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GRADUATE COLLEGE

PERCEPTIONS OF AIDS EDUCATION ISSUES: A QUALITATIVE STUDY OF AT RISK INDIVIDUALS

A Dissertation

SUBMITTED TO THE GRADUATE FACULTY

in partial fulfillment of the requirements for the degree of

Doctor of Philosophy

By

TERESA A. MITCHELL

Norman, Oklahoma

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PERCEPTIONS OF AIDS EDUCATION ISSUES:
A QUALITATIVE STUDY OF AT RISK INDIVIDUALS

A Dissertation APPROVED FOR THE
DEPARTMENT OF EDUCATIONAL LEADERSHIP
AND POLICY STUDIES

BY

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DEDICATION

To my parents, John and Tiny Mitchell, who taught me respect for a job well done, expected nothing less than my best, and loved me no matter what.

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ABSTRACT

Seven young people who had attended Oklahoma public schools and received the state mandated AIDS education program were interviewed in depth to determine why they chose to engage in at risk behavior subsequent to being taught the dangers of such behavior. Each participant had risked exposure to the AIDS virus through direct blood exposure or through unprotected sexual activity.

The research affirmed certain elements of current AIDS education theories and revealed areas which should be added to instructional methods and curriculum content. Significant patterns affecting the participants' behavior choices were (1) divorce of their parents, (2) family mobility during school years, (3) age at initial at risk behavior, (4) trust in the word of their sexual partners, and (5) lack of values instruction at home. There was a general theme of hopelessness and doubt that any type of educational program could have affected their behavior.

The conclusions and implications of the research indicated a need for further research into what the public schools can do for the dysfunctional student who resists being told how to live life. A need was indicated for collaboration among the home, school, and community organizations to provide extensive instructional programs and supplemental family services which are necessary to combat the global AIDS epidemic.

CHAPTER I

Introduction

In the spring of 1981, a mysterious pattern of disease appeared among a small number of patients in New York, Los Angeles, and San Francisco. Deadly infections began to kill young homosexual men, and existing medical treatments and antibiotics were not successful in stopping those infections. "It was an immunologist from Los Angeles named Michael Gottleib who in 1981 reported the first cases of what was then called gay pneumonia" (Gorman, 1996/1997).

During the first months of 1982, the same disease pattern emerged among heterosexual men and women who had a history of using drugs intravenously (Flanders & Flanders, 1991). The next reported victims of the infectious disease were hemophiliacs who had been treated with a blood clotting-factor concentrate to control bleeding. In all of the groups plagued by these opportunistic infections, the normal immune capabilities of their bodies' disease-fighting abilities were compromised and ineffectual. Thus, the disease was named acquired immune deficiency syndrome (AIDS). Current medical research has determined that the earliest case of AIDS known to date was from an African man who died in

1959. This discovery suggests the virus first infected people in the 1940s or early 1950s (Haney, 1998).

"The idea that a virus was involved in AIDS crystallized in 1983" (Flanders & Flanders, 1991, p. 7). During the next three years, scientists and medical researchers struggled to isolate the virus in order to develop screening tests to detect the presence of AIDS in blood and to develop treatments to fight the infection. The virus was called human immunodeficiency virus (HIV) because of its depletion of the body's immune system. Money to support the medical research was slow in materializing because the victims of the disease were distinct classes of outcasts and social pariahs who had meager resources and almost non-existent political influence (Shilts, 1987). "But suddenly, in the summer of 1985, when a movie star was diagnosed with the disease and the newspapers couldn't stop talking about it, the AIDS epidemic became palpable and the threat loomed everywhere" (p. xxi). The national perception of AIDS changed when Rock Hudson's death brought world-wide attention to its presence and threat.

> In February 1986, President Reagan directed Surgeon General Dr. C. Everett Koop to prepare a "major report" on the AIDS epidemic. The surgeon general completed his report in October 1986. Identifying AIDS as a national health problem, the report discussed AIDS high-risk sexual behavior in explicit terms, outlined preventive measures including the use of condoms and called for AIDS education starting in elementary school (Flanders & Flanders, 1991, p. 39).

On April 24, 1987, Oklahoma Governor Henry Bellmon signed into law House Bill 1476 (See Appendix A) which mandated that AIDS prevention education be taught in every public school in the state of Oklahoma. Classroom instruction began in the fall of 1987, and the curriculum written by the Oklahoma State Department of Education in cooperation with the Oklahoma State Health Department remained almost untouched until the fall of 1997 when a revised curriculum was published.

TABLE

Diagnosed HIV+ and AIDS Cases in Oklahoma for Young People Who Would Have Received Formal AIDS Education

Year of Diagnosis	Age Category	Number of New Cases
1988	13-19	5
1989	13-20	12
1990	13-21	25
1991	13-22	25
1992	13-23	56
1993	13-24	51
1994	13-25	44
1995	13-26	67
1996	13-27	80
1997	13-28	82

Source of Data: Oklahoma State Department of Health, HIV/STD Service (March, 1998).

From the beginning of the school prevention program, the number of HIV/AIDS cases among Oklahoma young people has continued to rise (See Table), and this pattern is repeated across the nation (Billings, 1996; Lacayo, 1996/1997; Oklahoma State Department of Health, STD/HIV

Service, 1998). The evidence indicates that many adolescents are engaging in behavior that puts them at a potentially high risk of contracting the disease in spite of having received specific instruction in school about its dangers and prevention.

This proposed research project is to conduct a naturalistic, qualitative study of five to fifteen (Tesch, 1984) Oklahoma teenagers and young people in their early twenties who have engaged in at risk behaviors and placed themselves in danger of contracting the virus. The research will be limited to participants who have received the state mandated AIDS education curriculum through their local Oklahoma public schools. If the responses of the participants indicate similar patterns in their perceptions of the state AIDS curriculum, the study could be a theory-generating proposal for a change in the state public educational AIDS policy and perhaps in other preventive interventions as well. There is a direct correlation with similar attitude education in the areas of sex education, drug and alcohol abuse prevention education, and driver education courses (Longshore, Summer, 1990). There is also the possibility that the project could call for further research concerning any additionally discovered problems. An analysis of the perceptions of the

participants would suggest the conclusions of this emergent design research.

Problem Statement

The problem being investigated in this study can be stated at two levels. Indirectly, data are being sought which might improve the effectiveness of AIDS prevention programs. More directly, the perceptions of young people who have engaged in at risk behaviors will be explored to determine why the state mandated education programs were not effective in protecting these young adults from possible exposure to the AIDS virus.

Research Questions

The initial questions which drive this study are:

1. What perceptions of their public school AIDS education experiences are held by Oklahoma young people who have placed themselves at risk of contracting the disease?
2. Why did these participants engage in at risk behavior despite having received formal AIDS education in school?
3. How do the perceptions of these participants relate to the existing models researched in the current literature?

4. What are the views and observations of these young people from which a model AIDS education program could be developed?

Significance of the Study

The failure of the current state AIDS curriculum is evident in the continued rise in the number of reported AIDS/HIV cases among Oklahoma's youth. The significance of the study lies in the use of personal opinions and experiences of young people who received AIDS education in Oklahoma schools and still contracted the virus or who placed themselves at risk of contracting it. This study could be a factor in the improvement of educational methods, curriculum content, and techniques of instruction which could result in a downward trend in the AIDS statistics in Oklahoma.

Limitations of the Study

The study was limited by the restricted access to the HIV+/AIDS young people in Oklahoma. The identities of these young people are kept strictly confidential, and special effort was made through the Regional AIDS Interfaith Network, the Red Cross, Planned Parenthood, Meals on Wheels, and local support groups in order to contact possible participants. None of those who were identified agreed to participate in the study. The

actual participants were young adults who had placed themselves in danger of exposure to the virus through unprotected sexual activity and through direct blood contact.

Limitations associated with participants who were drug users included impaired brain functioning and decreased ability to analyze their personal behavior and state their reasons for placing themselves at risk of contracting HIV/AIDS. The participants from the drug rehaiblitation center had more difficulty remembering facts and incidents from the past and also in concentrating and maintaining a train of thought during the interview. It was a challenge for the researcher to utilize questioning techniques which assisted participants in being able to focus their thinking without the questions shaping their responses.

The participants included six females and one male, and this gender imbalance limited the male point of view for the study. Fewer males volunteered to be a part of the project, and two young men who initially agreed to participate cancelled their scheduled interviews at the last minute. Both cited the need to work during the set interview time and then refused to reschedule a more convenient appointment.

The small number of participants (seven) was also a limitation of the study. Tesh (1988) reduced her

original recommendation of 10 to 15 participants and stated that five to ten could provide a desirable phenomenological study. Obviously, a greater number of subjects would have provided a wider variety of responses, but the vast differences among the seven participants made it possible to obtain a varied profile.

There were three races represented in the study, Caucasian, Hispanic, and Native American. The socio-economic levels ranged from one subject who was receiving public assistance to one participant who classified her family as "rich". Their geographic locations throughout the state during the years of adolescence included a small town of less than 350 population up to the largest urban city in Oklahoma.

CHAPTER II

Related Literature

Introduction

The goal of this literature review is to examine the development of attitude education throughout the history of the United States and to relate the incorporation of AIDS education into the historical tradition of the American public school system. The areas of focus in the literature include the historical perspective of attitude education, the policy and legal issues concerning AIDS, and the educational and social issues of AIDS. The components of five models of successful AIDS education programs are discussed, and the Elaboration Likelihood Model of Petty and Cacioppo (1981) is explained and related to the procedures outlined in the AIDS education program models. The literature discussed represents a comprehensive analysis of current publications and journals, material from Educational Resources Information Center (ERIC), dissertations, historical publications in educational literature, and major works in the recent history of the AIDS epidemic since 1986.

An Historical Perspective of Attitude Education

Formal education in the early history of the United States centered on the church and the need for the community to provide children with instruction in religion and morals. The main objectives of education throughout its history have been to help people become smart and to help them become good (Lickona, 1993). The American colonists brought their cultural heritages with them from their homelands, and the schools they established had a mission to perpetuate this heritage (Gutek, 1970). "The American colonial educational experience, then, basically consisted of the reconstruction of imported English institutions in light of the New World environment" (p. 21). The church, state, and school shared a close relationship in those early days, and the schools were adjuncts of the church-state. Thus, the purpose of formal education in colonial America was to teach religious principles and the tenets of government. Horace Mann (1867) advocated that the common school be a center of civic education, a school of democracy, and a training ground for responsible public service. This practice persisted through the nineteenth century (Silin, 1995).

During the late 1800s, Friedrich Froebel, an American educational philosopher and practitioner, defined education as " . . . leading man as a thinking,

intelligent being, growing into self-consciousness, to a pure and unsullied, conscious and free representation of the inner law of Divine Unity, and in teaching him ways and means thereto" (Froebel, 1896, p. 1). He focused on the kindergarten as the place where children were to be allowed to "unfold" according to a pre-determined plan with no interference from the teacher, only guidance that encouraged the child in play and "self-activity" (Gutek, 1970). This educational philosophy also continued in the United States throughout the latter decades of the nineteenth century.

The emergence of the scientific method and direct observation during the late 1800s took precedence over religious conviction in education.

> Based in a philosophy of pragmatism rather than idealism, the progressives believed that the early childhood curriculum should be built on psychological rather than logical principles. . . . The school helps children learn appropriate behavior through social interaction and the reconstruction of experience, not through the imitation of moral models (Silin, 1995, p. 85).

This period in American education became known as the Progressive Era, roughly between 1890 and 1917. Compulsory attendance laws were enacted, and many immigrant children entered school for the first time (Dryfoos, 1994). "Social reformers, distressed by the poor health and the terrible living conditions of the immigrant children initiated efforts to transform schools

from places that concentrated strictly on the Three R's to places that tried to make up for the impact of poverty" (p. 20).

The psychological theory of education led to more socially relevant curricula in the 1900s, with the work of educators becoming more culture-bound and value-saturated because its goal was to prepare children to live within specific communities and traditions (Silin, 1995). As the school gradually assumed more of the educational responsibility formerly held by the home, the school program expanded to include instruction in social behavior.

Parents, and American society in general, have come to view schools as trustworthy organizations that are easy to locate in any community (Dryfoos, 1994).

> . . . schools are now required, as a practical matter, to take on more responsibilities than ever before. They must cope with drug abuse, violence, and other problems. They must make education more inclusive and technically competent than ever before. They cannot do so without sustained intellectual, organizational, technical, financial, and political support (p. xii).

In most advanced nations today, the educational establishment is increasingly considered as a primary means for solving social problems. In some instances, the future welfare of nations has been placed squarely upon the shoulders of the schools and universities (Worthen & Sanders, 1987). Technology, the economy, values, and political theory are all societal elements

that schools are expected to address for the advancement of the general welfare of the countries. It is not surprising then that a response to a national health crisis would be required from its educational system.

The spread of the AIDS virus is a social problem which presents a serious challenge to American society today, and the school system has assumed, and in many states has been mandated the burden of educating students about its dangers. "Realistic and meaningful instruction remains as potentially one of the most effective and efficient means for achieving a reduction in the rate of HIV infection" (Robenstine, 1993, p. 10). This educational effort has in general been launched without financial support from government entities. Federal and state funding for AIDS research, prevention, and education has been slow to develop due to lack of strong governmental leadership and because of the stigma associated with the disease (Shilts, 1987). The lack of outside funding for educational programs has forced schools to assume yet another legislated responsibility and absorb the cost. Schools have had to designate funds, create curriculum, train teachers, and amass community acceptance and support while attempting to navigate through the quagmire of political, legal, and policy issues associated with AIDS. It has been a

difficult challenge, and has caused many problems for teachers, administrators, and boards of education.

Educational Policy and Legal Issues Regarding AIDS

The educational community faces a three-fold policy issue where the AIDS virus is concerned. The first policy issue requires schools to develop programs and curriculum content to educate and inform students about the dangers of the disease and the methods of transmission. An emphasis of this research project will focus on this policy area and the challenges associated with developing effective and acceptable policies which implement AIDS education.

The second AIDS policy area of concern centers around how schools choose to deal with students and employees who are infected with AIDS. Both issues create immediate problems for schools as the AIDS epidemic spreads and more people are exposed. Babies born with AIDS in the early or middle 1980s presented few problems for school systems because they usually died from the disease before reaching school age. However, this trend reversed itself in the early 1990s and is not the case today. "As the medical field increases its knowledge about the virus and develops more sophisticated treatment techniques that delay or prevent progression from seropositive to AIDS, there will inevitably be more

infected children reaching school age" (Liss, 1989, p. 94). The schools must now be prepared with written policies protecting the rights of those infected with AIDS to pursue an education or to continue with their jobs and careers as long as they are able.

The third AIDS policy issue which must be confronted by school districts is that of the confidentiality which must be maintained concerning the identity of each individual carrying the virus. Legislation has been enacted which prevents the disclosure of the identities of AIDS patients in order to protect them from stigmatization and discrimination (Harvey, 1994; Liss, 1989). Parents with children in school will demand to know if there are any teachers or students infected with AIDS who are teaching or attending classes with their children (Schoeman, 1991). Because the risk of transmission of the virus in school settings is well-established as minimal, strong arguments exist for protecting confidentiality of the individuals with HIV infection by not disclosing their HIV status (Harvey, 1994).

Administrators are caught in the middle between protecting the infected students and employees and receiving public criticism and pressure for doing so. The school which develops and follows AIDS policies in a pro-active manner rather than waiting to be confronted by

an immediate crisis will prevent chaotic, volatile, and panic reactions from the local community (Liss, 1989). Schools must develop policies and procedures that provide not just for current AIDS challenges but for an automatic system of review when any future health concern develops.

There are existing federal and state laws which mandate free and uniform public education, equal access, and least restrictive environments for all students regardless of health problems. Denying educational services to a child with AIDS invites court action and the resulting negative media attention directed at the school system. The U.S. Supreme Court has ruled (School Board of Nassau County, Florida v. Arline, 1987) that HIV-infected children are extended the protection provided by the Rehabilitation Act and the Education for All Handicapped Children Act and are protected from discrimination in their access to employment and educational services. Thus, a district which tries to prohibit a child with AIDS from attending school is in violation of the law and is susceptible to legal action and the resulting publicity. The courtroom is not the place for the school district to decide policy matters. Decisions about AIDS policy made in the offices of physicians and school district administrators are more likely to protect the confidentiality of the infected

child or employee and serve the best interests of all the people involved (Liss, 1989).

