

A DESCRIPTION OF TEACHERS' BELIEFS ABOUT
STUDENTS WITH AIDS USING Q METHOD

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STUDENTS WITH AIDS USING Q METHOD

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PREFACE

With the increase in the number of women of child bearing age with AIDS, and the improvement of medical interventions for those children already diagnosed with HIV/AIDS, there will be a rise in the number of children with AIDS in our public schools. This study was conducted to explore the beliefs of teachers toward those students. The specific objectives of this study were to determine: (1) what types of beliefs teachers have toward students with AIDS; (2) if there are differences in the beliefs of male and female teachers; and (3) if there are differences in the beliefs of special education and regular education teachers.

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CHAPTER 1

INTRODUCTION

In the early 1980's our country observed the beginning of one of the most devastating social problems to face us, the epidemic of infection with the human immunodeficiency virus (HIV) which leads to acquired immunodeficiency syndrome (AIDS). The starting point in our nation was the spring of 1981 when men in large metropolitan cities began to die horrific deaths from incapacitated immune systems. By June, the fatality rate was at 60%, with over 450 men dead and an average of one new case being reported to the CDC daily ("Current Trends in AIDS," 1983).

It was not until 1983 that researchers and doctors found the virus responsible and attached a name to this disease, AIDS. Currently, AIDS is the fifth leading cause of death for people between the ages of 25 and 45 in the United States ("Deaths from AIDS," 1998), the sixth leading cause of death among 15 to 24 year olds ("Trends in Risk Behavior," 1998), and the ninth leading cause of death for children ages one to four (Kascht, 1993). It appears that as we near the 21st century, "plague" is the principle metaphor by which the AIDS epidemic is understood in the United States (Sontag, 1989).

Acquired Immune Deficiency Syndrome is the suppression of the body's normal ability to fight off disease by attacking the body's immune system. It is a retrovirus, meaning it can live in its host for a long time without causing any overt manifestations of the illness. It is detected either through viral load, a recently

discovered test that measures the level of the AIDS virus in the bloodstream, or through the presence of antibodies in the blood. These antibodies show up about 3 to 6 months after contracting the virus, but, in rare cases, it can take up to one year to detect them (Ford & Russo, 1997).

A person with HIV is not synonymous to a person with AIDS. Rather, AIDS is the final stage of this immune system decline. What differentiates AIDS from HIV positive status is one or more of a number of specific infections, such as; Karposi's Sarcoma (a distinct cancer), Pneumocystis Carinii (a rare type of pneumonia), a lung condition called lymphocytic interstitial pneumonia which can develop in children, and/or a CD-4 (T-cell) count of 200 or less, (with the average person's count at 800-1000). Contrary to what many believe, people do not die of AIDS; they die of the diseases associated with its destruction of the immune system. They die of diseases others might consider insignificant illnesses, but take advantage of the weakened immune system in persons affected with AIDS.

Prevalence

AIDS has been one of the fastest growing diseases in today's society. In 1981 there were only a few reported cases in the United States. By October 1996, there were over 548,000 cases reported in the United States, just under 10,000 of those are people under the age of 20 (Center for Disease Control, 1996). It has been estimated that over 1 million people in the United States have been infected, that means that 1 in every 250 people could be infected with HIV, 1 in every 100 males and 1 in every 800 females (LeRoy, Powell, & Kelker,

1994).

The cumulative number of AIDS (these statistics do not include HIV cases) cases in our country reported to the Center for Disease Control as of June 30, 1998 is 665,357. Of those, 657,077 are adult and adolescents; 554,048 are male and 104,028 are female. Through the same time period, 8,280 cases were reported in children under the age of 13. The total death count attributed to AIDS in our country is 401,028 (60%) of which 4,811 are children under 15 years of age (CDC, 1999).

In the United States pediatric cases of AIDS (children 13 and under) have risen dramatically, with 232 reported cases in 1984, to over 7,000 cases in 1995 (CDC, 1995; Jessee, Nagy, & Poteet-Johnson, 1993). Considering that some children will be asymptomatic for years, and thus go unreported, it is believed that for every child with AIDS, another 2 to 10 are possibly infected (Kascht, 1993). As of 1997 the number of children living in the United States with HIV/AIDS is more than 12,000, with nearly 40% of those school age (Kowalski, 1997).

A major reason of the suspected increase of pediatric cases is the increased rate of heterosexual transmission. Women are the fastest growing group of people with AIDS (Sims, 1998) and as the female AIDS infected population increases, so will the number of children being born with the disease. By the year 2000, it has been estimated in research conducted by Jessee et al. (1993) that there will be 5 to 10 million infants born worldwide infected by HIV

and an estimated 82,000 children will be left motherless by the AIDS epidemic (Kascht, 1993).

When considering that the average latency period between HIV infection and the AIDS diagnosis is 10 years, it is estimated that in the U. S. one in every five cases of persons in their twenties diagnosed with AIDS were infected as adolescents (Rotheram-Borus, Jemmott, & Jemmott, 1995).

American teenagers are engaging in behaviors that put them at risk of acquiring HIV infection, leading to AIDS. A survey conducted by the Center for Disease Control entitled Youth Risk Behavior compiled information from students still attending high school, grades 9-12. As of December 1997: 38%, 42%, 49% and 61% of 9th, 10th, 11th, and 12th graders, respectively, reported having had sexual intercourse. 12%, 14%, 16% and 20% of 9-12 graders, respectively, reported having four or more sexual partners, and 24%, 29%, 37%, and 46% of the same respective groups reported to be currently sexually active ("Trends in Risk Behavior," 1998). This report does not include children in those age groups that are not in school, which places them at a higher risk of dangerous sexual behavior.

In 1991, HIV infection/AIDS was the sixth leading cause of death among 15 to 24 year olds in the United States (Bellenir & Dresser, 1995). The number of AIDS cases reported per 1000 teenagers in the United States is 2.33, while only .75, .20, and .28 in France, Germany, and the Netherlands, respectively (Mann, 1999). Between July of 1988 and July of 1989, AIDS cases among 13-19 year olds increased by 43% (Center for Population Option, 1990) and has multiplied

more than 16 times since June of 1989 (Sims, 1998). Every minute, five young people around the world are infected with HIV with half of all new cases of HIV in the United States occurring among young people under the age of 25, one quarter of which are between 13 and 21 (Brown, 1999). Teenagers and women account for 44% of those cases (Sims, 1998). In the United States, 62% of Adult and Adolescent AIDS cases and 58% of Pediatric AIDS cases have died through December of 1997 (Oklahoma State Department of Health, 1998).

On a positive note, there has been a 15% overall decrease in AIDS cases since 1997 ("Trends in Risk Behavior," 1998). The decrease has been seen among all groups, with an 8% decrease for women and a 16% decrease for men. The decreases are primarily due to new drug therapies. The death rate from AIDS related illnesses has declined for the past two years, with a 42% decrease between 1996 and 1997 (Center for Disease Control, 1998). This decline has moved AIDS from being the 8th overall leading cause of death in the U.S. to the 14th. In human terms, the decline means that about 16,000 people are alive today who would have died in 1997 had the mortality rate continued as it had been in previous years (Brown, 1998).

Oklahoma AIDS Statistics

In the state of Oklahoma, as of March 31, 1999, there were 2,134 persons that are HIV positive and 3,243 reported with AIDS. Of this number, 78 are children between 5 and 19 with HIV and 27 have AIDS in the same age group. Pediatric (<13 years) statistics indicate that Hemophilia/Clotting Disorder, Mother with/At Risk for HIV Infection, and Risk Not Identified, accounted for 21%, 64%,

and 14% of the HIV cases, respectively. In the same categories 24%, 53%, and 7% account for AIDS cases in this age group, with the addition of 3% AIDS cases from blood transfusions. Statistics for adolescent exposure are not separated from those of adult cases in Oklahoma. The breakdown for adults is as follows: HIV: Men Having Sex With Men, 48%; Injecting Drug Use, 13%; Combined, 10%, Hemophilia/Clotting Disorder, 0%; Heterosexual Contact, 10%; Blood Transfusion, 1%; and Risk Not Identified, 18% (Oklahoma State Department of Health, 1999).

The same categories for AIDS cases is: 61%, 11%, 13%, 1%, 6%, 2%, and 6%, respectively. The state of Oklahoma began recording data on AIDS in June 1983, and for HIV in June 1988; since that time, 1,855 people in Oklahoma are known to have died from AIDS associated diseases (Oklahoma State Department of Health, 1999).

With the number of infants and young children in our country carrying the AIDS virus, schools across our nation will have increasing responsibilities in meeting the needs of these children. With over 85,549 women currently diagnosed in the United States with AIDS, 84% of child-bearing age (13-44), the appearance of HIV affected children in our schools will continue to escalate (Center for Disease Control, 1998).

As the numbers of children with HIV/AIDS who attend our schools increase, it is crucial that teachers' interactions with, attitudes toward, and knowledge about these students are known. Information about teachers' beliefs toward students infected with HIV/AIDS could aid in the development of professional

practice in which all students are treated equally. The purpose of this study is to assess the beliefs and values held by teachers toward students with HIV/AIDS.

Stigma

Public opinion has helped to form our society's response to AIDS. Besides being concerned about the health aspects of prevention, Americans are increasingly having to react on an individual basis to persons with HIV/AIDS in our neighborhoods, workplaces, and schools. The attitudes of people regarding victims of HIV/AIDS cannot be discussed without an indepth investigation into the stigma surrounding this disease. AIDS stigma is as much an epidemic as the disease itself (Herek & Glunt, 1988) and how teachers allow that stigma to influence their attitudes toward students with HIV/AIDS will have a major impact on their students' attitudes toward this disease.

The meaning of the term "stigma" has evolved over the years from the ancient Greek's definition referring to a bodily mark or brand, to the more contemporary usage as an undesirable or discrediting differentness (Pryor & Reeder, 1993). What remains unchanged is the phenomena of social rejection that stigmatized people can experience leading to prejudice and discrimination. The stigmatized person, as described by Jones, Farina, Hastorf, Markus, Miller, and Scott (1984), is seen as flawed, blemished, discredited, or spoiled in some way. This "mark" initiates a process that sets up barriers to interaction and intimacy. Therefore, a "normal" person may feel repelled by or try to avoid the stigmatized person. In few circumstances is this stigmatization more apparent than when associated with persons who are afflicted with Human

Immunodeficiency Virus or who have been diagnosed with Acquired Immune Deficiency Syndrome.

Stigma Associated with AIDS

The stigma that surrounds persons with HIV/AIDS is well documented (Crandall, 1991; Crandall & Coleman, 1992; Kelly, St. Lawrence, Smith, Hood, & Cook 1987; Range & Starling, 1991). Crandall and Coleman (1992) further delineate this stigma into two separate components. The first is the social stigma that comes from the association with already stigmatized groups, i.e. homosexuals and intravenous drug users. In North America the majority of those afflicted with HIV/AIDS are in one of those groups, even though the heterosexual population has steadily seen increases in the disease. This type of stigma is labelled as "tribal stigma," (Goffman, 1963) the mark or fault afflicting the members of a social group. The second type of stigma Crandall and Coleman described is attached to persons with HIV/AIDS as it is viewed from the aspect of a deadly contagion. This is because illnesses represents a limitation of our body, so the illness itself becomes stigmatizing. Serious or fatal illnesses often take on a symbolic meaning as well (Sontag, 1978), and because they are stigmatizing we tend to avoid people with terminal illnesses. The resulting social rejection that people may experience from their HIV/AIDS status can lead to anxiety, depression, and low self-esteem (Birenbaum, 1970; Crandall & Coleman, 1992; Taylor, Lichtman, & Wood, 1984). Stigma not only disrupts the emotional stability of the person, but it interferes with the normal process of relationships causing the stigmatized person and those who interact with him/her

to feel tense, awkward, and embarrassed (French, 1984; Kleck, Ono, & Hastorf, 1966).

Teacher Beliefs and Attitudes

The beliefs that teachers' hold influence their perceptions and judgements, which in turn affect their behavior in classrooms (Pajares, 1992). Beliefs like attitudes are often expressed in actions (Allport, 1954) and teachers' attitudes play a crucial role in a communities acceptance or rejection of the individual affected with HIV/AIDS and the situation he/she is in (Bruckner, Martin, & Shreeve, 1988). Attitude refers to the position an individual possesses and harbors about objects, persons, groups, or institutions (Sherif, Sherif, & Nebergall, 1965). Having an attitude means that the individual is no longer neutral; he/she is either for or against, positive or negative, toward the object of his/her attitude. The attitude one holds predicts the behavior that they will show, because once this favorable or unfavorable value is attached to the object, individual, or group, the person holding the attitude relates to them in a selective way. Attitudes are inferred from characteristics and consistent modes of behavior over a span of time (Campbell, 1950; Sherif, 1948: Sherif & Cantril, 1947; Sherif & Sherif, 1969).

In 1992, a study investigated the attitudes of special educators concerning students with HIV/AIDS (Evans, Melville, & Cass, 1992). The study concluded that 81% of the participants said they would teach students with HIV/AIDS, compared to a 1989 study by Peach & Reddick that found only 26% of general education teachers would teach these students. What wasn't determined was if

the reluctance to work with a student having HIV/AIDS was due to the difference in training between general educators and special educators, attitudes toward persons with HIV/AIDS or, attitudes toward the fear of a contagion?

Few studies have been conducted dealing with teachers' susceptibility of contracting contagious diseases from students, even though elementary students in particular frequently go through periods of contagious disease such as chicken pox, measles, colds, flus, etc. One such study (Gillespie, Cartter, Asch, Rokos, Gary, Tsou, Hall, Anderson, & Hurwitz, 1990) dealt with the contraction of the human parvovirus B19 in an elementary school and day-care in which 58% of the school and day-care personnel had evidence of the B19 infection. This study commented that the only identifiable risk for these personnel to be infected was their occupation due to the prolonged close contact with infected students. Could the fear of contagion then be a factor for teachers working with students having contagious diseases?

Teacher Bias/Prejudice

Teachers are socialized in the same society that produces others with prejudicial or biased attitudes. Therefore, it is logical to assume that teachers also hold some degree of prejudice toward individuals or groups. The significant issue isn't whether teachers are prejudice or bias-free, but whether that prejudice or bias effects their functioning in the instructional process, and, in turn, the educational experiences of their students. Teachers feel differently about different students in their classrooms (Jackson, Silberman, & Wolfson, 1969).

These discriminative attitudes are then associated with differential teacher behavior toward those students (Silberman, 1969).

Trying to define prejudice is a difficult undertaking, because as with stigma, there is no one definitive definition. Allport (1954) defined prejudice as "an averted or hostile attitude toward a person who belongs to a group simply because he belongs to that group and is therefore presumed to have objectionable qualities ascribed to the group" (p. 7). Pettigrew (1971) describes prejudice in both cognitive and affective domains as an effective, categorical mode of thinking involving rigid prejudgment and misjudgment of groups of people. Regardless of the definition subscribed to, the common characteristics are negative attitudes generalized to group members, preconceived preferences, unreasonable and irrational bias, and judgements formed prior to or in disregard for known facts (Gay, 1979). Prejudice does not limit itself to individuals, but to groups as well, and since individuals belong to many groups, students being one, it would seem applicable that teachers may hold some type of prejudice or bias as well.

Gay (1979) theorized that the attitudes teachers hold about their students and how they relate to them on an interpersonal basis is more important in making a difference in the school lives of these students than what is formally being taught through the curriculum. Teachers' attitudes, values, beliefs, and behaviors create a psychological framework in which teaching and learning occur. If that framework is filled with negativism about a student's worth or ability, other events occurring in the classroom may be affected.

Significance of Study

The literature review has suggested that persons with HIV/AIDS are:

1. stigmatized because of the disease itself (Herek & Glunt, 1988; Katz, Hass, Parisi, Astone, & McEvaddy, 1987; Pryor & Reeder, 1993; Rozen, Markwith, & Nemeroff, 1992);
2. further stigmatized if they are associated with an already "shamed" group (Goffman, 1963; Herek & Glunt, 1988; Johnson, 1987; Pryor & Reeder, 1993);
3. often treated with less compassion and consideration than others with life threatening disease (Bailey, Reynolds, & Carrico, 1989; Kelly, St. Lawrence, Smith, Hood, & Cook, 1987);
4. surrounded by an atmosphere of fear because of the lack of knowledge of others (Chaiken & Darley, 1973; Peach & Reddick, 1989); and
5. subject to uncomfortable and decreased personal interactions (French, 1984; Gruman & Sloan, 1983; Gussow & Tracy, 1968).

The number of children with HIV/AIDS in, or entering into our public school systems is rising. The beliefs and attitudes of teachers toward persons with HIV/AIDS may impact their interpersonal relationships with these students. This study is an exploration of those beliefs. Specifically, would a teacher's knowledge of a student's HIV status effect their attitude toward, or opinion of, that student? Additionally, would the teacher's knowledge of the mode of contraction of the virus affect their beliefs, or even produce bias or prejudice toward the student?

Statement of the Problem

Students may be stigmatized in the eyes of teachers by the labels of HIV/AIDS. This stigma may also extend to teacher's perceptions of these students. Differential perceptions may change the teacher's views of students with HIV/AIDS. Males and females respond differentially because humans respond differently based on gender. Teachers in various disciplines often

perceive students differently; special education teachers tend to be more supportive and adaptive and perhaps less critical to the needs and characteristics of students than are general education teachers.

Research Questions

The knowledge, beliefs, and attitudes that the teacher of a student with AIDS holds toward that student can have a profound influence on the student's acceptance by his/her classmates, school, and community. Negative attitudes or beliefs that teachers hold toward students affect the expectations the teacher has for that student (Salvia, Clark, & Ysseldyke, 1973). If the teacher holds a personal bias toward a student's choices or lifestyle, those biases can effect teacher-student interactions and interrupt the learning process. Through interviewing teachers about their knowledge, concerns, beliefs, and opinions toward students with AIDS, an instrument was created allowing teachers to rate their own feelings regarding students with HIV/AIDS. The data collected with that instrument was then analyzed using Q-method to discover the perceptions of teachers toward these students. The exploration of the beliefs of teachers toward students with HIV/AIDS is a subjective undertaking, therefore the method chosen for this study needed to allow for the review of the introspective opinions of teachers regarding the issue of students with HIV/AIDS.

Q-method is designed as a scientific study of a person's communication of his or her point of view. The purpose of this study is to examine the beliefs, values, and personal feelings that teachers have regarding students with HIV/AIDS using Q method. The research questions therefore are:

1. In what ways do teachers perceive students with HIV/AIDS?
2. In what ways do the types of beliefs concerning students with HIV/AIDS differ among males and females?
3. In what ways do the types of beliefs concerning students with HIV/AIDS differ among general educators and special educators?

CHAPTER II

REVIEW OF RELATED LITERATURE

The phenomena of social stigma is prevalent throughout our country. Just looking at a newspaper or listening to a radio report can demonstrate that fact. For example, a majorette is barred from performing in a football game because she is 1 1/2 pounds over the weight guidelines given by the school's band director; a man paralyzed from the waist down is forbidden by his church diocese to marry his nurse, because he cannot consummate his marriage; a paraplegic writes that now she is one of the people her mother used to tell her not to stare at; or a black business man who moved into an affluent white neighborhood is picked up twice by the local police and questioned routinely about why he is in this neighborhood (Jones, Farina, Hastorf, Markus, Miller, & Scott, 1984). We cannot live our day-to-day lives without frequent contact with those individuals who deviate from the norm, whether the deviation is physical, mental, or social, the stigma associated with these individuals permeates the society we live in.

Definitions of Stigma

Stigma has been defined in a variety of ways, but one definition encompasses a multitude of situations, including those above, when it states that stigma is a "pattern of social prejudice, discounting, and discrediting, that an individual experiences as a result of another's judgements about his or her personal characteristics or group membership" (Herek & Glunt, 1993, P. 229).

The stigmatized person is often seen as one who is flawed, blemished, discredited, or spoiled (Jones, et al., 1984). Others see stigma as "a contaminant, it spoils the identity of its bearer and labels the person as inferior, dangerous, or bad" (Pryor & Reeder, 1993, p. 284). The stigma can loom so important in the defining of a person that it becomes a "master status" attribute that defiles the perception of all other aspects of the persons' abilities and character (Frale, Blackstone, & Scherbaum, 1990).

Dimensions of Stigma

The concept of stigma can be explained through critical dimensions or elements. Jones et al. (1984) theorized that there were six dimensions to stigma: concealability, course, disruptiveness, aesthetic qualities, origin, and peril. When examining the stigma of persons with AIDS, each of these dimensions comes into light. Therefore, they will be explored in some detail.

Concealability focuses on those characteristics of stigma that are obvious, such as being a paraplegic, while others are more hidden, such as having a psychiatric condition. Concealability is an important aspect of stigma because at one end of the continuum the stigmatized person may be in a situation where no one knows about the "mark" or, to the other extreme, in a place that they are always "on-stage" and having to contend with the social affects of it. Such is the case of a person with HIV status who, at the beginning of the disease, may feel and look perfectly healthy, but as the disease runs it's course, will show physical deterioration and maybe mental deficits as well.

It cannot be assumed however, that if the mark can be successfully concealed, it will have no effect on interpersonal relationships. In addition to the effects of hiding a mark physically, as with make-up, or clothing, the inner effects of guilt or shame might also surface. These feelings can be crippling and prevent appropriate social interactions (Jones et al., 1984). Some people will go to great lengths to hide what they perceive to be a mark, such as an epileptic who, even with medically controlled seizures, did not tell others of his "disease" (Kleck, 1968). A study by Freeman & Kassebaum (1956) discovered that a group of males who were illiterate were so ashamed of this mark that they wore thick lensed hornedrimmed glasses in hopes of appearing studious to others.

The marked person may also fear discovery; a very real concern of the HIV/AIDS infected individual. Just the deceptiveness of hiding such a secret may have adverse effect on the stigmatized person as well. These considerations, fear of discovery and anticipation of a disastrous social interaction were the mark discovered, could lead to the belief that the social interaction of a marked person will be effected even when others are totally ignorant of the stigmatizing condition.

