIDS, that they can say no.(Interview #1) }

The element of distancing surfaced in two further interviews, with one subject describing her typical clients as "old people", and the other saying that "they haven't worried about it yet".

\textbf{Fear and Concern}

As was hypothesized, many of the conversations that these students had both with fellow students and with their peer group suggested that in both groups, there is an element of "fear and concern" regarding the contraction of the virus from others.
Five subjects mentioned discomfort expressed by classmates with respect to possible transmission of the virus on the job. When subject #4 was asked specifically about the types of concerns that have been brought up by fellow students, she responded this way:

*S:* It seems to me that they were more joking about it than serious, but I don't know. I think everybody is a little bit afraid of AIDS even when we're doing our accu-checks, we're really careful.

The element of concern at times reflected the subject's perceptions on the uncertainty of current scientific information available on the modes of transmission. Thus one subject stated that even if you followed the proper procedures in the hospital, there still would be the chance of contagion. This subject used the analogy of a cold:

*S:* Yeah, at times, uh then it can sound like you follow the procedure there is no way that your gonna get AIDS. Whereas I think there still is the chance that you can get it. I don't think that they're that certain... that there's no way you can get it from contact that you have in the hospital.

*I:* Why do you think that?

*S:* I don't know. It's a risk that you're taking, uhmm it's just like when someone has a cold, somebody has a cold, they say if you take precautions you won't get it but there still is the chance that you will. (Interview #4)

Other examples illustrating concerns expressed by fellow students emerged in a number of additional interviews where the "fear of working with needles", clients that "bleed a lot" after doing accu-checks and being "afraid of coming into contact with someone that had AIDS" were all cited as reasons for their concerns. One subject, reiterating conversations she had had about AIDS, suggested that the "single girls" in the discussion group were not as concerned
as the "married girls" who were worried about their families at home. When she was asked about these conversations, she stated:

S: Well that's what this would have been, like in our orientation to going into the hospital, uh it was brought up, you know, how would you feel working with you know an AIDS patient, and you know they asked how many people would not want to do it...and how many people wouldn't mind it, and I think maybe one person put up their hand saying I wouldn't want to do it...and then informally you know we'd talk about it as students and it was like you just worry about things because... it seemed the single girls didn't worry that much but, the people who had families and were going home, they're the ones that kind of worried more because they had other people.... that they were worried about so....(Interview #1)

As might be expected, the fear expressed by the subjects' friends outside the university was of a more general nature. Two subjects claimed that friends had expressed concern for them in having potentially to care for or interact with a FWA. Phrases such as they "think I'm crazy" for getting involved or, "If you do that, won't you get AIDS?", typify the responses made by such peers.

In general, although "fear and concern" was a theme that emerged during the interviews, it was not as significant as hypothesized. "Fear and concern" was more often expressed with the subjects' social group within the university than it was through their peer group.

Discrimination

When the subjects were asked about conversations they may have had with friends about AIDS or more specifically about AIDS as it related to their chosen profession, the attitude toward discrimination came up a number of times. Discrimination appeared as often within the sphere of school
(3 interviews) as it did within the peer group outside of the university (3 interviews). The issue of blame was central in many of these accounts, where friends of the subjects plainly state that homosexuals and intravenous drug users deserve to get the virus, based on their choice of lifestyle, whereas no such distinction was made about children based on their innocence in the situation. This can be seen in the following quote where the subject was asked about any sources of information she may have used to come to her own understanding about AIDS. She states:

S: I don't know we haven't really discussed AIDS that much I think a lot of people, people I talk about AIDS or the needle intravenous drug users or the homosexual, they feel they deserve it.

I: People that you talked to feel that way?

S: Yea not basically campus, but out from where I live at home, they feel that they deserve it, but the children the sick children don't deserve it, because they had no decision and they ....other people such as homosexuals and drug users they feel that they deserve it because they are doing something against "God". (Interview #5)

It is difficult to ascertain to what extent the attitudes expressed by peers impact on the attitudes of the subject, however, in the above example, when the same subject was asked how she responded to such statements made by friends she replied:

S: How do I, I can't , uhm I don't feel, I'm not the type of person to impose on someone else's decisions. That's their decision if they want to feel that way or not. I feel sorry for somebody that has AIDS whether they're a homosexual or an I.V. user because their lifestyle, they never intended to catch AIDS, it's just their lifestyle. (Interview #5)

The subject's reaction to her friend's statements that homosexuals and I.V. drug users "deserve to get AIDS" or that they are doing something "against God" would lead one
to believe that at best, her peer's attitudes about AIDS do not offend her, and at worst, that she is in agreement with them. Clearly her perceptions and attitudes about AIDS extend beyond just the basic epidemiological factors of the disease in so far as she states that although they never intended to contract the disease, "it's just their lifestyle".

The issue of discrimination was found in other interviews as well where phrases such as "sarcastic remarks" made by fellow nursing students, or "if you've got AIDS I'm not going anywhere near you", made by friends, surfaced in the dialogue. During the discussion about her friend's attitudes, one subject stated quite clearly that her friends were "closed minded" and that they had said to her "ugh, how could you do that" [work with someone with AIDS].

Although the issue of discrimination did not appear often during the interviews, clearly some of the views that are held by both classmates and peers portray those deemed to be in "deviant" categories of lifestyles to be "getting what they deserve" and acting against the "will of God".

Although one cannot clearly state that these views were endorsed by the subjects, it is of interest to note that in only one case did any subject overtly reject the views held by others.

Data on discussions that the subjects had with other nursing students uncovered one example of anti-
discriminatory attitudes held by the subject. In this case, she was repeating information she had exchanged with a classmate, where the classmate had overheard a conversation that had taken place in the hospital. She was asked about any opportunity she might have had to discuss AIDS as it related to her work in the hospital. She states:

S: Um, we really didn't discuss that because we, I don't know if we will get an AIDS patient while we're students. First year students basically we are getting old people who need bed baths and chronic care who need bed rest. There was once a conversation I overheard.

I: Uh hem.

S: This couple of persons said "well I don't know if I could work with her. I said, yes now, but if it actually comes to it can I? And a friend of mine, she said she overheard a conversation once, it was at Hotel Dieu. A patient who was supposed to have AIDS, but this is just overhearing... that this nurse did not want to be his nurse... was refusing to be his nurse.

I: You have a choice don't you?

S: Uh I don't know, I really don't know. I know if it's health beliefs, like say you're a person who does not believe in I.V. and you're asked to start an I.V. you can say "I can't its against my religion" things like that. That's your own personal health beliefs. It might interfere from you ever getting a job at times. But she [the nurse] was saying "I don't want to be his nurse" and he [the patient] was right there.

I: So he could hear her saying that?

S: Exactly. She was talking to another person and they were transferring him from something. They had him all covered up head to toe and he had a mask on, he had goggles on, he had this thing over his head, um all covered up and here's this nurse saying "uh yuck" and I thought "good nurse... just wonderful she's really doing a lot for this patient talking like that right in front of him."

I: What did your friend say to you about that when she was repeating it?

S: She was, she was disgusted at the nurse. She said "How can she be like that?" He may have been covered up for a reason, maybe he had like some isolation disease when you are transporting a patient from room to room, they may have to be covered from head to toe... but a lot of my friends, my nursing friends have the same attitude as me I think on AIDS. That it doesn't... I say now that it doesn't bother me, like I think I could handle it going into the hospital. I think if I ever had a patient I could handle it. I say that now and that's just the way I feel about it now.

(Interview #8)
It appears that this subject is in agreement with her classmate with regard to the nurse's behaviour toward the patient. This is illustrated by her statement "and I thought, good nurse... just wonderful she's really doing a lot for this patient talking like that right in front of him". Apparently, this subject makes the judgement that the nurse is acting in a discriminatory fashion, of which she disapproves. Once again though, the aspect of uncertainty surfaces in the dialogue as the subject states that she feels this way "now", suggesting that perhaps in the future she might feel differently.

In a few instances, despite their efforts to conceal their negative feelings about AIDS, subjects inadvertently responded in a manner that appeared to disclose some of their personal beliefs. The following subject when asked about discussions she might have had with fellow classmates, states that you learn to treat the client from every point of view: psychologically, physically and emotionally. She continues by saying:

S: Yeah, right, just because he or she has a disease that you don't like, you don't treat them bad. (Interview #8)

Although one cannot be sure of what is meant by "a disease that you don't like" it does not lead the reader to believe that she is unbiased about AIDS, and rather than saying that they deserve the same quality care that any other patient would be accorded, states instead that "you don't treat them bad."
The ambiguous nature of statements made by subjects concerning discussions they have had with others is highlighted again in the following statement, where the subject talks about her view on her own role as a nurse as it relates to caring for someone with AIDS:

*S:* Um well when we talk about it... me and my friends and relatives, I don't degrade AIDS or any other disease because I'm not in the profession to degrade them, I'm in the profession to help them. (Interview #11)

**Summary of Findings**

The influence of friends in nursing in the university setting, as well as their peer group outside, show that the topic of AIDS was more often discussed with non-nursing friends than it was with colleagues. The nature of these discussions revealed that within the University setting conversations were more task oriented with concerns being expressed about specific procedures than they were with their peer group. The married-single distinction was also referred to, with those in the married category expressing deeper concerns.

The issue of discrimination was as prevalent in the non-nursing group of friends as it was in the category of classmates, although the discrimination expressed by peers appeared to be more overt.

Discussions concerning the opinions of friends both in and out of the university seemed to portray many of the subjects as ambiguous concerning their feelings and attitudes about AIDS.
Lastly, a general theme that emerged from the data, particularly as it related to conversations engaged in with classmates, was a notion of distancing. This distancing from the "reality" of AIDS appeared in a variety of different modes: lack of prevalence of the problem in Windsor, year of study, in terms of level of study and type of practicum, type of patient and location for practice upon graduation.

The Media

At the outset of this research, it was hypothesized that one of the major influences in the social construction of AIDS for nursing students would be the media. It is therefore not at all surprising to find that virtually all of the subjects in this study (10 of 11 subjects or 90%) mentioned the media (television, newspapers, magazines, radio shows) as one of the major sources of their information about AIDS. In addition, this information not only helped to augment their knowledge about AIDS but served in some instances as catalysts for the formation of certain attitudes they held regarding those infected with the virus and the reactions of others towards them.

The apparent influence that the media have had on the construction of AIDS for these subjects can be categorized as follows: AIDS specific information that the subjects have incorporated into their own stocks of knowledge utilized in
their imagination of hypothetically dealing with an FWA, and information based on the moral rather than the factual information on AIDS, in the form of either situational accounts from people in the media or constructed scenarios (docu-dramas) used in the media that have attempted to connect AIDS to settings and characters to which the viewers can relate.

Out of the ten interviews where the media was mentioned in some way 72.9% of the references were factual in nature, and 27.0% were attitudinal.

AIDS-Specific Information

One type of response pattern that emerged during the interviews concerning the media was factual in nature: here the subject seemed to have garnered information from the media that she used in her construction of AIDS. One subject, when asked about other types of AIDS-related information she has picked up from the media, the subject responded the following way:

S: Well they're finding new interesting things everyday like AZT works extremely well in AIDS infected infants and young children. They don't know why but it works extremely well, and um what else... just recently...there was this discovery of this cucumber root in China and they're afraid that people would OD on it because it is extremely toxic, but people who are desperate enough will go for it. And what else, the pentamidine, I watched that with interest on the Journal um I don't know if you saw it or not but they had the emergency, what's known as the "Emergency Medical Release Act" or something for drugs that are not yet approved. So the Journal tested it and had a doctor call Ottawa and Ottawa said "Oh sir no problem" they told the Journal people and they had a doctor call and say "Look I need aerosol Pentamidine" and they said "Oh sir you can't get it" so you know the Journal exposed that and now it's O.K. to get aerosol Pentamidine. (Interview #3)
In the above case, the subject learned something through the media about AIDS, in this case how new drugs are put on the market and what drugs have been found to be effective for the treatment of some AIDS-related symptoms in children as well as adults.