The Educational and Social Issues of AIDS

The role of the public school in America has undergone a vast change since the Colonial period which yielded basic instruction in reading, 'riting, and 'rithmetic. The educators of the 1990s are faced with the challenge of still providing students with the basic academic skills while at the same time equipping them with the social skills necessary to survive in modern society. Teachers are no longer called upon just to present facts and information; they are required to demonstrate proficiency in being able to influence the attitudes, beliefs, values, and actions of their students.

Just as the role of the school has changed in the past 300 years, the role of the American family has also undergone a metamorphosis. Skills, values, and attitudes which were formerly learned in the home from parents and grandparents are now an accepted and expected part of the public school curriculum. The school has been given the responsibility for educating youngsters in areas that were once the sole prerogative of the nuclear family. Students in school today receive group instruction in cooking, driving, physical fitness, fine arts, sexuality,

drug and alcohol abuse, values, AIDS prevention, and many other peripheral subject areas.

One of the greatest challenges facing the public school today is that of providing young people with life and death education about AIDS prevention. "Over the last 10 years, the Acquired Immune Deficiency Syndrome (AIDS) has become one of our nation's major health problems" (Nettle, et al, 1995, p. 45). The fact that AIDS is of national concern means that the American young people are being affected as well as infected and that ". . . no one is in a better position to assist youth in preparing to confront the issue of AIDS than the nation's educators" (Tonks, 1992-1993, p. 48).

Public school teachers are being called upon to provide instruction about a subject that is not yet included in college teacher preparation programs (Billings, 1996). It is a subject that did not even exist when the majority of today's practicing teachers were receiving their professional training. Curriculum guides are being hastily compiled, in-service programs are being quickly presented, and teachers are being pushed into instructing in a curriculum area which they did not choose to enter. Many instructors are personally uncomfortable with the subject matter and resist having to talk about it in the public classroom (Tonks, 1992/1993). This is not a positive climate for

successful educational prevention programs, and it is often an open invitation to failure.

In some areas of the country, local school boards are reluctant to have such a controversial subject as AIDS brought into the curriculum and the classroom. ". . . (T)o provide education specific enough to speak directly to the behaviors that transmit this deadly virus is to provoke a confrontation between issues of health and safety and issues of morality" (Dodds, Volker, & Viviand, 1989, p. 120). Robenstine (1993) discusses the difficulty of educating students about a subject containing such sensitive information:

> AIDS is a behavior-bound disease. Thus, to be effective, education must lead to changes in behavior that eliminate or reduce substantially the risk of HIV infection. In formulating and implementing policy, we must first acknowledge that sexual practice is a biologically-based, socially-complex behavior. It derives from biological impulses that are hard to resist; sexual attractiveness is a prominent standard in our youth-oriented culture. And, there continues to be disagreement about the appropriateness of certain educational messages employed to prevent HIV infection. HIV/AIDS exposes deep-seated fears and inhibitions in American society. As a result, what is fundamentally a public health issue has too often become a religious one (p. 13).

The connection to illegal drug usage and to the homosexual lifestyle makes the discussion of AIDS taboo in many conservative school districts. School officials in those communities are hesitant to offend their patrons and do not want to risk instituting programs of instruction that will bring citizen protests (Popham,

1993). There are parents and community leaders who refuse to believe that students are having sex or are engaged in using drugs. These leaders are adults who are not coming to terms with the societal issues of teenage sexuality, homosexuality and the use of illicit drugs (Brownlee, McDonald, & Ackerman, 1997). Their refusal to accept reality and deal with it openly and honestly is a contributing factor to the rise in AIDS cases among their children (Bell, 1991).

Because AIDS results from a virus that often has no immediate overt symptoms, and the effects are many times not felt for several years after infection, it is common and easy for people to deny the existence and severity of the epidemic. James Popham, a professor emeritus at U.C.L.A., acknowledges this problem and states, " . . . American school officials and the state and local school boards that guide them have not yet recognized the singularly important role that education must play if our nation is to cope with this health calamity" (1993, p. 559). Until HIV/AIDS is perceived as a true problem which must be confronted, the grim statistics among teenagers will continue to escalate.

The fact that the AIDS epidemic is a new societal phenomenon is one of the reasons that the educational establishment has not yet developed an adequate instructional prevention program and curriculum. In

1987, the State of Oklahoma mandated AIDS education in every public school. During the following years, other states followed suit, and by 1991, The Journal of School Health (December, 1992) reported that the percentage of students who were receiving AIDS education in school had increased to 83%. There has been no emergence of a successful nation-wide instructional model, and usually the design of AIDS prevention programs has been left up to the dictates of local boards of education. The result has been a wide variety of programs with vastly different designs and methods of implementation. The haphazard organization of education prevention programs is not providing the unified approach which is needed for an effective assault in the nation-wide war against AIDS (Bell, 1991; Huerta, 1996).

Another negative factor which is slowing the public schools' response to the AIDS epidemic is the relatively low number of students who are infected with the disease and have made their diagnoses public. "As of March 1, 1991, . . . (t)he proportion of adolescent cases between ages 13-19 represents less than 1% of all diagnosed AIDS cases for males and approximately 1% of all diagnosed cases for females" (DiClemente, September 1992, p. 325). It is not uncommon for parents, community leaders, and educational officials to hide their heads in the sand and refuse to acknowledge that there actually is such a thing

as the AIDS epidemic because there are so few publicly known cases among their local student bodies (Brownlee, McDonald, & Ackerman, 1997, Popham, 1993). Public announcements of the disease many times are made only after the death of a young person, and often the true cause of death is concealed and is listed as pneumonia or other secondary infections which result from the breakdown of the immune system. This avoidance of reality provides communities a convenient method of escaping the responsibility of creating AIDS education programs for informing school children (Miller & Becker-Dunn, 1993).

However, the small proportion of adolescent AIDS cases in schools is not an indication that there should be no concern for this age group. The incubation period of the HIV virus can take several years (Lui, Darrow, & Rutherford, 1988), and it is imperative that consideration be given to the patients who are diagnosed with AIDS as young adults in the 20-29 year old age group (DiClemente, 1992). These young people were engaging in at risk behavior when they were in school, and it can be determined that this was the time period in which they became infected. ". . . (W)e can assume that many AIDS symptomatic individuals between the ages of 20 and 29 were probably infected with HIV even before they left elementary school" (Tonks, 1992-1993). Therefore, AIDS

education must certainly be presented at the elementary and junior high age levels.

Educating pre-teens about the dangers of AIDS is even more offensive to many conservative school patrons. If they refuse to believe that teenagers are having sex or are experimenting with drugs, it will be much more difficult for them to acknowledge that the younger elementary students could also be involved in those same behaviors. This problem must be solved before a decline will be seen in the deadly AIDS statistics involving young people.

Adolescents themselves pose a dilemma for effective AIDS education. It is difficult for some teens to believe that HIV is a danger to them personally because they lack a personal point of reference and do not know anyone their age who is infected (Flax, 1989). Many teenagers who are HIV positive are not yet aware of it themselves, and if they are aware, they usually do not tell others (Humm & Kunreuther, 1991). Those who are unaware of their HIV status have no reason to change their behavior, and they will continue to expose others to the virus through the continuation of at risk behaviors (Popham, 1993). The resulting fear, prejudice, and ridicule of their peers invites secrecy and denial by teenagers living with AIDS. At a time in their lives when social acceptance and inclusion are of tantamount

importance, young people will do almost anything to avoid being ostracized, even if it means keeping a deadly secret (Bell, 1991). Successful AIDS education programs must be prepared with a goal of first convincing the students of their need for self-protection and preservation of health before instructing them in how to implement the methods and techniques of prevention (Baldwin et al. 1996; Tonks, 1992/1993).

Another area of concern in at risk behaviors often occurs in school-sponsored and community-supported competitive athletic programs. The increasing use of injected anabolic steroids by teen athletes desiring to "bulk up" and gain muscle mass is an additional opportunity of exposure to blood borne pathogens. A national survey of high school seniors found seven percent who reported using steroids. In the same study, it was determined that between 250,000 and 500,000 high school seniors use steroids, with more than one third of them injecting the drugs (Buckley, et al, 1988). School-based AIDS education programs must therefore label steroid use as being among the at risk behaviors which young people should avoid.

It is also an inherent trait of young people to take risks. The teenage years are traditionally the age of experimentation and daredevil behavior (Brownlee, McDonald, & Ackerman, 1997, Flax, 1989). The

consequences of drunk driving, the possibility of an unwanted pregnancy, and the well-publicized dangers of drug abuse have not had a lasting impact upon the rising statistics of teenage alcoholism, pregnancy, and drug addiction (Humm & Kunreuther, 1991). It is difficult to convince teens to protect themselves in situations which pose an immediate consequence, and this makes AIDS prevention education even more difficult because the consequences of AIDS may not be evident for another ten years.

With all of the negative influences against providing AIDS education programs in the public schools, there is still overwhelming evidence of public support for the programs. Douglas Kirby (1992) reports that 94% of parents are in favor of AIDS education for school students. The difficulty comes in trying to find curriculum content and teaching approaches that will satisfy the diverse expectations and standards of these parents. It must also be acknowledged that there will continue to be problems, no matter what kind of curriculum approach is created, because the disease is associated with some of the most controversial issues of our time.

> Even the most comprehensive and society-wide HIV/AIDS education and risk-reduction campaign is not going to eliminate all risk behaviors. Parallel efforts must be stepped up to combat the poverty, racism, sexism, and homophobia that contribute to the behaviors. But as deep-seated and seemingly

> intractable as these problems may be, they are no excuse for not going forward with the best HIV/AIDS education efforts we can muster (Humm & Kunreuther, 1991, p. 43).

Public schools must accept the challenge, deal with the societal objections, and formulate local programs and policies based on positive research findings in order to provide their students with the best AIDS prevention education programs possible. It is literally a matter of life and death.

AIDS EDUCATION PROGRAM MODELS

The Dodds, Volker, and Viviand Model of AIDS Education

Dodds, Volker, and Viviand (1989) developed a model for AIDS education based on the belief that the program must focus upon prevention of the epidemic in the context of positive interpersonal and sexual relationships and that it must also consider the needs of educators and parents. They state:

> Specifically, a program of information and education for children on AIDS should consider the following strategies. (1) It should be developed with the school system in the context of prevailing community/family values and in cooperation with parents, educators, and others. (2) It should begin as early as possible in the schools, continue throughout the entire course of schooling, and be integrated into a variety of related curricular content areas. (3) It should address the critical need for adequate teacher preparation in the delivery of content, discussion of sensitive issues and concerns, and utilization of available resources. (4) It should include objectives and cognitive content that are developmentally

> appropriate and enhancing to the psychosocial/psychosexual development of the child. (5) It should foster an understanding of body integrity and safety, disease prevention, and positive health promotion, particularly as they relate to human sexuality and drug abuse. (6) It should acknowledge and include the range of potentials of human sexuality. (7) It should use relevant, specific, age-appropriate language. (8) It should encourage and support attitudes, values, and behaviors that are consonant with responsible decision making both interpersonally and as regards society. (9) It should include a means for evaluating the effectiveness of the program and the curriculum (p. 121).

There were three sources used by Dodds, Volker, and Viviand in developing their model: The Surgeon General's Report (Koop, 1986), Confronting AIDS (National Academy of Science, 1986), and the Centers for Disease Control guidelines (1988). The combination of the recommendations made in the above mentioned documents has resulted in an educational AIDS model which strives to provide truthful and accurate information about the at risk behaviors which transmit the AIDS virus and at the same time attempts to avoid alienating and offending those who need to hear its message.

The U.S. General Accounting Office Model for AIDS Education

In the summer of 1988, the U.S. Senate Governmental Affairs Committee requested that the U.S. General Accounting Office (GAO) devise a model for preventive AIDS education. The GAO complied with that request and

then evaluated the applicability of the resulting model through field investigations of twelve "exemplary" AIDS prevention programs (Longshore, 1990). The staff of the GAO conducted interviews with nationally recognized AIDS experts, including academic researchers, practitioners, and policy advocates and asked them to identify AIDS prevention campaigns which they felt contained all the elements they considered necessary for a program to be thought of as successful. Selection of the programs was limited to the three U.S. cities which had been hit hardest by AIDS: New York City, Los Angeles, and San Francisco. The twelve "exemplary" programs were selected from those interviews and were evaluated using the GAO model. The GAO model identified the elements of effective AIDS education in relation to intravenous drug users and their sex partners, black and Latino populations, and adolescents. It drew upon previous research conducted in the longer standing areas of public school health education about smoking, drug abuse, and teenage pregnancy and made cautious implications of that research with similar education programs concerning AIDS.

The GAO then recommended the consideration of seven factors to be included in an effective AIDS education program: (1) target group boundaries, (2) the specific characteristics placing the group at risk, (3) media most likely to reach the group, (4) factual information

appropriate to the group, (5) skills for risk reduction, (6) motivators for risk reduction, and (7) intended outcomes (Longshore, 1990). The focus pertained more to the design of the message and did not provide details about program design elements of assessment, evaluation, and revision.

Several conclusions specifically related to adolescents emerged from the GAO's evaluation field investigation research conducted on the identified twelve exemplary AIDS education programs. It was discovered that teenagers did not accept sexual abstinence as a preventive measure unless preaching and moralizing were excluded as a part of the presentation. The young people responded positively when emphasis was placed upon their rights to make their own decisions and choices regarding sex. The fact emerged that few adolescents are well-informed about contraception techniques, and this lack of skills and knowledge continues to contribute to the spread of the virus. The GAO recommended that specific sex education information and specific instruction concerning contraception techniques be included in AIDS education programs. One expert concluded that teaching young people about AIDS without talking about sex is like "trying to teach kids about baseball without mentioning the ball and glove" (U.S. General Accounting Office, 1988, p. 25).

Teaching young people skills that can be used to change behavior is an important facet of the GAO model. It is recommended that teens be taught practical contraceptive techniques such as how to properly put on and remove a condom and how to effectively sanitize intravenous needles and syringes. Interpersonal skills are also stressed as to how a teen can effectively resist peer pressure to use drugs or engage in unprotected sex. Practice in using these verbal and nonverbal skills and arguments is an important and necessary element of the educational program.

In the media and motivation areas of the GAO model, it is emphasized that radio is the medium most likely to reach teenagers. The use of radio and television public service advertisements alone has been found to be ineffective, but a combination of radio/TV campaigns along with face-to-face contact with young HIV positive patients has been shown to make a difference in adolescent behavior. The GAO evaluation found that seeing and talking to people with AIDS provided teens with a credible source regarding the consequences of the infection.

Motivation for behavior change in young people was not affected by emphasizing the degenerative and fatal nature of AIDS. Students had problems with relating their current behavior to low-probability events that

might take place several years in the future. An effective educational strategy was found to be that of placing emphasis upon the immediate consequences of AIDS such as the ugly skin lesions which appear and the stigmatization and loss of popularity resulting from the disease which can affect a teen's social life.

The Bandura Model of AIDS Education

The societal efforts implemented to control the AIDS epidemic have been concentrated mainly on making people aware of the methods of its transmission and the steps necessary to prevent infection. Unfortunately, tradition indicates that the possession of information alone has not been enough to exert an impact on health-impairing habits. People continue to smoke, over-eat, use drugs, and contract sexual diseases in spite of the long history of public information campaigns about the health risks associated with such behavior (Bandura, 1992).

> To achieve self-directed change, people need to be given not only reasons to alter risky habits but also the means, resources, and social supports to do so. Effective self-regulation of behavior is not achieved by an act of will. It requires certain skills in self-motivation and self-guidance (Bandura, 1986). Moreover, a difference exists between possessing self-regulative skills and being able to use them effectively and consistently under difficult circumstances. Success requires not only skills but also strong self-belief in one's efficacy to exercise personal control (p. 90).

Albert Bandura (1992) has developed a social cognitive theory which includes a causal model for

effecting change in negative, detrimental lifestyle practices. He believes that effective health communications should ". . .instill in people the belief that they have the capability to alter their health habits and should instruct them on how to do it" (p. 97).

Bandura lists four components of his causal model. The first component is informational, giving people facts and information and increasing their awareness of risks to their health. The second component deals with the self-regulation and social skills which are necessary to transform informed concerns into effective, preventive actions on the part of the learner. The aim of the third component is to enhance people's skills and assist them in constructing resilient self-efficacy by providing them with opportunities to practice the skills in role-play, high-risk situations. The fourth and final component is concerned with finding and creating social supports for these desired behavior changes (1986).