Another of Jones et al.'s (1984) dimensions is course, "those features of marks that determine the pattern followed by socially degrading conditions over time" (Jones, et al., p. 36). The course followed by a stigmatizing condition will significantly influence interpersonal relationships (Freeman, 1961; Gussow & Tracy, 1968; Schwartz, 1957). Three characteristics that Gussow and Tracy (1968) felt would ultimately lead to the social rejection of a marked individual

dealt with course; the characteristics would be (1) progressively crippling over time, (2) nonfatal and chronic, and (3) appear to be incurable. Shears and Jensema (1969) concluded that whether or not the condition was remediable, in part, determined the acceptability of people with stigmatizing conditions. Irreparable conditions caused victims to be less acceptable. This finding would lead one to believe that a person with AIDS would be in a less acceptable position than other stigmatized people, considering that AIDS has no cure and is often fatal.

Disruptiveness is the property of a mark that “hinders, strains, and adds to the difficulty of interpersonal relationships” (Jones et al., p. 46). It goes to follow that the more visible and aesthetically displeasing the mark is, the more disruptive it will be in the interpersonal relationship. Other researchers investigating stigma, such as Vann (1976), used a factor-analytic procedure and found a factor they termed “antipathy and interactive strain.” This factor appears similar to Jones’ dimension of disruptiveness. Some of the most relevant studies investigating disruptiveness or interactive strain, dealt with mental disorders. Family members and even mental health professionals found themselves flustered, upset, and confused when first dealing with a person having a psychiatric disorder (Farina, 1981). It was hypothesized that the reason for the disruptiveness in the interactions was due to the fear of wild or unforeseen behavior. In the case of individuals with AIDS, the disruptiveness is likely more of a fear of rejection on the part of the affected individual and discomfort on the part of the others involved.

The fourth dimension to stigma is that of aesthetics. This refers to what is deemed to be beautiful or pleasing. This factor has also been called "proximate offensiveness" (Siller, Ferguson, Vann, & Holland, 1968). Regardless of the term used, it refers to the response of a person toward the stigmatized with rejection, revulsion, and disgust. This particular dimension surfaces frequently when the person with AIDS is homosexual or an IV-drug user (Conrad, 1986; Crandall, 1991; Stevenson, 1991).

Origin is the fifth dimension in Jones et al.'s view. This dimension considers how the mark began. The way the mark originates greatly influences how people react to the person bearing the mark. There is general agreement among researchers that the person is treated better by others if it is perceived that they are not judged to have caused the mark (Crandall & Moriarty, 1995; Freidson, 1966; Orcutt, 1976; Vann, 1976). Triplet and Sugarman (1987) demonstrated that the origin of AIDS is seen by many as controllable and, therefore can elicit high anger, low pity, and few indications of a desire to help them.

Peril is the sixth dimension of stigma that is described by Jones et al. (1984). Peril focuses on the danger posed by the stigmatized individual. It is in this dimension that AIDS education can make a significant difference on the reaction of others to the person with AIDS. Jones et al. (1984) theorized four possible sources of peril, or reasons, that the stigmatized individual may be feared. The first is that the person with the mark may remind others of their own vulnerability to illness and death. In a study conducted by Bishop, Alva, Cantu & Rittiman (1991) they suggested that when a disease is perceived to be

contagious this contagiousness becomes the focus of other people's attention and shapes their interactive behavior with the person infected.

The second possible source of peril as seen by Jones deals with what Goffman (1963) called "courtesy stigma." A courtesy stigma is shared by those who are close to the stigmatized person. Because people are often judged by the company they keep, family and friends of the person with AIDS may also become stigmatized. Goffman's (1963) "courtesy stigma" was illustrated in a study conducted by the American Civil Liberties Union (Hunter, 1990) which examined over 13,000 cases of HIV/AIDS related discrimination and found that 9% of those affected felt that it was the close association they had with an HIV infected individual that targeted them for discrimination. This social contamination may also spread to objects that are associated with the marked individual. Rozin, Markwith, and McCauley (1994) found that the stigma of being a murderer, being homosexual, having a serious accident, having tuberculosis, or having AIDS can be transmitted to objects that were once associated with the stigmatized person. Therefore, people have reacted negatively to sleeping in a bed or owning a car that has once belonged to a person carrying the above mark(s).

The third source of peril considers that some people may be tempted to engage in a stigmatizing lifestyle, such as prostitution, drug addiction, or homosexual relationships, i.e. to desire the "forbidden fruit." The last source is obligation, meaning that outside people, those knowing or seeing the marked person, may feel pressured into helping them out, even when they do not desire

to do so. This discomfort multiplies if they see the person's mark as persisting for an indefinite length of time. An ongoing mark may require a lengthy obligation instead of a one-time offer of assistance.

Other Factors or Variables of Stigma

The six dimensions of concealability, course, disruptiveness, aesthetic qualities, origin, and peril may be central to the theory of social stigma, but they are not the only factors or conditions that may affect the stigmatized or marked individual. One factor of stigma that may affect the severity of personal interaction is the kind or type of mark an individual possesses. For example, a study completed by MacDonald and Hall (1969) concluded that sensory disorders have a less drastic effect on interpersonal relationships than do mental disorders. In the same study it was also demonstrated that the marked individual may have varying difficulties of relationships relative to the factor of environment that the person is engaged in. In the case of HIV/AIDS, the person could have an understanding family with a strong support system, but a rejecting and fearful work environment.

The individual characteristics of the marked person may also be a factor in determining the ease of an interpersonal encounter. Whether the person is tall, short, fat, thin, has a nasal voice, their ethnicity, etc. may affect how others react in an interaction. This hypothesis was researched in an institution for the mentally disabled, and it was discovered that punishment was administered differently depending on the personal characteristics of the individual being punished (Farina, Thaw, Felner, & Hust, 1976).

The attributes of the nonmarked person may also be a variable which influences the relationship between the stigmatized individual and another. The role and prior experience of the non-marked person can influence the behavioral exchange. In a study conducted by Wright and Klein (1965) it appeared that people who come in contact often with those who are stigmatized, such as family and friends, are less affected by the mark. Contrastingly though, in a study linking AIDS to homophobia by O'Hare, Williams, and Ezoviski (1996), it was demonstrated that knowing and being around a homosexual person did not predict less fear of AIDS.

Finally, the situational circumstances under which the interaction occurs is another variable that may effect the stigmatized person's role in the interaction. Marked individuals can incite different feelings and often contradictory motives in others. They may make a person feel guilty, especially if it is known that they have been treated unjustly. Or sometimes they may illicit a feeling of contempt and animosity that precludes whether people care if they were treated unfairly or not. Such is often been the case in dealing with persons with HIV/AIDS. The level of stigma associated with a AIDS victim's sexual orientation is greater if the person is homosexual (St. Lawrence, Husfeldt, Kelly, Hood, & Smith, 1990). Further, unfavorable reactions have been demonstrated if the person is seen to have been personally responsible for their condition (Bailey, Reynolds, & Carrico, 1989; Crandall, 1991; Crandall & Moriarty, 1995; Leone, & Wingate, 1991). Interestingly, in the study by Leone and Wingate (1991) the participants not only responded more negatively toward homosexuals with AIDS than toward those

acquiring the disease through a blood transfusion, they also displayed more negativity to those using IV-drugs, than toward the homosexuals, thus demonstrating personal responsibility to be hierarchial in nature.

Stigma and Persons with HIV/AIDS

Stigma, and various reactions to it, is an intense consequence for people with AIDS. Persons with HIV/AIDS, especially at the beginning of the epidemic, were fired from their jobs, driven away from their homes, socially isolated, (Anderson, 1992; Bishop, Alva, Cantu & Rittiman, 1991; Herek, 1990; Herek & Glunt, 1988), and even forced out of school ("Board Votes", 1985). Persons with AIDS are seen more negatively than persons with cancer, cardiac conditions, and diabetes (Katz, Hass, Parisi, Astone, & McEvaddy, 1987). Several studies have investigated and concluded that, even in the health field, AIDS carries a more stigmatizing "mark." Nurses were the object of an investigation by Blumenfield, Smith, Milazzo, Serepian, & Wormser (1987); mental health workers by Knox, Dow & Cotton (1989); and primary care physicians (Gerbert, Maguire, Bleecker, Coates, & McPhee, 1991; Kelly, St. Lawrence, Smith, Hood, & Cook, 1987) all demonstrated avoidance and overestimation of casual contact with persons with AIDS. In a 1997 study of rural school nurses' attitudes toward AIDS and homosexuality, the investigators found that the school nurses most positive in their attitudes about homosexuals were less likely to have strong religious beliefs. Additionally, the nurses most positive toward taking care of a person with AIDS were older and more likely to feel their facility was prepared to handle the medical needs of the people affected (Yoder, Preston, & Forti, 1997).

AIDS related stigma may interact with preexisting stigma in complex ways. For instance, if a diagnosis of AIDS reveals a man's previously hidden homosexuality, a double stigma immediately results (Herek & Glunt, 1988). Being identified as a person with AIDS transforms a man from discreditable (secretly gay) to discredited (openly gay).

Individuals with HIV/AIDS may also be seen as having multiple types of stigma (Pryor & Reeder, 1993). In an early work of Goffman (1963) he describes three major types of stigma. The first type, an anathema of the body (e.g., obvious physical disfiguring), may be seen in the later stages of AIDS when the individual is often emaciated and may also have physical sores. He called the second type of stigma a character flaw. A character flaw may be seen in two of the behaviors of many HIV/AIDS infected individuals, IV drug use and/or homosexual orientation, which have been linked to moral or disgusting attributes (Conrad, 1986; Pryor, Reeder, Vinacco, & Kott, 1989). Numerous researchers have implicated biased attitudes toward homosexuals in the public's fear and negativity to AIDS and persons with AIDS (Anderson, 1992; Magruder, Whitbeck & Ishii-Kuntz, 1993; Trezza, 1994). Lastly, the association with many HIV/AIDS infected individuals with racial/ethnic minority groups (Croteau, Morgan, Henderson & Nero, 1992; Hutchinson, 1992) or the already stigmatized social group of gay man, provides a "tribal" categorization. The connection of HIV/AIDS to homosexuality has influenced how many people react to persons with HIV/AIDS, even when they are not homosexual (Pryor & Reeder, 1993). Already discussed is the stigma attached to the AIDS victim, the stigma attached to the

sexual orientation of the victim, and the stigma attached to objects having belonged to the individual. There are additional theoretical perspectives of stigma to account for the reaction to persons with HIV/AIDS which will now be addressed.

The idea of social contamination, also known as courtesy or tribal stigma, is seen by Rozin and Fallon (1987) as acquiring its reactions from the application of the tenets of sympathetic magic (Frazer, 1890/1959). These tenets, or laws, were first conceived to account for the magical practices and beliefs in traditional cultures. The first law is contiguity. This principle suggests that once something comes into contact with another thing, they will continue to influence one another. The second law is similarity. Similarity assumes that if two things are similar, then acting on one will influence the other. Relevant to the stigma attached to persons with AIDS, Rozin, Markwith, & Nemeroff (1994) discovered that clothing once worn by an individual with AIDS was felt to be contaminated, thus reinforcing the principle of contiguity.

A different view of stigma as it relates to individuals with HIV/AIDS is offered by Weiner, Perry, and Magnusson (1988). They argue that causal attributions can be important in reactions by others to individuals who are stigmatized. According to attribution theory, the perceived cause of the stigma should determine the reactions to the person, future expectations regarding the person, and other behavioral responses such as altruistic actions toward the person. Applying this theory then, people may contribute more blame for HIV infection to a homosexual who engaged in risky sex than to a child who was infected through

a blood transfusion. Pivotal to Weiner's analysis is the attribution of control. The homosexual may be blamed more for their plight than the child, having more control over their world than a child would. Other research studies support these findings. Reactions to those who experience sickness are mediated by the attributions people make about the cause of the illness (Schmidt & Weiner, 1988). Therefore, persons who do not contract AIDS through behavior such as homosexual intercourse or drug abuse are seen as "innocent victims" (Albert, 1986). This is exemplified in a *Newsweek* caption early on in the epidemic when a teenage hemophiliac and an infant with AIDS were described as "the most blameless victims" (Gelman, Abramson, Germaine, McAlevey, & McKillop, 1985), the opposite being a "blameable victim," that is, one who was infected with the virus through stigmatizing behavior. If victims are felt to have brought about their own illness, the reactions from others are less sympathetic to them (Meyerowitz, Williams, & Gessner, 1987).

The symbolic approach (Pryor, Reeder, Vinacco, & Kott, 1989) to understanding the stigma associated with HIV/AIDS suggests that AIDS has acquired a symbolic meaning in our culture. As a symbol or metaphor, AIDS may represent homosexual promiscuity, moral decadence, and the wrath of God for moral transgressions (Conrad, 1986; Krauthammer, 1983). Physicians who participated in a study utilizing open-ended thoughts such as "AIDS is like....," often tended to make derogatory comments such as "the wrath of God," "the plague brought to us by a minority of aberrant individuals," and "poetic justice, almost" (Norton, Schwartzbaum, & Wheat, 1990). In a survey by Johnson (1987)

seeking to find out how tolerant people were of those with AIDS, the results indicated that the most important factor leading to intolerance for those who have AIDS is a political/religious variable. Johnson (1987) hypothesized from his study that AIDS victims have become stigmatized by the association of their disease with a condition (homosexuality) which conservative religious fundamentalists consider abhorrent. The Reverend Fred Phelps, leader of the Westboro Baptist Church in Topeka, Kansas, is the centerpiece of a group whose religious beliefs epitomize the intolerance of the homosexual, with or without AIDS. A few years ago he took on Topeka councilwoman Beth Mechler, labeling her a “Jezebellian switch-hitting whore” because she questioned his claim about gay men engaging in sex in a park. He preaches to his congregation that “God laughs when homosexuals die” (Henderson, 1998).

AIDS can easily be exploited for ideological and political purposes because of its prevalence among already stigmatized groups. For instance, a Houston mayoral candidate joked that his solution to the AIDS epidemic was to “shoot the queers” (Shilts, 1987). The idea that AIDS is an ideological and political issue is further exemplified in the comments by Republican columnist Patrick Buchanan (1987):

There is one, only one, cause of the AIDS crisis—the willful refusal of homosexuals to cease indulging in the immoral, unnatural, unsanitary, unhealthy, and suicidal practice of anal intercourse, which is the primary means by which the AIDS virus is being spread through the “gay” community, and thence, into the needles of IV drug abusers [and to others]. (p.23)

Stigma by itself is a concept that only becomes substantive when a type of

reaction, whether it is interactive or avoidant, occurs. Whether interaction or avoidance occurs, those involved bring their own preconceived notions and personal history to the situation. Allport (1954) in his book the Nature Of Prejudice states that every event has certain aspects that cue us to bring a prejudgment into action. That prejudgment is composed of our attitudes, both positive and negative. Closely tied to stigma, prejudgment, and attitude, is the idea of prejudice. Several of the studies already cited have alluded to the prejudicial attitude that many people have regarding homosexuals, IV-drug users, or persons who are promiscuous. Ackerman and Jahoda (1950) offered a definition of prejudice: "prejudice is a pattern of hostility in interpersonal relations which is directed against an entire group, or against its individual members; it fulfills a specific irrational function for its bearer" (Allport, 1954, P. 12).

When examining the first part of that definition it seems similar to Goffman's "tribal stigma," which was explained as a mark or fault afflicting members of a social group. It could be implied also that the second part of Ackerman's definition of prejudice is true when considering homosexuals with HIV/AIDS. The abhorrence that some people feel toward homosexuals may fulfill a "holier-than-thou" need in them.

The dimension of bias and prejudice that is important to the present study is that prejudice is composed of both attitude and beliefs, because where one is found, the other is usually found. Therefore, the attitudes and beliefs that one holds toward a person, group, ideal, or concept will somehow, somewhere, express itself in action (Allport, 1954).

Beliefs About Illness

Nespor (1987) suggested that beliefs have a stronger affective and evaluative component than does knowledge. In order to investigate how a teacher's beliefs may influence his or her relationship to a student suffering from HIV/AIDS it is necessary to examine how individuals in general perceive illness.

Most research by social scientists in the area of health has been devoted to examining the beliefs of the person who was ill (Mechanic, 1972; Rosenstock, 1988). Few studies have investigated the reactions of others toward the person with an illness. A very early study by Parson (1950) examined the "sick role" and how it affected interpersonal relationships. Much more research was conducted and studied involving what has been labeled as the "Just World View" (Heider, 1958; Lerner, 1965; Myrdal, 1944; Ryan, 1971). The just world hypothesis was formulated by Melvin Lerner after research into the belief that people have a need to believe that the world is a place in which people get what they deserve and deserve what they get (Lerner, 1970, 1971, 1977; Lerner & Miller, 1978; Lerner, Miller & Holmes, 1976; Lerner & Simmons, 1966; Miller & McCann, 1979).

All of the initial research concerning the just world view was conducted prior to the AIDS epidemic; however, when discussing stigma and AIDS, the findings of Goffman (1963) indicated that it is common for people to view another person's physical disability as evidence of a moral defect or as just retribution for something his or her parents or tribe did, and therefore, was justification for the way he or she was treated. In the mid-60's Walster (1966) conducted a study

that indicated that the more harm created by an accident, the greater the responsibility the subjects associated to the person who caused it. In this just world view then, could people who have contracted AIDS (an incurable, i.e. harmful disease) through sex or drugs be held responsible for it?

In the just world philosophy people are able to confront their world as though it were stable and orderly and are reluctant to give up this belief because it serves an important adaptive function. The justness of others' fates however is tied directly to the fates of the persons themselves. If others can suffer unjustly, then the individual must admit to the frightening prospect that they could as well. As a way to deal with this unsettling dilemma individuals are motivated to restore the injustice. Lerner (1970) found in a study he conducted that one way to restore justness was to persuade oneself that the victim deserved to suffer. This view is not unlike the causal attribution view of stigma researched by Weiner, et al. (1988) toward individuals with HIV/AIDS. A second way to restore the injustice would be to compensate the victim. If the victim could not be compensated, as a victim of AIDS could not, and it didn't seem that the victim deserved to suffer, as with a young child, then the third way to restore the justice was to derogate the victim and justify the misfortune after the fact. Essentially, blame the victim for their circumstances. This type of justification mirrors the fifth of Jones et al. (1984) dimensions of stigma; origin.

An examination of the just world hypothesis by Gruman and Sloan (1983) demonstrated that ill persons were more derogated than healthy one. They found, in addition, that the more serious the illness, the more significant the

belittlement. This finding closely parallels the dimension of "course" and the findings by Gussow and Tracy (1968), that irreparable conditions caused victims to be unacceptable to others. Subjects in their study also tended to derogate victims of preventable disease, of which AIDS is one, more than those of unpreventable disease.

In a follow-up Sloan and Gruman study (1983), other factors were discovered which influenced the reactions of persons toward victims of illness. The perceived fatality of the disease is one such factor. Although it is closely linked to severity, they are not synonymous, because a disease can be severe, cause pain and suffering, and still not be fatal.

Gruman and Sloan (1983) further hypothesized that the observer's relationship to the victim may also effect the reaction to the illness. Farina (1981) investigated the relationship toward persons with mental illness and found that as familiarity increased, reactions toward the individuals were affected in a more positive way. This more positive interaction reduced the disruptiveness of the interaction as defined by Jones et al. (1984).

Another aspect of the observer's interactions with a victim may deal with the possibility of personal threat of the illness. Chaiken and Darley (1973) demonstrated that a person observing the misfortune of another after having to perform a task was influenced by whether or not they felt they would have to perform the same task at a later time. This could indicate that people would respond to a victim of illness differently if they felt they may contract the disease as well.

Lastly, the knowledge of cause and treatment of a disease may also effect the beliefs of the people interacting with the victims of disease. This hypothesis is drawn by Gruman and Sloan (1983) partially from the work of Sontag (1978) in which in the case of cancer there appeared to be an aura of mystique which comes from the medical community's inability to determine origin and treatment of the disease. In the case of HIV/AIDS, although the spread of the disease is basically accepted and understood, the cause and treatment remain elusive.

In summary then, there appear to be several factors which influence the beliefs of people toward victims of illness: preventability, severity, fatality, experience with those affected, knowledge of cause, and the effectiveness of medical treatment. Several of these factors have been paralleled with Jones et al. (1984) dimensions of stigma, specifically; course, disruptiveness, origin and peril.

The studies discussed thusfar have dealt with the beliefs of people in the general population with no particular regard to occupation or vocation. The study conducted here is interested in what teachers believe about students being affected with HIV/AIDS.

Teachers' Beliefs and Gender

The importance of investigating teachers' beliefs is based on the assumption that beliefs are the best indicators of the decisions individuals make throughout their lives. Rokeach (1968) argued that all beliefs have a cognitive component that represents knowledge, an affective component that ties to emotions, and a behavioral component that surfaces when action is required.

The power of beliefs is often drawn from previous events or episodes in a person's life that affect the comprehension of subsequent events (Nespor, 1987). Tying that concept to the present study, how teachers were raised, or their current friendships and acquaintances with individuals who are ill, homosexual, and/or have AIDS, could affect the teachers beliefs toward students they encounter.

Teacher gender has proved to be a discriminating characteristic in many studies. Belief differences between male and female teachers were evident in a 1969 study by Conine that investigated teachers' acceptance or rejection of students with disabilities. A Likert-type scale for measuring attitude was utilized and resulted in females scoring significantly higher than males in their acceptance of students with disabilities.

Garrett (1977) investigated the effect of teacher gender in relation to what factors they believed affected their teaching performance. He discovered that although both male and female teachers agreed that having good skills in human relations was the most important factor, there were differences between their beliefs in the areas of: (1) how students' socioeconomic status affected performance, (2) how the teacher's success was tied to student performance, (3) the characteristics of the student's in their class and how that affected performance, and (4) the importance of content knowledge.

A 1990 study conducted by Greenwood, Olejnik, and Parkay discovered that there was a statistically significant relationship between teacher gender and efficacy beliefs. The study utilized four different teacher efficacy belief patterns.