A similar account about factual information emerged during another interview where the subject talked about AIDS related information that she has incorporated into her own working life in the hospital as she says in response to the question:

I: Have you seen a lot of, you know, programs or magazine articles on AIDS?

S: I think there was one article in nursing I guess in California, I saw a bit on that, but that was you know the nurses working out there and there was a lot of...

I: Was this a film you saw?

S: It was on T.V. Yeah it was about nursing in San Francisco and I guess they were just talking about all the precautions they take and how a lot of nurses don't want to work and then you saw them you know goggled and all this stuff taking blood samples. (Interview #1)

In a few cases, information on AIDS that was assimilated from the media was actually used by the subject to imagine carrying out one of the procedures on someone with AIDS, as the following interview demonstrates:

S: Like depending if they had sores. I didn't think about this earlier but if they had blood [coming out of sores] that's when I would worry. That's the biggest thing with me. But like if they don't have open sores, then I'm not worried about it [referring to range of joint motion exercises on someone with AIDS]

I: O.K. what is it about blood, when you say that's the biggest thing, what is it about blood that concerns you?

S: Well from what I've read and from what I've heard on T.V. and from what I understand, AIDS can only be transmitted through blood and sexual contact, it can't be transmitted through sputum or hugging or close contact in that way. So I would be worried, well actually if I didn't have gloves on I
actually... well I actually worked with you know the glucose? [glucose tolerance test]

I: Yes.

S: And I didn't have gloves on, and my teacher said as long as you don't have any open sores on your hands don't worry about it. (Interview #10)

In this case the subject was using knowledge that she had received through the media and connecting it to a procedure that she had carried out recently. In doing the glucose tolerance test she was coming into contact with blood and she realized during the interview that there might have been a possibility of the AIDS virus being present in the blood. Although she usually wore gloves when taking blood, in the above instance she had not.

Another subject when asked whether or not she would have any difficulties giving a bed bath to a FWA seemed to be quite frightened at the possibility of this occurring, recognizing on the one hand that she would not want to stigmatize the patient, but not feeling too sure of herself on the other. She was asked:

S: What is it specifically about AIDS that would make the procedure any more difficult? [bed bath]

R: Because, you hear so much about it and it's so prevalent and it's a threat to life. I mean if it hits you there's no cure for it. And that's one of the things that gets you. You didn't even ask for it and you got it. You know like cancer, you get it but I guess you would feel the same way if a person had hepatitis, you know. Anything contagious like that, that you could get, it's scary you know.

S: uh huh um, again is this information that mostly you're getting from...?

R: Yeah, from the media, from newspapers and you're not sure how to deal with it when you actually go in there, you know, everybody's a human being and like to be treated like a human being. They don't want anybody going in there and say, oh my goodness, you know. And it scares a lot of people you know and I'm a person you know whether I'm going to be a nurse or not it scares you. (Interview #9)
AIDS, Attitudes and the Media

The following two quotes illustrate the range of responses given concerning the moral rather than factual presentation of AIDS in the media. The first respondent, when commenting on the treatment of a FWA in the media, referred to a soap opera called "The Young and the Restless", and stated:

S:  Well there is this one character on it that has AIDS, and there was this man married to her and he knew she had AIDS, but it was really good. They were in a restaurant and someone comes up and says "Oh is it true that you have AIDS?" and he was going [the husband] "Ah it's none of your business", and she was very calm about it. They asked her to move and all this because she has AIDS, and through the whole thing I thought what stupid jerks! (Interview #8)

The above quote demonstrates a typical affective comment that was elicited through discussing AIDS presented by the media and was quite consistent throughout the interviews. Clearly the subject matter presented on television was not there for factual reasons and the subject responded to it evaluatively. This type of response was thought to be attitudinal rather than factual in nature, in so far as the subject was responding on an emotional level and empathized with the character. Similar responses based on attitudes rather than facts emerged in five of the interviews.

As further support of the affective type of responses that emerged during a discussion of the media's coverage of AIDS, respondent #10 when asked about the source for specific information concerning the virus being present in saliva responded with the following:

S:  I've gotten that (the information) from books, news, I've watched um, actually there is one episode of 21 Jump Street...
I: I've never seen that show.

S: No, it's very good. And this one boy had AIDS and he was dying of it and everyone avoided him and just the main cop was kind of his buddy, he was his body guard, and they talked about that in there too.

This particular subject seemed quite upset about the way that the character with AIDS was treated by others on the show and she went on to say that at the end of the show there was a message about AIDS presented. Although the presentation of AIDS in this particular case was partly factual, it seemed to initiate an attitude in the subject that appeared to have been incorporated in part into her own general attitudes about AIDS.

The last example for this particular affective pattern of response clearly shows the subject as both reflective and critical of the society in general as far as its treatment of PWA's, which in part was stimulated by the media. She was asked:

I: Is there any other influence that has led you to have the attitudes that you have about your own risks, about your feelings about AIDS?

S: I've seen a lot of television programs, like dramas and that, and I saw these programs where... I hate seeing the wall-flower in the corner, I want to try and get them involved and when they... I've seen shows where people are alienating this one person because they had a blood transfusion and the blood was bad because it wasn't properly screened for AIDS. I can't see people's attitudes, like best friends and they'll say Oh? I want nothing to do with them. That's what gets me is how can these people be so stupid? How can they treat people, other people like that? (Interview # 8)

Lack of Media Impact

It was surprising to find even one subject who did not mention the media in some form or another as a source for her own construction of AIDS. However, it should be noted
that this particular subject stated that until the interview she had not given AIDS much thought at all. As she observed:

S: Well I have never really thought about it (AIDS) so much until you and I have talked about it right now to be perfectly honest, but I think that I tend to be the type of person that doesn't take anything too seriously until it hits home. Maybe that's bad, I don't know, but I'm cautious you know and that's...I don't think I've had any great fears about it (AIDS). (Interview #2)

AIDS Hysteria

To reiterate briefly what was stated in the introduction to this research, the media has often presented AIDS in a somewhat "larger than life" fashion. Particularly during the initial stages of its onset, persons infected with the virus as well as the effects of the virus itself were reported in an irresponsible manner. It was not surprising to find that many of the subjects referred to media coverage with terms such as "hysteria" embedded in their dialogue. Subject #3 stated that she was concerned about her own vulnerability to the virus at a certain time in her life, which she attributed to both the media attention given to AIDS as well as the style of their presentations:

S: I know it was probably paranoid, but at the time the media, they were really fanning the hysteria and I was getting concerned and I wanted to know (whether or not she had the virus) and since I've educated myself to find out and it isn't transmitted through kissing or anything like that. (Interview #3)

Truth or Fiction - Media Reporting

The last pattern to be discussed that emerged during the interviews with regard to the media can best be described as a mistrust of what is being reported as factual information. The following interview demonstrates this type of response to media coverage about AIDS and illuminates the general
mistrust of media coverage on the subject as well as the concern of the subjects to know exactly what the risks are for contracting the disease:

S: It's interesting, I mean there's so much ah, there's so much information being released about it that ah you know it's hard to get a gauge on, and you wonder if they really know, cause they don't seem to really know everything about it, and they say well yeah ten years from now they'll say you can...you know someone sneezed on you and you...[became infected]. (Interview #1)

In a similar light, a second subject had trouble deciphering the information she had received on the transmission of the virus as it pertained to "offering the bedpan" to a client with AIDS, unsure whether or not urine was considered a "body fluid" as it relates to transmission.

The following question was asked of her:

I: Is that, would that be a problem? [offering a bedpan]

S: Um, not particularly this, because they said through urine um, you can't; there's not really, I don't think there is from what I've heard... urine. [the virus present]

I: Who's they? You say they who's they?

S: The media. I don't know, I read an AIDS article. (Interview #9)

Summary of Findings

In summation, the data on the role of the media in the construction of AIDS by these subjects showed their impact to be of significant magnitude for all but one respondent. They thus support the general hypothesis.

Further, this impact appeared to be both factual as well as attitudinal in character. The subjects seemed to have used the information attained through the media on AIDS in the following ways: AIDS specific information pertaining to potential risks for themselves in a health care setting and
information based on the moral rather than factual content of media presentations which the subjects responded to in an affective manner, and seemed to incorporate into their own attitudes about persons infected with the disease and the stigma that has been attached to it in a positive way.

The Institution

At the outset of this research, the "institution" was envisioned to encompass not only the university, with professors, course work and textbooks included, but the hospital as well. As the interviews unfolded, it became apparent that these two mechanisms of socialization had different responsibilities toward the student and impacted differently on the subjects.

With the above in mind, the Institution category was differentiated to delineate the separate and somewhat unique influences of the university and the hospital.

The University as Information Transmitter

Overwhelmingly, the most cited piece of information that the students used in their imagined scenarios of caring for someone with AIDS was the use of sterile gloves, which they learned through the university and which all subjects mentioned at varying points during the discussions.

Although in general, the topic of AIDS was apparently not discussed in any depth during lectures for these first year students, the lack of variability in responses
concerning the use of gloves was remarkable. It became clear as the interviews unfolded that for these student nurses the use of gloves was almost second nature. This varied depending on the particular procedure being discussed, with those procedures involving the handling of bodily fluids requiring the use of gloves more often and the condition of the client being a factor as well.

(a) Protective Devices: The Sterile Glove

With regard to the use of gloves, most subjects made an assessment of the procedure first before incorporating gloves as a part of the technique they would use for caring for someone with AIDS. This demonstrated the ability of the subjects to organize information passed on to them from the university and to assess a procedure for any perceived risks as it related to AIDS.

To illustrate this, the first procedure discussed was "assisting the client to a sitting position", which in itself does not require the nurse to wear gloves. When asked to imagine carrying out this procedure on someone with AIDS, ten of eleven interviewees said that it would not change the way they performed the procedure. Only after probes were used to specify the condition of the patient did the use of gloves appear in their dialogue. The following exchange illuminates this response pattern:

I: Think about the procedure [assisting the client to a sitting position] and having watched it or participated in doing it, is there anything about the fact that the client has AIDS that may make you a little wary about doing this procedure?
S: Honestly, no.

I: No. O.K. that's fine. Um what about if the client was lying in bed and they had open sores or lesions on their body and you had to help them to a sitting position? Would that be a problem do you think?

S: Right. Well if they were, like if they had their clothes on like if they were draped and I covered them, if they weren't like if they didn't have their clothes on I would probably put gloves on (Interview #10).

Although the first procedure discussed during the interviews, assisting the client to a sitting position, was thought to be theoretically unproblematic for the students even when dealing with someone with AIDS, the following excerpt shows the lack of similarity in viewpoints for first year students. Subject #4 was asked about carrying out the procedure on someone with AIDS and she responded the following way:

S: Um, it would be done the same way, I know myself I'd feel a little awkward doing it.

I: Awkward in what sense?

S: Um I know that you're not supposed to get it from casual contact, but still when you're moving somebody they could grab a hold of you or whatever um, and I'd just take a little more care especially if they had open wounds on them.

I: When you say take more care, what specifically do you mean?

S: I guess actually for this it would be pretty hard just trying to avoid touching anywhere around where the wound is especially if they just got out of surgery and there was some bleeding, but otherwise you would carry it out the same way.

The above example serves to illustrate the ongoing process in which these students are engaged as they actively construct the "reality" of AIDS for themselves. On the one hand are those forces that impinge on them from the outside, such as the media, friends and family, and on the other
hand, the institution is attempting to re-socialize these individuals to see the medical reality of AIDS from a nursing perspective as a specific case with procedures, precautions, and rules for the nurse to follow.

For some of these students, the "lay reality" of AIDS is still at the forefront due to the fact that they do not have the specific knowledge to place AIDS into the nursing milieu, as the following dialogue demonstrates. Here the subject is attempting to decide whether or not moving a client in bed would constitute an "isolation" situation.