There are several societal difficulties which must be overcome when applying Bandura's model to the combating of the AIDS epidemic. The puritanical roots of American society have contributed a tradition of hesitation and problems with talking frankly about sexual practices and giving sexual information to the general public. There has also been a traditional belief among Americans that talking openly about sex will promote

indiscriminate sexuality, especially among teenagers (Bell, 1991). Therefore many schools have faced opposition in offering sex education programs and even greater opposition to discussions of AIDS.

In addition to receiving factual information about AIDS, people need to know how to apply that knowledge to realistic circumstances which they will encounter in life. Bandura (1992) recommends social modeling as an effective technique for equipping people with the strong self-efficacy techniques needed to change detrimental health habits. He favors the use of videotape and live role-model presentations involving participants who have strongly similar characteristics to those who are watching the presentations. The "actors" should be the same age, sex, status, etc... as the target audience. This component is applicable to AIDS education through video or live presentations showing young people ways to effectively handle at risk situations that they will commonly encounter in their lives.

Bandura's components which feature increasing self-efficacy and enhancing social skills for confronting problems require extensive opportunity for participants to practice their newly acquired skills. He recommends guided practice sessions in which young people are coached in role-playing realistic circumstances and given immediate feedback on their performance. This practice

technique enhances their feelings of self-confidence in dealing with risky situations. The greater their self-confidence, the more likely it is that they will be able to maintain their positive behavior techniques. Bandura recommends that this modeling practice should be an integral part of any AIDS education program.

The fourth component of Bandura's model, that of enlisting and creating social supports for desired change, is the most difficult to implement. The sexual and drug practices which are the methods of AIDS transmission are subject to an inordinate amount of peer pressure among teens. A girl who carries condoms can be labelled a slut. A boy who is asked to use condoms can feel that his faithfulness and sense of manliness are being questioned. Intravenous drug users often are under the influence of the drugs that they have ingested and are incapable of practicing the proper sterilization techniques for killing the AIDS virus. These are social norms that present major roadblocks in developing positive support systems for helping young people to resist temptation. "In short, if AIDS prevention programs are to achieve much success, they must address the sociocultural realities that impose constraints on the exercise of self-protective measures" (p. 109).

The Popham Model of AIDS Education

James Popham (1993) has identified three key requirements for an effective AIDS prevention education program: (1) Functional knowledge, (2) Personal skills, and (3) Motivation. Students must possess the basic facts about the methods of transmission of the AIDS virus and knowledge of the symptoms, effects, and final results of the disease. He advocates that they should be taught how to avoid the risky situations which can place them in danger of contracting the virus. Handling at risk situations is where the possession of personal skills is of utmost importance to a young person. Students need instruction in developing and using the skills necessary to avoid dangerous behavior, in how to extricate themselves from situations when they realize that they are at risk, and how to utilize protection if they consciously choose to engage in dangerous behaviors.

The possession of appropriate personal human relations skills is critical for teens who find themselves in situations where there is a danger of contracting AIDS. They must be able to effectively deal with other people because AIDS most often comes from contact with others. It is difficult for people of all ages, not just teens, to be able to tactfully say no, insist upon using a condom, refuse to use a dirty needle, or extricate themselves from a compromising situation

without offending the other person(s) involved. Popham contends that young people need to be taught specific techniques to use in the risky situations they are most likely to encounter in life. Once they have been taught the skills, they need the time and opportunity to be able to practice those skills under controlled circumstances until they feel comfortable and prepared to use them on their own. This type of instruction requires more class time than most current AIDS education programs are allotted in the curriculum (Popham, 1993).

Motivation of students to use the newly gained information and techniques is a critical phase of any AIDS education program. "If AIDS educators can't truly incline students to use HIV-related skills and knowledge, then the whole effort is a waste of time" (p. 562). Students can possess all the facts, all the right words and techniques to be used at critical times, and all types of prevention items, but if they choose not to use them, the virus will continue to spread. The continual challenge to educators is how to convince the students that changing their behavior is really in their own best interests.

Popham (1993) reports that the most effective motivational programs he has seen rely heavily on the influence of the teen peer group. Students are impacted when they see other teens who are HIV positive as a

result of typical teenage behaviors. Panels of young people who are actually infected with the virus can make the disease become a reality for young people who have had the attitude that they are invincible, invulnerable to disease, and that nothing bad could ever happen to them. Bringing patients with HIV/AIDS into the school setting could cause controversy in a school district, but if their physical presence was disallowed, a videotape would be the next best arrangement. Students need to see others like themselves who have made the wrong decisions and are now faced with a lifetime of consequences. This type of approach would personalize the disease and increase awareness for students.

Any type of educational endeavor which is designed to influence behavior will necessarily require an investment of time. Because the behaviors associated with contracting AIDS originate from strong psychological and physical forces, it will require even more instructional time in order for the prevention programs to achieve positive results (Iverson & Popham, 1992). The duration of the programs must be adequate for students to master the information and obtain the desired skill level. Popham is dismayed by the average one to two hour AIDS education programs he usually sees in schools and concludes,

> To influence student behaviors, I believe that a unit on AIDS education must be of 10 to 15 hours'

> duration at grades 9 or 10, along with a number of three- to five-hour instructional activities at earlier grades and one or more three- to five-hour booster sessions after the main AIDS unit has been concluded. In short, I suggest that it will take from 20 to 25 hours of classroom instruction in order to have an AIDS education program that really influences student behaviors (p. 562).

The model AIDS education which Popham advocates has solid research to support its tenets (Popham, 1993). But there are several factors that would make it difficult to implement in many school districts. His emphasis upon knowledge of the disease would be acceptable to the majority of parents and school patrons, but his insistence upon instruction in prevention techniques would alarm the conservative and fundamentalist religious elements of a school district. Instructing students in the proper techniques of condom usage or how to properly clean intravenous needles would cause many parents to protest that the school was promoting teenage sexual and drug activity. Having students role play the skills necessary to avoid situations which could end in sexual intercourse would open the school district to the same criticism. This is another example of adult attitudes which seem to indicate that if something is ignored it does not really exist.

The amount of instructional time recommended by Popham is the final detrimental factor to his program gaining wide acceptance. The American public school system is currently under increasing pressure to provide

accountability to the taxpayer in the form of higher test scores, reduced drop-out rates, and safe and drug-free schools. The 25 hours of instructional and practice time needed for Popham's program would take almost a week out of an already too-crowded school year. To devote that much time to such a controversial and questionable social endeavor is a risk that many school boards, school administrators and curriculum directors are not willing to take. They are walking a fine line between community criticism and the personal conviction that they have a moral obligation to provide their students with the best opportunity possible to avoid a fatal disease.

The Tonks Model of AIDS Education

Douglas Tonks (1993), is a former Senior Associate with the IOX Associates research and development firm and has done formal research and evaluations of education-related HIV programs. He has identified specific goals which he feels should be established in order for HIV prevention education to be successful. An increase in the percentage of students who remain sexually abstinent is the first goal. The longer the first sexual experience can be delayed, the fewer sexual partners an individual will have in his or her lifetime. This decreases the number of opportunities for a person to be exposed to the AIDS virus. The emphasis on abstinence

buys time to allow emotional maturity to catch up with a teenager's hormones.

If a student is already sexually active, an effective HIV education program encourages a return to abstinence. This is an almost impossible endeavor, and Tonks admits that, "no school-based research program has yet succeeded in meeting this goal" (p. 50). However, just because it is a difficult undertaking, does not mean that it should be set aside. Abstinence is still the only prevention method providing complete protection from AIDS, and it must be emphasized at every opportunity.

For students who choose to remain sexually active, a third goal of Tonk's prevention program is to increase the use of condoms and spermicide among teens. He advocates that specific instruction should be provided in the use of prevention methods that increase safety and give the greatest amount of protection against the virus. The more familiar teens become with condoms and how to use them in conjunction with spermicide, the more likely they will be to carry the protection and then to use it when the occasion arises.

Tonks also includes emphasis against alcohol and drug abuse as part of an effective AIDS education program. Students should be taught that they are more likely to engage in high-risk behaviors if they are under the influence of a mind-altering chemical. Alcohol use

lowers inhibitions, making it more difficult for a person to say no or to practice common sense behaviors. Intravenous drug use affords direct exposure to the virus if needles are shared with others. Chemical abstinence is an important part of sexual abstinence as the final goal of Tonks' model.

The emphasis on abstinence in Tonks' model makes it highly acceptable to the Religious Right which is gaining influence in school districts across the nation. In fact, many of these religious groups insist that total abstinence be the only goal of AIDS education programs. The conservatives do not even want the word "condom" to be mentioned as a method of prevention of AIDS (Bell, 1991). At an AIDS curriculum meeting, the father of a junior high student spoke during an open forum session saying, "I just came to make sure that you're not going to talk about condoms in class. I don't want my daughter to know about them yet" Anonymous Parent (personal communication, September 16, 1995). Once again, reality is being denied.

Tonks' advocacy of condom and spermicide usage among teens will make his program controversial and prohibit its implementation in some conservative school districts. But his emphasis on saying no to drugs and alcohol will be a selling point with these same educational powers. It remains to be seen if the program he recommends is

accepted in its entirety or only in part by districts implementing or modifying AIDS education programs.

EVALUATION OF ATTITUDE CHANGE

The Elaboration Likelihood Model of Richard Petty and John Cacioppo

Petty and Cacioppo (1981, 1986) have developed a model of a general theory of attitude change that they have titled the Elaboration Likelihood Model (ELM). They believe that it "provides a fairly comprehensive framework for organizing, categorizing, and understanding the basic processes underlying the effectiveness of persuasive communications" (1986, p. 3). The purpose of AIDS education is to persuade people to act responsibly in relation to the AIDS virus, and persuasive communication is a basic construct of every AIDS education program. Because AIDS education is centered around influencing people's attitudes and actions, the Elaboration Likelihood Model can be used to analyze the structure and content of the programs and curriculum.

Petty and Cacioppo have identified two distinct routes to attitude change, the central route and the peripheral route. The central route emphasizes thoughtful consideration of the object or issue in question. A person using the central route to attitude change will pay close attention to the facts, details,

and arguments about the message, will actively attempt to understand them, and will then evaluate all the possibilities presented. The person can then take all of the information and integrate it into forming a coherent and reasoned position relative to his or her initial attitude. This route is based on logical evaluation of the true merits of the case which have been presented in the persuasion attempt. It is associated with long-term or permanent changes in attitude.

The second route to attitude change is called the peripheral route. It requires less thought and is based upon rewards or punishments associated with the message, perceptions of the message presentation, simple inferences, and outside cues. This route does not require logical thought and can be based upon an impulse, impression, or feeling associated with the presentation method. Changes in attitudes as a result of the peripheral route are likely to be made more quickly but be of shorter duration than changes made by the central route.

The follow-up research studies done by Petty and Cacioppo have indicated that enduring attitude change depends "on the likelihood that an issue or argument will be elaborated upon (thought about)" (1981, p. 263). The extent and amount of thinking and consideration by a person determine the amount of behavior and attitude

change that takes place and how long that change will last. Changes as a result of the central route are more likely to be permanent in nature. Peripheral route changes last only as long as the cues remain the same or feelings are unchanged. Changes made on impulse without much consideration can be reversed just as rapidly.

For a person to elaborate on or think about a persuasive message, Petty and Cacioppo state that motivation and ability must be present (1986). Motivation is present when the topic under consideration has a high personal relevance to the individual being targeted for an attitude change. If the topic at hand has a direct impact upon people's lives, they will be more likely to give it serious thought and consideration.

The ability to think about and consider a message is crucial if a lasting change in attitude is to be made. A person who is distracted or who is rushed for time will not be able to concentrate upon the subject. If the topic is not seen as applicable to the recipient's life, little thought will be given to it at all. The ability to process information is crucial to its impact.

AIDS prevention education in public schools is a deliberate attempt to effect attitude and behavior changes in students. There is a wide variety of techniques included in HIV/AIDS programs across the United States, and the results of these methods have not

yet been favorable to the control of the disease. Petty's and Cacioppo's research on successful attitude change can be used to analyze these programs to make suggestions for improvements.

It is evident that the many models for AIDS education programs focus upon the peripheral route to attitude change. Celebrity spokespersons appear in television public service advertisements and in school video presentations warning against the dangers of AIDS and imploring people to use caution. The use of celebrities and of one-time classroom visits or video presentations by AIDS patients are examples of "outside cues" mentioned by Petty and Cacioppo. This can cause impulsive changes in behavior or attitudes, but these changes have been shown to be less effective and more susceptible to recidivism over time (Petty & Cacioppo, 1986).

The emphasis on rewards and punishments in the peripheral route are also components of many AIDS education programs. Students are frightened with stories of the pain and physical disfigurement associated with AIDS. They are warned of social ostracism and discrimination which result when AIDS is diagnosed and revealed to friends and families. While fear can be a strong motivator, Petty and Cacioppo have found that it is not usually enough motivation for a lasting, permanent

change in attitude or behavior. AIDS education must focus on behavior change and moral reasoning rather than exclusively transmitting knowledge or arousing fear (Wolfe, 1993).

The components of AIDS education models which can be evaluated as successful using Petty and Cacioppo's Elaboration Likelihood Model are those which allow enough time for students to be able to consider the effects of AIDS upon their own lives. The students are presented with motivating factors which can be shown to be pertinent to their own personal situations. This AIDS education over a long period of time is the key to the central route of permanent attitude change. If students are given enough time to learn the facts about AIDS, coached in the interpersonal skills needed to resist temptation, allowed to consider how those facts and skills affect them on a daily basis, and are assisted in evaluating their own personal positions in relation to the AIDS epidemic, Petty and Cacioppo can project that permanent behavior and attitude changes will result. This is the ultimate goal of an AIDS education program.

Summary

The advent of the AIDS epidemic has presented the American public school system with one of its greatest challenges. The health and safety of students are at

stake, but there is much controversy about the content and methods of what should be taught to those students. Public school AIDS education programs have not been in existence long enough for valid evaluations to have been conducted as to their effectiveness. The sometimes ten year length of incubation of the disease makes the current evaluation studies less than adequate, but they are the only research programs possible under the circumstances. The political, legal, social, and religious obstacles can seem almost insurmountable to local school districts trying to cope with serving the needs of the students while satisfying the varied expectations and demands of community political and religious factions. As time progresses and more research is conducted to evaluate the effectiveness of the current models, a clearer picture will emerge to define valid content and procedures.

When the magnitude is fully understood of the HIV epidemic and the impact that it is now having and will continue to have upon the children in the classroom, AIDS education will become a priority of school boards and communities. They will then realize that communicating facts, figures, and definitions is the easy part of education about AIDS, but the changing of addictive and pleasurable behaviors will present the parents and school system with the most difficult challenge. The acceptance

of this challenge can form the basis for research-grounded, effective programs to prevent the tragic consequences of these behavior choices among young people. Their lives depend upon the acceptance of this challenge.

Post script: As a follow-up to this study, a review of the literature for the past three years was conducted to determine if there were additional AIDS education programs which had demonstrated effectiveness in reducing the number of students placing themselves at risk of contracting the AIDS virus. The results of this search revealed that there were no AIDS education program statistical studies published during this time period.

CHAPTER III

RESEARCH DESIGN AND METHODOLOGY

Introduction

This chapter includes the methodology chosen for the study and an explanation of the reasons for the choice. A discussion of the personal characteristics and qualifications of the researcher is included to illustrate the difficulties which were encountered with the participants in the interview process. The complexities of the sample selection and the data collection are discussed in relation to the unique challenges presented by the AIDS virus.

Methodology

The researcher chose phenomenology as the qualitative research method for this study because the focus of the research centered upon the beliefs and opinions of the participants. Bogdan and Biklen (1982) state that, "Researchers in the phenomenological mode attempt to understand the meaning of events and interactions to ordinary people in particular situations" (p. 31). The ordinary people involved in this study were five to fifteen (Tesch, 1984) young adults who had been students in Oklahoma public schools and had received instruction in AIDS prevention through classroom presentation of the state-mandated AIDS curriculum.

After having received this instruction, the participants knowingly engaged in behaviors which placed them at risk of contracting the AIDS virus.

The personal ideas and perceptions of the young adults were vital to this perspective-seeking study. Hakim (1987) defines qualitative research as being " . . . concerned with individuals' own accounts of their attitudes, motivations and behavior" (p. 26). The participants behaved consciously in a manner which placed them in danger of becoming infected with AIDS in spite of their having been taught the danger involved in that behavior. Their perceptions of <u>why</u> they took the risk or of <u>what</u> motivated their particular actions were the central focus of this study.