Teachers were asked to respond to two items in four different patterns by means of a 5-point Likert scale ranging from strongly agree to strongly disagree. The four patterns were: (1) teachers in general cannot motivate students and I am no exception to this rule; (2) teachers in general can motivate students, but I cannot; (3) teachers in general can motivate students and I am no exception to this rule; and (4) teachers in general cannot motivate students, but I personally can if I try hard. Sixty percent of the female teachers were classified in the third pattern, "teachers can; I can," while only 35% of the male teachers fell into that same pattern.

The influence of teacher gender and student grade level on student teachers' beliefs concerning student decision making was investigated by DeVoe (1987). The findings demonstrated that only the male student teachers felt that students should have little responsibility to make their own decisions.

Gender differences among secondary teacher candidates in the areas of self-confidence and educational beliefs were investigated in a longitudinal study by Kalaian and Freeman (1994). The study discovered that females believed in a more student-centered approach to instruction than did males, and that the females were more willing to work with exceptional students than were the male participants. Additionally, males tended to report higher levels of self-confidence beliefs than the females throughout the study.

Gender Differences and Beliefs About AIDS

The gender of a participant in a study has been found to be a determining characteristic in a wide variety of issues; religiosity was studied by Feltey and

Poloma (1991); adult aggression by Lightdale & Prentice (1994); parenting responsibilities were investigated by Lorber (1975); and sex discrimination issues were explored by Sapp, Harod & Zhao (1996). Of interest to this study are differences in the beliefs between males and females toward persons with AIDS.

Walkey, Taylor, & Green (1990) analyzed the AIDS stigma in relation to moral worth. Their study found evidence to support that women, although holding a relatively negative view of AIDS patients, still were more positive in their attitudes than were men.

Individuals' characteristics and how they perceived persons with AIDS was researched by Range and Starling in 1991. They concluded that for both men and women as practical knowledge about AIDS increased the stigma toward the person with AIDS decreased. However, they found that overall men held more stigma toward persons with AIDS than did women.

The content and function of attitudes toward persons with AIDS has been investigated (Brandyberry & MacNair, 1996) with significant differences found between women and men. Men were discovered to be more likely than women to use a defensive attitude function which, according to Katz (1960), protects people from their own unacceptable impulses. The researchers hypothesized that the women scored lower in defensiveness because they are more openly afraid of the emotional threat of death, not the fear of death itself. The study indicated that women have different beliefs and attitudes about death, scoring significantly higher on scales about death than did men. They suggest that one reason for this may be that women are raised to be more emotionally vested in

relationships than men. Additionally, the study demonstrated that males held more negative attitudes toward homosexuals and had less factual knowledge than did females.

Beliefs Regarding AIDS and Teacher Gender Differences

Although there are several studies regarding the issue of teacher's attitudes toward students with AIDS (Bruckner and Hall, 1995; Evans, Melville & Cass, 1992; Peach and Reddick, 1989; Brucker, Martin, & Shreever, 1988) seldom do they delineate differences in beliefs by gender. However, the 1995 study by Bruckner and Hall did specify differences in beliefs about AIDS between male and female teachers. Female teachers were more receptive to a requirement that teachers attend an AIDS awareness course than were the male participants. Male teachers felt more strongly that protective equipment such as gloves and eye goggles should be provided for all teachers who must come in contact with an HIV infected student than were the female teachers. Additionally, the male teachers felt more strongly than the female teachers that HIV/AIDS is the number one health threat to the world community.

Belief Differences Between Special and General Educators

In some studies participants have been asked if they believe students with AIDS should be taught in special education classes due to their illness (Bruckner and Hall, 1995; Evans, Melville & Cass, 1992). If students were to be segregated due to AIDS then the beliefs of the special educator would be of primary importance in dealing with these students. A limited number of research studies have inquired about the differences in beliefs of special vs. general educators.

One of the earliest studies comparing the beliefs of these two groups was conducted by Fine (1967). The study investigated the difference in attitude toward children with mental retardation between general and special class teachers. The findings of the study indicated that special class teachers placed a higher emphasis on personal and social adjustment of students than did the general class teachers. Also the special class teachers tended to be less demanding than the general class teachers in regards to pressing the children to "try harder."

Algozzine (1980) conducted research to determine if there were belief differences among general and special educators when it came to rating bothersome behaviors in students. His study suggested that certain behaviors are more disturbing to general education teachers than they are to special education teachers. Algozzine proposed that the difference in belief may be attributed to the fact that special educators had more exposure to students having bothersome behaviors than did general education teachers.

Safran and Safran have conducted two studies that demonstrate differences in the beliefs of general and special educators toward students. The first, in 1986, was to determine whether teachers' judgements of problem behaviors are influenced by classroom context, i.e. disruptive/nondisruptive and teacher type, i.e. general education /special teachers. The study indicated that general education teachers were least tolerant of what they viewed to be overt, intrinsically disruptive behaviors than were the special educators. In 1987 they specifically investigated teachers' judgements of problem behaviors and found

that general education teachers believed student behaviors were more severe than did their special education colleagues. In addition, the general educators had less tolerance toward the student behavior.

Attitudes of school personnel toward students in special education was investigated by Anderson, Criswell, Slate, and Jones in 1993. A survey was given to 334 certified school personnel regarding students receiving special education and special education services. The findings of the study suggested that the most positive attitudes were elicited by the special education teachers and administrators, while the more negative attitudes came from the general classroom teachers and the vocational instructors.

A similar study of 174 certified school personnel by Criswell, Anderson, Slate, and Jones (1993) demonstrated a significant difference in attitudes between the general and special educators. Also demonstrated was that working with students in special education produced a more positive attitude for special educators, but not for general educators.

Beliefs about service delivery for students in special education in a rural setting was researched by Monahan, Marino and Miller (1996) which indicated that general education teachers believed students with special education needs should be served in a special class, while special education teachers believed that service delivery should take place in the general education setting. The study further stated that the special educators believed it is the resistance of the general educators that hampers the success of the student with special needs in the general education setting.

Teacher Biases

Although teachers may try to be impartial in their dealings with students, most would probably grant they are more personally involved with some students than they are with others, albeit this involvement can be negative or positive (Jackson, Silberman, & Wolfson, 1969). Teachers' attitudes toward children do correlate with differential teacher behavior (Good & Brophy, 1972; Silberman, 1969).

A Good and Brophy (1972) study was conducted as a replication and extension of Silberman's 1969 study. In both of these studies it was demonstrated that there are four different categories of students; attachment, concern, indifference, and rejection. Students were placed in one of these after the teachers were asked specific questions relating to each category. For the attachment students the question was; If you could keep one student for another year for the sheer joy of it, whom would you pick? For the concern students the question was; If you could devote all your attention to a child who concerns you a great deal, whom would you pick? The indifference and rejection questions were, respectively; if a parent were to drop in unannounced for a conference, whose child would you be least prepared to talk about; if your class was to be reduced by one child, whom would you be relieved to have removed.

Teacher behavior was affected by the way the teacher felt about the students. It was concluded that teacher concern and indifference were more readily expressed than rejection and attachment, because they present less role conflict or bias (Good & Brophy, 1972). Teacher's also form differential

expectations based on information given about the students (Baron, Tom, & Cooper, 1985; Braun, 1976; Good, Sikes, & Brophy, 1973). Salvia, Clark and Ysseldyke (1973) and Foster (1976) studied the effect of labeling on teachers' stereotypes and expectations of students. They found that teachers held fewer positive expectations toward students who were labeled with a deviancy label, even if the student's behavior was not deviant. Would an HIV/AIDS, IV-drug user, or homosexual label present a bias toward that student as well?

AIDS in the Educational Community

Several studies have been conducted on the attitudes and knowledge of children toward persons with AIDS (DiClemente, Zorn, & Temoshok, 1987; Fassler, McQueen, Duncan, & Copeland, 1989; Price, Desmond, & Kukulka, 1985; Smith, Minden, & Lefevbre, 1991). Others have concentrated on the attitudes of health professionals (Kelly, St. Lawrence, Smith, Hood, & Cook, 1987; Ross & Hunter, 1989; Royse, & Birge, 1987), and still others have specifically investigated the attitudes of social workers toward individuals with AIDS (Dhooper, Royse, & Tran, 1987-88; Diaz, & Kelly, 1991; Peterson, 1991; Shi, Samuels, Richter, Stoskopf, Baker, & Sy, 1993). Less often do we find studies investigating the attitudes or beliefs of teachers in the public education system toward students with HIV/AIDS.

In 1988 a survey of 500 teachers attending graduate classes were questioned about their opinions regarding children as well as fellow teachers being allowed to attend or to teach in public school if they were diagnosed with HIV/AIDS (Brucker, Martin, & Shreever, 1988). The results indicted that

relatively young teachers, those not having completed one-third of their career, were strongly supportive to the idea of children with AIDS being educated in the public school system. These teachers further believed that children with AIDS should be allowed to participate in academic as well as co-curricular activities. However, the respondents were split almost 50-50 on issues concerning infected teachers. The following three questions were the cause of the split: (1) should all teachers be tested for AIDS, (2) should beginning teachers with AIDS be allowed teaching certificates, and (3) should teachers with AIDS related illnesses (ARC) be permitted to keep teaching. At the time of this study the primary groups contracting AIDS were homosexuals and intravenous drug users. Could it have been then that the issue of whether or not these children, and especially these adults with AIDS, should be allowed in the schools was more a result of teachers' private religious beliefs and prejudices about lifestyle or sexual preference than an issues of AIDS itself?

Both teachers' and administrators' attitudes were examined in a 1989 study conducted by Peach and Reddick. In this study 200 building level administrators and teachers in rural mid-Tennessee were surveyed. Results suggested that both administrators and teachers did not feel they had enough knowledge in the area of AIDS. Not surprisingly then, both groups felt that they would be at risk if persons with AIDS were in the schools and, as a result, that persons diagnosed should not be allowed to attend public schools. They felt separate facilities and services should be provided. Administrators were more comfortable about the confidentiality rights of persons with AIDS than were the teachers, with 55% of

administrators feeling confidentiality was important, and 76% of teachers disagreeing. It was interesting that there was a significant difference in reactions in both groups if the questions addressed a person with HIV as opposed to a person diagnosed with AIDS. Neither group staunchly objected to working with an individual who was only HIV positive. Both groups felt that the district should be held liable if a student or other school district personnel became infected from another student or employee in school activities. Both groups felt that teachers should know immediately if they are working with a HIV or AIDS infected student.

AIDS was not found to be a biasing factor for general education teachers considering special education placement of students (Walker, & Hulecki, 1989). One hundred and thirty teachers were randomly assigned to two groups, one received information of a child with AIDS and the other of a child with rheumatic fever. The teachers were then required to complete a Likert-type scale indicating agreement or disagreement with four statements regarding the child's expected difficulties and the environment that would best meet the child's needs (a general or special education classroom). The researchers concluded that for the particular participants in their study AIDS was not a biasing factor in the teacher's expectations regarding academic functioning or peer relationships.

In 1992, a study was conducted dealing specifically with special educators' knowledge and attitudes with respect to AIDS (Evans, Melville, Cass). 105 special educators enrolled in a graduate course at a university completed a survey about HIV/AIDS. An average of 80% of the questions were answered correctly by the teachers. Surprisingly, only 62% of the females taking the

survey knew that AIDS could be transmitted to infants by nursing. Females and males were least familiar about the average life span of persons with AIDS, and the number of affected teenagers. Analysis of the attitudinal responses demonstrated that 92% of the teachers wanted more information. Even so, 81% said they would teach students with HIV/AIDS. This is compared to the previously cited study by Peach and Reddick (1989) that found only 26% of general education teachers would teach students with HIV/AIDS. Seventy-nine percent of the teachers did not feel students should be segregated into classes for students with health impairments (Evans, Melville, & Cass, 1992).

In 1991 Bruckner and Hall conducted a follow-up study to the 1988 research of Bruckner, Hall, and Shreeve discussed above. The authors wanted to discover whether, and in what sense, teachers' attitudes had changed over the past few years. The study also expanded the original research by gathering data from a national sample and by increasing the number of items addressed.

Bruckner's study consisted of a 22 item questionnaire presented in a Likert-like format. A random sample of 1500 teachers were selected from a national pool of 2,000,000 teachers representing all 50 states of the United States. There were 698 respondents out of the 1500 selected. The findings indicated that: (1) there was strong opposition to mandatory testing for AIDS, (2) teachers did not feel that they should be required to teach a student infected with HIV/AIDS, (3) that teachers whose students were offered a course on HIV/AIDS awareness were more positive toward allowing a person with HIV/AIDS to continue in the educational institution than those whose students were not offered an awareness

course. The participants in this study were split on whether education related to acquisition and transmission of the HIV virus should be taught at school, or in the home by parents.

One of the more recent studies conducted on school-age children infected by AIDS was developed to ascertain teacher's beliefs and to analyze the attitudes of primary grade teachers regarding working with these students (Adams & Biddle, 1997). This study utilized a Likert-type questionnaire constructed from related literature. The subjects were 88 1st to 5th grade teachers in a suburban, middle-class Ohio district with no reported HIV-infected students enrolled.

The statement eliciting the strongest reaction was that, "Teachers should be informed if there is an HIV- or AIDS- infected student in their class," 83% of the teachers strongly agreed, with no one disagreeing even mildly. Additionally, teachers overwhelmingly agreed that they wanted more inservicing about AIDS.

This study demonstrated that not much has changed in regard to the attitude of teachers and their responsibility to teach an HIV or AIDS infected student since the Bruckner, Martin, and Shreeve study in 1988. In the newer study, Bruckner reported that 58% of the teachers surveyed disagreed that they should not have to work with infected students while the Adams & Biddle study reported only 47% disagreed. It would appear that teachers have accepted the fact that they must educate these children.

When questioned as to whether students with HIV or AIDS should be educated in a place separate from noninfected students, only five of 55

respondents agreed. What was interesting was that all five of them “strongly agreed”. The idea of educating infected students separately appears to have changed over time. For instance, in the Bruckner et al. study (1988), 31% agreed that infected students should not attend class. In 1992, Evan et al. only 5.8% agreed. However, in both the 1992 Evan et al. study and the Adams & Biddle study (1997) there were high percentages of undecided, 17% and 35%, respectively, whereas the Bruckner study in 1988 had only 5% undecided.

A lack of flexibility in teachers’ routines seemed to surface when examining the response to the statement, “I am willing to modify both curricular plans and classroom instructions so that HIV/AIDS infected students can be included in my class”. This statement generated the highest percentage of undecided response (40%), even though 60% of the teachers participating had special education training.

High percentages of undecided responses were reported on questions concerning mandatory testing and participation in contact sports. Furthermore, although almost all the teachers were aware of universal precautions, only about half of them consistently practice its procedures.

Q-Methodology

The studies described above were all quantitative in nature and were conducted through surveys. They did not address the personal beliefs of the teachers as told in their own words. The mode of contraction of AIDS was discovered to be a stigmatizing factor for some when interacting with persons with HIV/AIDS, but has not been addressed when dealing with teachers. It is

necessary to determine if teacher's beliefs about AIDS are affected when the mode of contraction of the disease is known to them, because this knowledge may influence whether or not teachers are told if a student has AIDS, or at least how much information should be released about a student's contraction of the disease. This study was interested in the beliefs and opinions of teachers toward students with AIDS, including mode of contraction. It will be conducted through the completion of a Q-sort.

Q Method was introduced in 1935 by William Stephenson, a psychologist/physicist. Q method provides a foundation for the systematic study of subjectivity. In a Q study a participant is presented with a set of statements about a topic, and is asked to rank-order them using a continuum ranging from "like me" to "unlike me." This process is referred to as Q-sorting. These statements are matters of opinion, not fact. The subjectivity of a Q-sort stems from the fact that the participant is sorting the statements from his/her point of view. Correlations among participants and a factor analysis of the sorts are then computed (Brown, 1993).

Q-Sorts Concerning AIDS

Previous researchers have conducted Q research in dealing with the subject of HIV/AIDS. The social, emotional, and motivational behavior associated with HIV infected pediatric patients was assessed via Q-sort by Moss, Brouwers, Wolters, Weiner, Hersh, and Pizzo (1994). LePoire (1994) investigated the attraction toward nonverbal stigmatization of gay males and persons with AIDS through a Q-sort study as well.

Q-Sorts in Education

Cutbirth (1996) investigated the attitudes and beliefs of teachers toward the inclusion of students with special needs into the general education classroom via Q method. The study inquired as to whether teachers' attitudes were consistent with the theoretical perspectives about inclusion. This research indicated that there were four factors that separated the attitudes of the teachers participating in the study. The factors indicated a particular belief or attitude held by those grouped within that factor.

Factor A respondents were called the Philosophists. They had staunch idealistic views, which were demonstrated, through their belief in the equal worth and opportunity for every child. The second factor respondents were labeled the Local Decision-Makers. Of utmost importance to this group was the perceived unfairness of forced placements decided by law, district practice, or parental pressure. Factor C respondents, the Individualists, felt that the rights of each individual student should solely determine placement. The last group, Factor D, were the Socialists. Socialists were felt to believe that the socialization of students with disabilities with the nondisabled student should be the most important factor considered when determining placement.

Cothran (1996) investigated students' and teachers' values in physical education by conducting a Q-sort. The results of this study indicated five factors. The first were the Playful Friends, who rated friends as the highest priority for physical education class. The second factor group was the Skilled Competitors. They valued physical education for its emphasis on skill and its display in game

play. The third factor respondents, the Friendly Learners, were interested in friends, grades, and learning. Another factor group were the Well-Behaved Students. This group focused on getting good grades, getting along with others, and learning emphasizing appropriate student behavior. The last factor in this study was the Social Comparison group. It was unique in that the factor was associated with only one school. The significant focus of this fifth factor group was the diversity of students in their school and how other people in their physical education class were similar or different than they were.

Subjective judgements of professionals' interactions with consumers of early intervention programs was investigated utilizing Q-method by Sexton, Snyder, Wadsworth, Jardine, and Ernest (1989). They discovered three viewpoints among the parents of children enrolled in an early intervention program. The first viewpoint tended to share beliefs that family-centered practices were defined by honest and understandable professional communication. Those participants comprising Viewpoint 2 felt that the professionals supported parental priorities, even when they conflicted with the priorities held by the professionals themselves. Viewpoint 3 consumers shared the perspective that family-centered practices were characterized by professionals who consistently responded positively and immediately to parental suggestions.

As with the above studies, the investigation of teachers' beliefs toward students with HIV/AIDS was a subjective undertaking. The present study investigated the beliefs concerning HIV/AIDS in the teaching community. Do teachers' personal beliefs imitate that of the other populations discussed in the

above literature review? Knowledge and acceptance of alternative lifestyles and choices were shown as mitigating factors in others' attitudes toward individuals with HIV/AIDS, and it is hypothesized that the teaching community will be no different. Additionally this study inquired into the beliefs of teachers regarding moral obligations felt concerning their duty to inform students truthfully of issues concerning the stigmatized, often ostracized, and, for some, detestable subject of AIDS.

CHAPTER III

METHOD

Chapter Overview

The purpose of this study is to investigate the subjective nature of teachers' opinions and feelings toward students with HIV/AIDS. This chapter begins with an explanation of Q method chosen because of its suitability in describing belief structures within a population. Following the explanation of Q method is a description of the pilot study used to develop the Q-sort. The chapter continues with a description of the subjects who participated in the study, the instrument used to determine teachers' feelings and opinions, the procedures and conditions of Q-sorting, and the process used for analyzing the data.

Research Method

Although medical advances continue to fight the disease of HIV/AIDS, there remains the problem of more children entering our schools with this devastating condition. The attitudes of teachers and their beliefs regarding children with HIV/AIDS influences their behavior toward these children. In order to research how teachers feel about students with HIV/AIDS, it is necessary to choose a method that allows for the systematic review of subjective data.

The ability to systematically review subjective beliefs is "especially relevant for the communication scientist whose research assesses the perceptual world of individuals" (Stephen, 1980, p. 204). Q-method relies on systematic procedures to discover intraindividual beliefs among items for participants (Sexton et al.,

1998). Q method is concerned with ensuring that self-reference persists, rather than being compromised by, or confused with, the researcher's external frame of reference into a subjective phenomena (McKeown & Thomas, 1988).

In undertaking this self-reference, Q-method enables the participants to demonstrate their viewpoints through the completion of a Q-sort. This procedure entails having a participant systematically rank-order a set of statements, the Q-sample, according to specific instructions.

In Q method the variables considered are the actual participants completing the Q-sorts, not the Q-sample consensus statements used in the sort (McKeown & Thomas, 1988). Therefore, people, through each Q-sort arrangement, not statements, are correlated using factor analysis of the $n \times n$ correlation matrix. Persons significantly associated with the concluding factors are assumed to share a common perspective about the topic being investigated. The association of each participant with each point of view is demonstrated by the strength of their "loading" on the factor. Each participant's factor loading indicates the degree of association between that person's individual Q-sort and the underlying attitude or belief supported by the factor. Positive loading on a factor would indicate a shared subjectivity with others on that factor, while a negative loading would indicate rejection of that factor's perspective. The last step in the data analysis involves the calculation of factor scores, when each statement in the Q-sample is scored for each factor. Factor scoring fosters the task of interpreting the meanings of the factors through the construction of a factor array and through

the determination of statements whose ranks in the arrays are statistically different for any pair of given factors.

Using both quantitative correlational and factor analytic systems with an in-depth qualitative search for subjective meaning, Q method allows participants to define their feelings and opinions. With Q method only subjective opinions are an issue, and even though they are unprovable, they can have structure and form. It is the aim of Q analysis to make this form tangible for purposes of observation and investigation (Brown, 1980). In terms of the study being conducted here, the analysis of the beliefs of teachers toward students with HIV/AIDS may help in determining if teachers hold stigmatizing views toward students which could disrupt the teacher/student relationship thus potentially impeding the learning process.