S: Yeah we have taken a little bit in class about procedures for isolation and things, but I really don't think it would apply to moving a client... I'm not sure. (Interview #4)

When probed, using the situation of incontinence during the procedure, the same subject stated that she would then use gloves. The addition of gloves to the procedure at the onset of incontinence shows a concern for keeping her hands clean, but also may serve as a reaction to the trigger of faeces being a "body fluid" for which she had been instructed to wear gloves.

The procedures that were discussed during the interviews were chosen on the basis that they would be perceived by the subjects as ranging from the unproblematic scenarios, in terms of what had to be done with the client, to the more problematic. At one extreme was "assisting the client to a sitting position", where the nurse simply had to adjust the client's position in bed, on the other extreme were
procedures such as "disimpaction", removing stool digitally, or perineal care, which is washing of the client's genital region. It was hypothesized that those procedures that under normal circumstances would be more difficult for the nurse to perform, would invoke further anxiety in the presence of AIDS. This hypothesis was only partly supported by the data. While there was more anxiety expressed by the subjects for carrying out what were perceived to be the "problematic" procedures, the addition of AIDS to the scenario generally did not escalate their anxieties any further.

To illustrate the distinction between carrying out a simple procedure versus one where the potential for embarrassment exists, the following subject talks about performing "removing stool digitally" or "disimpaction". Having been asked about the procedure, she replied:

S: Well just basically the whole thing about doing it.
I: Uh, huh.
S: And uh, it's just hard to do it. I don't know, people get, well my friend did it and it was just like... the smell.
I: Right.
S: I don't know, like to me that's a private area of someone's body and I don't think I'd want someone doing that to me, so... Interview #10)

The subject showed no additional anxiety over the procedure when the case of AIDS was introduced and she stated that she would use "gloves anyways" when performing this particular procedure.
When discussed with a different subject, the same procedure invoked a different response. This subject felt that in addition to the use of gloves, which are a standard piece of equipment for the procedure, she would also wear a gown as further protection for performing this on someone with AIDS. As she stated:

S: I think maybe gowning yourself too, you know because you're dealing, well, usually they're really constipated for that so... just ah you know make sure how you deal with disposing of the...

I: So it wouldn't be diarrhea obviously because you wouldn't be performing this procedure, right?

S: Well you know if someone's constipated though too, they do have a lot of a ... you know mess [faeces] so maybe gowning yourself for that you know covering...(Interview #1)

In discussing the procedure of "removing stool digitally", six subjects stated that performing the procedure on someone with AIDS would not be any more difficult than on anyone else. Two subjects stated that they would double glove, two subjects stated that they would wear both gloves and a gown, and one additional subject stated that she would be concerned about the glove tearing while performing this procedure. It is clear from the variety of responses that the subjects are incorporating specific techniques they have learned in the university and applying these techniques in a somewhat creative way, based on their perception of the risk factors of the procedure. Insofar as the actual procedure has not been discussed as it relates to AIDS, witnessed by the variance in responses, clearly these
perceptions come from sources outside of the university setting.

(b) Other Types of Protective Techniques

Data on the influence of the university as an institution for socialization showed that in other areas, such as specific precautionary techniques which might be applied to the AIDS scenario, a greater degree of variability did exist. The use of such things as gowns, masks, the practices of reverse and non-reverse isolation, hand washing, and handling of body fluids were used creatively by the subjects in relation to the procedure being discussed. Although there was greater variability of responses with regard to the above as they related to different procedures, the specific precautionary measures they cited varied little among the subjects.

The second most cited practice that the subjects used in the imaginary AIDS scenario was a gown. Although in general, the use of a gown was mostly incorporated into procedures with a "high" theoretical risk factor, this was not always the case. The following subject was asked to imagine performing "transferring the client from a bed to a chair" on someone with AIDS, and if this might create any problems for her, to which she responded:

S:  No, not unless he had an open wound and you would have to be careful.

I:  What would you do?
S: Um well if it were near where my hands were going to be I'd wear gloves, if not you just have to be careful not to touch them, cause there's nothing else to protect yourself, I guess actually you could wear a gown, but yeah you could wear a gown if it were like on his legs and stuff but, actually there isn't much contact except for within your hand reach when they grab you around your waist cause they're not that sturdy, but no I can't perceive a problem. (Interview #9)

Subject #5, while discussing the procedure of "perineal" care, suggested as well that the use of a gown would be appropriate if the client was incontinent. This particular procedure was ranked higher in terms of its potential for anxiety than the previous procedure discussed due to the fact that it involves the washing of the genital region of the client. This subject was asked the following question:

I: If the client was incontinent and you had to perform peri-care, would that be more of a problem?

S: Well when people were incontinent I would probably wear a gown over my uniform.

I: Where did you learn about a gown in terms of peri-care purposes for incontinent patients?

S: Umm, I'm not sure if its in Potter and Perry, but it's just my own reasoning.

I: Where does that reasoning come from?

S: Umm protective isolation, Potter and Perry, coming into contact with body fluid.

Here again, one can see the attempt of the subject to connect something that they are concerned with, yet institutionally uninformed about, to something familiar. The subject has not been specifically instructed on this particular scenario, so in this sense she is unable to call up direct information passed on to her from the institution to assess the situation. She makes the decision that the faeces would be categorized as a "body fluid" and has been
instructed about the precautions to take when coming into contact with these fluids, so she has incorporated this information to the AIDS scenario.

When asked about problems she might have carrying out the procedure of "assisting the client to a sitting position" in the presence of open sores, the same subject stated that she would wear a gown to protect herself. This information she learned through her textbook under the headings of "isolation and reverse isolation" techniques:

S: Potter and Perry mentioned about wearing a gown when you either come into contact with a patient that is in an isolation category or reverse isolation category.

The subject assumes from other types of information that the client would in fact be in either isolation or reverse isolation and then makes the connection to the use of a gown. What is interesting to note here is that she has not been specifically instructed that a client with AIDS would in fact be in these isolation categories, which again illuminates the process of constructing the reality of AIDS from a variety of sources on the individual level.

The Organization/Environment Dichotomy: The Student as Interpreter

Although the process of re-socialization into a profession has been presented in the past as clean and precise, with those aspiring to become members looking up to and modelling their behaviour upon those already with membership in the profession, the interviews uncovered an
interesting contradiction of views held by a couple of students toward the trustworthiness of information presented by the School of Nursing. What is of particular interest here is that, contrary to what has been thought in the past about initial socialization, students appear to be actively interpreting and responding cognitively and affectively to the institution as information source. At the same time they are comparing this information to other sources that filter in from the environment, as in the cases of media reporting, friends' opinions, and family concerns. This theme emerged in two of the interviews, where the subjects were asked similar questions about whether or not they had ever questioned information they had been given by the university with regard to AIDS. Subject #2 responded the following way:

S: With regard to AIDS?

I: Or the treatment of bodily fluids for example where they said "no it wasn't a concern" and maybe to you it was?

S: No I don't think so, as a matter of fact I would think that any information that they have given us as far as protecting ourselves has been very cautious, I would do whatever they told us to do in that regard, like I don't think... they would probably... no I can't say that, no I don't think so.

A different response to the same question emerged in a second interview where the subject had perceived the information quite differently:

I: Have you ever had any... in terms of the things we've been talking about...the things you've learned in lab, has there ever been an occasion where either you or yourself in a group have not necessarily questioned what you've been told but um had doubts about... in terms of the , like they've said this is the proper way to do it and you say... not so sure.

S: Yeah at times, uh then it can sound like you follow the procedure there is no way that your gonna get AIDS. Whereas I think there is still the chance that
you can get it. I don’t think that they’re that certain that there’s no way you
can get it from contact that you have in the hospital.

I: Why do you think that?

S: I don’t know, it’s a risk that you’re taking, um it’s like when someone has a
cold, somebody has a cold, they say if you take precautions you won’t get it
but there still is the chance that you will. (Interview #4)

The Ideological Influence of the Institution

Having discussed some of the information which these
subjects have received from the University and have in turn
utilized in their imagined scenarios of carrying out these
procedures on a PWA, one can now begin to discuss the
influence of the aforementioned institution on an
ideological level for the student. The institution’s role in
the re-socialization of its students is two-fold: imparting
the necessary skills for the nurse to meet the requirements
of the profession, and transmitting an ideology that fits
these skills into a framework of what the profession
attempts to achieve. This means that the student nurse is
not only required to carry out technical procedures in the
manner that they are taught, but also to view the
client/patient on a level beyond the medical one, such as
taking into account his or her emotional, social, and
psychological aspects and conditions of their client. This,
of course, is paramount, with respect of the fact that in
many cases the client has already had to succumb to others
deciding what is best for him/her, and is often by the
nature of his or her illness, put in a demoralizing state.
This applies very directly to the client with AIDS, where
historically PWA's have been isolated from the rest of the hospital's patients and in many cases have consequently felt ostracized.

Although the affective dimension of hypothetically caring for a PWA did not surface with any regularity during the interviews, there did appear to be some variance in the way that these students perceived their role as a nurse with respect to the client's mental and emotional state. The following quote demonstrates the conflict for this subject between her own fears of caring for someone with AIDS versus how she feels the institution wants her to act in that type of situation. She was asked about problems she might have giving a bed bath to someone with AIDS:

* S: Because you hear so much about it and it's so prevalent and it's a threat to life. I mean if it hits you there's no cure for it. And that's one of the things that gets you, you didn't even ask for it and you got it. You know like cancer, you get it but I guess you would feel the same way if a person had hepatitis, you know. Anything contagious like that, that you could get, it's scary you know.

* I: Again is this information that mostly you're getting from...? 

* S: Yeah the media, from newspapers and you're not sure how to deal with it when you actually go in there [the room] you know, everybody's a human being and like to be treated like a human being. They [the institution] don't want anybody going in there and say "Oh my goodness", you know. And it scares a lot of people you know and I'm a person you know whether I'm going to be a nurse or not it scares you.(Interview #9)

It is clear from the above text that the subject is both cognizant of how she feels and how she is supposed to act.
In this particular case there appears to be a great deal of cognitive dissonance between the two, this being another example of the clash of organizational versus environmental influences during the process of re-socialization.
In a similar light, when a second subject was asked to try and remember any discussions she might have had about procedures that might be higher risks for nurses, she responded the following way:

S:  Not really, but in class we had a few ah, very few discussions, nothing major but um, you're taught that whoever you deal with, no matter who they are or what they've done or what they have you have to treat them holistically. You have to treat them all the way around from every point of view... psychologically, physically, emotionally. Just because he or she has a disease that you don't like you don't treat them bad.

I:  So basically you're treating everyone universally the same?

S:  Right.

Two values emerge from the above dialogue. The first is that the subject is aware of how the university expects the nursing student to treat every patient, and the second, more implicitly, that she is aware that AIDS is a disease that some people "don't like". This again demonstrates the incongruence between the subject's awareness of professional normative expectations within the nursing occupation and collective lay attitudes that filter in from the environment. This expression of normative values espoused by the profession emerged in one other interview where the subject clearly states that although she hasn't studied AIDS in the university she is aware of her role as caregiver from a nurse's perspective:

S:  Oh yeah, like I don't even understand everything or know everything about it [AIDS], because I haven't studied it. But you know, what are you going to do? You have a client, you've got to treat them, there's no sense in demoralizing them, I mean that's not what you're there for. (Interview #11)
The Hospital as Information Transmitter

It was not at all surprising to find that the hospital was only a secondary factor for the transmission of knowledge for these first year students by virtue of the fact that their time spent in the hospital was minimal compared to time spent in classrooms. As in the case of the university, the use of gloves was the most commonly identified technique learned, in part, in the hospital.

Nurses as Information Sources

Encompassed in the initial premise that AIDS would be a significant issue for these student nurses was the hypothesis that practising nurses in the hospital would have contributed to the attitudes both cognitively and affectively of these students. This hypothesis was based on the fact that as practising nurses, some, if not many, of the R.N's would have encountered the issue of AIDS either directly or indirectly within the hospital. It was thought that perhaps in some cases these experiences would have been shared with the student nurses for the purpose of enriching both their knowledge and indirectly augmenting the behavioural and affective components of their attitudes.