It is the goal of a qualitative researcher to " . . . attempt to understand behavior and institutions by getting to know well the persons involved, their values, rituals, symbols, beliefs, and their emotions" (Nachmias and Nachmias, 1987, p. 287). The data gathered from these individuals may contribute to the developing AIDS education theory base and may provide additional information which can be used in changing and restructuring the current curriculum content and methods of instruction to complement the theory. The AIDS education models discussed in the related literature are compared to the participants' responses to ascertain if

the characteristics of one or several combined could be used to provide structural framework for a more successful AIDS education program in Oklahoma.

It was essential that the ideas and suggestions of the participants be analyzed and considered in formulating any theory contributions to existing AIDS education practices. Maruyama and Deno (1992) stress the practical importance of qualitative educational research on the way teaching is conducted in schools or other educational settings. They advocate that the research findings should have strong implications for the ways education is practiced and the ". . . ways in which educational approaches can be modified to be more effective. . . " (p. 112). The researcher then becomes the "conduit" for making the participants' voices heard (Denzin & Lincoln, 1994). AIDS education is a developing facet of the public school curriculum, and a phenomenological research approach is particularly appropriate for this study because the method is, " . . . often used for exploratory research in areas where relatively little is known . . ." (Nachmias & Nachmias, 1987, p. 29).

The personal qualifications and experiences of the researcher in a phenomenological study can have a direct bearing upon the research process. The researcher is important as a vital or "key" element (Bogdan & Biklen,

1982; Tesch, 1988) in the conduct of the research and can play a part in the interpretation of the participants' responses (Langenbach, Vaughn, & Aagaard, 1994). It is important to note this researcher's 27 years of educational experience in working directly with teens and young adults in a public school setting in the role of classroom teacher, guidance counselor, assistant principal, and building principal.

Gay (1992) points out that the interview technique requires that a researcher possess an additional level of research skill and a variety of communication and interpersonal relations skills. Masters degrees in secondary education and in guidance and counseling were assets in this researcher's ability to establish the rapport and trust necessary to conduct interviews with teens and young adults which focused upon their behaviors in the sensitive areas of drug abuse and sexual practices.

This researcher's personal and professional encounters with at-risk students are the reason this particular research study was undertaken. It would be reasonable for a reader to question the motivation and objectivity of this study in view of the fact that the researcher is a 48 year old, Caucasian female who grew up on a farm in the Oklahoma Panhandle. How can a middle-aged woman with a strong Southern Baptist religious

background relate to the drug abusing, sexually promiscuous, and homosexual young people who were the participants in this study? Would the lack of lifestyle experience on the part of the researcher result in misunderstanding and misinterpretation of the data? The answers lie in the daily contact with teens that the researcher has maintained since becoming a teacher in 1971. This contact has included personal counseling about discipline, drug abuse, pregnancy, and interpersonal relationships. The overall success of this effort is verified by the number of young adults who still maintain contact with the researcher today even though they have graduated from school and have gone on to pursue their life interests. This contact would not be maintained if a positive relationship had not been initially created.

To successfully establish open communication with a young person requires the ability of the researcher to listen, to ask appropriate questions, and to empathize without passing judgment, reacting negatively, or imposing/interjecting personal values into the conversation. Subjectivity on the part of the researcher necessarily must be a composite of personal values, attitudes, beliefs, interests, and needs (Glesne & Peshkin, 1992). Subjectivity must be identified, and the researcher must have a strong sense of self while

conducting the study. "Indeed, what questions drive your work, what emotions you feel as you contemplate the subject of your research, are clearly important matters" (p. 100). The challenges of values, communications, and subjectivity on the part of the researcher made this study an interesting and exciting one to undertake.

Because of the 27 years of almost daily personal contact with young people, this researcher feels a particular need to assist them in the struggle against an AIDS epidemic which is threatening an entire generation. Soltis (1990) identifies and labels as "intervention" (p. 249) this type of qualitative research which is used to bring about and document change. An intervention is needed in the current AIDS education programs which are not meeting the needs of the students. That was the goal of this research.

Max van Manen (1990) discusses the personal motivation for a researcher's choice of qualitative methods:

> For us this phenomenological interest of doing research materializes itself in our everyday practical concerns as parents, teachers, teacher educators, psychologists, child care specialists, or school administrators. As educators we must act responsibly and responsively in all our relations with children, with youth, or with those to whom we stand in a pedagogical relationship. So for us the theoretical practice of phenomenologcial research stands in the service of the mundane practice of pedagogy: it is a ministering of thoughtfulness (p. 12).

It is the hope of this researcher that future students will benefit from this study through increased relevance of curriculum materials and teaching approaches.

Selection of the Sample

Participants for this research were required to meet one of several criteria which included having used intravenous drugs and shared needles with another person, having had direct blood exposure from another person, or having engaged in unprotected sexual activity which placed the participant at risk of contracting the virus. They had to have received AIDS education in an Oklahoma public school. The young people interviewed were chosen from drug rehabilitation support groups, HIV/AIDS support groups and alternative school programs for pregnant teens in Oklahoma. Sample selection of participants was facilitated by the current proliferation of urban and suburban support groups sponsored by hospitals, public service groups, and religious organizations. All volunteers who met the profile criteria were subsequently interviewed.

A more challenging aspect of the study was the confidentiality factor involved with protecting the identities of HIV/AIDS patients. To obtain the names of individuals whose identities are a closely guarded secret, it was necessary to work with the Oklahoma State

Department of Health, the American Red Cross, the Christian AIDS Network, Meals on Wheels, and the Regional AIDS Interfaith Network. These organizations could not legally provide the names of the young people who were infected with the virus, but they furnished the researcher's name and phone number to those individuals so that they could personally contact the researcher in order to voluntarily become a part of the study. Two HIV+ individuals responded but declined to participate.

The need to maintain confidentiality of the interview responses was also a unique aspect of this research project. Not only were the identities of the participants kept confidential, but the interviews had to be screened to remove or reconfigure any identifying information which could provide clues to the name of a school, support group, or specific geographical area in Oklahoma. The tapes and interview transcriptions were destroyed after the project was completed.

Data Collection

A one to two hour unstructured in-depth interview was utilized to gather data from each participant. Hitchcock and Hughes (1989) identify the aim of an unstructured interview to be to "create an atmosphere where the individual feels able to relate subjective and often highly personal materials to the researcher" (p.

87). The interviews were necessarily intensive and searching, with emphasis upon the attitudes, beliefs, and perceptions of the participants (Kleine & Smith, 1989). Questions were open-ended and designed to include the areas of the participants' personal AIDS education while in public school, their subsequent behavior which placed them at risk of contracting the virus, their personal perceptions of why they engaged in that behavior, and their suggestions and opinions about what an effective AIDS education curriculum should include (See Appendix B). They were also asked to identify any factors which they felt might have made a difference in their decisions about participating in at risk behaviors.

The basis for this data collection was developed through a pilot study conducted in the fall of 1993 in a graduate research methods class at the University of Oklahoma. The questions were completed through suggestions of the professor and fellow students and were modified somewhat during the interviews themselves. No changes had to be made in the existing set of questions as the interviews were being conducted. The unstructured aspect of the interview situation allowed for adaptations which improved the understanding and input of the participants.

The interviews were audio-taped and then transcribed and reviewed to discover and code themes or patterns

inherent in the responses (Tesch, 1988). A participant profile was written to provide a character sketch which summarized the experiences of each individual and his or her contributions to this research. It was determined if there were any units of relevant meaning which could be clustered together to form one or more central themes (Hycner, 1985). When the themes/patterns were identified, the literature was reviewed to determine if connections could be established to existing AIDS education models. The participants' ideas and suggestions for improving the AIDS education curriculum were also analyzed and compared with current research literature to determine if a relationship existed.

The researcher was required to maintain theoretical sensitivity throughout this process. Straus and Corbin (1990) define theoretical sensitivity as "an ability not only to use personal and professional experience imaginatively, but also literature. It enables the analyst to see the research situation and its associated data in new ways, and to explore the data's potential for developing theory" (p. 44). The validity and reliability of the results depend upon the provision of evidence, consistency, and freedom from obvious bias apparent in the interviews (Tesch, 1988).

To identify the themes and patterns which emerged from the interview responses of the participants, it was

necessary to use coding and labeling procedures which facilitated analysis. A mixture of open and axial coding (Strauss & Corbin, 1990) was used to break the response information into parts, examine them and compare them for similarities and differences. Relationships among the responses were identified which led to the formation of theory about why AIDS statistics among teenagers in Oklahoma are increasing and to provide general recommendations for AIDS education program contents and curriculum.

Glaser and Strauss (1967) recognize the difficulty in obtaining accurate evidence from interviews, and they maintain that it is not so crucial for generating theory. They state that the researcher's ". . . job is not to provide a perfect description of an area, but to develop a theory that accounts for much of the relevant behavior" (p. 30). In light of this, the responses of young people at risk were used to generate theory about successful AIDS education programs.

Summary

This chapter describes the phenomenological approach taken in the research of the data for this study. The attitudes, perspectives, personal opinions, and beliefs of the young persons interviewed were vital in the development of the conclusions of the research. The

personal characteristics and limitations of the researcher were discussed and explained, and the sample selection and data collections methods were outlined. The personal nature of the research design dictated the choice of phenomenology as the research method for the study.

Chapter IV

PARTICIPANT PROFILES

Introduction

This chapter contains individual profiles of the participants and summarizes significant information taken from the interviews. The circumstances of each interview are discussed and a personal history is compiled from the statements by the participants. Additional information is provided about the AIDS education received by the participants, the type of at risk behavior in which they participated, and their personal opinions as to what changes they would recommend for future AIDS education programs in order to increase the relevance and effectiveness of these programs.

*Kimberlee: The At-Home Mother and Youth Minister's Wife

The interview with Kimberlee took place at her home in a small suburb of 15,000 people, about 30 miles from Oklahoma City. I knocked on the door of a small, one-car garage brick home and was met by a tall, slender 21 year old brunette who welcomed me inside. Two little girls, ages two and four, with blond hair and big blue eyes peeked at me from behind their mother's legs and shyly said, "Hi."

* The names of all participants and any identifying demographic data have been changed to maintain confidentiality.

As I arranged my interview materials on the dining room table, Kimberlee took the girls to their room, giving them instructions to play with each other and not to bother us while we talked. The girls were compliant and did not argue about having to go to their room. The interview lasted almost an hour, and Kimberlee was called away only once when the younger daughter fell from her teeter totter and began crying. The home was spotlessly clean, and the modest furnishings and wall decorations reflected the Christian beliefs of the owners.

Kimberlee's Personal Story

Kimberlee lived with her mother, father, and younger brother until she was ten years old. At ten, the event that she labelled, ". . . the most significant thing in my life. . ." happened, and her parents got a divorce. Not wanting to leave her school to move to where her mother's job transferred them, Kimberlee elected to remain in Oklahoma City with her father, brother, and grandmother. She stated, "I was raised kind of by my dad and my grandma." Kimberlee's grandmother lived in a tiny town fifteen miles from her family's former home, but she did not want to attend the rural school and continued to go to her previous school using her old address to falsify school records.

The next significant event in her life occurred in seventh grade when she met the boy who was to become her husband four years later. They were in the same class, and went through junior high and high school together. Kimberlee and Samuel began dating in ninth grade and she, ". . . knew he was the one I wanted to marry a year after I had been going out with him." The two were married just before beginning their senior year of high school.

When asked about her religious upbringing, Kimberlee stated, "From the time I was born, I went to a Baptist church, a Southern Baptist church. And I got out of it during the Divorce Years, as I call them." Her grandmother made her start attending again and she became involved in the local youth group. Upon marrying Samuel, she changed her membership to his church which was a more fundamentalist branch of the Baptist denomination. They are very active in the church, and Samuel currently serves as the Youth Pastor for the small congregation in addition to his job as a plumber. Kimberlee stays at home to care for and teach their two daughters. She said proudly, "I'm really happy with doing that, staying at home. And Samuel is very supportive of my doing that."

In spite of having a baby during the beginning of her senior year, Kimberlee maintained a 3.51 grade point average while participating in choir, the school literary club, drama, and science club. She associated with a

"fun peer group" of friends who had a similar religious background and similar interests. She remembered, "We never used drugs. Very few of them drank."

Kimberlee's At Risk Behavior, AIDS Education History, and Personal Opinions

When I asked Kimberlee how old she was when she first engaged in at risk behavior, she smiled and said, "It was February 14, 1992. And my daughter was born exactly nine months from that date." Concern about AIDS was not a factor curtailing their actions because, "I knew Samuel very well and, I, I trusted him. We both knew that there was no chance of catching AIDS from each other." I remarked that the reason must have been love, and Kimberlee answered, "Right, and the moment would be probably a more appropriate reason. I guess the heat of passion . . ."

Kimberlee and Samuel were a young couple who had been reared in Christian homes, who had attended AIDS education programs together, and who had discussed AIDS after classes in informal conversations. They were in love, planned to marry someday, and had made a commitment to each other to wait to have sex until after their wedding. Kimberlee stated, "We loved each other enough that we could have waited, and we wanted to wait. And we

were determined to wait, but it just happened that we didn't. I think it surprised us both."

My next question was if she was prepared with protection in case she had sex, and Kimberlee replied that her aunts had talked to her about sex and AIDS and had told her to carry a condom with her. Her response to them was, "No, we're not going to do anything. I don't want to carry it around." In referring to that first sexual experience with Samuel on Valentine's Day, she acknowledged,

> And quite honestly, if I had had one [a condom], I probably wouldn't have thought about it. If I had thought about it long enough to have him wear a condom or to have some kind of protection myself, then we wouldn't have done it. So there was really no chance of me being protected. There just wasn't time.

I asked Kimberlee what changes could have been made in her AIDS education that might have affected her behavior, and she responded, "None. I had been taught abstention all my life." She felt that abstinence should be stressed more in any formal AIDS education program because, ". . . a condom is not going to prevent AIDS. My father is a condom baby. . ." Kimberlee also included stressing the danger of pregnancy as a part of her ideal AIDS education program. She said with some wistfulness, "I wouldn't give up my daughter for anything, but Senior Year would really have been a lot easier if I'd waited a year later to have her." If she were to speak to a group

of young people in an AIDS education course today, Kimberlee said that she wouldn't tell them to protect themselves and she wouldn't give them condoms. She concluded, " I would just say, 'Don't do it.' and hope that they listened."

JAIME: Western Dancer and Mother of One

Jaime is a nineteen year old young woman who lives with her husband and eighteen month old daughter in a run-down housing addition in an older part of an Oklahoma City suburb. The majority of the neighborhood houses have been turned into rental property, and the yards are unkept with a few junk cars parked in the drives. An apartment complex in the next block has gang graffiti on the walls, and the area has a reputation for drug traffic.

When I arrived for the late Saturday morning interview, Jaime met me at the door drying her hair with a towel. She apologized for her appearance and told me that they had gone dancing the night before and were running late. She was dressed in rumpled jeans and a sweatshirt, and still carried the extra weight from her pregnancy.

Jaime's home was cluttered with clothes, toys, dirty dishes, and overflowing ashtrays. The air was thick with smoke. She removed some clothes from the living room couch and invited me to sit down. A young man was lounged on the far end of the couch watching television, and Jaime's little girl was toddling around, eating a cookie. I asked if there was a quiet room we could go to for the interview so that my tape recorder would pick up our voices, and Jaime told me that the other rooms needed

to be cleaned and couldn't be used. At that point, the young man offered to take the child into another room so that we could talk.

As the interview began, another young man came out of a back bedroom, and Jaime introduced him as her husband. I was confused, and Jaime explained that the first young man was her sister's boyfriend. The couple had spent the night with Jaime and her husband because they had gotten in too late from dancing to go home. The interview proceeded on the couch with Jaime's husband watching television on the floor in front of us. He listened to our conversation but did not interrupt. Jaime was a very talkative participant and often rambled during her answers.

Jaime's Personal Story

Jaime's parents were divorced when she was eight, and Jaime spent the next nine years bouncing back and forth between the two. She reported that she would live with her father until they had a fight, and then she would go to live with her mom until something else happened. There was a succession of stepparents in her life. When asked to describe her parents, she volunteered, ". . . my mom, she's a lunatic, and my dad, he's just rude." As a result of this instability, Jaime attended eight different schools around the Oklahoma City

metropolitan area before she got married at the beginning of her senior year.

Childhood was not a pleasant experience for Jaime. She moved so often that she did not have many friends. At age eleven, Jaime's brother joined her and her father, and she became friends with the boys he knew. She stated, "My whole life most of my friends have been guys." Her grades in school were poor until she met her husband her junior year, and then she started making A's, B's, and C's. She blamed her ditching school and making D's and F's on her problems at home, "I guess I was trying to get attention from my dad because he didn't pay any attention to me."