Instrument Development Study

Subjects

To conduct a study utilizing Q-method the researcher must establish the statements, the Q-sample or concourse, to be included in the Q-sort. For the present study, the statements were extracted from interviews with rural educators. These interviewees were selected because as classroom teachers they possess knowledge about the experience being studied; they were willing to talk about their knowledge and beliefs regarding AIDS and, because they represented a range of points of view; from special and general education experience, elementary and secondary level students, heterosexual and

homosexual lifestyles, and affiliations to a variety of religious and political groups (Rubin & Rubin, 1995).

This range of views was deemed important due to previous studies demonstrating that those specific attributes, gender of teacher, general or special education background, and grade levels taught, influenced beliefs and attitudes with regard to HIV/AIDS (Crandall, 1991; Crandall & Coleman, 1992; Johnson, 1987; Leone & Wingate, 1991; Walkey, Taylor, & Green, 1990).

Potential interviewees were approached by the researcher based on the researcher's knowledge of their gender, occupation, place of employment, religious beliefs, and sexual orientation. The researcher explained to each individual the purpose of the interview and the types of questions that would be asked during the interview.

The interviewees were solicited from rural elementary and secondary schools. Demographic information was asked of each participant and recorded prior to beginning the specific questions for the study. Each of the participants was asked his/her age, grade or subject(s) taught, religious affiliation, political affiliation, number of years teaching experience, and if he/she taught in the area of special or general education (see Appendix A). The question of sexual orientation was not asked on tape, but was volunteered by two of the male participants once the tape was turned off. Table I reflects the demographic composition of the interviewees.

Table I
DEMOGRAPHICS OF INTERVIEW GROUP

Field	Male	Female
General Educators		
(a) Elementary	20%	10%
(b) Secondary	30%	20%
Special Educators		
(a) Elementary	10%	10%
Number of Years Teaching		
(a) 1-10	40%	-
(b) 11-20	10%	40%
(c) 20+	-	10%
Subject		
(a) Special Education	10%	10%
(b) Secondary Sciences	10%	20%
(c) Secondary Language Arts	10%	10%
(d) Elementary 1 st – 5 th	20%	10%
Political Affiliation		
(a) Republican	30%	30%
(b) Democrat	20%	20%
Religious affiliation		
(a) Methodist	-	10%
(b) Christian	30%	20%
(c) Lutheran	10%	-
(d) Baptist	10%	-
(e) Catholic	10%	-

Interview Process

Before the interviews could be conducted an approval was obtained from Oklahoma State University's Institutional Review Board (see Appendix L). The application, #ED-97-068, requested information regarding the background and

purpose of the research, how the participants would be solicited, if the participants would be subjected to any potentially harmful conditions, and steps to ensure confidentiality. Additionally, the IRB committee questioned the benefit(s) of the study and required copies of both the consent form (see Appendix B) and the questions to be asked during the interview.

The purpose of the interviews in this study was to extract a collection of stimulus items, the Q-sample, to be utilized in the second portion of the research, the Q-sort. Although Q-sort statements can be obtained from many sources (McKeown & Thomas, 1988) such as printed material relating to a subject, written narratives, secondary sources (e.g newspaper editorials, television, or radio), or standardized (those taken from attitude and attribute scales), the interview process was chosen for this study because few of these sources have specifically been directed to the educational community.

Utilizing interviews to obtain the Q-sample is considered naturalistic because the statements are taken from the respondents' own oral communications. This is deemed to be most consistent with the principle of self-reference (McKeown, & Thomas, 1988) and therefore satisfies that integral characteristic of the Q method. There are two main advantages to the naturalistic method of obtaining the Q-sample; (1) the sample mirrors the opinions of the participants completing the Q-sort, and (2) because the items in the sample are based on the participants' own communications, they expedite the Q-sorting procedure and the characteristics of meaning of the sample items (McKeown & Thomas, 1988).

Questioning persons about their feelings and opinions concerning the subject of AIDS is considered a topical interview. Topical interviews are often begun with a series of preplanned questions that cover an issue or subject. Each of the main questions can create probes and follow-up questions. There are several purposes of probes in a topical interview: to acknowledge understanding of an answer, to encourage the interviewee to keep going and give longer, more detailed answers, and to gain evidence and sequencing of events (Rubin & Rubin, 1995).

The following open-ended questions were asked of each interviewee:

- (1) What do you know about students with HIV/AIDS?
- (2) What do you think should be done about health issues regarding students with HIV/AIDS in the schools?
- (3) What should teachers know in general about AIDS?
- (4) What type of information should teachers know about students with HIV/AIDS?
- (5) What policies should schools have regarding students with HIV/AIDS?

An example of a probing question occurred with interviewee number five, a forty-nine year old, female physical education teacher. When asked "What should be done about health issues regarding students with HIV/AIDS in the schools?" Her answer was that teachers should be informed if a student is infected. The probe questions was, "All teachers?" This type of probe forced the interviewee to elaborate on her answer and question herself even farther as to her most explicit feelings about this subject.

Interviewing continued until the answers to the main questions and the probe questions were becoming redundant. Redundancy, or the point at which there is no new material being gained, is called the saturation point (Glaser &

Strauss, 1967). Interviewing is discontinued once the saturation point is reached. Ten interviews were conducted before reaching the saturation point.

Q-Statement Categories

Each interview was completed and transcribed. At this time the process of choosing some statements while rejecting others began. Two basic techniques were used to determine which statements would best represent the population being researched. The first was an unstructured sampling, in which the items were chosen with little effort to ensure coverage of sub-issues. The possibility of sub-issues when dealing with such an emotional topic as students with AIDS appeared likely, so the notion of an unstructured sample was disregarded. The second was the more systematically constructed structured sample which was created through deductive and/or inductive designs (McKeown & Thomas, 1988). Both designs were utilized for this study, and are explained below.

While deductive designs are based on theoretical considerations, inductive designs are derived from the patterns that are observed as the statements are collected. The literature reviewed in Chapter 2 provided seven categories that help determine how others react to persons who are ill. The categories were: just world view, preventability, severity, fatality, knowledge of cause, effectiveness of medical treatment, and experience with those affected. These categories provided the theoretical basis of statement choice.

The theoretical categories of "effectiveness of medical treatment," "severity," and "fatality" dealt with a commonality of medical interventions, or lack thereof, and were therefore combined under the heading of severity/fatality/treatment."

The category of "experience with those affected" was considered a statement more suitable to ask demographically. As a demographic statement the original text was altered to, "Do you know, or have you known anyone with AIDS?"

With the combining of the three categories into one, and the elimination of "experience with those effected," four of the seven categories discussed in the literature were selected for inclusion in this study. Since these categories, "knowledge of cause," "preventability," "severity/fatality/treatment," and "just world view" are all based on literature describing the stigma associated with AIDS and theories surrounding reactions to illness, they are seen as being deductive in nature.

It was apparent that some of the statements did not "fit" under any of the four category headings and yet they were deemed significant due to the frequency that they were mentioned by the interviewees or the importance that an interviewee placed on them. Therefore, a fifth category was created: Teacher Responsibility. Examples of these types of statements were: "I would probably tell my closest friend if a student in my class had AIDS" or "A teacher who is unaware of how HIV is transmitted is not a good teacher because they have not been learning themselves." Creating this fifth category was not originally anticipated but was deemed necessary after analysis of the transcription of the interviews. The added category of "teacher responsibility" is inductive in nature, as it emerged from the pattern of statements provided by the interviewees.

Q-Sort Statements

Structuring a Q-sample in order to attain the best representation of statements is not the same as selecting them randomly from a population as might be accomplished in a R-method study. Instead the sample is composed artificially, albeit with scientific principles to guide the researcher (Brown, 1980, Stephenson, 1953). The researcher is challenged with separating all of the gathered statements related to a single topic in order to represent in miniature the feelings, beliefs, and/or opinions of the persons completing the sort.

There were a total of 137 statements extracted from the interviews before saturation of responses discontinued this process. Once this population of statements was accumulated, the next task was choosing which, and how many, of these statements were necessary for the Q-sort process.

Stephenson(1953) recommends a procedure for structuring a sample. This procedure entails dividing the statements into categories, *A, B, C....*, with levels of *a, b, c,*, respectively, which then produce an $a \times b \times c \dots$ combination, one level at a time for each category. By replicating statements *m* times, there will be $m \times abc\dots$ number of combinations. Table II demonstrates the procedure for this study.

Table II
CONCOURSE STRUCTURE

Category	Levels	N
A. Just World View	(a) Controllable (b) Uncontrollable	2
B. Severity/Fatality/Treatment	(a) Fear (b) Isolation	2
C. Preventability	(a) Mortality (b) Education (c) Risk	3
D. Teacher Responsibility		1
E. Knowledge of Cause		1
<p>(Number of combinations = $2 \times 2 \times 3 \times 1 \times 1 = 12$ X 4 replications = 48 Statements)</p>		

When using this procedure the number of statements in a concourse is determined by the number of multiples of the basic design. It is important, though, that the statements chosen are significantly different from each other so that the sort produces the kind of comprehensiveness needed in the sample as a whole (Brown, 1980). Additionally, care should be taken to attempt to balance the statements with “positive” and “negative” assertion of meaning (Stephenson, 1953).

Utilizing both theory and an inductive design yielded five categories

for the concourse statements in this study: Just World View, Preventability, Severity/Fatality/Treatment, Teacher Responsibility, and Knowledge of Cause which represent A, B, C, D, and E, respectively. Within the Just World View category the statements can be divided into (1) controllable and (2) non-controllable. An example of this would be that, "Students deserve AIDS if they engage in homosexual sex," this statement perceives control by the student, i.e., to engage or not in homosexual sex. However, the statement, "Too much money is spent on people with HIV/AIDS" does not give the AIDS infected person control over the outcome. The category Severity/Fatality/Treatment separates into (1) fear and (2) isolation. The statement, "If a student were HIV+, I would be less fearful of them than if they had AIDS," demonstrates fear whereas, "Students with AIDS should not be allowed to participate in sports" demonstrates isolation. The Preventability category can also be divided into levels; (1) morality, (2) education, and (3) risk. The following statements demonstrate morality, education and risk, respectively, "I feel it is my moral responsibility to tell students to abstain from premarital sex," "I think that AIDS education is meant to frighten students," and "I would tell my own child to avoid a student I knew had AIDS." The remaining two categories of Teacher Responsibility and Knowledge of Cause do not have level divisions among the statements. After completing the structuring procedure, forty-eight statements were chosen to complete the Q-sort concourse. The concourse of the Q-sort can be found in Appendix C.

Q-Sort Procedure

To restate earlier explanations, Q-sorting is a process whereby individuals model their opinions/feelings/beliefs by rank-ordering statements along a continuum of “most like me” to “most unlike me.” This sorting process involves the selection of the participants, the conditions of instruction, and the actual sorting of the statements. Permission for this portion of the study was requested and granted through the IRB at Oklahoma State University, IRB #HE-99-024 (see Appendix K).

Participants

The participants performing a Q-sort are referred to as the P-sample or P-set (person-sample). Subject selection for the P-set is determined either by theoretical (persons are chosen due to their special relevance to the goals of the study) or pragmatic (random selection) grounds. For this study these volunteer participants were chosen theoretically, based on certification as teachers in Oklahoma schools. These participants were graduate university students working in the field of education and/or practicing teachers in rural school settings.

Q methodology allows an intense study of the perspectives of a particular group of individuals using a small number of participants because of the intensive orientation of the research. This is because the subjects have the status of variables (Brown, 1980). All that is required are enough subjects to establish the existence of a factor for the purpose of comparing one factor to another. Q method is not concerned about what proportion of the population belongs to each

factor, only about the different factors which may exist in the population being studied. As in the structuring procedure for the set of Q concourse statements, the composing of a P-set can also be determined by the use of experimental design principles (McKeown & Thomas, 1988).

All of the Q-sort participants came from the “class” of teachers. The characteristics of the teachers are the main effects. The literature review demonstrated that characteristics such as gender, area of specialization, age of students, religious affiliation, and political affiliation all can have a bearing on a person’s attitude toward individuals with AIDS. The five characteristics given above would represent dimensions, each dimension would have its own types, or levels. Gender has 2 levels: female and male. The teachers’ area of specialization would also have two levels, general and special education. The grade level taught by the teachers would be represented by either elementary or secondary. Religious affiliation could potentially have representation from every known religion, therefore it would be held to three levels: Christian (specific sect given), Christian (nondenominational), and Non Christian. Political affiliation will be represented by three levels also: Democrat, Republican, and Independent. Utilizing this procedure, as recommended by McKeown and Thomas (1988), yields a $2 \times 2 \times 2 \times 3 \times 3$ factorial design. Thus, there will be at least 72 participants in the Q-sort process.

Teachers in rural elementary and secondary schools were invited to participate in the study. One method to recruit participants was to invite teachers taking graduate education classes at a state university to participate. Another

recruitment technique was to go to a variety of school campuses in a rural school district and ask for volunteers during the teachers lunch or planning times. A letter explaining the study was given to interested subjects. Informed consent was signed before respondents participated and the signature portion was removed from other study materials to ensure confidentiality (see Appendix D).

Respondents were given verbal instructions to complete the Q-sort. The respondents were told to sort the statements according to which are "most like me" (+5) or "most unlike me" (-5). This range is determined by the number of statements in the Q-sort. As a rule Q-samples with 40-60 statements utilize a range of +5 to -5 (Brown, 1980). It would be expected that on an issue as sensitive as AIDS the distribution will be more flattened (platykurtic) since this provides more opportunities for responses at the extremes and reduces the number of responses at the neutral or "don't know" center of the distribution. Although the items are ordered on a continuum from positive 5 to negative 5, for data analysis the continuum ranges from one to eleven +5, +4, +3...-3, -4, -5). A script with exact directions was read by the administrator of the Q-sort (see Appendix E) and a matrix was given to each participant to record their ranking of each Q-sort statement (see Appendix F).

An important aspect in a Q study is the follow-up interview completed after the Q-sort, in which a participant is given the opportunity to expound on his/her reasoning for ranking items (Brown, 1980). These interviews provided the researcher a chance to clarify the thoughts of the respondent and understand

their logic in the choices made. For this study the following questions were asked of some participants after completing the Q-sort matrix:

1. What personal experience or characteristic of yourself caused you to place the chosen statement under the +5/-5 columns?
2. Was there a significant statement that you would have liked added to the statements? Why?
3. Was there a specific statement you would rather have not had to sort? Why?

The demographic information collected from each member of the P-set included the same as that from the interview participants, and additionally each respondent was asked: at what grade level should AIDS education begin, who should be informed if a student has HIV/AIDS; who should have final say if a student with AIDS can attend school; how often do you use universal precautions when dealing with bodily fluids; who should teach AIDS education; and do you know anyone who has (had) AIDS? A sample of the demographic data requested from each participant in the P-set is included in Appendix G. Table III reflects the characteristics of the P-set participants as explained in the P-set design.

Table III
DEMOGRAPHICS OF P-SET

	Male	Female
General Educators		
(a) Elementary	2	17
(b) Secondary	9	21

Special Educators		
(a) Elementary	2	15
(b) Secondary	1	14
Political Affiliation		
(a) Republican	7	24
(b) Democrat	5	31
(c) Independent	2	7
(d) No Response	-	5
Religious Affiliation		
(a) Christian (nondenominational)	1	6
(b) Christian (specific sect)	10	51
(c) NonChristian	-	1
(d) No Response	3	9

Data Analysis

After the Q-sorts are conducted and recorded, data analysis involved the sequential application of three statistical procedures: correlation, factor analysis, and computation of factor scores. All observations in Q-technique are premised on a common unit of measurement, "self-significance" (Brown, 1980; McKeown & Thomas, 1988). Factor loadings indicate to what extent each Q-sort is similar or dissimilar to the factor array for that type.

The computer program by Schmolck (1997), PQMETHOD 2.0, was used after the Q-sorts were coded. The computer program calculated the correlation matrix. Factors were identified with varimax rotation based on how much of the variance they accounted for and if the "loads" were significantly different from one another. The factors represent a particular point of view for the respondents that "load" heavy on that factor. A significant load for this study was calculated by

the computer program. Factor loadings are correlation coefficients that suggest a similarity of viewpoint among certain members of a sample.

Q arrays are produced for each factor once rotations are completed. Some sorts will be more closely aligned to certain factors than others. Using a procedure known as wrapping, factor scores are computed as z-scores. The z-scores are compared to determine the most prominent items of each factor and are arranged in a factor array. The array is used as a way for the researcher to interpret the beliefs of respondents for each factor.

Interpretation of Factors

In Q-methodology factor analysis determines how many different Q-sorts are evident. Those sorts which are highly correlated to one another may be considered to have a factor resemblance, those belonging to one factor being highly correlated with one another, but uncorrelated with members of other factors. The number of factors is totally dependent on how the individuals sorted the statements. In this study, the factors indicated different beliefs held by teachers about students with HIV/AIDS, with those individuals sharing a common conception defining the same factor. A positive loading, or correlation, on a certain factor indicates that the individual shares subjectivity, or has similar views, with others of that factor (McKeown & Thomas, 1988).

The original set of factors provide the raw statistics for probing the subjective relationships from vantagepoints that are of interest to the study. Factor rotation allows saturation of as many Q-sorts as possible on the factors extracted initially. In Varimax factor rotation the computer program repositions

the factors to highlight the connection between the beliefs of the Q-sort participants.

Factor arrays, corresponding to the values used in the original Q-sort continuum were created using factor scores. Each factor array is a representation of a distinct set of beliefs concerning students with HIV/AIDS. A factor array, with scores ranging from +5 to -5, indicates the positive and negative ends of the opinion continuum, and is generated for each significant factor. Whether or not a factor was considered significant was determined, in part, by the eigenvalue, the number of sorts that loaded on a factor, the number of nonsignificant sorts of each factor, and the percentage amount of the total variance that the factors could account for.

The PQMETHOD 2 program also displays a list of "Distinguishing Statements," which aid in the interpretation of each factor. This part of the computer program identifies specific statements which are ranked in such a way by one factor group as to set them apart from the rankings of the others. The program identifies statements that are significant at the $<.05$ and $<.01$ level.

The demographic information obtained from each participant was connected to the factor scores for each statement in the Q-sample. This information was qualitatively interpreted as representative of the sample of teacher's participating.

Validity, Reliability, and Generalization

Post-sort interviewing of the participants who achieved the highest loading of each factor was conducted in order to assure the credibility and interpretations of the findings. The post-sort interview allows the participants to elaborate about

their individual sort and gives them the opportunity to share why they believe as they do. These interviews, and the interviews that were conducted to create the consensus statements, help to establish and confirm a study free of bias.

Validity has traditionally not been an issue for Q methodology because the concept of validity has little standing since there is no outside criterion for someone's own point of view (Brown, 1980). More accurately, validity in Q methodology can be explained as the ability of the participants to share their perspectives on the topic under investigation, and to the researcher's ability to accurately portray the subjectivity expressed (Dennis, 1992/1993). The initial interviews conducted through open-ended and probe questioning assist the researcher to accurately portray the beliefs of the interviewees. The post-sort interviews aide the researcher in demonstrating reliability of the interpretations of each factor.

Similarly, reliability by itself does not always produce useful information in Q (Brown, 1992/1993, 1999). If predictability is what is important in the reliability criterion, then it really is not very significant to Q research. This is due to the fact that reliability pertains to statements of fact, where Q is interested in statements of problems (Bass & Thomas, 1992/1993).

The concept of generalization can be explained in two ways, the first appears technical and pertains to statistical inference (random samples with generalizations made to larger populations), the second, which is what is employed by Q, is concerned with substantive inference "about" a phenomenon (Thomas & Bass, 1992/1993). In a certain respect Q factors are already a

generalization, the factors indicate, in general, what a group of people believe about a given subject. Although Q does not allow us to know what percentage of a population believe like Factor A (as a quantitative survey would) it does tell us that factor A people believe differently than factor B, or C, etc. There have also been some replication studies that have proven that similar factors are demonstrated across applications, testifying to both generalization and also the reliability of the factors (Brown, 1999). For the present research, generalization was promoted also through purposeful sampling, i.e. teachers of various backgrounds, ages, levels of experience, and ages made up the P-set.

CHAPTER 4

RESULTS

Results of the investigation into the beliefs of teachers concerning AIDS are discussed in this chapter. The participants of this study were inservice teachers representing both special education and general education, and teaching classes from the elementary to the university level. The participants completed Q-sorts on the topic of AIDS, with an emphasis on students with HIV/AIDS. They based the array placement of each of the 48 Q-sort statements on their personal beliefs of the importance of each statement. They did this by rank ordering them from -5 (most unlike me) to +5 (most like me). A total of 101 Q-sorts were administered. Of those, 81 were completed following the directions given and therefore were included in the data analysis.

The first part of this chapter provides the reader with descriptive statistics concerning the Q-sorts. The rest of the chapter concentrates on the interpretation of the beliefs of the teachers who comprised the four factor solution chosen as most appropriate to this study.

Eigenvalues and Variance

According to McKeown and Thomas, (1988) eigenvalues (how the factor's importance is estimated by calculating the sum of its squared factor loadings), are the most common statistical option in Q method to determine if a factor is significant enough to warrant serious attention; eigenvalues greater than 1.00 are considered significant. The PQMETHOD 2.0 software program by Schmolck

(1997) was used to complete computations. The computation of the eigenvalues of the 81 sorts produced a range from 28.24 to 1.01, before dropping below the 1.00 significance level. Cumulatively, factors one through twenty accounted for 85.93% of the total variance.

Flagging Factors

The PQMETHOD 2.0 program computed correlations and factor rotations with all sorts combined being rotated into three, four, five and six factor solutions. Factors are flagged as “pure” by the program if they meet two related conditions; (1) $a^2 > h^2/2$ - its square loading on this factor is greater than half the sum of its squared loading on all factors, and (2) $a > 1.96/\text{SQRT}(N)$, loading significant at $p < .05$ (Schmolck, 1997).