The data on the influence that practising nurses had on the students' perceptions and attitudes about AIDS, clearly showed that in most cases what was transmitted from the practising group to the student group were specific techniques for handling possible contagious materials as
well as precautionary measures taken when dealing with patients. Seven of the eleven interviewees cited interactions with practising nurses as one source of specific knowledge they had acquired. Although in many cases this knowledge was not directly linked to the spread of AIDS, these students had related information from other areas and connected it to the issue of AIDS.

The use of sterile gloves was the most commonly mentioned practice which nursing students used in their imagination to carry out a specific procedure on someone with AIDS. In a number of cases this technique was something they had learned from other nurses, although originally, it had not necessarily been used in the treatment and care of a PWA. This can be seen in the following response where the idea of "double gloving" was applied by the subject to the AIDS scenario:

*S*: Well, if I know that I’m working with a patient with AIDS and I thought there might be a chance of the glove tearing, I would wear two gloves.

*I*: How do you know about that?

*S*: (laugh) uhmm, lets see where did I learn that, uh just in Potter and Perry but working with and my lab instructor when we were performing surgical not surgical procedures but clean procedures sterile procedures you...

*I*: What type of procedures?

*S*: Clean procedures, sterile procedures, you can wear two sets of gloves instead of taking another set off and putting another set on. (Interview #5)

Similarly, another subject brought up the use of gloves when she was asked to imagine carrying out the "range of joint motion exercises" on a person with AIDS:
S: Um then I would have gloves on, and there's different kinds of gloves I guess there's um ones we use everyday and I guess things can permeate through these...

I: Right.

S: So there is a new latex glove, so I'd probably get a different type of glove.

I: Where did you hear that? I've never heard of that.

S: Well I think, I think the nurse... our clinical instructors discussed it. We had like a little talk about it afterwards, and they said well in California like over in the States they use these other gloves a little more...

I: Right.

S: Because...

I: What are they thicker?

S: Yeah they're a different, I guess the Japanese developed them or something they're, you know more expensive but they ah, you know ensure that you're protected. You've got to get different gloves than the everyday ones we use. (Interview #1)

The use of gloves was mentioned by three other subjects. One interviewee related the use of gloves on a PWA from instruction on caring for someone with "herpes", another from instruction on "handling blood and urine" and the last subject related using gloves from "hearing about nurses carrying out CPR" in emergency situations away from the hospital.

In addition to the use of gloves for a variety of procedures, other types of information were cited as well, with practising nurses being the source for such information. During a discussion about some of the issues that nurses might face with regard to AIDS, the following subject referred to such hospital practices as "universal care" and "confidentiality" as types of information that she
had received from a practising nurse, in this case a sister-in-law. She explained:

S: Well I have a sister-in-law who is a nurse and I once had a discussion with her about it and she said how it is, especially since it is so confidential and the nursing staff is not necessarily aware that the person has AIDS like that's a problem.

I: Uh huh.

S: Yes because of confidentiality that sometimes they are not aware like she works in an operating room where there is blood and stuff like that so they take the precautions that the person has AIDS under all circumstances because they can't be too sure, and I think uh if she can work in an atmosphere like that and she is just fine, like I'm sure that she stuck herself and cut herself a number of times and I think that maybe I don't worry about it enough but it seems to me that all the cases I've heard, uh if a person just sticks himself once or twice nothing happens so maybe it is not something we know that we should be getting all hysterical about maybe it takes more than that, and there's people who have had relationships even and haven't gotten anything so maybe it's not as contagious. (Interview #2)

In conjunction with the transmission of certain types of information, there is also a degree of modelling apparent in the above quote. The nursing student recognized that her sister-in-law was able to work in a potentially dangerous environment without any harm having come to her and she related that information to herself. Although this was discussed earlier in the section on the "Family," it is clear that in this case the influence of a practising nurse, who is a relative as well, has affected the way this student perceives herself with regard to potential risks of dealing with AIDS in the hospital.

Other types of information that the students claimed had been learned from practising nurses in the hospital were the "handling of sharps", the practice of "hand washing" and the "use of mouth pieces" for doing CPR.
One the other hand, a lack of information being shared between students and practising nurses was the second most prevalent pattern. Four of the eleven interviewees claimed that they had not discussed any specific information as it might relate to AIDS or otherwise with other nurses in the hospital. The following quote illustrates the typical response given by these subjects. Subject #9 was asked the following:

I: What about, have you had any um, exposure in a hospital when you were doing something that a nurse working in the hospital said you should be wearing gloves or something like that?

S: No, not at all.

Nurses as Support Mechanisms

As expected, there were a few cases where the subjects referred to practising nurses in a supportive role. Although this response pattern was not as significant as originally hypothesized, it was important nonetheless. One subject referred to a talk given in the hospital by a nurse who was responsible for "infection control" and she stated that the nurse explained to the students that "it was easier to contract hepatitis than AIDS." The student perceived the nurse to be attempting to "ease their minds" about AIDS because she felt that many of the students were concerned about it. She states:

S: Um when we got our orientation in the hospital during first semester, we spent practically the whole day orienting us to the hospital so a big thing when you start in nursing is about hand washing and with you know people with AIDS or without AIDS it's just really important to wash your hands a lot and they tell us all the different times you need to wash your hands and so mostly it was I'm not sure if she was a nurse but she was in charge of disease control with the hospital, or infection control I should say. I guess so
she came to talk to us and she was telling us about how for example hepatitis is a lot easier, a lot more... we are at more risk for getting hepatitis than we are for AIDS. And she just explained to us how important it is to wash your hands no matter who you're in contact with and you know, just to prevent disease spread, so that was about the big extent of our [orientation].

I: Did she specifically talk about AIDS or was she just talking about infection control generally?

S: Well she would bring up AIDS because I think she knew it was in our minds a lot, they knew a lot of people without clinical experience are going to be worried about that and so I think she was trying to ease our minds about you know, that AIDS isn't easy...you're not going to contract it just from touching a person or something like that, and it's important, not just for AIDS but any infection that you do the proper hand washing.(Interview # 3)

Not only was the nurse in charge of "infection control" acting supportively by trying to ease the minds of the students about the risk of infection with AIDS, she was also transmitting information to the students on precautions to take to prevent the spread of disease. Support displayed by a practising nurse was seen in one other case where the subject stated that "if she [her aunt] can work in an atmosphere like that and she is just fine", then perhaps there is less of a risk for her than she originally thought. The actuality of her aunt "working in the trenches" and remaining unharmed, seemed to alleviate some of this subject's concern.

The Nurse as a Role Model

It was hypothesized that many of the students would have assimilated practices and techniques used in the hospital from watching nurse practitioners utilize them. It is in this sense that the R.N. in the hospital serves as a "role model" both negatively and positively for the student. It
was of interest to note that in the above category there was no mention made by any of the students by nurses or registered nurses who had served as positive role models either directly or indirectly. Conversely, although not in significant proportions, two subjects cited examples of nurses in the hospital who acted in ways with which they did not agree.

With regard to the "nurse as a role model" in the treatment of someone with AIDS, the following discussion highlights one case of a negative role model. As the subject describes:

S: We really didn't discuss that because we, I don't know if we will get an AIDS patient while we're students. First year students basically we are getting old people who need bed baths and chronic care who need bed rest. There was once a conversation I overheard...

I: Uh hem.

S: A friend of mine, she said she overheard a conversation once, it was at Hospital X. A patient who was supposed to have AIDS... but this is just over-caring... that this nurse did not want to be his nurse, was refusing to be his nurse...

I: You have a choice don't you?

S: Uh, I don't know I really don't know. I know if it's in health beliefs, like say you're a person who does not believe in I.V. and you're asked to start an I.V. you can say "I can't it's against my religion", things like that. That's your own personal health beliefs. It might interfere from you ever getting a job at times. But she [the nurse] was saying "I don't want to be his nurse" and he [the patient] was right there!

I: So he could hear her saying that?

S: Exactly. She was talking to another person and they were transferring him from something. They had him all covered up head to toe and he had a mask on, he had goggles on, he had this thing over his head, all covered up and here's this nurse saying "oh yuck" and I thought "good nurse... just wonderful, she's doing a lot for this patient talking like that right in front of him".

I: What did your friend say to you about that when she was repeating it?
S: She was, she was disgusted at the nurse. She said "How can she be like that?" (Interview #8)

Hospital Protocol

It was not that surprising to find that in general, these students at this point in their education were unaware of how the various hospitals that they worked in handle AIDS in terms of specific measures that are taken to ensure the safety of all those present. Although this was not specifically stated by a number of subjects, one interviewee highlighted this uncertainty about hospital protocol when asked about the risk of performing "transferring the client to a chair" in the presence of open wounds or lesions. She responded in the following fashion:

S: Well I would assume that they'd be covered.

I: Why do you say that?

S: Bandaged, well you shouldn't, unless it was something that had to be exposed to air. Usually you bandage something up like that to prevent infection. Um if they didn't... well it would be fine as long as I didn't have any open cuts or wounds and I'd make sure mine were covered.

I: How do you know about that?

S: I don't know, you see, because I'm not familiar, I don't know much about how you would deal with these. But if I saw something I would make sure, you know, you don't want any blood coming into contact with yours. So maybe with an AIDS victim, I'm not sure how they would deal with that in a hospital but maybe they'd specify in the reports or kardexes so you'd know this and that. (Interview #9)

In addition to these students being uncertain about hospital policy and procedures for caring for someone with AIDS, the notion of mixed messages being sent by those people responsible for their training emerged. The following quote, although only one case, shows that the types of
precautions that are suggested by those in charge can vary
from one instructor to the next.

I: They .. in the hospital for example would never say to you, you know if
you're going to be taking blood whether for a diabetes test or whatever make
sure you're gloved ?

S: No they haven't in the hospital with this instructor. But with my instructor in
last semester in second semester she said you should always wear gloves for
everything if there is the chance of you coming into contact with body fluids
or blood or even medications that can be absorbed through the skin you
should wear gloves. She works in Detroit. Now I don't know if that is a
direct result.

I: These are sessional instructors that come in?

S: Yeah I don't know if that's a result of her experience but she said at her
hospital in Detroit. They always carry gloves in their pockets always. It's
very rarely that I've seen nurses here with gloves in their pockets.(Interview
#3)

There was nothing mentioned by the subjects with
reference to what has been discussed in the section on the
ideological influence of the institution as it related to
the hospital. Clearly at this stage of their education, the
hospital serves as a practising ground for theory that they
have learned in school. Apparently the time spent in the
hospital has had little impact on the perceptions these
students have about AIDS as it relates to their professional
lives.

Summary of Findings

Data regarding the University as an institution for re-
socialization showed that at this point in the curriculum,
the topic of AIDS had not been covered in any depth. With
regard to the above, it was of great interest to uncover how
these nursing students would imagine caring for someone with

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AIDS by discussing certain procedures they were both familiar with and had practised, through an imaginary AIDS case scenario.

The use of gloves was the most common practice they had learned in school that they incorporated into their imagined AIDS scenario. All subjects at varying points during the interviews connected the practice of wearing gloves to caring for someone with AIDS. The use of gloves varied depending on the procedure being discussed, with those procedures involving the handling of "bodily fluids" involving the use of gloves more often. The condition of the client was also a factor in the students' minds with regard to the use of gloves.

In discussing the use of gloves it was found that most students made an assessment on both the procedure and the condition of the client before stating that they would use gloves. When asked about the first procedure, "assisting the client to a sitting position", ten of eleven subjects stated that the fact that the client had AIDS would not change the way they performed the procedure. Only after probes were used in the form of questions regarding "open sores or lesions on the client" did the subjects state that they would then wear gloves. One subject stated that although she knew AIDS was not supposed to be transmitted through casual contact, she would still feel awkward doing this on someone with AIDS. When this subject was asked where her concern
came from she stated "probably a lot of it from the media". This was presumed to be an example of the "lay reality" of AIDS coming into direct conflict with the "nursing perspective" of AIDS and demonstrated the confusion that appears to exist during the process of occupational re-socialization.