Religion did not play a part in Jaime's early childhood. She commented, "My dad's an atheist, and my mom, I don't know what religion she is. . ." Jaime began going to church when she was in 6th or 7th grade. "I went to church on my own one day, and I found a church." She fell in love with the church, liked the people, and made friends. She said, "I was just as happy as I have ever been in my life when I was in church. Then we moved. It was too far for my dad to drive to take me to church since he was an atheist."

The loss of her church was a turning point in Jaime's life. She remembered, "I lost all my friends and everything, and I started ditching school again. I

started hanging out with a bad crowd. They were drug users and stuff." Though Jaime said she did not use drugs, she never felt pressure from her friends and was not "put down" for not using. Her life continued with that peer group until 11th grade when she met a senior boy who would become her husband.

While "hanging out" at lunch one day, Jaime was introduced to a friend of a friend. They started talking, and she remembered, "We kind of got together, and we started dating. While we were dating, he told me we were gonna get married. He didn't ask. He told me." Jaime's friends insisted on a formal proposal, so one night at a local country and western ballroom, "He had to get down on one knee in the middle of the whole place and ask me to marry him twice within five minutes. . . . it was real romantic."

Jaime's dream wedding was planned for June of 1995, after her graduation from high school, but the plans had to be changed. She reported, ". . . we had sex and stuff, and we didn't really think about protection, which is kind of a mistake for us." The resulting pregnancy moved the wedding to the beginning of her senior year, and the young couple moved in with Jaime's mother until their daughter was born.

Jaime's At Risk Behavior, AIDS Education History, and Personal Opinions

Jaime was fifteen and in 9th grade when she had her first sexual experience with a boy she had been dating for two years. She recalled, " I was a virgin, and he was a virgin. At least he said he was." Shortly after having sex, the couple broke off the relationship. Jaime's reason was, "I guess having sex just kinda ruined the whole relationship. But that's OK, 'cause I'm happy with who I've got now." She pointed at her husband who was lying on the floor watching cartoons.

AIDS education was not a memorable part of Jaime's public school experience. She credited her lack of knowledge to the many different schools she attended and to the fact that, "They never really talked much about it. I guess they thought that if they just didn't tell you. . . about sex, you wouldn't learn or something." She felt that the teachers could have handed out pamphlets about AIDS, and proposed a parent/student night at school where AIDS education would be discussed. I asked if she would have participated in an AIDS education night with her parents and she responded, "With my mom, not my dad. My dad's too much of a redneck."

If given the opportunity to speak to a group of young people about AIDS, Jaime said she would tell them, "Please don't do it. If you feel that you absolutely

have to 'cause your hormones are just driving you crazy, make sure you are on the pill, you have a condom, and you get their sexual background." Her ideal AIDS education curriculum would include parental participation, pamphlets explaining the disease, and a film with kids talking about AIDS. She felt that it would be effective to include a skit about a kid finding out that he had AIDS.

When asked if she would have listened to advice about AIDS from a movie star or sports figure, she replied, "Not me. 'Cause the way I looked at it since I was a young kid, is that they're just actors anyway. How can you ever tell if they're telling the truth or not?" Jaime thought that advice from her siblings would be much more effective in influencing her behavior. She also said that seeing a young person who had AIDS would make, ". . . a lot of kids. . . stop and think first before they go out and sleep with 20 different people."

CAROL: Bankrupt, the Mother of Two, and Afraid to be Tested for AIDS

When I called Carol to arrange the interview, she readily agreed to participate if the time and location could be put off a week. She and her husband were declaring bankruptcy and had to be out of their apartment by the weekend, so she would not be able to speak with me until they were settled.

A week later, I arrived at their new apartment to meet a petite young woman of 20 years and her three year old son. Boxes from the move were stacked throughout the living room and kitchen, and supper was on the table. I told Carol that I would be glad to wait until they had finished their meal, but she wanted to do the interview. She took her son back to the bedroom where her husband was tending their year old daughter, and we proceeded with our conversation.

Carol's Personal Story

Carol lived in Oklahoma City until she was twelve, and then her father and step-mother moved to a suburb where she attended junior high and graduated from high school. The oldest of three girls, Carol never knew her natural mother who was married to her father for only a short time.

An average student, Carol's grades ranged from A's to probably, ". . . a D here and there." She participated in high school soccer as her only extra-curricular activity before getting married. Church was not a positive aspect of her life, and she attended for only three years. She recalled,

> My parents took me to the Church of Christ, but I never really liked it because I was forced to go. I had to go. You knew everyone there didn't like you because you were the kid that came on the church bus.

Carol had a variety of friends during her junior high and high school years. She characterized some of them as popular, some as the nerds that nobody talked to, and others as kids who were really wild. Some of Carol's friends drank and did drugs, but she denied joining them in those activities. It was a friend in 9th grade who introduced her to the boy who would eventually become her husband. She smiled and said, ". . . we just hit it off from the beginning."

As a result of peer pressure, Carol and her boyfriend began having sex when she was a freshman. Her father discovered what was going on and grounded her for six months. This tactic did not drive the couple apart, and their reason for having sex took on a new meaning when she entered high school. Her boyfriend had dropped out of school and was available whenever she had time to be with him. She remembered with some embarrassment,

> When I was sixteen, we were trying to get pregnant 'cause I felt that my home life--it was so bad. I didn't have any kind of support, and I thought that was the way to get out. I don't know what I was thinking. . . .My junior year, we had sex regularly then because I had my own car and I had about an hour and a half between Vo-Tech and high school, and I could see him. We had sex regularly then, and in January of my junior year, I got pregnant.

The couple was married after Carol finished her junior year, and she stayed in school after the birth of their son and received her diploma. They later had a second child who was a year old at the time of the interview.

Carol's At Risk Behavior, AIDS Education History, and Personal Opinions

Carol first put herself at risk through unprotected sexual activity when she was fifteen years old. She was not enthused about the experience and stated, "Even at the time, the only reason I even wanted to have sex was because all my friends were doing it." Her boyfriend, who was two years older, did not pressure her for sex. She was the one who insisted that she was ready. She remembered being told by him, "No, no, you're not ready. No, no, no." When I asked what her reply to him was at that point, she laughed and said, ". . . I was like yeah, yeah, yeah."

I asked Carol if AIDS was a concern for her when she started having sex, and received a negative reply. She

commented that it was the first time for both of them, so she was not concerned. I asked her how she knew that she really was his first partner, and she answered,

> I trusted him. I believed him. You know, we had been together for nine months at that point, and we had a really close relationship. I could have easily been duped though. I was really naive as a teenager, really naive, and since my family connection wasn't really strong, I just wanted someone to care for me.

Unfortunately, AIDS has now become a concern for Carol. During a one-month break-up with her future husband, she went out with someone else and had sex with him. She admitted to being scared of being tested for AIDS even though she felt that she should take a test. She commented, "I know I should be [tested], and I want to be. But it's like, I can't have one. I've got two kids and I'm married, and I don't want to . . . know."

Though Carol attended Oklahoma public schools the entire time she was in school, she had no memory of any formal AIDS education in the classroom. She had a vague memory of some sex education material presented when she was twelve. She said,

> I remember seeing a film on how a woman gets pregnant. And that's all I remember. After they told us how a woman got pregnant and showed us a little cartoon film (laugh), they told us about AIDS. That's all I remember. To me, at that age, it was important because I knew people who were having sex.

Carol's father and step-mother did not educate her about sex or AIDS. She recalled, ". . . they never sat

me down and talked to me. They assumed I learned about sex and stuff like that from school." There was one time that her step-mom initiated a conversation about sex, but Carol was so embarrassed that she told her step-mother, "I've already done all that. Don't talk to me." Her parents did not force the issue, and nothing more was said. Carol laughed, "And the next thing they knew, I was seventeen and pregnant."

I asked Carol what type of AIDS education would have made a difference in her life, and she stated that more attention and more time spent talking about it in class would have put more emphasis on the dangers. Television and movie stars or sports figures would not have made an impression on her. She answered, "I think they're big heads that make too much money. They don't practice what they preach anyway." She recommended talking with someone who had AIDS, and I inquired as to what age person she meant. She answered, "Like high school, fifteen or sixteen years old. They have got AIDS and they have to live with the reality that they're gonna die from that disease more than likely." But she also admitted that reaching students would be difficult because, ". . . they're not gonna listen to you."

If given the opportunity to speak about AIDS to a group of young people, Carol said, "I would tell them that the most important thing is to save themselves for

marriage." She blamed many of the nation's problems of teenage pregnancy, teens on welfare, and teens with AIDS on the fact that parents are not instilling self-esteem in their children. She stated, "I believe that a lot of problems we have in our society today is because no one is teaching their children that they're important enough to wait until they're married to have sex."

Protection from AIDS through the use of condoms was something that Carol wanted the schools to teach students. In her opinion, condoms should be brought into the classroom and students should be shown how to use them correctly. She commented that students who were not going to save themselves for marriage needed to know about protection. Her attitude toward the school being given the responsibility for educating students about all of these dangers was, "It's hard to teach kids morals in a couple of days."

JIM: Cocaine User, Incarcerated on Gun Charges

Jim had been sober from drug abuse for five months when he agreed to participate in an interview. He volunteered after hearing my research study presentation to a group session for young addicts at an Oklahoma City drug rehabilitation center. Jim had placed himself at risk for contracting AIDS through engaging in unprotected sex with multiple partners beginning at the age of fourteen. A recent AIDS test had returned negative, and Jim was relieved and proud that he had not engaged in at risk behavior for the past five months.

At age nineteen, Jim was a tall, well-built young man with dark brown hair styled in a "buzz" cut. The past five months of his life had been spent in the drug rehabilitation center after his release from jail. He was looking forward in six weeks to his completion of the rehab program so that he could return to his shaved ice business and get on with his life.

Jim's speaking style was terse and to the point. His sentences would often trail off as he stopped to think of an answer or remember something from his past. Answers to my questions were often made in incomplete sentences marked by poor grammar. He was sincere in his desire to participate and to try to help others avoid the same mistakes that he had made in his life.

Jim's Personal Story

Jim was born in Texas and grew up as the middle child between an older brother and a younger sister. His family moved often, and Jim described his childhood as, ". . . bouncing back and forth" between Texas and a small Oklahoma community of about 13,000 in the south central part of the state. He never stayed more than three years in one place. Grade school was a combination of Texas and Oklahoma schools. Junior high was spent mostly in Texas, and high school was again split between Austin and the town he referred to as his home. His experience in his Oklahoma high school was erratic, "I did about three different years there, but I never did a whole year there. I would just go for a semester or something and then I would leave. . . . I went to school when I felt like it."

Athletics was the focus of Jim's life throughout childhood. He was an avid and talented participant in football, baseball, and basketball. He commented, "I was always playing sports, and that was really all I did until I burnt out on it when I was about fifteen or sixteen."

Jim's memories of growing up were positive, "I had a happy childhood, I'd say. Nothing real bad. Mom and Dad were addicts, but it was still a good childhood. They always provided." When questioned about his parents'

addiction, Jim revealed that drugs and alcohol were abused in their home and that he carried on that behavior, beginning in his early teen years. His parents divorced when he was sixteen, and his life from that point was a series of more frequent moves and an increased involvement with drugs. Jim's personal addiction was interrupted when he was arrested and jailed on gun charges during his senior year of high school. He earned a General Education Diploma while incarcerated, and was released to the rehabilitation center to complete a drug treatment program.

Other than sports, Jim had no extra-curricular activities in school. His grades were good until high school and, ". . . I just quit caring about it." Religion was not a regular part of his life, and he only went to church, "every once in a while." His world revolved first around sports and then became dominated by his "wild" peer group. He had visited his friends between being released from jail and entering the rehabilitation center and found that, ". . . they're just as bad as they always were." Jim was concerned about what the future held for his friends. He related that their involvement with cocaine was getting worse and said,

> I don't know what they're gonna do. You know, I pray for them every night. Maybe something will happen. See, I had to get busted. . . . Go to prison. Come here [the drug treatment center]. It

> got too bad for me. Maybe it'll get too bad and they'll have to do something to get help.

Jim's At Risk Behavior, AIDS Education History, and Personal Opinions

Jim was, " 'bout fifteen or fourteen" when he first had unprotected sex. He related, "Just sex--unprotected. That's all it was. It's the only reason I'd be at risk right now. Unprotected sex. I never used needles or anything like that." His addiction to alcohol played a part in his decisions about his sexual activities. When asked if he thought about exposure to disease before he had sex, he answered,

> I's drunk usually. I just didn't even think about it at all. I did later on. It was like, 'I didn't ever talk to her again. I don't even remember her name.' A couple of girls kind of worried me, you know, but that's just how I am. I worry about stuff like that.

Worry and concern about exposure to AIDS came later for Jim. He remembered, "When I got a little older, I started wisin' up a little and wearin' condoms and stuff."

During the first part of the interview, Jim had no memories of any AIDS education being taught to him in school. He insisted, "I don't really remember anything. Nothing that even sticks in my memory." As the interview progressed, he made a few comments that indicated that he had received some information in a Texas school.

Jim did not believe that there could have been any changes in the school's AIDS education program which would have affected his behavior. He said, "I knew what was right. . . . I don't know if anyone could have did anything 'cause I didn't listen to 'em." He confided that no adult had ever talked to him about AIDS,

> No principals or counselors or anything ever pulled me aside. It might have helped if I'd a thought someone cared, but I don't know. I was pretty--I wanted to do what I wanted to do, and that was all there was to it.

Jim did not feel confident that if he were to talk about AIDS to a group of young people he could make a difference in their behavior. His philosophy was that people can be told many things but that most have to learn the hard way and for him to just tell them something would be a waste of breath. From his drug treatment experience with other addicts he related, "You come into this rehab and you can just look into their eyes and tell they need to go get some more until they're ready to--They got to hit a bottom."

Jim expressed more confidence that a person who was a role model for young people might be able to make an impression that would stick with them. He thought that maybe a famous athlete might have made a difference for him. He commented that if he had been spoken to by an athlete he would have, ". . . listened to what he said

instead of. . . talking or messing with girls or something."

During this questioning, Jim remembered an experience in Texas where several young people infected with AIDS visited his school to talk about their situations. He was impressed and recalled, ". . . that really got me. . . And that was really kinda something, you know." He felt that speakers with AIDS would make a similar impression on others.

STACY: The Rich Girl Who Lost Everything to Crank

Stacy was asleep in her room at the drug rehabilitation center and had to be awakened and brought to the interview room for me to talk with her. She had agreed to participate in the study after hearing my presentation of my research project at one of her group counseling sessions. A recent AIDS test had shown that she did not have the virus. Her slurred speech and glassy eyes made me doubt the validity of some of her informational answers, but the opinions she expressed were spoken with sincerity and conviction. She was nineteen and the mother of two sons ages 21 months and three months. She appeared to be about 50 pounds overweight, with straight, dark blond hair, blunt cut below her ears. She wore no makeup.

Stacy's attitude during the interview ranged from sarcastic, to boastful, to regretful. She was restless, moved constantly back and forth in her chair, and often ran her hands through her hair. At one point, she became tangled in the microphone cord and pulled the tape recorder to the edge of the stand. She told me that she had been in the center for only two weeks, and she occasionally showed evidence of denial of her addiction. In reviewing the transcript of our conversation, I do not doubt that she expressed her true opinions in response to my questions, but I do question the truthfulness of some

of the claims she made about aspects of her personal history.

Stacy's Personal History

Stacy grew up in a military family and lived in several states before moving to an Oklahoma City suburb at the age of nine. She had an older and a younger brother, and was in the process of a divorce from her 31 year old husband. Stacy described her family as being very wealthy when she was a child. She boasted, "I had everything, which meant Daddy had a lot of money and Mommy had a lot of money. I was very spoiled. I got whatever I wanted."

When she was twelve, Stacy became involved with a group of friends that often partied. She laughed, "I hung out with the people who got high." This peer group became important to her when her parents divorced that same year. She coped by turning to alcohol and recalled,

> I began drinking. I began rebelling. I don't know, I guess I had all this stuff and all the money. If I wanted my dad's credit card, all I had to do was just go get it out of his billfold. At age twelve, I got into drinking.