A three factor solution accounted for 46% of the variance and resulted in 37 participants loading on Factor A, 16 on Factor B, 15 on Factor C, with 13 participants (16%) not loading on any of the three factors, thus making their sorts nonsignificant to the study. The four factor solution accounted for 51% of the variance and yielded 30 participants loading on Factor A, 12 on Factor B, 13 on Factor C, 8 on Factor D, with 18 (22%) nonsignificant sorts. Computing a five factor solution, accounting for 56% of the variance, resulted in 29 participants loading on Factor A, 7 on Factor B, 12 on Factor C, 7 on Factor D, 2 on Factor E and 24 (29%) nonsignificant sorts. The last solution computed utilized a six factor criteria which accounted for 58% of the variance and resulted in Factors A-E having 23, 9, 8, 3, 3, and 3, participants, respectively, with 32 (39%) sorts having no significance.

It is clear that as more factors were computed there was an increase in nonsignificant sorts. It is apparent that Factor A is clearly the strongest of the factors, with more participants sharing this belief, regardless if there were three, four, five, or six factors extracted. The five and six factor solutions resulted in 24 (29%) and 32 (39%) nonsignificant sorts, respectively, which would in turn produce weak analysis and interpretation of the factor beliefs, therefore further interpretation of these sorts was abandoned. Although the three factor solution resulted in less nonsignificant sorts than did the four factor solution, 13 vs 18, and there was a 5% difference in variance accountability, there were enough participants in Factor D of the four factor solution (approximately 10%) to warrant further analysis and interpretation of this belief group. For the complete list of participants and factor loadings see Appendix H.

The interpretation of the four factor solution will include its descriptive statistics, the array placement of each statement with z-scores, the correlation of the factors to each other, the naming of the four factors based on the beliefs represented in each, interpretation of the beliefs represented by each factor, distinguishing statements for each factor, characteristics of the participants loading on each factor, and discussion of the post-sort interviews.

Four Factor Solution: Descriptive Statistics

Correlations between the four factors were calculated. Factor correlations ranged from .32 to .55. Factors one and four were the most dissimilar with a correlation of .32, while factors one and three demonstrated the least dissimilarity with a correlation of .55. All correlations presented an acceptable degree of

difference between the four factors for the purposes of further interpretation.

Table IV displays the correlation between the four factors.

Table IV
Correlation* Between Factors A, B, C, D

	A	B	C	D
A	1.00	.50	.55	.32
B	.50	1.00	.50	.49
C	.55	.50	1.00	.43
D	.32	.49	.43	1.00

*Rounded to two decimal places

The final phase of the Q analysis includes the calculation of z-scores. The z-scores were computed for each statement for each factor and were used to place the statement in the appropriate order for each of the four factors. The z-scores demonstrate a more precise location on the array as well as a more explicit difference between the placement of individual statements.

Statement Array Position

Each statement in the Q-sort is preceded by a code: JWV, KC, SFT, P, and TR. The first four codes represent the theoretical perspectives previously identified through the literature review: Just World View, Knowledge of Cause, Severity/Fatality/Treatment, and Preventability. The fifth code, TR, was derived

from the teacher interviews that served to create the stimulus statements used in the Q-sorts. TR represents Teacher Responsibility. Table V shows the statement, its array position, and its z-score.

Table V
Statement Array Position and z-Scores

Statements	Factor:	A	B	C	D
JWV 1 Elementary age students with AIDS would be treated more kindly than secondary students.	2 .581	-1 -.266	1 .25	5 -1.511	
JWV 2 Too much money is spent on people with AIDS.	-4 -1.085	-2 -.960	0 .169	-2 -.806	
JWV 3 I believe people who contract AIDS are promiscuous.	-4 -1.288	-4 -1.423	-1 -.566	-3 -.918	
JWV 4 I would feel differently toward a student who was homosexual and not heterosexual.	-4 -1.291	0 -.112	0 -.187	0 -.388	
JWV 5 Students deserve AIDS if they engage in homosexual sex.	-5 -2.004	-5 -1.458	-4 -1.275	-3 -.873	
JWV 6 I would feel differently toward a student who was born with the AIDS virus than toward a student who acquired it because of their lifestyle.	-2 -.646	0 -.011	1 .579	-2 -.619	
JWV 7 I feel that students are less fearful than educators about being around other students with AIDS.	4 1.300	1 .234	3 .967	0 -.319	
JWV 8 If a student had AIDS in my school, he/she would be harassed.	2 .587	-2 -.835	1 .384	-4 -1.099	
JWV 9 I would treat hemophiliacs with AIDS differently because they are innocent victims.	-3 -.922	0 .116	-1 -.294	-3 -.898	

JWV10	A person who has AIDS and does not tell their partner, then has unprotected sex, should be legally charged with murder.	3 .955	2 .773	5 1.707	4 1.384
JWV11	I believe that AIDS acquired through sexual behavior is God's way of punishing people for immoral behavior.	-5 -1.996	-2 -.893	-4 -1.398	3 1.118
SFT 1	I feel that having AIDS would be worse than having any other potentially fatal disease.	2 .812	4 1.178	-3 -1.211	0 -.222
SFT 2	If I knew a student had AIDS I would be more cautious around him/her than if I did not know.	3 .828	5 1.920	4 1.251	4 1.369
SFT 3	Students with AIDS should be taught in special education classes because the teachers are trained to deal with sick kids.	-3 -1.062	-4 -1.247	-3 -1.098	-5 -1.675
SFT 4	Students with AIDS should be home-schooled.	-3 -1.041	-5 -1.480	-4 -1.407	-4 -.991
SFT 5	It is more dangerous for the student with AIDS to be with other students than it is for healthy students to be with a student with AIDS.	4 1.328	-1 -.191	-2 -.617	0 -.413
SFT 6	If a student were HIV+ I would be less fearful of them than if they had AIDS.	0 -.198	-3 -.983	-1 -.435	-1 -.422
SFT 7	AIDS is a death sentence.	1 .362	1 .462	1 .318	1 -.209
SFT 8	Students with AIDS should not be allowed to participate in sports.	0 -.209	-1 -.247	3 .768	-3 -.842
SFT 9	When I hear that someone has AIDS, the first thing that crosses my mind is, "How did they contract it?"	0 .045	4 1.452	2 .597	1 .294

P 1	I believe AIDS awareness lectures will change students' behaviors in regards to abstinence from sex or drug use.	4 1.216	4 1.114	0 -.188	3 .998
P 2	I think that AIDS is on the rise because of a lack of morality in our nation.	-2 -.773	5 1.532	4 1.603	5 2.116
P 3	I feel it is my moral responsibility to tell students to abstain from premarital sex.	-2 -.515	3 1.019	-2 -.673	4 1.468
P 4	I feel I am at risk in my professional environment to contract AIDS.	1 .266	-3 -1.060	-2 -.781	-1 -.609
P 5	Teaching educators to use universal precautions in dealing with bodily fluids will protect them from acquiring AIDS.	4 1.407	3 1.048	2 .624	3 1.090
P 6	I believe that biased or false information about HIV/AIDS would be given to students if all teachers are allowed to teach about it.	3 .813	2 .540	1 .565	-1 -.588
P 7	I think that AIDS education is meant to frighten students.	0 -.038	-4 -1.298	-3 -.798	0 -.232
P 8	I would tell my own child to avoid a student I knew had AIDS.	-4 -1.244	0 -.083	-1 -.243	-2 -.761
P 9	I believe that most teenagers think they are safe from AIDS if they are not gay or injecting drugs.	5 1.768	2 .888	5 1.826	4 1.163
P 10	My religious beliefs would influence my treatment of a student with AIDS.	0 .105	-5 -1.893	0 .210	-5 2.084
P 11	I would take care of a child's injuries before thinking about universal precautions.	2 .785	-1 -.502	2 .676	-1 -.521
P 12	I believe it is my moral responsibility to tell students that homosexuality is a sin.	-5 -1.776	-3 -1.070	-5 -1.580	2 .528

TR 1	I believe that even if a parent signed a statement that they did not want their child to receive AIDS education; it is my moral responsibility to answer their questions about AIDS.	1 .288	0 -.074	-5 -1.716	1 .356
TR 2	I would probably tell my best friend if a student in my class had AIDS.	0 .178	3 1.097	-4 -1.292	-2 -.638
TR 3	Teachers should not be forced to have a student with AIDS in their class.	-1 -.225	-2 -.512	2 .631	1 .262
TR 4	I should not be expected to take responsibility for the safety of all students.	-2 -.540	1 .365	-1 -.389	-2 -.635
TR 5	I would stay out of students' conversations about AIDS even if what they were saying was incorrect.	-1 -.327	-4 -1.377	-2 -.697	-4 -1.239
TR 6	A teacher who is unaware of how HIV is transmitted is not a good teacher because they have not been learning themselves.	3 .966	1 .225	0 -.186	-4 -1.009
TR 7	If I had a student with AIDS, and I could reduce my class size by one, it would be that student.	-3 -1.030	-3 -.974	-3 -.878	-5 -1.489
TR 8	I would hold my district responsible if I contracted HIV from a student that I had not been told carried the virus.	1 .293	1 .349	4 1.597	2 .632
TR 9	Teachers with AIDS should be restricted from certain positions.	-1 -.311	2 .778	0 -.058	-1 -.550
KC 1	Regardless of how a student contracted AIDS, I would welcome them into my class.	5 2.114	4 1.276	3 .959	5 2.056
KC 2	I believe that AIDS is on the rise among adolescents because parents and schools have lost control over children.	-1 -.371	2 .689	3 .979	3 .957

KC 3	I believe that students should be told how another student acquired AIDS, that way they will know it could also happen to them.	-2 -.510	-2 -.785	-5 -1.716	1 .170
KC 4	I believe there will always be a homosexual stigma associated with AIDS.	2 .690	5 1.941	4 1.203	2 .863
KC 5	I am more concerned about contracting Hepatitis from a student than contracting AIDS.	5 1.534	-1 -.402	5 1.865	2 .551
KC 6	My mind tells me a student with AIDS in my own child's class is safe, my emotions tell me otherwise.	1 .561	3 .989	2 .595	2 .756
KC 7	All public school teachers should be screened for AIDS, just as they have to be for TB.	-1 -.381	0 .152	-2 -.750	1 .261

Factor A: Nonjudgmental Realists

Participants who demonstrated a significant loading on factor A have been labeled the Nonjudgmental Realists. Nonjudgmental Realists view the AIDS epidemic as a medical crisis, not a moral crisis. Nonjudgmental Realists understand the need for AIDS education, both for students and educators. They believe that teachers need to stay informed so that students are given correct and unbiased information. Nonjudgmental Realists believe in prevention to keep everyone safe from the disease.

Nonjudgmental Realists do not think that AIDS was conjured up by God to destroy those that engage in aberrant behaviors. This was demonstrated by their placement at the extreme end of the continuum (-5) of the statement "I believe that AIDS acquired through sexual behavior is God's way of punishing people for

immoral behavior.” They don’t feel that anyone deserves AIDS, nor that specific AIDS victims are more, or less, innocent than others. Nonjudgmental Realists are accepting of people as they are, they are not critical in their approach to others. This is clearly established by the strong disagreement (-5)

Nonjudgmental Realists have with two of the concourse statements; “Students deserve AIDS if they engage in homosexual sex,” and “I believe it is my moral responsibility to tell students homosexuality is a sin.” Additionally, their nonjudgmental approach is demonstrated by the strong agreement (+5) with the statement, “Regardless of how a student contracted AIDS, I would welcome them into my class.” The placement of the statement “If I had a student with AIDS and could reduce my class size by one, it would be that student” on the negative end of the array continuum indicates that the Nonjudgmental Realists are not fearful of AIDS. The attitude of the Nonjudgmental Realists comes from a “live and let live” philosophy.

Nonjudgmental Realists seem to understand that teenagers view themselves as invincible and do not necessary grasp the concept of AIDS being a disease that does not discriminate among its victims. They see this as a fundamental and critical reason for AIDS education. Nonjudgmental Realists understand that the student with AIDS is at risk of serious health problems just from the routine illnesses that most children come in contact with. Their knowledge of the susceptibility of illness for the child with AIDS is reflected in the +4 placement of the statement “It is more dangerous for the student with AIDS to be with other students than it is for the healthy student to be with a

student with AIDS.” These teachers know the risk that the student with AIDS faces to be included in the school environment.

The Nonjudgmental Realists appear self-assured in their beliefs to the point that they are not worried about their own children contracting AIDS from a classmate, as indicated by the ranking in the -4 position of the statement, “I would tell my own child to avoid a student with AIDS.” Supporting this belief is the ranking at -3 of two different statements suggesting that students with AIDS be segregated by either home-schooling or by receiving their instruction in special education classes.

Nonjudgmental Realists believe that education is the key to reversing the tide of the AIDS epidemic. They demonstrate this by the +4 placement of two statements, “Teaching educators to use universal precautions in dealing with bodily fluids will protect them from contracting AIDS,” and “I believe that AIDS lectures will change students’ behaviors in regards to abstinence from sex and drug use.”

Confirmation of the beliefs of the Nonjudgmental Realists was further authenticated by post-sort interviews with the two participants who had the highest factor loading on Factor A. The first participant was a 26 year-old teacher/counselor at an elementary school. She had a .88 loading on Factor A indicating a very high association with this type of belief. She does not know anyone with AIDS.

This teacher was comfortable with the Nonjudgmental Realist label because she feels that AIDS is a dreadful disease, with no ties to immoral behavior, and

which can only be combated through education. The experiences that she has had that helped shape her beliefs were having AIDS awareness lectures at both the high school and college level which she felt helped her make more informed decisions about high risk behaviors. She was pleased that the elementary school she works in just completed a unit on AIDS with 4th – 6th graders and believes that AIDS education should begin at even a younger age .

This teacher believes that if children understand the facts at an early age they will not become the adults that think AIDS is God's punishment. She described herself as having strong religious beliefs, but not toward conservative values, such as believing that homosexuality is a sin, or that AIDS should be blamed on homosexuals or promiscuous individuals. When asked about intervening in a student's conversations about AIDS if she heard incorrect information, she responded that she would only interfere if the statements were medically incorrect. For example, she stated that if she heard a student say something like "queers get AIDS because they are sinners" she would not interfere because she feels that is more of an ethical/moral stance, but if she heard a student say that you can get AIDS from a toilet seat, she would correct them. This type of thinking supports the beliefs of the Nonjudgmental Realists that AIDS is not a moral issue, it is a medical issue.

This woman further explained that the only uncomfortable statements to sort for her were the ones that suggested someone would "deserve" AIDS, either because of lifestyle or sexual orientation. The reason that this bothered her was not because she had a dilemma over where to place the item, but rather because

she stated “it is upsetting to me that anyone would think someone deserved AIDS, but I am sure around here (small town in Oklahoma) they do.” This participant considers herself liberal which she felt was a good adjective to describe the Nonjudgmental Realists. Further questioning revealed that her new role as counselor increases the need for her to be nonjudgmental and open minded regardless of the problems her students may bring to her. She believed that all the major issues on the subject of AIDS and students was covered, but did ask why there were no questions regarding co-workers with AIDS.

Another teacher interviewed that loaded high on Factor A was a 40 year-old female secondary teacher. She loaded at .84 on this factor. She also did not know anyone with AIDS. She did however, have a friend that knew someone that “had been driven out of a small town” once it was known that her child had AIDS.

When asked to elaborate on why she felt a student with AIDS at her school would be harassed her answer mirrored the sentiment of the Just World View philosophy. Statements which support this philosophy are found almost exclusively on the negative side of the continuum array for Nonjudgmental Realists. The interviewee stated that those in her small town feel homosexuality is a sin and that they are afraid of AIDS, so by stigmatizing those that have AIDS (specifically homosexuals) they convince themselves they can’t get it, she further stated, “Stigmatizing becomes a habit.” This (stigmatizing) is one way they (the town’s people) can “relieve themselves of that burden (i.e. worrying about AIDS).”

Teachers subscribing to the beliefs of the Nonjudgmental Realists would welcome all students to their class. They would not care if they were heterosexual or homosexual, ill or healthy. They view students as children all deserving the same kind treatment. They do not feel that it is their place to judge others' morality. They are realistic and knowledgeable of the plight of those with AIDS, but optimistic in the role that education can play in its demise. The complete array for the Nonjudgmental Realists is shown in Appendix H.

Participants on Factor A: Nonjudgmental Realists

Thirty people identified with the Nonjudgmental Realists view. Their factor loadings ranged from .49-.88. The large number of participants on the factor indicates the prevalence of a nonjudgmental point of view among educators toward students with AIDS.

Nineteen of the Nonjudgmental Realists teach in the area of general education, 11 in special education. Only three of the Nonjudgmental Realists are male, two special educators and one general educator. Over half of the Nonjudgmental Realists, 17, have taught less than ten years. Just under half (14) of the Nonjudgmental Realists are in the 40-49 age range. Among the general educators, they represented the elementary and secondary grade levels equally, with nine teachers in each group. Most special educators taught at the elementary level. Sixteen of the Nonjudgmental Realists align themselves more closely with the democratic party. Table VI displays the characteristics of Factor A: The Nonjudgmental Realists .

TABLE VI

FACTOR A: NONJUDGMENTAL REALISTS ' CHARACTERISTICS

Participant Number- Gender- Reg. or Spec. Ed.- Elem. or Sec. Level	Load	Age	Years Teaching	Political Affiliation	Religious Affiliation
04-F-Sp-S	+.54	45	23	Democrat	Disciple of Christ
07-F-Sp-S	+.70	47	15	Independent	Protestant
09-M-Sp-S	+.57	50	26	Democrat	None
17-F-Sp-E	+.79	44	11	Republican	Methodist
19-F-Sp-E	+.77	47	23	Democrat	Methodist
22-F-Sp-E	+.56	49	25	Democrat	Methodist
23-F-Sp-E	+.68	47	5	Independent	None
24-F-Sp-E	+.71	46	6	Democrat	Presbyterian
29-M-Sp-E	+.50	40	3	Democrat	Baptist
30-F-Sp-E	+.76	47	25	Republican	Protestant
31-F-Sp-E	+.60	49	15	Republican	Lutheran
32-F-Sp-E	+.65	27	1	Democrat	Catholic
33-F-R-E	+.71	29	1	Democrat	Catholic
35-F-R-E	+.48	46	23	Republican	Baptist
36-F-R-E	+.67	38	1	Democrat	Unitarian
40-F-R-E	+.45	24	3	Republican	Baptist
42-F-R-S	+.60	44	14	Democrat	Disciple of Christ
46-F-R-E	+.62	30	4	Independent	Nazarene
47-F-R-E	+.88	26	2	Democrat	Methodist
51-F-R-S	+.47	45	2	Democrat	Presbyterian
54-F-R-S	+.62	24	1	Republican	Christian
55-F-R-S	+.84	40	5	Democrat	None
56-F-R-S	+.58	23	1	Democrat	Catholic
59-F-R-E	+.59	28	5	Independent	Baptist
63-F-R-E	+.54	34	10	Democrat	Christian
69-F-R-S	+.71	36	13	Democrat	Presbyterian
70-F-R-S	+.77	50	23	Democrat	Catholic
73-F-R-S	+.45	41	17	Independent	None
78-F-R-S	+.77	33	9	Democrat	Christian
79-M-R-S	+.69	37	5	Democrat	Presbyterian

Factor B: Informed Guardians

Q-sorts of the teachers that loaded significantly on factor B have been

Labeled "Informed Guardians." What is of prime importance to Informed Guardians is the protection of both students and adults. They feel that it is not just the medical side of AIDS that students, and others, need to be protected from, but also the stigma and emotional strain that AIDS causes. They believe that if we educate students through lectures about abstinence and promote responsible decision making the students will not participate in activities that could spread AIDS.

Informed Guardians recognize the severity of contracting AIDS, as demonstrated in their extreme placement (+5) of the statement, "If I knew a student had AIDS I would be more cautious around him/her than if I did not know." This belief is not fueled exclusively by fear, but rather by an informed approach to a contagious disease. This is not to say, however, that Informed Guardians are not somewhat fearful of the disease. They ranked on the positive side of the continuum the statement, "My mind tells me that a student with AIDS in my own child's class is safe, my emotions tell me otherwise." Regardless though of the mode of contraction, and the slight fear, Informed Guardians would welcome any student into their class. This is supported by the +4 placement of that statement and by the -5 placement of the statement, "Students with AIDS should be home-schooled." Further evidence of this belief is the -3 placement of the statement, "If I had a student with AIDS and could reduce my class size by one, it would be that student."

How a student contracted the disease is also in the forefront of the mind of an Informed Guardian. The statement, "When I hear that someone has AIDS, the

first thing I think of is how did they get it?" was ranked in the +4 position, higher than in any other factor group. This curiosity is just that, the Informed Guardians do not want the information as a way to judge the student. This is clearly evident in their respective -5 and -4 placement of the statements, "Students deserve AIDS if they engage in homosexual sex," and "I believe that people who contract AIDS are promiscuous." The beliefs of Informed Guardians is not based on religion or the "wrath of God" as seen by their -5 placement of the statement "My religious beliefs would influence my treatment of a student with AIDS," and on the -2 placement of "I believe that AIDS acquired through sexual behavior is God's way of punishing people for immoral behavior."

Informed Guardians want to protect students. They want to protect them from making judgemental errors, such as engaging in premarital sex. In fact, they see it as their moral responsibility to tell students to wait until marriage to have sexual relations (+3). They strongly believe that it is a lack of morality (+5) that continues to fuel the fire in the rise of AIDS. Informed Guardians recognize that a majority of students feel they may be "safe" from AIDS by the positive placement of "I believe most teenagers think they are safe from AIDS if they are not homosexual or injecting drugs." Informed Guardians further want to protect the students from the stigma that surrounds AIDS. They feel strongly (+5) that this stigma is linked to homosexuality and, because of the stigma, feel that having AIDS would be worse than having any other potentially fatal disease (+4).

Informed Guardians feel the need to also protect teachers and others. They feel that "teaching educators to use universal precautions will protect them

from acquiring AIDS” is a way to help educators deal with the fear they may have concerning students with AIDS. They strongly believe (+4) that AIDS awareness lectures will alter attitudes in regards to abstinence from sex and drug use. They do not believe that AIDS education is meant to frighten students as demonstrated by the -4 placement of that statement on the continuum.