It had been hypothesized at the outset of this research that those procedures that under normal circumstances are theoretically more difficult for the student nurse to perform, would be equally, if not more so difficult with the addition of AIDS to the procedure. This hypothesis was only partly supported by the data. There was more anxiety expressed by the subjects for carrying out what were thought to be "problematic" procedures, however the addition of AIDS did not escalate these anxieties any further in most cases.

In general, it was with the more "problematic" procedures that a greater variability existed with regard to precautionary measures that the students would take with a PWA. This variability seemed to stem from the idea of "body fluids" with those procedures such as "giving an enema", "disimpaction", "perineal care", "rectal suppository" and "specimen collection" presenting the greatest differences in approaches taken by the students. As an example, when the procedure of "removing stool digitally" was discussed, six subjects stated they would not do anything differently, two stated that they would double glove, two subjects said that
they would wear both gloves and a gown, and one additional subject felt that she would be concerned about the glove tearing while performing this procedure. Although the first procedure "assisting the client to a sitting position", evoked similar responses from ten subjects with regard to changes they would incorporate when dealing with a PWA, one subject included the use of a gown as well as gloves when discussing this procedure in the context of AIDS.

Although only found in two interviews, the trustworthiness of information transmitted by the University also bore on the social construction of responses. Thus one subject stated that she trusted information the school had given her about AIDS, where the second subject was not certain that she was safe from infection in the hospital in spite of what she had been told by the institution. It was felt that this supported the notion that students are actively interpreting and responding cognitively to both the institution as an information source and at the same time letting information from the environment filter in as they construct their own "reality" of AIDS.

The University does not only act as an information transmittor for the students but also serves to re-shape their attitudes regarding their role on a social, psychological and emotional level with regard to the treatment of patients.
The influence of the University with regard to the affective dimensions of nursing was not as unclouded as in the case of information transmission. This lack of clarity was due to the fact that most of the dialogue that specified the university in this context was not as forthright as the factual information, which required a certain amount of deconstruction. The reaction to caring for a PWA on the emotional, psychological and social level only emerged during three interviews. Within these, however, there appeared to be a great deal of dissonance between how students thought they might feel about caring for someone with AIDS and how they thought the institution expected them to react. Dialogue such as "They [the institution] don't want anybody going in there and say 'Oh my goodness' you know", "Just because they have a disease that you don't like you don't treat them bad" or "you have a client, you've got to treat them, there's no sense in demoralizing them, I mean that's not what you're there for", typified the responses given by subjects on their views of how they see the dilemma of caring for someone with AIDS.

The hospital was secondary to the university in terms of information transmission. This was expected by virtue of the fact that the time spent in the hospital compared to that in the university was minimal.

An analysis of the influence of practising nurses on the attitudes of the student nurses showed that it was on the
"practical level", through the carrying out of specific techniques and procedures, that the practitioners made the largest impact. Seven of the eleven interviewees cited practising nurses in the hospital as one source of information they used in the "imaginary scenario of AIDS care." Within this sphere, the most cited practice was the use of sterile gloves for a variety of situations. Other techniques mentioned were the "disposal of sharps", the practice of "hand washing", the use of "mouth pieces" for C.P.R., and finally, the concepts of "universal care" and "confidentiality" in the treatment of patients.

Given the ambiguity of information on AIDS as it related to the hospital, it was hypothesized that the practising nurse would support the budding nurse in the hospital. This hypothesis was not supported insofar as only one subject claimed that a nurse had directly acted as a support for the students in view of their AIDS concerns. The aspect of the nurse as supportive was found in one additional interview, where an aunt, by virtue of "being in the trenches", had acted supportively for the student, as well as serving as a positive role model.

The final pattern that emerged from the data demonstrated that contrary to the general hypothesis, practising nurses in the hospital had not made a significant impact as positive role models for the student nurses. In
fact, the only case where the concept of "role model" appeared in the interviews, was in the negative sense.

Similar to the data referring to the university, the use of gloves was the most commonly cited technique the students had learned in part through the hospital. Five subjects mentioned they had learned about gloving, or double-gloving in the hospital. The information regarding the use of gloves also had an experiential aspect to it, where past experiences in the hospital were used by the subjects in their imagined AIDS scenarios.

In general, the students were not at all certain about hospital policy or procedures for caring for someone with AIDS and often said things such as "I don't know" or I'm not sure" when referring to what is done in the hospital.

There was one case of mixed messages being sent by two different clinical instructors with regard to the use of gloves. The student stated that an instructor during one semester had told her to "always wear gloves if there is the chance of coming into contact with body fluids or blood", but this was not the case in the hospital during her second semester. The student made the assessment that the difference between the two instructors was brought about through the first instructor's experience in Detroit hospitals.
Nothing was mentioned by the subjects with respect to the ideological influence of the hospital as it pertained to the care and treatment of AIDS patients.

**Other Sources in the Construction of AIDS**

In the design of this research certain theoretical influences were hypothesized to be important in students' construction of AIDS as it related to their chosen field. As the interviews were conducted, it became apparent that in addition to those influences hypothesized from theory and the literature on secondary socialization discussed previously, there were other influences that had also played a role in the students' knowledge and social construction of AIDS. In some cases these additional influences were connected either directly or indirectly to other derived categories concerned with professional socialization, in other cases, they were not connected yet still had impacted on the formation of the students' attitudes on the subject.

**Nurses in Organizations Outside of the Hospital or University**

In the previous section on the influence of the hospital as an institution for professional socialization, the importance of practising nurses was discussed. Although not expected at the outset of this research, the role of nurses in the social construction of AIDS for these students outside of the hospital and university setting proved
relevant. Nurses were encountered by these students in a variety of agency settings that impacted on their attitudes about AIDS as well as on their perceptions of possible risk factors for conducting certain procedures on a FWA.

One subject stated that, as a result of the hysteria created by the media, she decided to have herself tested for HIV in part influenced by some of her associations with homosexual males. It was during the process of having blood taken that she learned about some of the precautions nurses take when performing this procedure. She was asked the following:

I: When you mention things like double gloving where do you know about, like where do you have the practice of gloving in the first place?

S: We learn that in clinical like in the lab.

I: At the university?

S: Yeah, but not double gloving, the reason I know about double gloving is, and I’ll be the first to admit, back when AIDS was becoming a big deal so to speak in the media I had some friends who were homosexual and I had kissed, kissed them you know “hi how are you” and kissed them and I became very paranoid about that so I wanted to see its probably crazy I know but I was thinking of getting pregnant with him [her son] so I went to the health unit and I asked to be tested for the virus, and I was tested. I was really intrigued to see the procedure they went through when they took my blood sample for testing for the virus and they double gloved.

I: So that’s where you learned about it?

S: Yeah that’s where I learned about double gloving. (Interview #3)

A second subject stated that AIDS was discussed with her by The Red Cross when she gave blood and that she was required to fill out a questionnaire about AIDS:

I: Are there any other influences that you can think of in terms of helping to shape your views on AIDS that we haven’t covered?
S: I gave blood today and that's the main thing they focus on at the Red Cross, when you give blood is AIDS and it's ah... you know something that is prevalent.

I: What do they do at the Red Cross, they give you a form or something to inform you?

S: Yeah that you fill out yeah. Um they mostly ask you about the AIDS virus.

I: They ask you about...

S: Yeah, it's a questionnaire.(Interview #9)

One other subject mentioned the process of donating blood as a source of information on AIDS with references made to the "avoidance of needlesticks" and "trying to control the bleeding" as examples of precautionary measures that she learned by watching a nurse in a setting outside of the hospital.

It is not surprising that nurses emerge in other contexts outside the hospital and university insofar as the nursing occupation is at the forefront of the students' minds. They would arguably therefore be more attentive to interactions with other nurses than they would interactions with professionals from other fields.

Socializing Agencies in the Organizational Environment

It was learned after the interviews were conducted that one of the requirements for nursing students before entering their second year of study, is that they enrol in both a first aid course and also a course on CPR with an agency offering these courses. Not surprisingly then, five of the eleven subjects, when discussing the procedure of "mouth to mouth resuscitation", mentioned information they had learned
through a first aid courses or CPR as the sources for this information.

The procedure of "mouth to mouth resuscitation" was not studied in the university setting during the first year of the programme, and only those students who had already taken either or both a first aid course and CPR mentioned anything about the risks of performing this procedure on someone infected with HIV. Five other subjects had not studied it through the university or through an outside agency and therefore the procedure was skipped with these students.

Due to the fact that it was a requirement for all students at the end of first year to take both first aid and CPR, the agencies offering these courses, such as the St. John's Ambulance were thought to be theoretically extensions of the university as an institution for professional socialization, rather than as new categories not yet discussed.

The concerns associated with performing "mouth to mouth resuscitation" were discussed during such courses and the idea of using mouthpieces was posed in the event that the injured person might have AIDS. In the following exchange it is clear that the instructor in this particular case was attempting to downplay the risks associated with AIDS as it related to this procedure and she stressed the importance of "saving lives", as the subject stated:

S: Well I know what it is [cardio-pulmonary resuscitation] but I never learned it, I can do artificial respiration, I just took a first aid course.
I: Where was this?

S: At the St. John’s Ambulance. And it was funny because AIDS did come up there.

I: What did they say?

S: AIDS did come up there, um we had a very interesting group of people there. There were some from factories, some students, some supervisors and there were two nursing students. Somebody said something like “well what if they have AIDS” and the instructor said “who cares”, that’s what she said, she said “my duty is to save their lives”.

I: How did people respond to that?

S: They were sort of shocked, she said “look if you want to take the time to put a handkerchief or kleenex over their mouth, do whatever you want” she said, “but your first responsibility is to restore their breathing and save their lives”. And um there was silence, I don’t know if you could consider it shocked silence but I said out loud, “you can’t catch AIDS from saliva”. (Interview #3)

It appears from the above dialogue that there was some concern on the part of those taking the course that there might be some risk of the virus being transmitted through saliva. This subject apparently has garnered from some source that the virus is not transmitted through this mode. Also of note is the fact that the instructor in the above case does not present the situation of performing “mouth to mouth resuscitation” as one of particular risk for the lifesaver.

The question of saliva being a mode of transmission for the virus was prevalent in all of the interviews with students who had taken either first aid courses or CPR. Two additional students stated that performing “mouth to mouth resuscitation” on someone with AIDS would not be a problem due to the beliefs that “the chances of getting it from
mouth to mouth are not that high", "no one has caught it that way" and "they haven't proven that saliva passes AIDS".

This position was not adopted by all of the students who had attended either first aid courses or CPR. In fact, two other subjects voiced concern over the possible risk of contagion from performing "mouth to mouth resuscitation". Subject #2 was asked what specifically in the procedure would concern her:

S:  Well just the mouth to mouth, I would be overly concerned about saliva and sometimes when you're doing this with a person they can vomit and things like that. That sort of thing would make me um, I don't think I could do it... I'd like to think I could, but on the other hand I'd be foolish to try.

This subject was probed about using mouthpieces, but she was unaware of their existence and said that "if there is such a thing that would protect me, yeah". A similar type of concern was expressed by a different student where she cited the fact that "there can be the AIDS virus in saliva" as a reason for her concern.