Alcohol was followed by pain pills, which Stacy started "popping" two years later. This was the same year that she met and married a 26 year old man who owned his own business. The difference in their ages was part of his appeal to her, and she commented, ". . . I guess I

just placed him as kind of a father figure." After a year of marriage, she started doing crank and began to grow apart from her family, especially her brothers. She regretfully reported, ". . . we used to have a close bondage and now we don't even have a close bondage."

In spite of her admitted heavy drug use, Stacy stayed in school and graduated. She claimed to be an excellent student and basketball player who had been offered an athletic scholarship to the University of Oklahoma. However, she said she lost the scholarship when she failed a urinalysis drug screening. It seemed doubtful to me that O.U. would offer a scholarship to a pregnant seventeen year old, but Stacy was adamant in her statements. She also contended that she was an assistant manager at a Target department store when she was seventeen.

Stacy's marriage failed because, ". . . I just fell out of love with Joe because I got started doing really heavily into drugs. . . . I cheated on him and he's caught me and stuff like that." Their two sons were being cared for by Stacy's mother until her rehabilitation program would be completed. At the time of the interview, she was scheduled for fourteen more months of treatment.

Stacy's At Risk Behavior, AIDS Education History, and Personal Opinions

Stacy began drinking and became sexually active when she was twelve years old. She insisted that condoms were always a part of her sexual activity until she married her husband at age fourteen and no longer felt the need to use them. I questioned her to determine if she had placed herself at risk of exposure from her husband, and she agreed that she was not his first sexual partner. However, she disclosed that they had both been tested for AIDS and were negative.

Stacy had no memory of receiving AIDS education in school, but she did remember a special assembly dealing with sex education and birth control measures. She said, "I remember they showed us how to put on condoms and all that. . . . They had these people come in with the banana." When I questioned Stacy further about her memories of any AIDS education, she recalled a vague memory of a class discussion when she was a senior, but she explained, ". . . I was really into the crank, you know."

If she were to talk about AIDS to a group of young people, Stacy would use her life story as a negative example of behavior. She wanted her message to be, "At nineteen, I've lost all that [marriage, family, job], and

I'm sitting here [in rehab]. . . I don't want them to do what I'm doing."

Stacy's ideal AIDS education curriculum would use guest speakers like Garth Brooks and the television stars of Beverly Hills 90210 to make an impression on students. She also planned to include the group who demonstrated the condoms on the banana when she was in high school. She stated,

> I'd have them people come back and I would give out condoms. But that still wouldn't stop them [students] you know. It's their choice, but as long as I know that I went out of my way. . . if they use them, it's their decision. Because kids are not easy."

BROOKE: A Prostitute, Drug Addict, Pregnant and in the Custody of the State of Oklahoma at Fourteen

Brooke agreed to participate in my study after hearing about it at the drug rehabilitation center where she was receiving treatment for addiction to marijuana and crack cocaine. She had been tested regularly for the AIDS virus because of repeated unprotected sexual activity as a prostitute and while under the influence of drugs. At the time of the interview, her most recent test for HIV had been negative.

Before going to get Brooke for the interview, the rehab counselor told me that Brooke was anxious to participate because finally there would be someone to listen to her. She entered the room with a smile, a soon-to-be twenty year old with hazel eyes and brown hair falling to her shoulders. Her appearance was neat, and she had applied makeup in preparation for our meeting. I found her willing to discuss every aspect of her life and eager to share her theories on self-esteem and personal understanding. Her perspective of AIDS had changed three months previously when she learned that her 27 year old cousin had been diagnosed with spinal meningitis and found to be HIV positive.

Brooke's Personal Story

Brooke grew up in a large urban community in eastern Oklahoma. She had a sister who was six years older whom she described as,". . . a very strong woman" who would always help her when she was hurting and tell her that she was beautiful. Brooke expressed pride in her sister's educational accomplishments and recent marriage. Tears came to her eyes when she described the positive influence that her sister had upon her life.

Childhood was uneventful for Brooke, and she gave few details of her early years. The family lived across the street from a Methodist church, which she attended only a couple of times. She would go with a friend to Vacation Bible School during the summer. When Brooke was thirteen, her sister left for college, and Brooke missed her terribly. She spoke of the lack of communication that she felt with her parents and gave the example, ". . . when I started my period, I asked my mother to show me how to use a tampon, and she said, 'Read the box.' " That same year, Brooke's mother told her that she was leaving her father, and Brooke's world changed. It was a year before the actual separation occurred, and Brooke remembered, ". . . I had to sit in that house and think, and that's when I became sexually active and decided that my life was going down the tubes."

It was not long until Brooke began smoking marijuana and running away from home. Her parents were unable to control her behavior, and after she stole their car at age fourteen, they relinquished her to the custody of the State as an out-of-control child. A state judge ordered that Brooke should receive treatment for her drug problem, and she was placed in an inpatient treatment center for six months. Brooke recalled the experience,

> . . . I was pregnant at the time. I didn't know what I was gonna do. I was fifteen and in treatment. I just knew that I wasn't ready for a baby. . . . I decided to give the baby up for adoption. . . . And then when my four month checkup came, I went to the doctor, and they couldn't hear the heartbeat. . . . They did an ultrasound and I had something that they called a nine week demise where the baby had stopped forming. And they had just to do a D and C and clean me out.

The treatment center made a positive impact on Brooke, and she said with pride, "It changed my life, and my parents got the custody back." After completing her time in the treatment center, she stayed drug free and sexually abstinent for 20 months while attending Alcoholics Anonymous. She became involved in community service with the Crisis Pregnancy organization, helping counsel pregnant girls who wanted to keep their babies or give them up for adoption.

While sober and abstinent, Brooke attended high school and earned her diploma with a 3.6 grade point average. She was a member of Student Council and participated in speech, drama, and debate. She received

support from a group of friends with similar interests and recalled, ". . . I had some real healthy friends at the time and they were real. This was when I was sober and doing really well."

Brooke's life took a downward turn the next year when she moved to Dallas to live with her mother. Her peer group changed to a biracial crowd which was violent at times. She related that her peers thought that she was weird and stated, ". . . I was kind of not so into all the violence and all that kind of stuff and hurting other people. I was kind of into myself. . . " Her old habits resurfaced. She started dating an African-American young man; her self-absorption soon turned to drinking, and she once again put herself at risk of contracting AIDS. She admitted,

> . . . I relapsed on marijuana, and I got pregnant. I moved back to [Oklahoma]. When I found out that I was pregnant, I started going back to A.A. for about four months. I had a baby girl named Angela, and she's 26 months right now. . . . When she was a year old, I relapsed on marijuana.

Brooke's use of marijuana escalated to smoking joints mixed with crack which she called, "Primos". She began dancing at a strip club and also went to work for an escort service. The next year of her life was dominated by drug abuse and prostitution.

A second rehabilitation center is helping Brooke to regain control of her life. She expressed gratitude for what the program would be able to do for her. She said,

> I put myself in many high risk situations. I crossed a lot of lines that I normally wouldn't have crossed in that year. . . . I got out there, and I needed some inpatient treatment to remind me of what my tools are and who I am 'cause I lost who I was.

At the time of Brooke's interview, her immediate goal was to complete her treatment program and make a home for her two year old daughter. The child had originally accompanied Brooke to the treatment center, but the arrangement did not work out satisfactorily. Members of Brooke's church were taking care of the baby until Brooke finished her program. She commented about her daughter, "She used to live here with me, but it was just too much to work on myself and raise her. I couldn't give any--I couldn't give what I didn't have. . . . When I get everything done, I'll get her back."

Brooke's At Risk Behavior, AIDS Education History, and Personal Opinions

Brooke first had unprotected sex at the age of thirteen, in August before entering the eighth grade. When I asked what her reason was for having sex, she initially replied that her best friend had done it and she didn't know that she wasn't supposed to do it. She quickly retracted that statement and admitted,

> . . . well, I kinda guess I knew in my heart that I wasn't supposed to be doing that, but I didn't have a reason not to. I thought it would be fun. I cried the whole time, and he didn't even notice. It was horrible, but I guess it wasn't

> really premeditated either. It was just something I did real spontaneous.

Brooke's reply to my question concerning her memories of AIDS Education in school was that she did not remember anything about it. Upon further questioning, it was apparent that she had received information about AIDS in her science classes through discussions of universal precautions, blood borne pathogens, and specific answers to student questions about the transmission of AIDS, but she did not consider that to be AIDS education.

In Brooke's opinion, an AIDS education program should be presented to students on a personal level, separate from courses in the standard high school curriculum. Her philosophy was,

> I know it's wrong to give them morals, but for young people at high school, it's important to teach them why it's important to respect yourself and not have sex. . . . There needs to be some voice inside them that they know that they want to save themselves for a special time.

She also felt that a special assembly would be more effective than teaching about AIDS in a regular class. She commented, "Everyone knows about AIDS, but they don't talk about it in an educational way. It's a science." She wished that someone infected with the virus had come to school to speak to her. She said that she would have been impressed by that. She added,

> If there was an assembly with a panel of people that might have been at high risk or did already have AIDS, I think that would have been a good eyeopener for young people. . . . It never really

hits home until you see someone that you know or that's in your age group have it.

The city Health Department provided Brooke with her most specific AIDS education. At fifteen, she went to them to be checked for sexually transmitted diseases, and the staff provided her with several pamphlets of information. When she became involved with the Crisis Pregnancy organization after the end of her first pregnancy, Brooke worked daily in providing information about pregnancy and AIDS to other young women. I questioned her as to why, after having all the information from school, the Health Department, and Crisis Pregnancy, she again put herself at risk through unprotected sex. She answered, "I was semi-diseased. Just sick. Not thinking about consequences. My disease was [that] I was using [drugs]. I had that invincible young feeling."

Brooke was specific about what she would say to a group of young people if given a chance to speak to them about AIDS. She would say, "AIDS is a major part of the caution about having sex. But the biggest caution is if you lose yourself when you start engaging in sex at an early age. Pregnancy and disease are minor as far as losing yourself." But Brooke was not confident of her ability to convince young people to abstain from sexual activity. She had the feeling that, ". . . no one's gonna be able to stop them individuals who are gonna do

it. . . . I think that people are walking around with blinders on."

Because she was not completely confident in her ability to convince other young people, she stated her belief that testimonials from a television star like Ellen Degeneres or a basketball player like Michael Jordan would make a difference. She would also provide condoms to students at school, even though some people would interpret that to mean that the school was telling the students that it was OK to have sex. She felt that the true message in passing out condoms would be, "We're saying that it's OK to be safe."

LEE: Tough, A Fighter, A Girl with an Uncertain Future

Lee had completed all but ten days of a drug rehabilitation program when she volunteered to do an interview with me. She had just received negative results from an AIDS test and was relieved to have a second chance to get her life in order. Her light brown hair was cut short with shaved "sidewalls" above her ears and neckline. She looked younger than her nineteen years, and she carried 170 pounds on a frame of 5'9". The answers she gave were laced with profanity and tough talk, and she expressed regret at having failed the drug test that would have allowed her to have a career in the military. Her plans were vague as to what she would do when she left the treatment center.

Lee's Personal Story

Lee had spent all but a year of her life in a tiny town of 340 people about 70 miles from Oklahoma City. She had an older brother and six younger brothers and sisters. At the age of eleven, following her parents divorce, she moved with her father to Georgia and lived there for about eighteen months. In describing the move to Georgia and the change in her life, she said, "That didn't work out at all. I come back and my mom was remarried. I hated my stepdad. That's when I started using."

In school, Lee was an A and B student until she began "messing with drugs." She managed to maintain passing grades in her classes so that she would be eligible to play basketball and softball. She stated her philosophy as, "I didn't really give a shit. As long as I had a 60 and I was eligible to play ball, I didn't care." She participated in 4-H and FFA, but as her drug use increased, she dropped out of everything but sports.

Religion was an option that Lee's parents left to her choice. She recalled about their beliefs, "My mom, she was brought up in a Catholic school and stuff. My dad, he was one of those Southern Baptist guys. . . . There wasn't no religion forced upon me or nothing.

Lee described her peer group as a group of five or six boys and girls who did some "pretty dangerous stuff". They would skip school together and go to the lake to get high. They also formed a "pack" to intimidate others. Lee spoke of often getting blood all over her from, ". . . beating the shit out of people who crossed us." These friends played a major part in her life outside of sports. They liked to go to clubs and "mosh pits." When I expressed my ignorance of what constituted a mosh pit, Lee gave her definition,

> You just go in, and everybody's messed up. They're wearing these tattoos and grunged out. You get down in that pit, and basically they beat the hell out of you is what they do. Jumping around and shit. Jump off the stage into 'em. Catch you.

> Throw you around. Throw you on the floor if they want to.

During her junior year, Lee enlisted with the Army National Guard through a special program designed to allow her to go through Basic Training before her senior year. Upon graduation from high school, she would have been eligible to enter directly into the Guard and begin a career. Her drug use ruined that opportunity. She said with regret, ". . . I screwed that up. . . . I flunked the drug test, and they kicked me out."

Basketball then became Lee's major interest, and she described herself as "real good" at it. She was counting on her athletic ability to enable her to attend college, but she was not able to achieve that goal either,

> I would have had a scholarship this year, but I fucked it up doing drugs. I quit school my junior year. I got me a job. I was working, and I started smoking crack. I messed it all up. Now I'm in rehab trying to get everything together.

Lee's At Risk Behavior, AIDS Education History, and Personal Opinions

Lee began drinking and smoking pot when she was thirteen, and her first sexual experience came the following year. She reported that she always used protection until she turned fifteen and, "Just slowly quit using condoms." By that time she was also using acid, cocaine and crack. She described her behavior,

> I usually had unprotected sex. Not really. Not all the time. Except for this dude who was

> bisexual. I didn't know it 'til afterwards, and we didn't use no protection. I've had sex with women,but that ain't really--I guess you can't--that would be hard to contract something like that. I never shot up, shared needles or nothing. I've beaten some people down. Blood'd just be everywhere. It's all on us and shit. I guess that'd be risky, huh?

Her school's AIDS education program was something that Lee remembered very specifically. She could recall seeing films about people's stories, writing papers, and being given statistics about the disease. The classes were told in detail how the disease could and could not be spread. Her school also provided the students with a phone number to call if they wanted to be tested. In her opinion, "They did it pretty thorough. . . . I guess they did a pretty good job. . . . But most of it you really don't listen to it."

Because Lee spoke of receiving AIDS education before she began her at risk behavior, and because she could recall specifically what had been taught, I asked her to tell me the reasons that she decided to go ahead and place herself at risk. She replied,

> You just don't buy no rubbers. If you got it, that's fine. Shit. It's just not the top thing on your mind at the moment. (laugh) It should be. I mean, I know I should do it, but it's just one of the things you take for granted. You just blow it off. You shouldn't do that really. Fuck around and you're dead.

I then asked Lee if she planned to protect herself in her future behavior, and she admitted that she could not be sure,

> I can't say that I will every time, but I think that I'll try. 'Cause I had my test, my AIDS test, and I's kinda worried a little bit, but it come back negative. I guess it's kinda like a second chance deal. I know I'm clean, so I'll probably stress the protected sex a little more.

Lee's recommendations for improving AIDS education programs included providing more realistic videos that didn't look "so stupid, so fake." She also felt that bringing in kids who had AIDS and were "into the same things" as the audience would have a greater impact on students. Scare tactics were also recommended by Lee, and she wanted to, "Show some stuff of people who are real, real, sick." Advice from a metal band or alternative music group like Smashing Pumpkins would be something that Lee said she would have respected. When I asked her if she felt that those bands used good sense in their own behavior, she laughed and answered, "No, but we'd listen to them if they told us that, probably."

If she were able to speak to a group of young people and tell them about AIDS, Lee was not sure of what advice she would give. She said, "I wouldn't know what to tell them. I couldn't tell them nothing that they probably hadn't already heard. . . " She told me that she would stress the use of protection during sex and her main advice would be to, "Tell them there ain't no ass worth dying for."

CHAPTER V

FINDINGS AND ANALYSIS PATTERNS

Introduction

Upon analysis of the participants' personal history information and of their responses to the specific interview questions, several common patterns emerged. This chapter contains the analysis of the patterns and relates those patterns to the AIDS education models outlined in the related literature discussed in Chapter II. It also addresses the four research questions from Chapter I upon which this study is based.

Each of the following sections contains citations which answer the research question: How do the perceptions of these participants relate to the existing models researched in the current literature? The three remaining research questions are answered within specific divisions of this chapter.

Divorce

Every participant in this study revealed that he or she came from a home in which the parents were divorced. The participants' ages at the time of their parents' divorces ranged from infancy to sixteen, with five parental separations occurring when these children were between the ages of eight and thirteen. Each participant indicated a

negative and long-lasting personal response to the break up of the parents' marriage.