An interview with a high loader on factor B further supported the interpretation of the Informed Guardian views. She is a 44 year-old special education teacher in a high school setting of a very small town. She stated that the root of her beliefs about the lack of student understanding of AIDS and the need for intense AIDS awareness training is based on the conversations she hears every day. She hears students talk about who they had sex with and feels that students are still having multiple partners with no regard to the potential for contracting disease. She stated that she “fears for them (students).”

This participant revealed that in her small town, under 5000 people, that there have already been two deaths of former high school students of AIDS. She herself, did not know the victims, but does know the sisters of the victims in both cases. She has not personally known anyone with AIDS.

This interviewee expressed strong feelings about how ostracizing having this disease would be for students at her school, or in her community, because of the small town mentality that only homosexuals and drug users get AIDS. The need to protect and guard these students was paramount for her. She does not want teachers to be forced to take students with AIDS, but not because of the rights of the teacher, but because of the need for the student to be wanted and

welcomed. She also talked about the placement of the statement regarding how a student contracted AIDS. Her belief was that although knowing how someone contracted AIDS would not affect how she would treat them, if others were honest they, too, would admit that curiosity feeds the desire to know. This participant felt that the statements used in the sort were comprehensive, but, similar to the interviewee in the Nonjudgmental Realists group, wondered why there were no statements about teachers with AIDS.

The Informed Guardians ranked positively that AIDS is a death sentence and that those who have AIDS and continue to have sex without informing their partners should be charged with murder. This interviewee not only felt this to be true, but was even stronger in those convictions than the typical Informed Guardian. She strongly supported telling students to wait for sex until marriage and stay away from drugs. She felt this was the approach that educators should take to combat the spread of AIDS.

Distinguishing Statements

Beliefs held by Informed Guardians are distinguishable from Nonjudgmental Realists in several characteristic statements. The Informed Guardians placed the statement, "My religious beliefs would influence my treatment of a student with AIDS" on the negative array. In fact, they placed it in the -5 position, indicating a very strong opinion in this regard whereas the Nonjudgmental Realists were ambivalent to the statement, ranking it at "0." Additionally, Informed Guardians gave a negative ranking (-1) to the statement, "I am more concerned about contracting Hepatitis from a student than AIDS."

Nonjudgmental Realists, on-the-other-hand, felt very strongly about the statement, ranking it at +5. The difference between the two rankings could be (1) because Nonjudgmental Realists understand that Hepatitis is easier to contract due to its ability to survive for several days outside of the body, or because, (2) Informed Guardians, possessing the knowledge of both contraction and safety precautions, are just not overly concerned about contracting AIDS or Hepatitis. The beliefs of the Informed Guardians are further distinguished from the beliefs of the Nonjudgmental Realists when considering disclosure of mode of contraction. The Informed Guardians, want to know how a student acquired AIDS, as evidence in the +4 ranking of that statement, whereas the Nonjudgmental Realists claim they are indifferent to knowing (0). Informed Guardians appear to believe that teaching students about AIDS is an educational strategy to help students make better decisions, not to frighten them of the disease. This is indicated by the -4 placement of that statement, but the "0" placement of the statement by the Nonjudgmental Realists demonstrates that they are not necessarily in agreement. The factor array for the Informed Guardians is shown in Appendix H.

Participants on Factor B: Informed Guardians

Thirteen participants identified with the Informed Guardians beliefs. Their factor loadings ranged from .32-.66. Four of the Informed Guardian group were female special educators. There were no male special educators in this group. There were three male and six female general educators that aligned with the Informed Guardian belief. The Informed Guardians ranged from age 22 to 45,

with a similar number of teachers represented in each age range. As with the Nonjudgmental Realists, about half (7 of 13) had taught under ten years. More associated themselves with the Republican party, with two refusing to answer the question. Table VII displays the characteristics of the Informed Guardian group.

TABLE VII
FACTOR B: INFORMED GUARDIAN CHARACTERISTICS

Participant Number- Gender-Reg. or Spec. Ed.- Elem. or Sec. Level	Load	Age	Years Teaching	Political Affiliation	Religious Affiliation
10-F-Sp-S	+.55	45	3	Democrat	None Given
12-F-Sp-S	+.44	42	20	None Given	None Given
14-F-Sp-S	+.55	44	20	Republican	None Given
25-F-Sp-E	+.66	34	10	Democrat	Baptist
34-M-R-E	+.42	28	1	Democrat	None given
39-F-R-E	+.32	25	3	Republican	Christian
48-F-R-E	+.52	38	7	Republican	Baptist
49-F-R-E	+.50	22	1	Republican	Methodist
57-F-R-E	+.48	26	2	Republican	Latter Day Saints
65-M-R-S	+.48	33	11	Republican	Baptist
67-F-R-S	+.51	42	10	None Given	Protestant
76-F-R-S	+.62	35	14	Republican	Church of Christ
80-M-R-S	+.64	32	5	Republican	Protestant

Factor C: Accountable Pragmatists

Twelve individuals aligned with factor C and have been labeled the Accountable Pragmatists. Accountable Pragmatists take a practical approach in dealing with students or other individuals with AIDS. They want to strike a balance between principles, like morality and responsibility, and self-preservation. Accountable Pragmatists try not to judge others' behavior or lifestyle, but still feel that in the end, the people with AIDS who engaged in at-risk

behaviors must be accountable for the choices they've made and the consequences of those choices.

Morally, most Accountable Pragmatists believe that both parents and schools have lost control over young people and that the nation as a whole has lost its moral fiber. This is demonstrated by the positive placement on the continuum of those beliefs (+3 and +4, respectively). However, they strongly believe that it is not their moral duty to tell students that homosexuality is a sin (-5) or that they should not engage in premarital sex (-2). Accountable Pragmatists do however, feel some responsibility to correct a student's misinformation about AIDS if they hear them discussing the subject but only if the parent has given permission. An Accountable Pragmatist would not override the moral right of a parent to refuse AIDS education in the school, this is clearly demonstrated by the -5 placement of the statement, "I believe that even if a parent signed a statement that they did not want their child to receive AIDS education; it is my moral responsibility to answer their questions about AIDS."

When considering obligation, Accountable Pragmatists feel that the individual with AIDS must be responsible for their behavior. They demonstrate this convincingly with their placement at the +5 position of the statement, "A person who has AIDS and does not tell their partner, then has unprotected sex, should be legally charged with murder." Although they do not judge that person for having AIDS, as shown by the -4 placement of statements JWV 5 and JWV 11 ("Students deserve AIDS if they engage in homosexual sex," and "I believe that AIDS acquired through sexual behavior is God's way of punishing people for

immoral behavior,” respectively), Accountable Pragmatists do believe in disclosure for those interacting with the individual with AIDS.

Accountable Pragmatists also feel strongly that districts must be accountable for teachers’ safety and disclose to them if they have students in their classes with HIV/AIDS. This is clearly pointed out with the +4 placement of the statement, “I would hold my district liable if I contracted HIV from a student that I had not been told carried the virus.” They do not, however, feel that others need to know. They do not think that it would be fair, nor beneficial, for other students to know who has AIDS and how they got it. They indicate this strong belief by placing that statement in the -5 position. They believe themselves to be accountable too for the information that they are told, and would not tell their own best friend if they had a student with AIDS in their classroom (-4).

In general, Accountable Pragmatists believe they might care for a student’s injuries before using universal precautions (+2), but acknowledge their own desire for preservation in that if they knew about the disease they would be more cautious (+4) and less likely to act without following the proper procedures. Preservation also becomes evident for the Accountable Pragmatists when they admit that even though their mind tells them that their own child is safe with a student having AIDS, their emotions tell them maybe that isn’t so. They also feel strongly on the issue of students with AIDS participating in sports. To them the risk of injury and contamination to others is not worth it, as evidenced on their ranking of the statement, “Students with AIDS should not be allowed to participate in sports” in the +3 position. However, Accountable Pragmatists

balance their need for preservation with their accountability as teachers when they believe that students with AIDS should not be home-schooled (-4) nor placed in special education classes (-3).

Accountable Pragmatists appear to have a reasonable knowledge base about AIDS and current information. They very strongly (+5) believe that teenagers think themselves safe from AIDS if they are not homosexual or injecting drugs. Along with that thought is the feeling that there will always be a homosexual stigma surrounding AIDS, with that statement receiving a +4 on the continuum from the Accountable Pragmatists. Accountable Pragmatists seem to understand how AIDS is and is not transmitted as demonstrated when they ranked "I am more concerned about contracting Hepatitis from a student, than contracting HIV" in the +5 position.

A post-sort interview was held with a 44 year-old female special education teacher. She has never been in contact with someone with AIDS. She agreed that her beliefs are based on a balance between morality and accountability but tempered with self-preservation. This woman felt that her views on accountability came straight from her childhood. She commented that her father always stressed the principle of "free will," but added there was accountability in accepting the consequences from the options that free will gives us. She explained that although she is knowledgeable about AIDS and how it is and is not acquired, she would always be a little cautious around someone that has AIDS, not necessarily for herself, but for her own children.

When asked about religion influencing her beliefs she shared that her father was, and her husband is, a minister. She felt though, that her religion guides her to make moral and ethical decisions, not judgemental. She felt strongly, as did the other Accountable Pragmatists, that a person who has sex knowing that they can pass on the virus to an unsuspecting partner, should be held accountable for murder, or at least, attempted murder.

Unlike her fellow Accountable Pragmatists, she did not believe that if a student came to her with questions about AIDS she would only answer them if the parents have given permission for information about AIDS to come from the school. Specifically, she said, "If a student comes to me confidentially with an honest question, I feel I must give them a confidential honest answer. It really wouldn't matter what the parents said."

When asked about students with AIDS participating in sports, she qualified the statement to include contact sports. This participant was not sure how much AIDS awareness lectures will change students' behaviors in regard to sexual abstinence. She believes that your attitude about premarital sex really comes from the home and also that students believe nothing bad will ever happen to them, it is always "the other guy."

A second post-sort interview was conducted with a 32 year-old male 3rd grade teacher. He also believed that the title and definition of Accountable Pragmatist as used to describe the factor C group was accurate. He feels that our parents have lost control over children and that one of the reasons for that is because parents are so much younger that we are actually having to educate

parents along with their children. He feels that students are not concerned about contracting AIDS if they are not in a high risk group because they think they are indestructable. He believes that young people feel it “won’t happen to them,” which is one reason he is not convinced that AIDS awareness lectures will have much effect at the teen age level.

He stated that although he does not know anyone with AIDS, he does know of people with AIDS in his community and although they did not contract HIV through homosexual sex, they are still stigmatized as if they had. For that reason he placed the statement regarding AIDS and the homosexual stigma surrounding it in the +4 position of the continuum.

This participant feels very strongly that morality issues should be discussed at home with parents, not in schools which is why he ranked statements dealing with moral issues at the ends of the array. This participant also clarified the statement about sports saying that students with AIDS should not be allowed in contact sports, the risk of cuts and bleeding was too high. Neither of the interviewees had additional statements they felt should have been presented that weren’t, nor did they feel any that were given were inappropriate.

Distinguishing Statements

Several statements in sorts completed by the Accountable Pragmatists were ranked in positions that separated them from the rankings of the previous two factors. The first statement that demonstrated a significant difference, dealt with the issue of holding a district liable if a teacher got AIDS from a student that they were unaware had the disease. While both the Nonjudgmental Realists and

Informed Guardians ranked it +1, the Accountable Pragmatists felt strongly about it, ranking it a +4. The Accountable Pragmatists were the only group that felt so strongly about not disclosing to students how another student got AIDS, that they ranked the statement at -5, with the other two ranking it -2. The Accountable Pragmatists also were the only group of the three that felt that having AIDS would not be worse than having any other potentially fatal disease as demonstrated in their ranking of -3, while the Nonjudgmental Realists and the Informed Guardians ranked it +2 and +4, respectively. This would be in line with a pragmatic attitude toward diseases being nondiscriminatory or, in the case of someone who acquired through at risk behaviors, being accountable for the consequences of the choices we make. Accountable Pragmatists were indifferent, or maybe just not sure, if AIDS awareness lectures would help to change student's behaviors regarding sex and drugs. They ranked this statement at "0", while the Nonjudgmental Realists and Informed Guardians felt strongly that lectures would help (+4). Lastly, there seems to be some indecision about the amount of money that is spent on people with AIDS for those believing as the Accountable Pragmatists do. This is shown by their "0" ranking, while the other groups clearly think the money being spent is needed, ranking it at -4 and -2. The Factor C: Accountable Pragmatists array can be seen in Appendix I.

Participants on Factor C: Accountable Pragmatists

There were twelve participants that identified with the factor C, Accountable Pragmatists. Their loading on this factor ranged from .35 -.71. Eight of the twelve were female, with nine in general education. The majority, eight of twelve, of the

Accountable Pragmatists had taught less than ten years, with five of those in their first year. Half identified themselves as Republicans and all but one aligned with a Christian faith. Table VIII displays the characteristics of the Accountable Pragmatists.

TABLE VIII
FACTOR C: ACCOUNTABLE PRAGMATISTS' CHARACTERISTICS

Participant Number- Gender-Reg. Or Spec. Ed.- Elem. or Sec. Level	Load	Age	Years Teaching	Political Affiliation	Religious Affiliation
05-F-Sp-S	+ .59	45	23	Republican	Episcopal
21-F-Sp-E	+ .68	44	12	Republican	Methodist
28-F-Sp-E	+ .60	53	6	Democrat	Baptist
43-M-R-S	+ .66	56	1	Republican	Episcopal
44-M-R-S	+ .40	30	6	Independent	Episcopal
45-F-R-E	+ .63	46	12	Democrat	Baptist
50-M-R-S	+ .54	29	1	Republican	Protestant
53-F-R-S	+ .53	23	1	Independent	Church of God
60-M-R-E	+ .71	32	1	Democrat	Baptist
62-F-R-E	+ .51	36	1	Republican	Assembly of God
68-F-R-S	+ .55	42	21	Democrat	Agnostic
74-F-R-S	+ .35	27	5	Republican	Baptist

Factor D: Forgiving Moralists

The participants that identified with factor D have been labeled the Forgiving Moralists. Forgiving Moralists believe strongly (+5) that our nation has a lack of morality. This does not distinguish them from the Informed Guardians, who also ranked this statement at +5, nor much from the Accountable Pragmatists, who ranked it a +4. What does separate the Forgiving Moralists from the others is that their religious beliefs drive their behavior toward students.

Forgiving Moralists rank the influence of their religious beliefs on their treatment of students with AIDS at a +5. For the Forgiving Moralists the influence of their religious beliefs is two-sided. On one side is the belief that they have a moral responsibility to tell students to abstain from premarital sex (+4). They also feel it is their moral responsibility to tell students that homosexuality is a sin, as demonstrated in their placement of this statement in the +2 position.

Forgiving Moralists believe that schools and parents have lost control over children and that is why AIDS is on the rise. Forgiving Moralists believe that AIDS acquired through sexual behavior is God's way of punishing people for the immoral behavior, this is evidenced by their placement of this statement in the +3 position. The fact that it is not any higher on the array would indicate that although Forgiving Moralists consider this to be true, they do not feel it is true for everyone with AIDS. Of the eight participants who align with the Forgiving Moralists, one placed this statement at a +4 and another at +5.

On the other side of the influence of their religious beliefs they are guided to treat all students with respect and kindness. This is demonstrated by their placement of the statement, "Regardless of how a student contracted AIDS, I would welcome them into my class," in the +5 position. It is further demonstrated by the -5 placement of "If I had a student with AIDS and could reduce my class by one, it would be this student." Forgiving Moralists probably would live by the credo, "Hate the sin, love the sinner." Although the other groups also placed this statement on the negative end of the continuum, none placed it higher than a -3.

Further evidence is given to support the idea that Forgiving Moralists' religious beliefs guide them to treat students equally and without judgment because they feel elementary students with AIDS would not be treated with more kindness than secondary students (-5), even though secondary students are more likely to have had some control over the behaviors that may have led to their acquisition of the HIV virus. They also do not hold separate beliefs toward students who are born with AIDS from those who acquire it through at risk behaviors (-2), nor do they think that being a hemophiliac makes the student any less innocent than others with AIDS (-3). Forgiving Moralists do not want to separate students with AIDS from the general population, this belief is supported by their placement of the following statements, "Students with AIDS should be home-schooled" (-4), and "Students with AIDS should be taught in special education classes because the teachers are trained to deal with sick kids" (-5).

Forgiving Moralists believe strongly as do Accountable Pragmatists that having AIDS and then having unprotected sex with an uninformed partner, should lead to legal charges of murder, this is demonstrated by the +4 placement of that statement. Forgiving Moralists align with Nonjudgmental Realists and Accountable Pragmatists in their belief that teenagers think they are safe from AIDS if they are not homosexual or injecting drugs.

As with Nonjudgmental Realists and Informed Guardians, Forgiving Moralists believe that AIDS awareness lectures will help to change students' behaviors in regards to acquiring AIDS. They also believe that teachers will be

safer if they are trained and implement universal precautions when dealing with students' bodily fluids.

One of the highest loadings on factor D was achieved by a 59 year-old female special education teacher. During the post-sort interview she stated that the title of Forgiven Moralists accurately labeled her feelings about students with AIDS. She explained that her upbringing as a Catholic is instrumental in her feelings and beliefs. This coincides with the +5 ranking of the statement, "My religious beliefs would influence my treatment of a student with AIDS." This participant stated that the "yardstick" she lived by as a child, and even now, is a question that her mother would ask her when she had done something that was wrong or naughty; the question was, "Is that what a good Catholic would do (or should have done)?"

This interviewee told me a story about when she was growing up in the small Oklahoma town she lives in. She remembers a time when she asked her mother why there was a "white" and "colored" drinking fountain at the drug store? She said that her and a friend tasted the water from both fountains and there did not seem to be a difference. Her mother explained about the segregation of blacks and whites and at the same time explained that God did not think we should treat people differently, that everyone should be accepted for who they are.

That upbringing and her mother's explanation is why she believes she would accept any child into her room, with or without AIDS, homosexual or not. In this way she supports the Forgiven Moralists' acceptance, respect, and kindness

for everyone. When questioned about her +3 placement of the statement, “ I would feel differently toward a student who was born with the AIDS virus than one who had acquired it through their lifestyle,” she answered that she would probably have less empathy toward a student who had acquired AIDS than toward a baby born with it. She referred to the baby as a “innocent victim” because they had no choices, and felt that would be “so very sad.” On-the-other-hand she believes she would never do anything that would make the non-innocent student feel bad or less welcome.

When questioned about talking to students about AIDS, this participant felt that if directly asked by a student, she would tell them that morally premarital sex was wrong (+4). She further elaborated that she would answer students’ direct inquiries even if their parents had directed the school personnel not to instruct their child in AIDS education. This interference without parental support is in some opposition with the overall Forgiving Moralists view. The Forgiving Moralists ranked that statement at the +1 position, but this interviewee felt more strongly about it and ranked it +3.

On one other issue this particular participant was in disagreement with the Forgiving Moralists’ overall beliefs. The Forgiving Moralists ranked the statement, “I believe that AIDS acquired through sexual behavior is God’s way of punishing people for immoral behavior” at a +3, whereas this woman ranked it at 0. When asked to elaborate on her feelings, she stated that she did not think that God punished with a disease. She explained that probably the other Forgiving Moralists ranked it higher because of the choices people make to have multiple

partners and take drugs. She also felt strongly, as did the other Forgiving Moralists, that students with AIDS should be educated in the most normal setting possible, including participating in sports, so that they would feel welcome and accepted.

Distinguishing Statements

Forgiving Moralists were the only group that placed the following statement on the positive side of the array (+3) "I believe that AIDS acquired through sexual behavior is God's way of punishing people for immoral behavior;"

Nonjudgmental Realists, Informed guardians, and Accountable Pragmatists, placed it at -5, -2, -4, respectively. Another statement that separated Forgiving Moralists from the other groups is that their religious beliefs influence their treatment of students with AIDS. This statement was ranked a +5 for the Forgiving Moralists, with the Nonjudgmental Realists, Informed Guardians, and Accountable Pragmatists ranking it 0, -5, and 0, respectively.

Forgiving Moralists felt strongest among the four groups that students with AIDS should not be barred from sports, giving this statement a ranking of -3. They also believed very strongly that elementary students and secondary students with AIDS would not be treated differently, ranking this statement at -5, while Nonjudgmental Realists, Informed Guardians, and Accountable Pragmatists ranked it 2, -1, and 1, respectively. Forgiving Moralists seemed to take offense to the statement that "A teacher who is unaware of how HIV is transmitted is not a good teacher, because they have not been learning

themselves,” as they ranked it -4, while the other groups ranked it 3, 1, and 0. The full array of rankings for the Forgiving Moralists can be seen in Appendix I.

Participants on Factor D: Forgiving Moralists

Eight participants aligned themselves with the Forgiving Moralists belief system. Their factor loadings ranged from .43-.73. Five of the eight were female, and were equally divided between general and special educators. Most, five of eight, had ten years or less of teaching experience. There were more Democrats than Republicans, with only one Independent. Table IX displays the overall characteristics of the Forgiving Moralists.

TABLE IX
FACTOR D: FORGIVING MORALISTS’ CHARACTERISTICS

Participant Number- Gender-Reg. Or Spec. Ed.- Elem. or Sec. Level	Load	Age	Years Teaching	Political Affiliation	Religious Affiliation
01-F-Sp-S	+ .73	45	20	Democrat	None Given
13-F-Sp-S	+ .58	59	29	Democrat	Catholic
18-M-Sp-E	+ .49	29	1	Independent	Christian
27-F-Sp-E	+ .53	42	10	Republican	Christian
38-M-R-S	+ .41	34	5	Republican	None Given
66-F-R-S	+ .55	29	6	Democrat	Pentacostal
71-F-R-S	+ .48	26	2	Democrat	Baptist
81-F-R-S	+ .57	28	2	Democrat	Christian

The beliefs of teachers toward students with HIV/AIDS has been described in the above pages. Also of interest in this study is to find whether teachers’ beliefs toward students with HIV/AIDS are affected by their gender or by their area of specialization. The literature review has demonstrated that a teacher’s

gender and area of specialization can be a discriminating factor with regard to some topics.