It is clear from the variation of responses made by the subjects concerning the risks of performing mouth to mouth resuscitation on someone with HIV, that in defining a situation, information is synthesized from a variety of sources by the individual actor before the cognitive, behavioural, and affective components of their attitudes are expressed. If this were not the case then one would expect to see the same types of attitudes expressed by all students who had received the same information on a given procedure and its supposed risks.
Although only encountered in one case, the prior education received by one subject also contributed to her attitudes about AIDS as it related to the field she was currently pursuing. When probed using the hypothetical situation of open sores existing on the client that she was to imagine "assisting to a sitting position", she drew on knowledge she had received prior to her nursing education to assess the situation:

S:  *Well in that case you would probably practice isolation techniques like I would imagine if a person had AIDS they would be in reverse isolation simply for their own protection, the idea being that they're immuno-incompetent o.k.?*

I:  *Right.*

S:  *So they are more at risk from myself than I would be from them.*

I:  *Where do you get that information from. Has that been taught to you in classes for example?*

S:  *No that is through my own... I have a BSC in biology and my major was immunology, plus my reading you know.* [Interview #3]

The final source of information on AIDS that emerged from the data in one case, was through the attendance at an AIDS seminar conducted through St. Clair College prior to her enrolment in the School of Nursing, through which she had received information about potential risks for health care workers as well as information on the epidemiology of the virus. When asked about the types of information they presented at this seminar she replied

S:  *Just how to protect yourself when you are dealing with a client, like double-gloving...*

I:  *This was from a nurse's perspective?*
S: Yes, double-gloving so when you are dealing specifically with body fluids if they have a cough then you wear a mask, but just ordinary touch, as long as you don’t have a cut and the place you’re touching doesn’t have a cut there is no problem with that. (Interview #8)

Summary of Findings

In addition to the influence of institutions of socialization discussed in the earlier sections, the construction of AIDS for these students also included information received from occupations and organizations distinct from the institutions of both the school and hospital. Furthermore, it was found that nurses located in agencies outside the organizational realm had impacted on the social construction of AIDS for some of the subjects.

One subject learned about the precaution of double gloving through watching a nurse at the health unit take a blood sample from her to test for HIV. Two other subjects stated that some of the information they had received about AIDS came about during experiences of donating blood, with one of these subjects making reference to "a questionnaire that you fill out" and a second subject citing examples of "trying to control the bleeding" and the "avoidance of needlesticks" as pieces of information she had learned about while watching a nurse take a blood donation from her.

Although not known at the outset of this research, students in the nursing programme must take both a first aid course and CPR through an agency offering them before entering their second year in the programme. It was therefore not surprising that five of eleven subjects
referred to one or both of these courses in the process of discussing the procedure of "mouth to mouth resuscitation" as it pertained to an imagined AIDS scenario.

Five additional subjects had not taken either of the courses at that point in time and stated that they were unfamiliar with the procedure of "cardio-pulmonary resuscitation." For this reason, the procedure was skipped with these subjects.

The agencies offering these courses, such as the St. John's Ambulance, were thought to be theoretically extensions of the university as socializing institutions rather than as new categories, as a result of the fact that it was a requirement of the university that the courses be taken as supplements to the nursing programme.

Various concerns about performing mouth to mouth resuscitation were discussed during these courses, with issues such as the use of mouth pieces and the question of whether or not saliva was a mode of transmission for the virus being paramount.

The question over the risk of saliva passing HIV was prevalent in all of the interviews from those students who had taken either or both of the first aid or CPR courses. Three of the subjects stated that they did not worry about the virus being present in saliva, with the remaining two not supporting this perception.
One case was encountered, where prior education within the university had led the subject to specific information that she utilized in her construction of AIDS.

This subject's prior degree in biology, with a major in immunology, was cited by her as the source for this specific information.

The final source of information on AIDS that emerged from the data was the attendance at an AIDS seminar. One subject, prior to her enrollment in the nursing programme, had attended an AIDS seminar and stated that some of the information she had concerning potential health risks for nurses and other health personnel she had learned through her attendance at this seminar.
DISCUSSION

The discussion of findings will follow the same categorical headings that were used in the review of theory on socialization into occupations and professions, highlighting those findings that support or modify the research previously conducted on professional socialization.

Attention will then turn to the findings that are not explainable from a macro perspective, with analysis given as to why these anomalies exist.

Having completed the discussion of how the findings of the present study either support current macro conceptualizations of the process of professional socialization or augment them, the discussion will then turn to the interactive experiences and interpretations of the nursing students, and how, through their conceptions of the definitions of situations and the role of significant others, they have come to piece together a socially constructed reality of AIDS and the process of professional socialization.

Findings of the Present Study that Support Previous Research Findings:

Role Strain

It has been proposed by Pavalko (1971) and supported in the literature on occupational socialization (Brief et al.,
that one of the characteristics of adult socialization is the "possibility of holding conflicting norms and occupying conflicting roles". This was evidenced in three cases within the present study, where subjects expressed some form of dissonance in the imagination of carrying out procedures on a PWA as it related to their "role" of nurse. The role designated by the institutions of both university and hospital came into conflict with the subjects' previous view of self. This dissonance was characterized by the use of phrases such as "it scares you" referring to going into the room of an PWA, or "I think everybody is a little afraid" in connection to doing an accu-check.

It is impossible to state whether the experiences of role conflict for these students are simply functions of the stage of socialization they are in, insofar as this research only dealt with students in their first year of study. It might be suggested however, simply by the experiences of practising nurses who have also experienced role conflict in the care of PWA's, that this conflict is not simply a function of the "stage" they are in with regard to the process of socialization, but rather, that professional values are not always fully internalized as suggested by general theory.

Anticipatory Socialization

As suggested by the research (Brief et al., 1979) and theory (Pavalko, 1971), anticipatory socialization was a
factor in the socialization experiences for two of the subjects. One subject whose sister-in-law was a nurse used a phrase like "and she said how it is" to characterize the role her family member played in her own socialization experience.

It should be noted, however, that having relatives occupying roles that the student desired to occupy herself did not yield the same results in both cases. In one case, anticipatory socialization not only allowed one subject occupation specific information and reflected attitudes concerning AIDS in the profession, but also served as a basis from which the subject could judge her own feelings and attitudes about the profession and AIDS as an issue. Due to the fact that her sister-in-law had worked in an operating room and was not affected by it in terms of exposure to HIV, the subject apparently used this information to reassess her own feelings saying that "maybe it is not something we know that we should be getting all hysterical about."

The impact of having relatives in the profession and the role that plays in anticipatory socialization was not significant for the majority of the subjects. This certainly raises questions about the ability to accept general properties of socialization, such as anticipatory socialization, when in a sample as small as the present one it was hardly present as a factor.
This interpretation is supported by the variability of responses even in two subjects, where the other subject with a relative in the profession stated that they had not influenced her decision to enter the profession and did not discuss them further.

Reference Groups

The concept of "reference groups" (Shibutani, 1955) where the individual aspiring to become a member of a particular group uses the members of that group as reference others by which to judge and evaluate themselves was supported by data from the present study.

Although the majority of students referred to specific techniques they had learned through discussions with various practising nurses and not the behaviour and attitudes of these nurses generally, there were situations in the experiences of some of these students where the behaviour and attitude of a reference other was used to evaluate self.

Subject #8 referred to the behaviour of a practising nurse and the discussion that she had with a fellow nursing student in a situation involving the transportation of a PWA by the practising nurse in a hospital. This subject used statements such as "this nurse did not want to be his nurse, was refusing to be his nurse" or, "and here's this nurse saying 'oh yuck' and I thought 'good nurse'" as demonstrations of the subject using the behaviour of another as a mechanism for judging herself.
In the above case the reference other's "negative" behaviour was used in the subject's view of self as reinforcement that she is not that way and that this behaviour demonstrated by the practising nurse was inappropriate from the subject's point of view.

The only other example that supported theory on the importance of reference others in the socialization experience of students, emerged in a discussion with subject # 7. She referred to "a nurse in charge of infection control" who, by what was referred to earlier as "modelling" appropriate role behaviour, had impacted on the student's own values and attitudes as it related to her definition of self.

Clearly two subjects out of eleven referring to the importance of reference others does not exactly support general theory on reference groups and their effect on socialization, however, this lack of impact within the present study's sample may be as a result of the lack of interaction that first year students have with practising nurses in the hospital.

Although this may explain why nurses in the hospital had not made more of an impact as reference others, the clear lack of impact by reference others in the university setting cannot be explained in this manner. Students have contact and interactions with professors and clinical instructors on a regular basis, and their conspicuous absence from the data
suggests that they are not as important at least for students in the first year as previously thought.

Idealism

Becker (1961) has identified that medical student begin their training with a strong sense of "idealism". This phase has also been suggested in the work of Psathas (1968) and Simpson (1967: 48) whose research on the socialization of nursing found that student nurses cited "being of service to suffering people" as their main reason for choosing nursing.

The concept of "idealism" elaborated in the literature by the above authors surfaced in a few of the interviews. This idealism was evoked by the subjects in statements that reflected values such as "the desire to help" or in the criticism of practising nurses perceived callous treatment of patients through remarks such as "how can she be like that." In addition, comments emphasizing the human qualities of patients such as "everybody's a human being and like to be treated like a human being" that focused on the psychological rather than technical aspects of patient care were also classified as example of "idealism".

Subject #11 typifies the idealism that was expressed by a few first year students in remarks she made such as "I don't think they should be degraded", referring to PWA's, or "I want my clients to die peaceably."
It is important to note that in general, at this stage of their careers, these nursing students demonstrated minimal knowledge of the immunological aspects of HIV, and as such, would therefore place a greater emphasis on other aspects in the treatment of the virus such as the emotional and psychological welfare of patients.

**Professional Consensus**

It has been suggested in much of the research and theory on professional socialization that, according to Richard Hall (1976: 76):

*Such a consensus is a hallmark of professionalism, regardless of its source.*

The work of Olesen and Davis (1966: 155-156) has suggested that, contrary to this general acceptance in the literature on attitudinal consensus, students do not radically alter their perceptions of nursing, "nor did they achieve greater over-all consensus among themselves or consonance within themselves in these respects."

Although the present research only looks at students in their first year of study, the data show that at least at this stage in the socialization process, there is neither consensus on an attitudinal level concerning ideological precepts about AIDS as it relates to the treatment of patients, nor is there consensus reached on the risks of caring for a PWA even, in the imagination of carrying out everyday standard procedures of a hospital nurse.
Although evidence of "professional consensus" was not present, certain values transmitted by the profession, particularly pertaining to the psycho-social aspects of client care, appeared in the interviews. One subject mentioned the "holistic approach" when dealing with a client, stating that "just because he or she has a disease that you don't like you don't treat them bad".

This subject makes an acknowledgement of the professional value of treating clients humanely, even in the advent of morally disapproving with the client's lifestyle or value system. Although recognition of this "universal approach" does not necessarily mean that it will be acted upon in practice, there is evidence of the permeation of professional tenets into the subject's cognitive process. This value was alternately demonstrated by a second subject who similarly demonstrated the assimilation of professional conduct in the care of patients with phrases such as: "there's no sense demoralizing them, I mean that's not what you're there for."

Although the present research does not significantly support past research conducted on the socialization of nursing students specifically, or medical students and other professionals generally, it is important to recognize the parameters that have shaped past research and the parameters that shaped the present study.
Without exception, the literature reviewed, both theoretical and empirical, looked at the socialization process as it takes shape through a number of years within various institutions using a longitudinal design. In the present research this was not possible, limiting the ability of this study to support notions of the socialization process overall, and comparison to past research could only be analyzed in terms of the entry phase to a professional socialization experience.

With regard to the aforementioned concepts and theoretical constructs that surfaced in data from the present study, what is of particular interest here is that, even in a sample as small as the present one, notions of reference groups, idealism, anticipatory socialization and professional consensus were more often conspicuously absent than present. If understanding the process of professional socialization is to be at all meaningful, one must attempt to understand why variability exists in populations both large and small.

Propositions not Supported by the Present Findings:

There has been some debate regarding the extent of the institution's role in the total professional socialization of its members (Bloom, 1965). One view (Merton, 1957) contends that the institution imparts on the student all the necessary skills, that upon graduation they can move directly into full fledged participation in the profession.
The other view (Becker, 1961) maintains that although the institution gives the student a minimum amount of competency, these skills must be augmented by the profession itself upon graduation.