The impact that divorce had upon their lives is best illustrated by their memories of the resulting family and personal instability. Kimberlee classified the situation as ". . . the most significant thing in my life--that my parents had gotten a divorce." She and her father subsequently moved in with her grandmother, and Kimberlee's home environment remained stable until she became pregnant and was married at age seventeen. Throughout the interview she referred to that significant time in her life as "The Divorce Years."

Stacy was 12 when her parents' marriage failed, and she identified that as the year in which she began drinking and participated in her first sexual experience. She characterized her attitude as rebellious, resentful, and uncaring. She married two years later while still in junior high.

The year that Brooke had to live with her parents after being told that they were going to get a divorce was a year of personal torment for her. She remembered, ". . . that's when I became sexually active and decided that my life was going down the tubes." She later danced in a strip club and followed that experience with employment as a prostitute for an escort service.

Lee moved to another state to live with her father after her parents' marriage collapsed, but returned to Oklahoma when she and her father could not get along. They were still estranged at the time of the interview. Her mother had remarried during Lee's absence, and her new stepfather made a negative impact on her life. Lee exhibited bitterness at the memory of her stepfather, and stated, "I hated my stepdad. That's when I started using [illegal drugs]."

Jaime suffered a double exposure to divorce that began when her parents separated before she entered kindergarten. Her father remarried and Jaime remained in his custody, but that second marriage ended when Jaime was eight. She and her father lived together through the majority of her childhood and adolescence, but whenever they did not agree on something, she would go to live with her mother. Jaime did not stay for long periods of time with her mother, whom she described as "a lunatic". Whenever they fought, she would move back to live with her father. The majority of her childhood was spent moving between the two households.

Carol's parents divorced when she was an infant, and she never knew her mother. The home life provided by her father and stepmother became so oppressive in her mid-teens that she deliberately tried to get pregnant as an avenue of escape. She expressed regret at being so "dumb" as to think

that pregnancy was a way to get out of that negative situation.

Of all the participants, Jim was the oldest (16) when his parents divorced. He spent the time after the divorce "bouncing back and forth" between his addict parents until he dropped out of high school his senior year. Despite his parents' abuse of alcohol and drugs, Jim described his childhood as a happy one. He concluded that his personal problems began at about 14 when he "burnt out on sports" and started experimenting with sex and drugs. He stated that his at risk behavior was influenced by the fact that he felt that no one cared about him.

The pattern of family instability created by divorce negatively affected all seven of the study participants. Their expressed feelings of inadequacy, insecurity, and not being cared about support the theories of Bandura (1992) and the GAO Model (1988). Those theories maintain that young people need strong self-concepts and a great deal of confidence in order to be able to use the social skills necessary to extricate themselves from the at risk situations which eventually occur for everyone. In contrast to extricating themselves, several of the participants admitted that they deliberately placed themselves in harm's way as an attempt to improve upon or find refuge from their negative family circumstances.

Family Mobility

Moving and changing schools was common to six of the seven young people in the study. Kimberlee was the only participant who remained in the same school system from kindergarten through graduation from high school. Each of the remaining six participants had moved at least twice during the years they would have received AIDS education in Oklahoma.

Jim could not remember how many times he had relocated between his parents in Texas and Oklahoma before dropping out of high school. He compensated for this instability with an uncaring attitude and a desire to do only what he wanted to do, regardless of the consequences. Brooke was removed from her parents' home when she was 14 and placed in the state's custody in order to receive treatment to overcome a drug habit. She managed to stay clean for 20 months. When her divorced parents regained joint custody of her, she recalled, "I moved to Dallas with my mom, and I relapsed on marijuana and I got pregnant."

Jaime had been in schools in four different cities. She said, "I moved around so lot [sic], I probably missed a lot of the stuff that they did [in school]. I went to eight different schools my whole life. . ."

Stacy was from a military family which moved before her parents' divorce. After the break-up of her family, she moved once again before getting married at fourteen. Her

marriage lasted long enough for her to remain in the same school system and obtain her high school diploma.

Migration to Georgia with her father lasted a year and a half for Lee. When she became estranged from him, she returned to the rural Oklahoma community where her mother lived and began the drug abuse and bloody fighting which placed her at risk.

Dealing with the problems presented by the mobility factor among teens was not listed as an aspect of any of the AIDS education models cited from current literature. The participants themselves recognized that moving from school to school could have prevented them from receiving information about AIDS during a time in which their behavior choices could have been influenced. The current educational practice of devoting only a short period of time to AIDS prevention instruction (Popham, 1993) increases the likelihood that a mobile student will miss the window of opportunity to receive vital information from school curriculum.

Age of Initial At Risk Behavior

Five of the seven participants began their at risk behavior during their junior high years. The youngest at the initial at risk experience was Stacy who was a 12 year old sixth grade elementary school student when she became sexually active. Kimberlee, who had vowed abstinence from

sex until after marriage, placed herself at risk during her junior year in high school at the age of seventeen. She was the oldest participant in beginning her at risk behavior.

The average age of all the participants' first at risk experience was 14.5 years. Five of the seven began their dangerous experimentation between the ages of thirteen and fifteen. These figures indicate that the eighth grade year of junior high was a critical time for these young students.

Of the five previously cited models of AIDS education programs, only the one by Dodds, Volker, and Viviand (1989) specifically targets the elementary school years as the age at which instruction should begin in AIDS prevention techniques. Their model recommends that AIDS education should begin as early as possible in the schools and should be integrated throughout the curriculum. The four remaining models target their instruction at the teen years, with Popham (1993) concentrating his instruction upon the ninth and tenth grades. By the tenth grade, six of the seven subjects of this research project had already begun their at risk behavior.

Unprotected Sexual Activity

Each participant listed unprotected sexual intercourse as the primary behavior which risked exposure to the AIDS virus. Lee had engaged in sex with both males and females, but she indicated that she did not think that she could have

been at risk with the female partners. A trust factor with their partners limited the participants' use of condoms for protection, and Jim said that he was often drunk and didn't care. Lee stated, "It's [condom use] not the top thing on your mind."

In addition, Jim and Lee had both been street fighters who had received direct blood exposure through cuts and abrasions resulting from the violent physical contact. It was during the interview that Lee realized that fighting had also exposed her to the risk of contracting AIDS.

Each of the five AIDS education models places its strongest emphasis upon teaching the danger of exposure to the virus through unprotected sexual contact. The GAO Model (1988) also utilizes research dealing with public school health programs designed to educate students about the dangers of smoking, drug abuse, and teen pregnancy. Bandura (1992), Tonks (1993), and Popham (1993) recommend social modeling and role playing in order to familiarize students with the words and actions which can assist them in handling at risk encounters involving sex in a positive and safe manner. Dodds, Volker, and Viviand (1989) emphasize responsible decision making related to education about attitudes, values, and personal behaviors. The models all recognize the fact that motivation is the key to any permanent behavior change and base their instruction techniques on positive motivational strategies appropriate

for the students' age levels. Jim illustrated the importance of positive motivation in his struggle to overcome his drug habit when he said, "You gotta want to really bad. I don't know if I want to bad enough yet or not."

Trust

Four of the six females in the study mentioned trust in their partners as a reason for engaging in unprotected sex. They each said that they had discussed AIDS with their lovers before their first sexual experiences but that they believed the boys when told by them that they were disease-free. Carol said, "I trusted him, but I could have been duped, though." Jaime's reason was, "I was a virgin, and he was a virgin. At least he said he was."

Kimberlee professed complete trust in her partner because she knew it was the first experience for both of them. She blamed "the moment" for their unplanned sex and said, "And quite honestly, if I had had one [a condom], I probably wouldn't have thought about it."

The strong psychological and physical forces which affect human sexual behavior are the central facets of the model authored by Popham (1993). He acknowledges that an educational prevention curriculum is of no value unless students are convinced that changing their behavior is in their own best interests and that they have control over

making those decisions. That motivation must come from within the individual, and the individual must possess the personal social skills necessary to carry out the motivated behavior. Brooke validated the strength of motivation when she said, ". . .no one's gonna be able to stop those individuals who are gonna do it."

Family Religious Practices

Only Kimberlee, the wife of the Freewill Baptist youth minister, reported regular church attendance throughout her lifetime. Stacy refused to answer the question, and the other five subjects had never attended church on a regular basis for more than two years. Brooke felt that morals should be taught in school and said that people should be told that it is wrong to have sex and given a reason why it is wrong. She said that no one ever told her that it was wrong and then admitted that she guessed she did know but that she did not really have a reason not to have sex. Stacy seemed to feel that marriage gave her protection from AIDS. She acknowledged that her husband had had previous sexual partners before he married her, but she said, ". . . I was married. I felt I could do that [have unprotected sex]."

Douglas Tonks (1993) places great emphasis on the teaching of sexual abstinence in his AIDS education model, and this is in agreement with most religious teaching in

Oklahoma churches. Instruction in morals and values has been a function of the church throughout the ages, and for the school to venture into this area is an invitation for controversy and community opposition. However, school may be the only opportunity for attitudes and values education to be presented to those students whose parents do not take them to church or talk to them about values at home.

Peer Groups and Peer Pressure

The peer group was identified as an important influence in the lives of all seven research participants. Six of the seven described their groups in negative terms and talked of the dangerous behavior engaged in by their group members and other peripheral friends. In several instances, the group had introduced the participant to at risk behavior and had provided encouragement to continue the behavior.

Jim and Lee had the most dangerous peer groups among the participants. Jim ran with a wild crowd that used cocaine and carried weapons. His break from them came when he was arrested on a weapon's charge, jailed, and placed in a drug treatment program. Lee and her friends skipped school, did drugs, and beat up anyone who got in their way. They frequented "mosh pits" where frenetic dancing preceded bloody violence in the pit, and then they would go out together and get high as a group activity.

Kimberlee was the only participant who associated with friends who got good grades, participated in extra-curricular school activities and who attended church regularly. She described them as a "fun" group. Her friends encouraged her in her goal of sexual abstinence until marriage, and she remembered, "We wanted to save ourselves, all of us [for marriage]."

The enormous influence of the teen peer group is recognized by Popham (1993) in his attempts to personalize AIDS for students. He advocates that young people with AIDS or who are HIV+ should be brought into schools and allowed to tell their personal stories to people their own age. Bandura (1992) acknowledges the inordinate peer pressure which can be exerted on a young person for both positive and negative results. He advocates the establishment of new peer groups when a teen is not receiving the group support necessary to maintain self-protective behavior.

Bandura does not speak to the fact that peer groups are quite difficult to establish for teens when they are having personal problems. Mobility was a definite problem in Jaime's lack of friends during her childhood and adolescence. She had been to eight different schools and said, "That's a lot of schools for a kid. That's probably why I never had any friends." She had the experience of moving into a new school and not being welcomed by the "right" crowd. In many instances the only crowd quickly

willing to accept outsiders is the crowd which is seeking another drug purchaser or an extra companion for wild parties. These groups welcome new students at a time when they are the most vulnerable and are trying desperately to fit in somewhere. This situation provides a perfect opportunity for at risk behavior.

The Feeling that Nothing Could Have Made a Difference

This section presents material which relates to the research question: Why did these participants engage in at risk behavior despite having received formal AIDS education in school?

All of the participants were aware in general of the dangers of AIDS exposure and the risk of pregnancy or disease when they made their decisions to place themselves at risk. But they all had specific reasons for deciding to ignore what they already knew or had been taught. Kimberlee, who was morally opposed to sex before marriage, was caught up in a moment of passion and acknowledged that there was really no chance of her taking precautions against AIDS. Up to that point, she had done everything prescribed by society to be able to protect herself. She was reared in a moral and religious home. She had the positive support of her peer group. She had studied the dangers of premarital sex in church and in school. She and her boyfriend had promised each other to wait to have sex until after they

were married. One unguarded "moment" on Valentine's Day was more powerful than all of the determination and motivation that she and her boyfriend possessed. Nine months to the day after that moment, she gave birth to her daughter.

Carol cited peer pressure as her reason for her first at risk behavior. She said that the only reason she wanted to have sex was that all her friends were doing it and she thought that the time was right. She was fifteen. The second time she put herself at risk was the result of anger and an attempt to retaliate against her boyfriend for the breakup of their relationship. She made a conscious decision to ignore what she had learned, and now, even though she lives in fear that she might carry the virus, she is too frightened to have herself tested for AIDS.

Alcohol and an "I don't care" attitude motivated Jim to place himself in danger. He commented that he was usually drunk and was not aware of or caring about what he was doing. He said that he was not sure that anything could have changed his behavior because he did not listen to anyone. His reason was, "I wanted to do what I wanted to do, and that was all there was to it."

During a span of six years, Brooke exposed herself numerous times to the possibility of AIDS. The first time was a spontaneous attempt at what she thought would be "fun" because her best friend had already had sex. Her at risk behavior continued through a miscarriage, the birth of a

daughter, and becoming a prostitute. The reasoning behind her actions was, "I was semi-diseased. Just sick. . . .I had that invincible young feeling."

The realization that AIDS education can be futile even in the best and most receptive of school climates is conceded by Bandura (1992). He contends that people protect themselves from harm only when they have a strong self-belief in their efficacy to exercise personal control. This characteristic is instilled in a person from the moment of birth through constant parental and societal reinforcements and is difficult to teach within the limitations of the public school classroom setting.

The Participants' Perceptions of Their AIDS Education

The information in this section addresses the research question: What perceptions of their public school AIDS education experience are held by Oklahoma young people who have placed themselves at risk of contracting the disease?

AIDS education in the Oklahoma public schools did not make a lasting impression on six of the seven participants. Their memories were vague and disjointed, and several commented that they remembered more discussion of sex education and teen pregnancy than of AIDS. They had different recollections of how much classroom time had been devoted to the subject, and it ranged from one week in

Kimberlee's sophomore biology class to "not a whole lot" in Jaime's school experience.

Jim related a vivid memory from a school in Texas which had invited some young people with AIDS to come to the school, tell their personal stories, and answer students' questions. Jim was impressed with these visitors and remarked, "And that was really kinda something, you know." But he said that nothing really stuck in his memory about any AIDS presentations in his Oklahoma schools.

Stacy and Brooke remembered nothing at all about AIDS education in their schools. Stacy tried to recall something specific that stood out during her classes, but finally conceded, ". . .honestly, I don't remember ever having AIDS education." Brooke was no more successful and admitted, "I don't think we talked about it."

Lee had the most detailed descriptions of what she had learned about AIDS in her small rural school. She and her classmates were shown films, required to write papers, were given informational brochures and pamphlets, and provided with agency phone numbers to call if they wished to arrange confidential AIDS testing. Lee felt that the school presentation had been thorough and that the teachers had done a "pretty good" job of presenting the material. But she indicated that she really had not listened to most of it because she just did not care.

The participants' sketchy memories of their instruction concerning such a vital, life-threatening subject as AIDS parallels the Elaboration Likelihood Model of attitude change of Petty and Cacioppo (1986). The teaching methods recalled by the participants were those that fit the peripheral route to attitude change which is labelled as the least effective by Petty and Cacioppo. Only a short time in school was devoted to the subject, and the students were not coached in how to specifically apply the facts and precautionary behaviors to their own experiences. Not one teaching method related by a participant fit the central route to attitude change which Petty and Cacioppo feel is the key to permanent behavior modification. In light of their theory, the participants did not have any opportunity at all to make a lasting change in behavior as a result of their public school AIDS education.

The Participants' Ideal AIDS Education Program

The ideas and suggestions discussed in this section relate to the research question: What are the views and observations of these young people from which a model AIDS education program could be developed?

Many ideas were voiced by the participants about the way they felt an effective school AIDS education program should be structured. Their central theme revolved around the tactic of scaring students with the dangers involved

with the abuse of sex, alcohol, and drugs. Jaime stated that she would ask students to "please" not have sex, but if they absolutely could not control themselves, she would provide specific instruction on the use of condoms. Her final advice to students would be, "If you know that person, then talk to them before you have sex. It's very, very dangerous."

Brooke was the most philosophical in her approach and emphasized that though AIDS is a major caution in having unprotected sex, she felt that there was a greater danger in the young person's loss of self. She wanted to stress self-respect and try to convince the students that it is important to save the experience for a special time. Providing condoms through the school system was another of Brooke's recommendations because she was convinced that no one was going to be able to stop those individuals who were determined to be sexually active.