Differences in Beliefs Among Male and Female Teachers

Of the 81 completed sorts analyzed, there were 14 male participants (15%). Among those 14, two produced sorts that were non-significant (11%), three had beliefs aligning with Factor A (9.6% of the Nonjudgmental Realists), three with Factor B (23% of the Informed Guardians), four with Factor C (33% of the Accountable Pragmatists), and two with Factor D (25% of the Forgiving Moralists). This breakdown indicates that there is no one belief among male educators toward students with AIDS, although the fewest number of men appear to believe in the “live-and-let-live” philosophy of the Nonjudgmental Realists .

The distribution of the 69 females completing sorts was: 16 (23%) produced sorts that were non-significant, 27 (42%) aligned with Factor A: Nonjudgmental Realists , 10 (14%) with Factor B: Informed Guardians, eight (11.5%) with Factor C: Accountable Pragmatists, and six (8.6%) with Factor D: Forgiving Moralists. As with the male educators, there does not seem to be a factor that encompasses the beliefs of all female teachers.

It would appear that male educators have some degree of difference in their beliefs than female educators as demonstrated by the relationship of gender to Nonjudgmental Realists, Accountable Pragmatists, and Forgiving Moralists. Among the total number of females completing significant sorts almost half (42%) believed as the Nonjudgmental Realists , that AIDS is a disease, *not* a moral

issue. In contrast, the smallest percentage of men in the study (9.6%) believed the same. Contrastingly, among the Forgiving Moralists, the smallest percentage of women (8.6%) and the second largest percentage of men (25%) believed that AIDS is *primarily* a moral issue. The percentage of the total men in the study that made up the Accountable Pragmatists (33%) was significantly different than the percentage of the women making up that belief group (11.5%). Although the differences between the percentage of men (23%) and women (14%) identifying with the Informed Guardians were not as great as with the other three factors, they are worth noting.

Questions were asked of study participants relevant to their beliefs about AIDS education, confidentiality, safety, and the rights of the individual.

Demographic information was illicit as well. Additionally, participants were asked if they knew, or had known, anyone with AIDS. Only slightly more women knew someone with AIDS, 45% (30 of 67), than did men, 43% (6 of 14).

Demographically, there were no significant differences between the men and women in relation to their political or religious affiliation, age ranges, subjects taught or number of years teaching. Due to the low number of men in relation to women in the overall study, percentages will be used to compare the responses of these two groups.

Two questions were asked concerning the issue of AIDS education. The first was at what grade should AIDS education begin? There was little difference in response between the male and females in the study, with regards to AIDS education. Fifty-nine percent of the men believed AIDS education should start in

the upper elementary grades (4-6), while 55% of the women agreed. The rest of the responses were shared between lower elementary (men-26%, women-49%) and junior high (men-17%, women-10%). [Note that the percentages add up to 100%+ because some teachers choose several responses]. Neither group felt that AIDS education should wait until high school, and only one women felt the AIDS education should only take place in the home. The second question centering around AIDS education inquired as to who should teach it. The majority of men felt that either the nurse (44%) or the health teacher (51%) should teach students about AIDS. The women, while agreeing that the nurse should lead instruction (54%), felt slightly stronger that if the subject came up in conversation any teacher should be able to teach about AIDS (32%), than they did about designating the health teacher (28%).

On the issue of confidentiality there was little difference in the beliefs between men and women that all teachers (men-43%, women-46%), the principal (men-50%, women-54%), counselor (men-64%, women-66%), and the teachers that came into daily contact with the student (men-50%, women-42%) should be told if a students has AIDS. Although the percentages of men and women who believe the nurse should be told is very high, the difference between the two is significant because while 89% of the women felt the nurse was a key person, 100% of the men felt that way. There were also differences in the beliefs about confidentiality when it came to telling the school board and the janitor. Only 13% of the women believed that the school board should be told, while 28% of the men felt it necessary to inform them. The opposite was true with the janitor,

43% of the men felt he/she should know, while only 28% of the women felt the same. There was one woman and one man that felt that no one should be told unless the student wanted it known.

There were slight differences in beliefs when teachers were asked who should decide if a student with AIDS is allowed to come to school. The majority of the men (57%) felt that the law has the last say, with 23% believing the school board has the right to decide. A majority of women agreed that the law had the right to decide (39%), but parents placed second (16%) for the right to decide. Neither men nor women felt very strongly that the principal, nurse, or doctor should be able to make that decision.

Each participant was asked how often they use universal precautions to protect themselves from possible contamination through bodily fluids. There were significant differences in the responses with regard to this practice. Forty-three percent of the men responded that they did not use universal precautions 50% of the time, while only 13% of the women said the same. Twenty-seven percent of the women say they use precautions 100% of the time, compared to only 21% of the men, while 39% of the women say they use precautions 75% or more of the time, with only 21% of the men saying the same.

Differences in Beliefs Between Special Educators and General Educators

The breakdown of the total number of special educators and general educators completing Q-sorts was 32 special educators and 49 general educators. Therefore, 40% of the sorts analyzed came from special educators, with 60% from general educators. The non-significant sorts were divided equally

between the special (9) and general educators (9). Of the 23 special educators with significant sorts, 52% (12) made up the Nonjudgmental Realists group, 17% (4) made up the Informed Guardians, 13% (3) composed the Accountable Pragmatists, and 17% (4) made up the Forgiving Moralists. General educators, who comprised 60% of the total number of Q-sort participants, with 40 being significant, made up 45%(18), 22%(9), 22%(9), and 10%(4), of the Nonjudgmental Realists, Informed Guardians, Accountable Pragmatists, and Forgiving Moralists, respectively.

Comparatively, the Nonjudgmental Realists were 40% special educators, 60% general educators, the Informed Guardians were 31% and 69%, the Accountable Pragmatists were 25% and 75%, and special and general educators each made up half of the Forgiving Moralists. Overall, it would appear that in terms of the beliefs of the Nonjudgmental Realists and Forgiving Moralists special educators and general educators share similar ideals. There were more general educators than special educators that share the beliefs of the Informed Guardians and the Accountable Pragmatists.

As with males and females, there were no significant differences between the special educators and general educators in relation to their political or religious affiliation, age ranges, subjects taught, or number of years teaching. In regard to questions concerning safety, confidentiality, student rights, and AIDS education there are only two areas where the beliefs of special and general educators produce much difference. The issue of who decides if a student with AIDS attends school demonstrated an overall agreement that the law should

have the final say, albeit the general educators were more united on that issue than the special educators. Hierarchially, the general educators felt that the law, doctor, and then the parents should decide, with 43%, 31% and 10% of the general educators agreeing to this. The beliefs of the special educators met with less agreement, with the law (31%) narrowly surpassing the rights of the parents and doctors, both at 25%.

The frequency with which educators use universal precautions when dealing with an injured student, is an area of difference. Thirty-three percent of special educators say they practice universal precautions 100% of the time, with 38% practicing at least 75% of the time. Only 20% of general educators, however, say they use precautions 100% of time, with 33% using them at least 75% of the time. Twenty percent of general educators use precautions less than half of the time, compared to only 16% of special educators.

Questioning when, and by whom, AIDS education should be taught produces little difference in the beliefs of general and special educators. Forty-five percent of general educators and 44% for special educators believe AIDS education should begin in the upper elementary grades, with 43% and 50%, respectively, believing the lower elementary grades would be best. As to who should teach the students about AIDS, 50% of special educators and 49% of general educators (both a majority) felt the nurse would be the most appropriate person to do so.

First hand knowledge of someone with AIDS is shared almost equally between the special and general educators participating in the study. Forty-three

percent of the general educators and 44% of the special educators state that they know, or have known, someone with AIDS. The issue of confidentiality also shows similarities in the beliefs of both groups. The majority of special educators felt that principals (78%), nurses (88%), and counselors (72%) all should know if a student in the school has AIDS. A few more general educators than special educators felt principals (82%) and nurses (92%) had a right to know, and a few less that counselors (61%) needed to be informed. In regard to teachers' need to know, about half of both general (45%) and special educators (41%) thought that the teachers dealing with the student on a daily basis had the right to know if one of their students had AIDS.

Summary

The results of the data interpretation indicates that there are four basic beliefs among teachers concerning students with HIV/AIDS: Nonjudgmental Realists, Informed Guardians, Accountable Pragmatists, and Forgiving Moralists. These four beliefs account for 63 of the 81 sorts completed. The other 18 sorts did not demonstrate significance on any of the four factors.

Male teachers, more than female teachers, aligned with the factor groups that believe morality is embedded in the HIV/AIDS crisis. There are some differences in the beliefs of male and female teachers when the issues are related to confidentiality, decisions regarding the appropriateness of a student with HIV/AIDS attending school, and the implementation of universal precautions when dealing with bodily fluids.

Among general and special educators there are similarities in the make up of the four belief groups, with the Nonjudgmental Realists having the highest number of each, and the Forgiving Moralists being split 50/50. As with the comparison of beliefs between males and females, there were differences in the beliefs between general and special educators on the topics of students with HIV/AIDS attending school and the implementation of universal precautions.

CHAPTER 5

CONCLUSIONS AND IMPLICATIONS

This research study was designed to explore the subjective views of teachers' beliefs about students with AIDS using Q-Method. We know that the number of school aged children with HIV/AIDS is rising primarily due to three reasons: (1) the heterosexual female population is the fastest growing group of HIV infected individuals (Sims, 1998); (2) as of 1997 40% of the 12,000 children known to be infected with the AIDS virus were of school age (Kowalski, 1997); and (3) the death rate for AIDS related illnesses, and the increase in the number of years a child lives with HIV/AIDS will have more children attending school for a greater number of years (CDC, 1998). This Q-study identified four general belief patterns, or perceptions, of teachers concerning these children. The teachers' beliefs are represented as: Nonjudgmental Realists, Informed Guardians, Accountable Pragmatists, and Forgiving Moralists.

Three research questions were investigated within this study.

- (1) In what ways do teachers perceive students with HIV/AIDS?
- (2) In what ways do the types of beliefs concerning students with AIDS differ among male and female teachers?
- (3) In what ways do the types of beliefs concerning students with AIDS differ among general and special educators?

Summary of Teachers' Perceptions

The largest number of teachers shared the Nonjudgmental Realists

perspective. Nonjudgmental Realists believe that AIDS is a medical crisis, not a moral one. A second belief group among teachers are the Informed Guardians. The protection of both students and adults is of critical importance to the Informed Guardians. The Accountable Pragmatists comprise the third belief group among teachers toward students with AIDS. They want to strike a balance between morality and responsibility, and the need for self-preservation. They believe as the Informed Guardians that our country is lacking in morality, but they do not agree that it is a teacher's responsibility to correct that. The last belief group identified through this study was the Forgiving Moralists. These teachers are driven by their religious beliefs and feel they have a moral duty to forgive sins, but at the same time, educate about the immoral behaviors leading to AIDS.

The strongest belief difference between male and female teachers seem to be that men are more inclined to believe AIDS is a moral issue whereas women believed it to be a medical problem. The use of universal precautions was more evident with females than with males. Special and general educators also differed in the use of universal precautions, with special educators stating they implement the procedures regularly, while general educators do not. As for beliefs toward AIDS, special educators were more prevalent in the Nonjudgmental Realists and the Forgiving Moralists, while general educators were most represented in the Informed Guardians and the Accountable Pragmatists.

Conclusions

The literature review clearly demonstrates there is a stigma surrounding persons with AIDS which is demonstrated by many professionals throughout our society (Anderson, 1992; Bishop, Alva, Cantu & Rittiman, 1991; Crandall, 1991; Crandall & Coleman, 1992; Herek, 1990; Herek & Glunt, 1988; Kelly, St. Lawrence, Smith, Hood, & Cook, 1987; Range & Starling, 1991). Teachers are professionals within our society also, so it would stand to reason that there would be teachers who would demonstrate stigmatizing beliefs toward students with AIDS.

The stigma of AIDS comes in many forms; fear (Peach & Reddick, 1989); decreased personal interactions (Gruman & Sloan, 1983); less compassion and consideration if the person is “blamed” for acquiring the disease (Bailey, Reynolds, & Carrico, 1989); and even stronger stigma if the person affected is associated with an already “shamed” group such as homosexuals or IV drug users (Herek & Glunt, 1988; Pryor & Reeded, 1993).

Examining the categories of the Q-sort statements and revisiting where specific statements were ranked by the four belief groups reinforces that there are teachers that recognize, and even support, some aspects of the stigma that surrounds AIDS. Fear is an aspect of AIDS stigma that is clearly recognized within the belief patterns of teachers. Fear is perceived by teachers believing as Forgiving Moralists, Informed Guardians, and Accountable Pragmatists. This is demonstrated by their respective +4, +5, and +4 ranking of the statement, “If I knew a student had AIDS I would be more cautious around him/her than if I did

not know.” The Informed Guardians further demonstrate the fear stigma of AIDS when they rank as a +4, “I feel that having AIDS would be worse than having any other potentially fatal disease,” and ” My mind tells me that a student with AIDS in my own child’s class is safe, my emotions tell me otherwise,” as a +3. The Accountable Pragmatists further perpetuate the fear stigma of AIDS with a positive ranking of the statement, “Students with AIDS should not be allowed to participate in sports,” (+3).

The increased stigma of AIDS when associating it to an already ostracized group such as IV drug users, person’s who are promiscuous, or homosexuals is also evident in several of the teacher belief patterns. Informed Guardians and Accountable Pragmatists believe that there is, and always will be, a homosexual stigma attached to the AIDS virus, as shown by their respective +5 and +4 rankings of that statement. This same sentiment was shared in post-sort interviews with a person sharing the views of an Informed Guardian and a Nonjudgmental Realist.

The Forgiving Moralists feel that God actually uses AIDS as punishment for immoral behavior (i.e. homosexual sex and promiscuity). This belief not only supports the stigmatizing aspect of AIDS because of group association, it also supports the Just World View (Lerner, 1970, 1971, 1977) of “people deserve what they get, and get what they deserve.”

Two aspects of stigma, decreased personal interactions, and less compassion or consideration directed to the person affected with AIDS if deemed

to have “caused” it, were not demonstrated by any of the four teacher belief patterns.

Implications

The beliefs that teachers hold influence their perceptions, attitudes, and judgements (Pajares, 1992), which in turn, are manifested in their behavior (Allport, 1954) and interactions with students. Four of the five categories utilized for the Q-sort statements were derived from the theory of stigma. These categories: Just World View, Preventability, Severity/Fatality/Treatment, and Knowledge of Cause, helped describe the beliefs of the teachers in this study.

For teachers holding to the Just World View, students with AIDS would deserve the disease because they did something judged as wrong, i.e. using IV drugs, engaging in homosexual sex, or displaying promiscuous behavior. With the exception of the Forgiving Moralists believing that God punishes immoral behavior with AIDS, no other belief group supported this view. Statements such as, “Students deserve AIDS if they engage in homosexual sex,” or “I would feel differently toward a student who was born with the AIDS virus than toward a student who acquired it because of their lifestyle,” were not ranked significantly by any group, including the Forgiving Moralists. This implies that although students who acquire AIDS may be irresponsible in their behaviors, teachers do not hold any animosity toward them, or feel less compassion for their fate.

The category of Severity/Fatality/Treatment encompasses the theory that the results of stigma are fear, isolation, and death (Gussow & Tracy, 1968; Sloan & Gruman, 1983; Walster, 1966). The aspect of fear has already been discussed

in the conclusions section, however the concepts of isolation and death were not found to be supported in teachers' beliefs. As a matter of fact, the teachers not only did not want to shun students with AIDS by placing them in home schools, (Nonjudgmental Realists ranked this statement at -3; Informed Guardians at -5; Accountable Pragmatists at -4; & Forgiving Moralists at -4) or special education, (-3, -4, -3, and -5, respectively) they welcomed them to their classes. The point made was that it did not matter how the AIDS was acquired, any student with AIDS was welcomed. This acceptance was shared across all teacher belief patterns as demonstrated by the ranking of "Regardless how a student contracted AIDS, I would welcome them to my class," by the Nonjudgmental Realists at +5, Informed Guardians at +4, Accountable Pragmatists at +3, and Forgiving Moralists at +5. Teachers across all four belief groups also rejected choosing the student with AIDS if they could reduce their class by one (-3, -3, -3, and -5, respectively). The implication of these rankings is that teachers will not isolate or reject students with AIDS, even if they feel the student had some responsibility in acquiring the disease.

The fatality of AIDS and how that ties to the stigma surrounding it (Sloan & Gruman, 1983) was also not supported by any of the teacher belief groups, with each group ranking the statement, "AIDS is a death sentence" at +1 or 0. It was not clear if the teachers ranked this statement in the middle of the array because they do not know much about the death rate among AIDS carriers, if they felt that medical improvements are now giving persons with AIDS a new lease on life, or

if they did not see death as a stigmatizing aspect of AIDS. The more neutral ranking does imply however, that teachers are not overly fearful of dying of AIDS.

Preventability (Crandall, 1991; Crandall & Moriarty, 1995; Leone & Wingate, 1991) deals with the theory that the stigma of AIDS is tied to the ability of people to protect themselves from acquiring the disease by not engaging in immoral behavior. Essentially, prevent the stigma by stopping the spread of AIDS through drugs and/or sex. According to the current study, teachers who believe in preventing AIDS do so either through AIDS education, or by preaching morality. Morality was the dividing concept in the beliefs of teachers. All but the Nonjudgmental Realists felt that our nation is lacking in morality, with the ranking of, "I think that AIDS is on the rise because of a lack of morality in our nation," at +5 for Forgiving Moralists, +5 for the Informed Guardians, and +4 for Accountable Pragmatists.

Those teachers that believe preventing AIDS means teaching morality, belonged mostly to the Forgiving Moralists and the Informed Guardians. Although educating others about AIDS was a high priority in all four belief groups, it was the means of doing so that helped provide the demarcation of the factors. For those teachers aligned with the beliefs of the Informed Guardians and the Forgiving Moralists, the implication regarding the concept of morality would be that they intend to teach students their (the teachers) concept of morality, i.e. do not have premarital sex, and also for some of those believing as the Forgiving Moralists, do not engage in homosexual sex because it is a sin.

Of paramount importance in considering the results of this study is

whether or not the educators would “walk the talk.” The question is whether teachers will “act” as they claim they “believe.” For example: teachers claim that education in the use of universal precautions is important to protect individuals from acquiring AIDS. This was demonstrated in the ranking of, “Teaching educators to use universal precautions in dealing with bodily fluids will protect them from acquiring AIDS” by the Nonjudgmental Realists (+4), Informed Guardians (+3), Accountable Pragmatists (+2), and Forgiving Moralists (+3). Yet, when asked in practice, “how often do you use universal precautions?”, many admitted to not doing so a good deal of the time. It is disconcerting that on an issue like universal precautions, which requires no emotional investment or interpersonal engagement, teachers do not seem to be “walking the talk.” The implication could be that teachers responded to some questions in the “acceptable” manner, but they may not carry them out in the same way.

Limitations

This study was conducted in a rural area in the state of Oklahoma so the findings may not generalize to other areas. Additionally, there were eighteen sorts that proved nonsignificant and therefore were not part of the analysis of the four belief groups. It is possible that one or more of those eighteen sorts represent another teacher belief that has not been described. Lastly, the number of men in the study was not remotely proportional to the number of women participating.

Future Research

Although a variety of ways of acquiring AIDS (IV drugs, heterosexual sex, homosexual sex, and/or promiscuity) were covered in this study, the idea of child sexual abuse, was not. If questions concerning child sexual abuse resulting in the child's acquisition of AIDS or any other STD were included, there may have been other belief patterns established.

Some participants in this study had concerns about beliefs of teachers toward co-workers with HIV/AIDS. Two of the six post-sort interviewees raised this topic. Would it matter to teachers if one of their peers had AIDS? Would they feel as charitable toward an adult and they say they would be to a child? Would the educational community be willing to accept a teacher with AIDS that was a known homosexual or past drug user? These issues have not been investigated and yet homosexuals, drug users, and people with AIDS are (mostly in secret) teaching in our schools.

During the post-sort interviews held with the highest loaders of each factor, it was determined that none of those interviewees had been personally associated with an individual with AIDS. Further research could be conducted using similar Q-sort statements but having only persons with personal connections to others diagnosed with AIDS perform the sorts to determine if the same factors would emerge.

Additionally, further research should be conducted to determine if teacher-student interactions are affected by information given to the teacher concerning a student's medical conditions and/or sexual orientation. Much like the studies on the effect of labeling on teachers' stereotypes and expectations of

students (Salvia, Clark, & Ysseldyke, 1973; Foster, 1976) teachers could be given information about students, with data collected on the resulting teacher behaviors. However, the acceptability of this type of research to an Institutional Review Board may present an ethical roadblock.

Lastly, similar Q research could be conducted focusing on the beliefs of other professional groups of people (doctors, nurses, police, etc.) toward persons with AIDS.

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APPENDIXES

APPENDIX A

Please complete the following demographic questionnaire.

- (a) Age Range: 21-25 _____
26-30 _____
31-35 _____
36-40 _____
41-45 _____
46-50 _____
51-55 _____
55+ _____
- (b) Gender : M _____ F _____
- (c) General Educator: Elementary Education _____
Secondary Education _____

Special Educator: _____
- (d) Number of Years Teaching: 1-10 _____
10-20 _____
20+ _____
- (e) Subject Taught: Special Education _____
Elementary 1st-5th _____
Secondary Sciences _____
Secondary Language Arts _____
Secondary History _____
Secondary Other _____
- (f) Political Affiliation: Republican _____
Democrat _____
Other _____
- (g) Religious Affiliation: Catholic _____
Methodist _____
Lutheran _____
Baptist _____
Jewish _____
Christian (non-denominational) _____
Buddhist _____
Muslim _____
Other _____

APPENDIX B

I, _____, hereby authorize or direct Jane Rupard, or associates or assistants of her choosing, to perform the following treatment or procedure:

1. An audio taped interview whereby open-ended questions will be asked of me regarding my opinions of students with HIV/AIDS in the classroom. In addition, I will be asked demographic questions concerning my teaching experience, age, religious and political affiliations.
2. The interview will take approximately one hour.
3. My name will not be requested, all tapes will be kept confidential until the end the study. At that time, the tapes will be destroyed.
4. The subject matter is of a sensitive nature; my participation is totally voluntary.
5. The results of this study will help classroom teachers to better understand how their personal feelings may effect their professional interactions with students.