Although as a result of the design of this research one cannot either defend or attack these positions regarding the "completeness of institutional socialization", findings from the present study suggest that at least during the initial stages of socialization nursing students assimilate information, attitudes and values from a variety of structural sources, including the institutions of the university and hospital, and that it is through a combination of structural forces that the socialization process unfolds.

Findings that Augment Past Research

Most of the research done in the area of professional socialization has largely ignored a variety of other structural factors that impact on the socialization process.

Data from the present study uncovered additional structural forces such as the family, the media, friends both within and outside the institution, and agencies in the organizational environment that, in conjunction with the institutions of the university and hospital, impacted on the socialization processes of the students.
The Family

Literature on professional socialization seems to imply that upon entering the institutional environment, the influence that the family has on the individual's socialization comes to a halt upon entrance to an institution, with the institution or organization taking over at that point.

Findings from this study showed that contrary to this idea, the family still played a role in the secondary socialization experience for students engaged in their first year of a nursing program.

The family was contributory in light of giving support to the socializee, voicing concern for subjects' vulnerability to the contraction of HIV, and lastly, influencing subjects' perceptions of AIDS as it related to their chosen career, explained through family convictions in religiosity.

The socialization experience for subjects does not occur in a vacuum, but rather the socializee acknowledges, affirms, and analyzes the opinions, values and attitudes of significant others within their families. This was particularly salient in the case of AIDS, where significant others in the subjects' families, including parents, spouses and others, at times expressed deep concerns for themselves and the subject over the risk of HIV infection. This was demonstrated through comments such as "he was afraid of me
catching, getting AIDS somehow and bringing it home and him having to deal with it."

It appears that regardless of how specific the institutional information is regarding HIV transmission, the fears of a husband confound the subject's ability to separate this information from the "reality" presented by a significant other. It is as a result of this conflict that the socialization experience gained through university and hospital becomes inter-connected to the socialization she receives through her family.

Alternately, the support of family members was also found to be important in how subjects perceived the potential for risk of contracting HIV, as well as in their views of nursing as a profession. Support most often surfaced in the form of verbal encouragement by some family member, but additionally occurred through overt behaviour of a significant other.

Peer Group and Fellow Students

In addition to the structural influences of the university and hospital on the socialization experience, socialization was augmented by the interactive experiences of students with fellow classmates and friends outside of the institutional setting.

Contrary to the general hypothesis that AIDS would have more relevance with fellow classmates than it would have with friends outside, the issues surrounding AIDS were more
commonly discussed with friends outside of the institutional setting than within. Discussions that subject's had engaged in with friends outside of the university setting revealed themes of discrimination expressed by friends in statements such as homosexuals and I.V. drug users "deserve to get AIDS", or portraying those infected as having done "something against GOD". Findings from this study show that many of the subjects were ambiguous concerning their feelings and attitudes about AIDS. This seems to suggest that in looking at the socialization experience of these students, particularly as it revolves around an issue that has ties to the moral agendas of others outside of the institutional environment, the interactions with friends also impacted on the socialization process.

Within the subjects' peer group in the university setting, findings from this study show that there appears to be a negotiation amongst students concerning specific procedures and tasks that are perceived to be problematic for the risk of contraction of HIV. As mentioned earlier, the married-single distinction made by these students seems to again suggest the interconnectedness of the family to the socialization experience, pertaining specifically to the fear of contraction of HIV, and knowledge and attitudes about AIDS.

One of the more interesting findings that surfaced in the area of peer groups was a theme labelled "distancing". 

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For many of these students the issues surrounding AIDS were conceptualized to be outside their sphere of reference, with perceptions such as "Like if I was in London [Ontario]", "we're not in that part of nursing" or "I plan to work in Chatham" as justifications for this distancing principle. This is of particular interest insofar as the seropositivity rate in Windsor is considerably higher than it is in London. This distancing becomes a shared reality through interaction with other students and the viewpoint of one becomes solidified by the reaffirmation of another.

The Media

In the short history of AIDS in western society the coverage by the media from a variety of angles has amounted to what might be called a "barrage". News reports, day-time soap operas, commercials, newspapers, magazines talk shows and documentaries have all contributed to the "presentation of AIDS" to the masses. It would be hard to imagine anyone in touch with some form of medium not having been exposed to AIDS and issues connected to it.

Impact of the media on the socialization experience for nursing students was hypothesized to be a significant factor, which was supported by the data. The influence of the media impacted on the knowledge these students had about HIV modes of transmission, as well as contributing to the formation of attitudes and beliefs these students had about those infected. Presentations of AIDS in a non-factual
situation, as in the case of dramas depicting "real life" situations, showed the influence to be a positive one. Students related feelings of anger and frustration at the way PWA's were treated in these dramas, with phrases such as "I thought what stupid jerks", or "I can't see people's attitudes" characterizing these sentiments.

Alternately, the media have also contributed to the understanding of risk factors associated with HIV; with the knowledge of risks associated with bodily fluids clearly defined, certain procedural precautions adopted by nurses in the care of PWA's all being examples. These aspects of media coverage of AIDS have contributed to the socialization experiences of these nursing students. However, it would be remiss to suggest that media coverage has been only positive.

As one might recall from the introduction to this paper, much of the early media coverage was depicted as "sensationalistic" and conducted in an irresponsible manner. The findings from this study suggest that this "media hysteria" has also played a role in the construction of AIDS for these students. Subjects in this study claimed to be uncertain about the trustworthiness of information presented in the media. Phrases such as "you wonder if they really know" or "there's not really, I don't think there is from what I've heard, [virus] in urine", characterized this uncertainty.
The impact of the media on the socialization experience of these nursing students pertaining to AIDS was documented in all but one interview. Clearly the media have played a significant role in the social construction of AIDS for these students.

The Institution

Findings regarding the role that the institution plays in the socialization of students supported past research in areas such as: the acquisition of skills, the learning of roles and the implementation of an ideological framework that fits these skills and roles into the larger context of what the profession is attempting to achieve.

For the most part, these students were able to recognize procedures from the perspective of presumed risk, as they pertained to AIDS, and incorporate one or more precautionary measures to reduce the risk of virus transmission. But what was of particular interest was the fact that even in a procedure that was hypothesized to be of "low anxiety", such as "assisting the client to a sitting position", overall consensus was not reached. Although ten out of eleven subjects stated that carrying out this procedure on someone with AIDS would not change the way it was performed, one subject stated that although she knew that AIDS was not supposed to be transmitted by casual contact she would "still feel awkward doing this on someone with AIDS". When asked where his concern came from he stated
"probably a lot of it from the media". This was presumed to be an example of the "lay reality" of AIDS coming into conflict with the "nursing perspective" of AIDS.

This suggests that during the process of socialization into a profession such as nursing, at least during the initial stages, information that is transmitted outside of the institutional environment filters in and is taken into account by the socializee as they actively construct and interpret their socialization experience.

Adding to the interpretive aspect of the socialization experience, findings from this study support the notion that students are not simply "tabula rasa" that the occupation or profession etches upon but rather are active participants in their socialization experience. Thus the trustworthiness of information passed on to the students from the institution was raised by one subject, who stated that she trusted information the school had given her on AIDS, while another subject stated that she was not at all certain that she was safe from infection in spite of what she had been told.

Questions that have been raised earlier regarding the notion of full "internalization of values" suggested by research reviewed earlier are further supported by the present findings. At this stage in their careers, the conflict in the internalization of professional values surfaced through the dissonance expressed by students toward how they "think" they might feel caring for a FWA versus how
they thought the institution expected them to act. Phrases such as "They don't want anybody going in there and saying 'Oh my goodness' you know" or "Just because they have a disease that you don't like you don't treat them bad", summarize the characterizations of this dissonance felt by subjects in discussing the imagined case of caring for a PWA. Judging by what has been found concerning the attitudes of practising nurses toward AIDS and those affected by it, and supplemented by the findings of this study regarding the full "internalization of values", there is little evidence that lay attitudes ever become totally disengaged during the process of professional socialization.

The hospital was secondary to the university both in terms of information transmission and assimilation of ideological tenets. This was due in part to the relatively little time these students had actually spent in the hospital compared to time spent in the university.

Although the influence of reference others in the hospital was significant in areas such as learning about precautionary measures taken to avoid contraction of HIV, this influence was far less significant in areas where behaviour and attitudes toward clients or patients were concerned. Practising nurses had not made a significant impact as positive role models for these student nurses, and the only case where a student had used the behaviour of a
practising nurse as a model to evaluate her own attitudes, proved to be an instance of negative role modelling.

Other Sources in the Construction of AIDS

Past research in the area of socialization of nursing students has clearly shown the impact of structural variables on the process of becoming a professional. One area that has been omitted in past research, but emerged in the present study, albeit unanticipated, was the influence of agencies in the organizational environment and of nurses in organizations outside the university and hospital on the socialization experience of students.

The construction of AIDS for these students involved interactions with, and observations of such nurses, through experiences of donating blood, enrolling in a first aid or CPR course or having a test for HIV taken through a local health unit.

Given the fact that the enrolment in a first aid course and CPR are mandatory requirements of the school of nursing program, these agencies offering these programs were essentially extensions of the institution and its role in the socialization of its members.

The socialization experience for nursing students ultimately involves the learning of a particular role, so it is not surprising that the behaviour and attitudes of nurses outside of the organizational context had particular
significance for these students, given the assumption that "becoming" a nurse would be at the forefront of their minds.

Having discussed some of the structural features that are involved in the socialization process for nursing students, augmenting past research with a variety of other structural factors that contribute to this process on a macro level of analysis, one can now turn to a discussion of how these structural factors actually work on the individual, or micro level, of analysis.

The Contributions of Symbolic Interactionism

The interviews that were conducted with these nursing students revolved around having each student imagine performing a variety of familiar tasks on a person with AIDS. The findings of this study clearly show that these students responded to questions about their feelings, imagined patterns of action and attitudes, based on their definition of the situation and the roles that were associated with these definitions. Clearly, from the variety of responses or definitions of situations these students offered, the socialization process is not simply a "mixmaster" process, where structural elements are thrown in and blended together, producing a professionally socialized individual. Rather, the socialization process on the individual level rests quite definitely on the variety of life experiences and interactions these students have had with significant others during both primary and secondary
socialization. It is through this process that these definitions become meaningful.

In defining a given situation as it related to performing a familiar nursing procedure on a PWA, such factors as the condition of the client, past interactions they had had with significant others in their families, interactions with friends both within nursing and outside, interaction with practising nurses and professors, all factored in to how they came to define the situation and their role within it.

The implementation of AIDS to the substantive part of the interview process was fruitful, insofar as it highlighted the problematic nature of the learning of institutional roles for the individual. In a number of interviews there was recognition by the subjects of the "normative" behaviour expected by the institution in the case of treating someone with AIDS, while at the same time acknowledgement was made of the fact that these expectations were somewhat problematic.

The methodological implications of symbolic interactionism for the present study were paramount to understanding the socialization process for first year nursing students. It was necessary for the researcher to try to understand this process from the viewpoint of the student through an interactive process, thus making a survey type design insufficient for these ends.
The Contributions of Phenomenology and a Sociology of Knowledge Perspective

For the structural functionalist, the socialization of individuals into professions is viewed from the vantage point that individuals enter a professional institution and over the course of the program, with certain structural variables being present, they come out of this professional program as socialized professionals.

This is a useful perspective for understanding general properties of the socialization experience, but it offers very little insight into why not all individuals are socialized to the same degree, or why individuals react to these structural variables as if they have some meaning to them.

In view of the limited nature of a purely structural explanation for the socialization of individuals into professions, phenomenology and a sociology of knowledge approach attempt to reconstruct how individuals define situations and respond to them based on the meaning they attach to them.

Findings from the present study show that in defining the situation of possibly caring for a PWA, these students drew on recipe knowledge, such as the presence of bodily fluids presenting a risk factor, incorporating protective devices such as gloves, masks, gowns and mouthpieces in determining what conduct would be appropriate on their part,
or that a PWA would, by the definition of the disease, be in some type of isolation category.

The "reality" of AIDS for these nursing students was not homogenous, but rather depended largely on the variety of life experiences they had had and the meanings they had attached to these individualistic experiences and the significant others encountered within these experiences.

The degree or character of secondary socialization for these students was apparent through the use of role-specific vocabularies, such as "isolation, reverse-isolation, immuno-incompetent, glucose tolerance tests", which were all indicators of health specific language.

The social construction of AIDS for these nursing students clearly involved a dialectical process whereby significant others in their lives, or principal agents, served to reinforce certain assumptions they had about the nature of social life, while at the same time having their subjective reality modified by peripheral others in their lives, or the chorus, through the process of interaction, or conversation.

AIDS clearly presents different realities to different individuals. The fact that the bases of certain aspects of these realities are connected to issues embedded in values transmitted during primary socialization that are harder to modify, the person's social location and life experiences,
clearly puts in jeopardy the ability of the institution to socialize any individual totally.

From what has been witnessed in studies about health care professionals and their attitudes toward persons with AIDS, institutional or professional socialization has not been able to fully dislodge some of the intrinsic moral values that these professionals have concerning those groups most commonly associated with the virus.
CONCLUSIONS

This research has sought to make a contribution to the general understanding of professional socialization processes, specifically illuminating this process as it relates to nursing students at the entry level of their programme.

Research generated to date regarding the professional socialization of individuals has been useful to a point, but has totally ignored the entry phase of nursing students during the process, and has treated the abstractions contained in socialization almost as independent phenomena that can be studied as part of an "objective" world.

Structuralist propositions that have been generated regarding socialization are of paramount importance if in fact they truly describe consistencies in the process that are representative of individuals engaged in becoming professionals. Failing this, these propositions can only be regarded as very general parameters that outline broad properties describing how socialization occurs.

Apparently by the abundance of quantitative-structurally oriented research, there seems to be acceptance that a structuralist explanation truly does represent a sufficiently accurate picture of what socialization into professions involves, and how the process unfolds.
This research has shown quite conclusively, however that an understanding of professional socialization must include both methodologies and theoretical frames of reference that situate the research on the level of the actor. Only by doing so can one account for the vast amount of variability that exists in the socialization experiences of individuals and explain why general theoretical constructs are not exhaustively supported in a sample as small as the present one.

More importantly, it is only through interactive methodologies and theoretical perspectives such as the ones contained in the present research, that one can begin to understand that it is not structural factors alone that facilitate socialization. Rather, these structural elements are augmented by the complex interactive experiences and subjective meanings that individuals attach to their life experiences with a variety of significant others, which make the "subjective" socialization experience become an "objective reality".

On a substantive level, the findings of this research challenge the exclusivity of the institution in its role in the secondary or professional socialization of individuals into professions. Upon entering the institutional sub-world, the nursing student does not leave values and attitudes internalized from his or her primary socialization "at the door", as it were, but continually evaluates new information
and attitudes presented by the institution against these "deeper" values.

The inclusion of AIDS in the methodological considerations as a problematic case for both the student and the institution, elucidated the negotiation of reality that occurs when information or values espoused by the profession conflict with the comparatively "fixed" realities presented to the student during primary socialization. It is through this understanding of "reality construction" that we can surmise why practising nurses working in health centers, in spite of education to the contrary, still display prejudicial attitudes and behaviours toward groups of individuals infected with HIV that have been societally defined as "deviant". There is little evidence that lay attitudes ever become totally disengaged during the process of professional socialization.

On the structural level, there was an assumption that the socialization of nursing students occurred under the auspices of two interconnected structures, the university and the hospital. Although these are the general institutions that are primarily involved in the socialization of nursing students, findings from this study showed the importance of agencies in the organizational environment, and that nurses in agencies outside of the university or hospital are peripherally involved as well.
In summation, the socialization of nursing students into their profession and the internalization of values associated with this profession, require the presence of certain structural elements for this process to occur and to be successful. However it is far too simplistic to assume that it is only the presence of these structures that facilitate professional socialization. The success or failure of the process, as determined by the internalization of values, is inextricably connected to the interactive experiences of students with others in both the institutional and the lay world in which they are situated. It is through a "dialogue" between these two worlds and the meanings therein, that an understandable "reality" of AIDS and nursing emerges for these students.

Recommendations

While this research has enhanced our knowledge of the socialization experiences of nursing students in the entry level of their program and emphasized the importance of the dialectical nature of reality transformation between the world internalized during primary socialization and the sub-world of secondary or professional socialization, it has only scratched the surface. Given the emphasis of past research toward a structural explanation of socialization, this research has cast strong doubt on the sufficiency of broad concepts that have emerged from the above literature outlining what the process of socialization is all about.
The problematic nature of AIDS from the perspective of nurse and institution has brought to the forefront the tenuous nature of re-socialization into a profession, particularly where issues in the profession clearly cross over into realms where attitudes are more deeply rooted.

It is therefore felt that further research into the impact that other situational factors, including primary socialization, have in subsequent professional socialization is needed if we are to broaden our understanding of socialization on the individual level and concomittantly on the macro level of analysis.

Lastly, given the limited scope of the present research, it was impossible to fully examine the relationship between findings from the quantitative data and data from the interviews regarding homophobia and its possible impact on the nursing process.

Cursory comparison of data from the homophobia scale with data from the interviews did not reveal a clear link between levels of homophobia and the construction of the imagined AIDS scenario. Although more than half of the subjects were scored as homophobic, there was little evidence of homophobia during discussions of possibly performing these procedures on persons with AIDS. These differences run contrary to the literature on AIDS/homophobia and require further investigation.
Can a quantitative measurement of homophobia predict the behaviour and attitudes of an individual who may later on be in the position of interacting with homosexuals? Research aimed at answering some of these questions is advocated.
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APPENDIX A

Interview: Procedures Discussed

* See pages 880-881 on isolation in Potter and Perry

Domains (from Potter and Perry, 1985)

1. Body Mechanics
   - Assisting client to sitting position (734)
   - Transferring from bed to chair (736)
   - Range of motion exercises (738-745)

2. Administration of medications
   - Oral (824)
   - Mucous membrane [rectal] (855)
   - Subcutaneous/ intramuscular (834)

3. Promoting comfort and safety (hygiene)
   - Tepid sponging (948)
   - Giving a bed bath (942)
   - Male perineal care (952)

4. Physiological needs
   - Bowel elimination [enema] (1149)
   - Removing stool digitally (1115)
   - Cardiopulmonary resuscitation (1195)

5. Infection control
   - Specimen collection
     - Blood
     - Stool
     - Urine
Influences on "knowledge construction and attitude formation"

1. Primary group: parents and family.
2. Institution: School of Nursing, Professors.
3. Peer group: other nursing students.
4. Practising nurses, those during clinical training.
5. The media, television, magazines and newspapers, textbooks and journals.
6. Friends outside of nursing: boyfriends, girlfriends etc.
APPENDIX B

AIDS and the Nursing Profession

Conducted by Syd Strom, graduate student, department of Sociology and Anthropology, University of Windsor as partial fulfilment of the requirements of a thesis for a Masters degree.

The following section contains questions concerning demographics. Please place a check mark in the space corresponding to the appropriate alternative for you. All responses will be kept in strict confidence.

Questionnaire

1. What is your father's occupation?

2. What is your mother's occupation?

3. In what country was your father born?

4. In what country was your mother born?

5. What is your marital status?
   Single ___
   Married ___
   Separated ___
   Divorced ___
   Living with a partner of the opposite sex ___
   Living with a partner of the same sex ___
   Widowed ___
   Other, please specify

6. Do you have any children?
   Yes ___
   No ___

7. If yes, how many? ___

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8. What is your religion?
   Protestant __
   Catholic __
   Jewish __
   Greek Orthodox __
   Jehovah Witness __
   Muslim __
   Hindu __
   Sikh __
   Other, please specify ________________________
   None __

9. What is your parents’ combined total annual income
   approximately?
   Less than 20,000 __
   Between 20,000 - 29,000 __
   Between 30,000 - 49,000 __
   Between 50,000 - 69,000 __
   70,000 or more __
   Don't know __

The following section contains questions about your
attitudes towards AIDS. It is not a test, so there are no
right or wrong answers. Answer each item carefully and
accurately as you can by placing a number, as indicated
below, beside each statement in the space provided.

1. Strongly agree
2. Agree
3. Neither agree or disagree
4. Disagree
5. Strongly disagree

1. I would allow my child to attend school where I
   knew that there was a child with AIDS. __
2. I would attend a concert which was intended to
   raise money for persons with AIDS. __
3. Persons with AIDS deserve to die. __
4. Good people don't get AIDS. __
5. Persons with AIDS should not be allowed to work in
   restaurants.
6. People get AIDS because they are immoral. __
7. I would not object to working in an office where
   someone with AIDS worked. __
8. Persons with AIDS should be isolated from
   society. __
9. I would eat in a restaurant where someone with
   AIDS is eating. __
10. Having AIDS is not something to be ashamed of. __
11. I would feel comfortable working closely with a male homosexual.
12. I would enjoy attending social functions at which homosexuals were present.
13. I would feel uncomfortable if I learned that my neighbour was homosexual.
14. If a member of my sex made an advance toward me I would feel angry.
15. I would feel comfortable knowing I was attractive to members of my sex.
16. I would feel comfortable being seen in a gay bar.
17. I would feel comfortable if a member of my sex made an advance toward me.
18. I would be comfortable if I found myself attracted to a member of my sex.
19. I would feel disappointed if I learned that my child was homosexual.
20. I would feel nervous being in a group of homosexuals.
21. I would feel comfortable knowing that my clergyman was a homosexual.
22. I would be upset if I learned that my brother or sister was homosexual.
23. I would feel that I had failed as a parent if I learned that my child was gay.
24. If I saw two men holding hands in public I would feel disgusted.
25. If a member of my sex made an advance toward me I would be offended.
26. I would feel comfortable if I learned that my daughter's teacher was a lesbian.
27. I would feel uncomfortable if I learned that my spouse or partner was attracted to members of his or her sex.
28. I would feel at ease talking with a homosexual person at a party.
29. I would feel uncomfortable kissing a close friend of my sex in public.
30. It would not bother me to walk through a predominantly gay section of town.
31. It would disturb me to find out that my doctor was homosexual.
32. I would feel comfortable if I learned that my best friend of my sex was homosexual. 
33. If a member of my sex made an advance toward me I would feel flattered. 
34. I would feel uncomfortable knowing that my son's male teacher was homosexual. 
35. I would feel comfortable working closely with a female homosexual. 
36. Babies born with AIDS should be held as much as healthy babies. 
37. People who have contracted AIDS through a blood transfusion need our moral support. 
38. Intravenous drug users who contracted the disease from a dirty needle have only themselves to blame. 
39. Homosexuals who have contracted AIDS from sexual contact are getting what they deserve. 
40. It doesn't matter how the disease was contracted, all people afflicted with AIDS need our compassion. 

Thank you for taking the time to complete this questionnaire, your effort is greatly appreciated.
VITA AUCTORIS

Sydney Alan Strom was born in Toronto, Ontario in 1956. He attended both public and high school in Toronto, and upon completion, was hired in a management capacity with CBS records of Canada.

Following four years employment with CBS, he spent the next few years in similar management positions with both Dylex and Imasco Ltd. of Canada.

At the age of twenty-five he decided to embark on a post-secondary education and enrolled at the University of Toronto. After one year there, he transferred to the University of Windsor, where he completed a four year honours degree in sociology.

In the fall of 1988, he was accepted into the Faculty of Graduate Studies and Research at the University of Windsor. Having completed one year in the graduate programme, he concurrently entered the Faculty of Education at the University of Windsor, where he received his Bachelor of Education Degree (Primary-Junior) in the Spring of 1990.

Having completed his degree in education, he returned full-time to the Faculty of Graduate Studies and Research to complete his Master of Arts degree, which he received in the fall of 1990.

Sydney is currently employed as a teacher with the Windsor Board of Education in the Public school system.