This is done as an investigation entitled **The Stigma of AIDS: An Exploration of Teachers' Beliefs.**

The purpose of the procedure is to develop an instrument in which to assess teachers' attitudes toward students with HIV/AIDS and specifically if the mode of contraction of the disease has any effect on the teacher-student relationship.

I understand that participation is voluntary, that there is no penalty for refusal to participate, and that I am free to withdraw my consent and participation in this project at any time without penalty after notifying the project director.

I may contact Jane Rupard at 918-832-8121. I may also contact Gay C. Clarkson, IRB Executive Secretary, 305 Whitehurst, Oklahoma State University, Stillwater, OK 74078.

I have read and fully understand the consent form. I sign it freely and voluntarily. A copy has been given to me.

Date: _____ Time: _____ a.m./p.m.

Signed: _____
Signature of Subject

I certify that I personally explained all elements of this form to the subject before requesting the subject to sign it.

Signed: _____
project director of her authorized representative

APPENDIX C

JUST WORLD VIEW:

- JWV1 Elementary age students with AIDS would be treated more kindly than secondary students.
- JWV2 Too much money is spent on people with AIDS.
- JWV3 I believe people who contract AIDS are promiscuous.
- JWV4 I would feel differently toward a student who was homosexual and not heterosexual.
- JWV5 Students deserve AIDS if they engage in homosexual sex.
- JWV6 I would feel differently toward a student who was born with the AIDS virus than toward a student who acquired it because of their lifestyle.
- JWV7 I feel that students are less fearful than educators about being around other students with AIDS.
- JWV8 If a student had AIDS at my school, he/she would be harassed.
- JWV9 I would treat hemophiliacs with AIDS differently because they are innocent victims.
- JWV10 A person who has AIDS and does not tell their partner, then has unprotected sex, should be legally charged with attempted murder.
- JWV11 I believe that AIDS acquired through sexual behavior is God's way of punishing people for immoral behavior.

SEVERITY/FATALITY/TREATMENT:

- SFT1 I feel that having AIDS would be worse than having any other potentially fatal disease.
- SFT2 If I knew a student had AIDS I would be more cautious around him/her than if I did not know.
- SFT3 Students with AIDS should be taught in special education classes because the teachers are trained to deal with sick kids.

- SFT4 Students with AIDS should be home-schooled.
- SFT5 It is more dangerous for the student with AIDS to be with other students than it is for the healthy student to be with a student with AIDS.
- SFT6 If a student were HIV+ I would be less fearful of them than if they had AIDS.
- SFT7 AIDS is a death sentence.
- SFT8 Students with AIDS should not be allowed to participate in sports.
- SFT9 When I hear that someone has AIDS, the first thing that crosses my mind is, "How did they contract it?"

PREVENTABILITY:

- P1 I believe AIDS awareness lectures will change students' behaviors in regards to abstinence from sex or drug use.
- P2 I think that AIDS is on the rise because of a lack of morality in our nation.
- P3 I feel it is my moral responsibility to tell students to abstain from premarital sex.
- P4 I feel I am at risk in my professional environment to contract AIDS.
- P5 Teaching educators to use universal precautions in dealing with bodily fluids will protect them from acquiring AIDS.
- P6 I believe that biased or false information about HIV/AIDS would be given to students if all teachers are allowed to teach about it.
- P7 I think that AIDS education is meant to frighten students.
- P8 I would tell my own child to avoid a student I knew had AIDS.
- P9 I believe most teenagers think they are safe from AIDS if they are not gay or injecting drugs.
- P10 My religious beliefs would influence my treatment of a student with AIDS.
- P11 I would take care of a child's injuries before thinking about universal

precautions.

- P12 I believe it is my moral responsibility to tell students homosexuality is a sin.

TEACHER RESPONSIBILITY:

- TR1 I believe that even if a parent signed a statement that they did not want their child to receive AIDS education; it is my moral responsibility to answer their questions about AIDS.
- TR2 I would probably tell my closet friend if a student in my class had AIDS.
- TR3 Teachers should not be forced to have a student with AIDS in their classroom.
- TR4 I should not be expected to take responsibility for the safety of all students.
- TR5 I would stay out of students' conversations about AIDS, even if what they were saying was incorrect.
- TR6 A teacher who is unaware of how HIV is transmitted is not a good teacher, because they have not been learning themselves.
- TR7 If I had a student with AIDS and could reduce my class size by one, it would be that student.
- TR8 I would hold my district liable if I contracted HIV from a student that I had not been told carried the virus.
- TR9 Teachers with AIDS should be restricted from certain positions.

KNOWLEDGE OF CAUSE:

- KC1 Regardless of how a student contracted AIDS, I would welcome them into my class.
- KC2 I believe that AIDS is on the rise among adolescents because parents and schools have lost control over children.
- KC3 I believe that students should be told how another student acquired AIDS,

that way they will know it could also happen to them.

- KC4 I believe there will always be a homosexual stigma associated with AIDS.
- KC5 I am more concerned about contracting Hepatitis from a student than contracting HIV.
- KC6 My mind tells me a student with AIDS in my own child's class is safe, my emotions tell me otherwise.
- KC7 All public school teachers should be screened for AIDS, just as they have to be for TB.

APPENDIX D

I, _____, hereby authorize or direct Jane Rupard, or associates or assistants of her choosing, to perform the following treatment or procedure:

1. To conduct a Q-sort regarding the beliefs of teachers toward students with HIV/AIDS and to request demographic questions.
2. My name will not be requested, all forms will be kept confidential until the end the study. At that time, the forms will be destroyed.
3. The subject matter is of a sensitive nature, but my participation is totally voluntary.
4. The results of this study will help classroom teachers to better understand how their personal feelings may effect their professional interactions with students.

This is done as an investigation entitled "The Stigma of AIDS: An Exploration of Teachers' Beliefs."

The purpose of the procedure is to determine the general types of belief held by teachers toward students with HIV/AIDS.

I understand that participation is voluntary, that there is no penalty for refusal to participation is voluntary, that there is no penalty for refusal to participate, and that I am free to withdraw my consent and participation in this project at any time without penalty after notifying the project director.

I may contact Jane Rupard at 918-832-8121. I may also contact Gay C. Clarkson, IRB Executive Secretary, 305 Whitehurst, Oklahoma State University, Stillwater, OK 74078.

I have read and fully understand the consent form. I sign it freely and voluntarily. A copy has been given to me.

Date: _____ Time: _____ a.m./p.m.

Signed: _____
Signature of Subject

I certify that I personally explained all elements of this form to the subject before requesting the subject to sign it.

Signed: _____
project director or her authorized representative

APPENDIX E

Script for completing the Q-sort:

“This study is designed to investigate your beliefs about students with HIV/AIDS in schools. You will be given a set of statements and asked to rank order them from those, which are most like your beliefs to those that are least like your beliefs, this is referred to as a Q-sort. Confidentiality is granted for all participants. In any publication of the results of this study, confidentiality and anonymity will be preserved.”

“In addition to completing the Q-sort some of you may be asked to participate in a telephone interview for further clarification of your choices. If you are willing to be interviewed, you will be asked to write your telephone number on your recording sheet, do not include your name. If your sort demonstrates a “high loading” on a factor you may be called to clarify why you choose to place specific statements on the extreme ends of the continuum.”

“Please read through the 48 statements in front of you so that you will be familiar with them. As you do this, sort them into three piles. The right pile will be those statements with which you agree. The left pile will be those statements with which you do not agree. The center pile is statements that you are not sure of or have a neutral opinion about.”

“You also have been given a large matrix with a “most like me” written on the right and a “most unlike me” written on the left. In each column there is room to place a statement card. After you are satisfied that the 48 statements you have just sorted into three piles are correct, study the pile on the right. This pile is the “like me” pile. Select three of the statements that are most like you and place them on a space under the “most like me” column of the matrix. It does not matter which one is in the top space. Now study the statements in the pile that is the “unlike me” and choose the three most unlike you to place under the “most unlike me” column. Continue this process going back and forth from “like me” to “unlike me” until all the columns are full. Once this is completed, review for accuracy.

“Record your statements by their corresponding letters and number on the recording form provided. Please also complete the demographic questionnaire that is attached to the recording form. Thank you for your participation. Please be sure to leave your recording form, demographic questionnaire, and signed consent form. A blank consent form is available to you for your records.”

APPENDIX F

Q-Sort Matrix

Most Unlike Me					Most Like Me					
-5	-4	-3	-2	-1	0	+1	+2	+3	+4	+5
_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____	_____	_____	_____	_____	
		_____	_____	_____	_____	_____	_____	_____		
			_____	_____	_____	_____	_____			
				_____	_____	_____				

APPENDIX G

Please complete the following demographic information sheet.

(a) Age _____ (b) Gender M F (c) General Education Teacher _____
Special Education Teacher _____

(d) Subject(s) taught _____

(e) Number of years teaching _____

(f) Political Affiliation

Republican

Democrat

Independent

(g) Religious Affiliation _____

(h) At what grade should AIDS education be begun in school?

Lower Elementary K-3

Upper Elementary 4-6

Junior High 7-8

High School 9-12

AIDS education should be taught at home, not in school

(i) Who should be informed if a student in the school has AIDS? (Choose all that apply).

All teachers

Principal

Parents of other students

Janitor

School board

Nurse

Other students

Counselor

Only the teachers that the student is in daily contact with

(j) If there is a dispute, who should have the final say if the student with HIV/AIDS can come to school?

Parent(s) of the student with HIV/AIDS
Doctor

School Board
School Nurse

Principal
Law

(k) Have you known anyone who has (had) AIDS? Yes No

(l) How often do you use universal precautions when dealing with an injured child?

100% of the time

75% or more

50-75% of the time

less than half of the time

(m) If AIDS education is to be taught in the schools, who should teach it?

Counselor

Health teacher

P.E. Teacher

Science teacher

Nurse

Any teacher as the subject comes up

APPENDIX H

Q-Sort	Factor 1	Factor 2	Factor 3	Factor 4
01FSpS	-.08	.32	-.00	.73X
02FSpS	.25	.46	.11	.46
03FSpS	.33	.19	.42	.39
04FSpS	.54X	.15	.36	.30
05FSpS	.41	.28	.59X	.15
06FSpS	.44	.26	.44	.43
07FSpS	.70X	-.12	.33	.14
08FSpS	.41	.27	.29	.24
09MSpS	.57X	.12	.51	.10
10FSpS	.34	.55X	.28	.16
11FSpS	.08	.32	.33	.23
12FSpS	.42	.44X	-.03	-.02
13FSpS	.13	-.05	.13	.58X
14FSpS	.18	.55X	.31	.07
15FSpS	.24	.46	.14	.47
16FSpS	.46	.29	.40	.32
17FSpE	.79X	.10	.15	-.02
18MSpE	-.05	.20	.08	.49X
19FSpE	.77X	-.13	.16	.19
20FSpE	.30	.36	.44	-.10
21FSpE	.32	-.06	.68X	.27
22FSpE	.56X	.12	.38	.08
23FSpE	.68X	-.20	.18	.04
24FSpE	.71X	-.07	.25	.23
25FSpE	.18	.66X	.12	.33
26FSpE	.53	.42	.33	.06
27FSpE	.26	-.20	.35	.53X
28FSpE	.39	-.07	.60X	.12
29MSpE	.50X	.18	.18	.25
30FSpE	.76X	.10	.02	.22
31FSpE	.60X	.05	.28	-.05
32FRE	.65X	-.01	.02	.21
33FRE	.71X	.15	.12	.18
34FRE	-.18	.42X	-.10	.29
35FRE	.48X	.20	.38	.15
36FRE	.67X	.21	-.01	.32
37FRE	.51	.21	.23	.41
38FRE	-.29	.24	-.04	.43X
39FRE	.17	.32X	.02	.18
40FRE	.45X	.13	.34	.15
41FRE	.52	.38	.13	.33

Q-Sort	Factor 1	Factor 2	Factor 3	Factor 4
42FRE	.60X	.07	.42	-.02
43FRE	.04	-.03	.66X	.14
44FRE	.05	.29	.40X	.11
45FRE	.26	-.11	.63X	.24
46FRE	.61X	.17	.06	.43
47FRE	.88X	.17	-.02	.02
48FRE	-.10	.52X	.37	.15
49FRE	.27	.50X	.40	.04
50MRS	-.10	.36	.54X	.02
51FRS	.47X	.20	.12	.41
52FRS	.43	.37	.39	.19
53FRS	.18	.35	.53X	.25
54FRS	.62X	.21	.38	.06
55FRS	.84X	.16	.09	-.11
56FRS	.58X	.47	.22	.07
57FRS	.29	.48X	.11	.36
58FRS	.50	.51	.10	.29
59FRS	.59X	.55	.16	.04
60MRE	.11	.23	.71X	.10
61FRE	.26	.19	.26	.26
62FRE	.19	.22	.51X	.34
63FRE	.54X	-.04	.13	.49
64MRS	.50	.43	.39	-.21
65MRS	.27	.48X	.17	.16
66FRS	.01	.43	-.05	.55X
67FRS	.36	.51X	-.08	.11
68FRS	.23	.10	.55X	-.14
69FRS	.71X	.27	-.01	.17
70FRS	.77X	.06	.20	-.03
71FRS	.25	.10	.37	.48X
72MRS	.51	.24	.23	.54
73FRS	.45X	.33	.17	.22
74FRS	.00	.26	.35X	.04
75FRS	.40	.51	.41	.10
76FRS	.15	.62X	.11	.10
77FRS	.47	.16	.32	.59
78MRS	.77X	.31	.24	.02
79MRS	.69X	.11	.35	.07
80MRS	.12	.64X	.11	-.03
81FRS	.32	.04	.23	.57X

APPENDIX I

Factor A: Nonjudgmental Realists

-5	-4	-3	-2	-1	0	1	2	3	4	5
JWV5	JWV3	JWV9	P2	TR3	SFT8	KC6	P11	SFT2	P1	P9
JWV11	P8	SFT3	KC3	KC7	P7	TR1	JWV1	JWV10	SFT5	KC1
P12	JWV4	TR7	P3	TR9	P10	TR8	KC4	P6	P5	KC5
	JWV2	SFT4	JWV6	KC2	SFT9	P4	JWV8	TR6	JWV7	
			TR4	TR5	SFT6	SFT7	SFT1			
					TR2					

Factor B: Informed Guardians

-5	-4	-3	-2	-1	0	1	2	3	4	5
SFT4	JWV3	TR7	KC3	KC5	P8	TR4	P9	TR2	P1	SFT2
P10	TR5	SFT6	JWV8	SFT5	KC7	TR6	TR9	P3	SFT1	P2
JWV5	SFT3	P4	JWV11	SFT8	TR1	JWV7	P6	P5	KC1	KC4
	P7	P12	JWV2	JWV1	JWV6	SFT7	KC2	KC6	SFT9	
			TR3	P11	JWV9	TR8	JWV10			
					JWV4					

APPENDIX J

Factor C: Accountable Pragmatists

-5	-4	-3	-2	-1	0	1	2	3	4	5
TR1	TR2	P7	TR5	JWV9	P1	JWV8	P5	SFT8	TR8	JWV10
P12	JWV11	SFT3	SFT5	TR4	JWV2	JWV6	P11	KC1	P2	P9
KC3	JWV5	TR7	P3	JWV3	TR6	JWV1	TR3	JWV7	SFT2	KC5
	SFT4	SFT1	P4	P8	TR9	SFT7	KC6	KC2	KC4	
			KC7	SFT6	P10	P6	SFT9			
					JWV4					

Factor D: Forgiving Moralists

-5	-4	-3	-2	-1	0	1	2	3	4	5
TR7	TR6	JWV5	JWV2	P11	SFT7	KC7	KC4	P1	P3	KC1
JWV1	JWV8	JWV9	JWV6	P6	SFT5	TR3	KC5	P5	P9	P2
SFT3	TR5	JWV3	TR4	TR9	JWV4	KC3	KC6	KC2	JWV10	P10
	SFT4	SFT8	P8	P4	SFT1	SFT9	TR8	JWV11	SFT2	
			TR2	SFT6	P7	TR1	P12			
					JWV7					

APPENDIX K

OKLAHOMA STATE UNIVERSITY
INSTITUTIONAL REVIEW BOARD

DATE: 09-29-98

IRB #: ED-99-024

Proposal Title: THE STIGMA OF AIDS: AN EXPLORATION OF TEACHERS'
BELIEFS

Principal Investigator(s): Charles R. Davis, Jane M. Rupard

Reviewed and Processed as: Exempt

Approval Status Recommended by Reviewer(s): Approved

Signature:



Date: October 8, 1998

Carol Olson, Director of University Research Compliance
cc: Jane M. Rupard

Approvals are valid for one calendar year, after which time a request for continuation must be submitted. Any modification to the research project approved by the IRB must be submitted for approval. Approved projects are subject to monitoring by the IRB. Expedited and exempt projects may be reviewed by the full Institutional Review Board.

OKLAHOMA STATE UNIVERSITY
INSTITUTIONAL REVIEW BOARD
HUMAN SUBJECTS REVIEW

Date: September 29, 1998

IRB #: HE-99-024

Proposal Title: THE STIGMA OF AIDS: AN EXPLORATION OF TEACHERS' BELIEFS

Principal Investigator(s): Charles R. Davis, Jane M. Rupard

Reviewed and Processed as: Exempt

Approval Status Recommended: Pending Revision

You will need to make the following revisions to your research project before approval is granted. When these changes are made, please submit a revised IRB application under the IRB number listed above. Once these changes are incorporated into your research project, IRB approval will be granted, and you may begin your study. If you have questions or wish to discuss the reviewers' comments, please schedule a meeting or call Dr. Carol Olson, Director of University Research Compliance (405-744-7076) or Gay Clarkson, IRB Executive Secretary (405-744-5700) in Whitehurst 203.

To receive approval, the following items must be addressed and/or incorporated into the research protocol:

- 1) On review, it is stated that no names, addresses or other identifiers will be utilized. The subjects are, however, requested to provide telephone numbers which does constitute an identifier. The Principal Investigator(s) should make sure that this information will be appropriately secured and access limited. Please specify how this will be done.
- 2) Please specify when the information will be destroyed.

Signature: 

Date: October 1, 1998

cc: Jane M. Rupard

Approvals are valid for one calendar year, after which time a request for continuation must be submitted. Any modification to the research project approved by the IRB must be submitted for approval. Approved projects are subject to monitoring by the IRB. Expedited and exempt projects may be reviewed by the full Institutional Review Board.

APPENDIX L

OKLAHOMA STATE UNIVERSITY
INSTITUTIONAL REVIEW BOARD
HUMAN SUBJECTS REVIEW

Date: 03-02-97

IRB#: ED-97-068

Proposal Title: THE STIGMA OF AIDS: AN EXPLORATION OF
TEACHERS' BELIEFS

Principal Investigator(s): Diane Montgomery, Jane M. Rupard

Reviewed and Processed as: Exempt

Approval Status Recommended by Reviewer(s): Approved

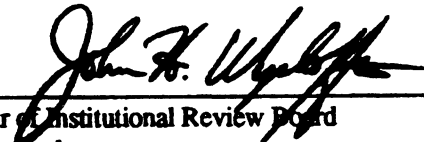
ALL APPROVALS MAY BE SUBJECT TO REVIEW BY FULL INSTITUTIONAL REVIEW BOARD
AT NEXT MEETING, AS WELL AS ARE SUBJECT TO MONITORING AT ANY TIME DURING
THE APPROVAL PERIOD.

APPROVAL STATUS PERIOD VALID FOR DATA COLLECTION FOR A ONE CALENDAR YEAR
PERIOD AFTER WHICH A CONTINUATION OR RENEWAL REQUEST IS REQUIRED TO BE
SUBMITTED FOR BOARD APPROVAL.

ANY MODIFICATIONS TO APPROVED PROJECT MUST ALSO BE SUBMITTED FOR
APPROVAL.

Comments, Modifications/Conditions for Approval or Disapproval are as follows:

Signature:



Chair of Institutional Review Board

cc: Jane M. Rupard

Date: March 13, 1997

VITA

Jane M. Rupard

Candidate for the Degree of

Doctor of Philosophy

Dissertation: A DESCRIPTION OF TEACHERS' BELIEFS ABOUT STUDENTS WITH AIDS USING Q METHOD

Major Field: Applied Behavioral Studies

Biographical:

Personal Data: Born in Pontiac, Michigan, on November 8, 1955, the daughter of Gerald and Jean Clement, one brother, Jerry. Married to Kenneth L. Rupard; we have a son, Jon.

Education: Received Bachelor of Science degree in Education majoring in Special Education from Wayne State University, Detroit, MI in June 1978; received Master of Science degree with a major in Special Education from University of Houston in December of 1990. Completed the requirements for the Doctor of Philosophy degree at Oklahoma State University in May, 1999.

Experience: Teacher of the Visually Impaired in New Caney, TX in 1981 and in Huntsville, TX at Region VI ESC from 1981 to May, 1986; Teacher/Supervisor for Deaf-Blind at the Lighthouse of Houston, Houston, TX from May 1986 to November 1990; Teacher for students with multiple disabilities in Spring ISD, Spring, TX, from November 1990 to May 1993. Special Education Teacher at Blackwell High School in Blackwell, OK, from August 1993 to May 1995. Teacher for Students with Emotional Disturbance in Ponca City Schools, OK from August 1995 to May 1997. Employed as a Special Education Coordinator for Fort Bend ISD in Sugar Land, TX, since August 1997.

Professional Memberships: Council for Exceptional Children, Association for Supervision and Curriculum Development, Autism Society of Greater Houston