Seeing and talking to young people who were infected with the AIDS virus would have made a difference to each of the seven participants. Lee recommended that the school should, "Show us some stuff of people who are real, real sick." Carol wanted to be able to talk with people who had AIDS in order to see what they were going through in combating the disease, and Jaime recommended a film of a young person finding out that he or she had the disease so that the audience could view the reaction. This methodology

follows the theory of the GAO model (1988) which places emphasis upon the immediate and visible consequences of AIDS. But it is in conflict with the ideas of Petty and Cacioppo (1986) which state that fear is only a temporary motivation and is not a likely method for permanent behavior change.

The participants were not in agreement about whether advice from a famous movie star, musical entertainer, or sports figure would have been valuable to them. Jaime commented that they were just actors who get paid to say things, and Carol felt that famous people were just, ". . .bigheads who don't practice what they preach."

Brooke believed that superstars such as Magic Johnson and Michael Jordan speaking out about AIDS would make a major difference for young people, but she said that she was most touched by the words of her 25 year old cousin who had just been diagnosed with the disease. She said that it never really hit home with her until she learned about her cousin. Her philosophy is in agreement with Petty and Cacioppo (1986) who contend that the personalization of a problem is effective in changing behavior for an individual.

Though all of the participants had definite ideas of what might work to make an AIDS education program successful in the school setting, all seven spoke about the reality of trying to teach something to someone who does not want to listen. They commented that they had been taught things

that they chose to disregard and that nothing had made a difference to them. Jim became a participant in this study because he wanted an opportunity to try to help someone else, and he commented, "If young people end up reading this or something, just let them know, 'Drugs ain't the path. A quick buck ain't the way.' Really, college and school is the answer." This was the hope of a young man who was still not sure if he would be strong enough to conquer his drug addiction.

Summary

This chapter discusses the patterns of divorce, mobility, religion, and peer relations which became evident upon analysis of the transcripted interviews. The at risk behavior of the subjects was explored in relation to the type of behavior chosen by each individual, the age at which the behavior began, and the reasons the participants gave for deciding to initiate the behavior. Comparisons and contrasts were made with the AIDS education models from the review of literature, and the participants' recommendations were presented for creating their own AIDS education models. The four research questions guiding this study were addressed throughout the chapter.

CHAPTER VI

CONCLUSIONS AND RECOMMENDATIONS

Introduction

This chapter reviews the purpose of the study, restates the research questions which guided the study, and discusses the methodology used to conduct the research. The findings and analysis patterns presented in Chapter V are reported, and the significant patterns which emerged from the research analysis are explained. The patterns are followed by recommendations for a model AIDS education program based upon the conclusions of the research. Finally, the conclusions and findings of the research are discussed in relation to the theories in related literature.

Review of the Study

Purpose

The problem investigated in this study can be stated at two levels. Indirectly data were being sought which might improve the effectiveness of AIDS education programs in the public schools. More directly, the perceptions of young people who had engaged in at risk behaviors were explored to determine why the Oklahoma state mandated education programs were not effective in

protecting these young adults from possible exposure to the AIDS virus.

Research Questions

The research questions which guided this study were:

Question One: What perceptions of their public school AIDS education experiences are held by Oklahoma young people who have placed themselves at risk of contracting the disease?

Question Two: Why did these participants engage in at risk behavior despite having received formal AIDS education in school?

Question Three: How do the perceptions of these participants relate to the existing models researched in the current literature?

Question Four: What are the views and observations of these young people from which a model AIDS education program could be developed?

Methodology

Phenomenology was chosen as the qualitative research method for the study because the focus of the research

centered upon the experiences, beliefs, and opinions of the participants. Seven young people were interviewed who had been students in Oklahoma public schools and had received instruction in AIDS prevention through the curriculum mandated by the State of Oklahoma. After having received this prevention education, the participants knowingly engaged in behavior which placed them at risk of exposure to AIDS.

The participants were interviewed at length about their at risk behavior and about their AIDS education experiences. Their perceptions of why they took the risk and of what motivated their behaviors were the central focus of this study. The AIDS education models discussed in the related literature were compared to the participants' responses to ascertain whether the characteristics of one or several models combined could be used to provide structural framework for a more successful AIDS education program.

Selection of the Sample

Participants in this study were volunteers who were required to meet one of several criteria which included having used intravenous drugs and shared needles with another person, having had direct blood exposure from another person, or having engaged in unprotected sexual activity which placed the participant at risk of

contracting the virus. The young people interviewed were chosen from drug rehabilitation support groups, HIV/AIDS support groups, and alternative school programs for pregnant teens in Oklahoma. All volunteers who met the profile criteria were included as participants in the study.

Data Collection

Participants were interviewed using open-ended questions designed to include the areas of the participants' personal AIDS education while in public school, their subsequent behavior which placed them at risk of contracting the virus, their personal perceptions of why they engaged in that behavior, and their suggestions and opinions about what an effective AIDS education curriculum should include. They were also asked to identify any factors which they felt might have made a difference in their decisions to participate in at risk behavior.

The interviews were audio-taped and then transcribed and reviewed to discover and code themes or patterns. The current literature was reviewed to determine if connections to existing AIDS education models could be established from the research findings. The participants' ideas and suggestions for improving the AIDS education curriculum were also analyzed and compared

AIDS education curriculum were also analyzed and compared with current research to determine if a relationship existed.

Participant Profiles

Individual profiles of the participants were presented in Chapter IV which summarized significant information taken from the interviews. The profiles described the individual circumstances of each interview, and a personal history was compiled for each participant based upon statements made during the interviews. The profiles contain information about the participants' AIDS education in school, the type of at risk behavior in which they engaged, and give their personal opinions as to what changes they would recommend for future AIDS education programs.

Findings and Analysis Patterns

Upon analyzing the data collected from the participant interviews, several patterns and themes became evident. Divorce of the participants' parents was a major factor in the life of each young person, and it contributed to other patterns of mobility and personal instability which followed the break up of the family units. The young age at which the participants began their at risk behavior was also a common theme. All but

one participant had risked possible exposure to the AIDS virus before entering the ninth grade.

A pattern of the participants' choice of the type of at risk behavior emerged from the interview information. All of the participants had engaged in unprotected sexual activity, and two had received direct blood exposure from another person through fist-fighting. A theme of trust in the word of their sexual partners was also apparent among the female participants. They believed their boyfriend or acquaintance when assured by him that he was not HIV+ or infected with AIDS. Although some expressed skepticism in the validity of those claims, the females chose to proceed with their at risk behavior.

The theme of religion was important to only one participant, and the others reported a lack of values training at home. This lack of values instruction and not being taught the difference between right and wrong was acknowledged as a reason for some of the participants' acquiescence to peer pressure to have sex. One young woman claimed that she had never been told why it was wrong to have unprotected sex.

In spite of their educational training in AIDS prevention, the personal circumstances of at risk behavior described by the participants indicated that they felt that nothing could have stopped them from engaging in that behavior. They admitted to knowing the

dangers and making a conscious decision to ignore those dangers. Even though they made statements that they believed nothing the school taught could have made a difference for them, they all felt that AIDS education should be taught in school because it might make a difference for others.

The analysis of the participants' perceptions of their AIDS education indicated that they had vague and disjointed memories of what and how they had been taught about it in school. It was evident that the students did not have or did not take advantage of the opportunity to make a significant change in their behavior as a result of AIDS education in school. Their recommendations for a program that might have made a difference for them centered around teachers' trying to scare students with the dangers connected to AIDS, and to the students' being allowed to see and talk to people their own age who were HIV+ or combating full blown AIDS. All were in agreement that their suggestions could be futile in trying to teach students who do not want to be taught.

Recommendations for a Model AIDS Education Program

The analysis of the interviews and the personal opinions of the study participants provided the following recommendations for components which should be included in a model AIDS education program for the public school:

1. AIDS education should begin in the early elementary school years and continue until graduation. The data from this study indicated at risk behaviors beginning as early as age 12, and our present emphasis on middle and high school programs is far too late to be effective. While the ideal time to begin such a program awaits further research, clearly it must precede the onset of at risk behavior.
2. Students should be given specific facts about the dangers of AIDS and told exactly what behaviors place individuals at risk.
3. Young people who are HIV+ or who have full blown AIDS should be brought into the school to tell their personal stories and answer questions from the student body.
4. Students should see and hear people they admire telling them about the dangers of AIDS.
5. Students should be encouraged to develop personal standards and codes of conduct by which to live their lives.
6. There should be instruction in methods of AIDS prevention, including emphasis on abstinence from sex until marriage. In addition to emphasis on abstinence, the participants asked for explicit instruction on the proper use of condoms.

7. AIDS education should be an integrated part of the entire school curriculum throughout the years, but it should also be emphasized at designated times during each school year. Schools throughout the entire state, or even throughout a regional grouping of states, should receive AIDS prevention instruction at the same time. This designated instruction period would increase the opportunity for mobile students to receive the vital information about AIDS prevention.
8. New students should be monitored through special orientation programs to assist them in forming positive peer groups and in becoming a part of school activities.
9. Small group counseling should be provided for students experiencing divorce in their families.

Of the five model AIDS education programs previously reviewed in this study, not one contains <u>all</u> of the elements recommended by the participants or derived from their response patterns. The above program recommendations constitute a combination of the desires of the participants, the patterns evident from their response analysis, and the model programs from current literature.

The analysis of the personal histories and opinions of the participants revealed areas of their behavior

which reinforced existing AIDS education theory and also identified areas which would benefit from further research. Additional study of these areas could add to the research base for public school AIDS education models. The conclusions and recommendations presented in this final chapter focus upon the analyzed patterns from the interviews which appear to be significant.

Conclusions

The pattern of parental divorce in the family of every participant is significant in light of the participants' psychological instability and the geographic mobility which followed those traumatic events. The special needs of a student from a dysfunctional family must be addressed in an AIDS education program in order to assist that student from also becoming dysfunctional in response to the circumstances resulting from divorce.

The difficulties of the public educational system's being able to provide young people with effective tools to use in AIDS prevention are cited by Lioeanjie (1996),

> . . . public education efforts, particularly targeting teenagers, face significant barriers. Many teenagers believe HIV to be only a "gay disease." Many also have limited comprehension of the disease's incubation period, often view themselves as "immortal," and many are products of dysfunctional homes that are unable to provide the kind of support and advice necessary to help them make good choices (p. 140).

The participants' psychological responses to their parents' divorces reinforce the social cognitive theory of Bandura (1992) which focuses upon effecting change in negative and harmful lifestyles. School programs must place greater emphasis upon instructing students in social skills and methods of coping to be used when they are faced with life-changing moments of decision-making. The school program can equip students with the knowledge and current facts about the dangers of AIDS, but if students do not have the emotional strength or internal motivation to use this information for their benefit, the program will have no chance to be successful.

The age of their initial at risk behavior was found to have occurred in late elementary and mid-junior high years for the majority of the participants, and this was a significant finding of this study. Their early age of beginning at risk behavior emphasized the importance that AIDS education be introduced in the primary school years in order to prepare students with preventive social skills to be used in dealing with the first and subsequent dangerous encounters. This finding is validated by Quackenbush and Villarreal (1988) and by Silin (1990) who advocate that HIV/AIDS education needs to begin with the youngest children and permeate the curriculum in order to break down current taboos associated with the disease and make the subject a more

comfortable one for discussion. There is a need for further research in the area of adequately preparing a proper age-related curriculum to teach such a sensitive and controversial issue to the youngest public school students.

Another area of need revealed by the participants in this study is for the school to provide special orientation for students who are just enrolling in the district. These students require specific assistance in finding positive peer groups and also in quickly being made to feel a "part" of their new school. New students' vulnerability to negative peer influences must be reduced in order to minimize the opportunity for them to engage in at risk behavior as a response to their unfamiliar circumstances.

This aspect of the study is in agreement with Popham's (1993) theory that new peer groups should be established when a student is not receiving the support needed for that student to maintain positive behavior. The methods for providing this assistance could be in the form of faculty members mentoring new students, orientation programs which last several months and track a student through the establishment of an initial positive peer group, and continual small group counseling for students whose families are experiencing a major

trauma such as divorce, a death, or the terminal illness of a family member or close friend.

An additional significant area of need which emerged from this research project is the need for AIDS prevention instruction to emphasize fighting as an at risk behavior. The two study participants who had engaged in fist-fights and beatings had not considered those activities as being a method by which they could expose themselves to AIDS. They were well aware of the dangers of unprotected sex and of sharing needles, but they did not relate body fluid exposure to a bloody nose or a cut lip. This is information which needs to be included and emphasized in every AIDS education program.

The students who were interviewed revealed a need for being given valid reasons for not engaging in at risk behavior. The pattern of no consistent religious or values training in the lives of six of the seven young people evidences a need for helping them to establish a set of personal standards and conduct by which to live their lives. "Religious teaching provides a moral framework for young people as they explore sexual life-styles and relationships" (Hedgepeth & Helmich, 1996, p. 35). The public school cannot provide religious training, but the community should not object to students being given instruction in how to form personal behavior codes which could save their lives.

There was a significant pattern of hopelessness expressed by all participants in their feeling that nothing in their AIDS education in school could really have made a difference in their individual choices to place themselves at risk. Several even admitted that they would probably continue their at risk behavior because they just did not feel strong enough to control their actions. Deborah Rugg (Summer, 1990) acknowledges the fact that AIDS education cannot be successful in all cases when she states that, "Some individuals will be unable to change or to maintain change following our best intervention efforts" (p. 17).

This feeling of hopelessness is one of the most important emergent factors of this research project. It is evident from the participants' responses that a formal AIDS education program in the public schools did not have a major impact upon them as dysfunctional students. This finding is validated by Moore and Forst (1996),

> . . . we must begin to realize that prevention education does not take place within a vacuum; that there are social, political, and cultural barriers that also impact health educators' abilities to function effectively, many of which are beyond the control of health educators but continue to inhibit the efficacy of prevention education in the United States (p. 7).

Further research is needed in the area of what the school can do for the dysfunctional student who is egocentric, stubborn, and devoted to doing everything his or her own way regardless of the negative consequences.

How can a precautionary behavior be taught to a student who has the "invincible young feeling"?

It is apparent from this research that the public schools alone cannot meet the AIDS prevention needs of the dysfunctional student. A wider, more concerted community effort is needed to reach those students who are outside the mainstream.

> If we accept that there are economic, political, and social as well as biomedical strands in the Gordian knot that is HIV/AIDS, then an effective educational response does not reside in the province of the health teacher alone. A successful response is a collaborative one involving teachers from all the disciplines, administrators, and parents. In order for students to understand the disease, they must understand the cultural context in which it is occurring. For it is this context that defines how individuals and society at large respond to people with HIV and assign resources to prevention, research, and care (Silin, 1990, p. 63).

This need for collaborative efforts between the school and community is echoed by Dryfoos (1994) and Lee and Berman (1992) who cite the complex range of social problems inherent in adolescent sexuality issues. There is a need for professionals from varied disciplines such as parent-teacher organizations (Dinkmeyer, Carlson, & Dinkmeyer, 1994), health service providers, and social service systems to work in tandem to provide services for educating the whole child. Research indicates that collaborative programs are more effective than limited ones (Hedgepeth & Helmich, 1996).

> Many examples exist of effective collaboration among the many sources of sexuality education:

> after-school programs utilizing trained peers; schools cooperating with local health clinics to offer comprehensive health services, including contraceptives, to students; churches and other religious groups inviting community health educators to conduct workshops; school and community-based educators coordinating efforts to improve delivery of services and reinforce messages; and local media campaigns developed to supplement and reinforce educational programs (p. 35).

The needs of today's students and their families cannot be met by the school alone because those needs exceed the resources available to most public schools. The factor which has a better opportunity for success with these children is a coalition of community and educational services working to provide the special assistance they so desperately require. Only a united effort of home, school, and community will be able to successfully combat the epidemic spread of the AIDS virus among the nation's young people.

Summary

In conclusion, this research project has affirmed certain elements of current theories regarding AIDS education and has revealed areas which should be added to existing instructional methods and curriculum content in the public schools. Areas of need have been revealed which would benefit from further research. The project has emphasized the need for a collaborative effort of community educational, political, and social arenas in order to make progress in the on-going battle against the

AIDS epidemic. Because each person risks the same fatal consequences of AIDS regardless of ability or individual personal circumstances, schools must be prepared and properly equipped to teach life-saving decision making to every student. This challenge cannot be met without the united assistance of the home and community because AIDS is no respecter of persons. The misfortune of one affects the lives of all.

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An Act

ENROLLED House
BILL NO. 1476

By: WHITE, HAMILTON (Jeff), BASTIN, DAVID (GUY), HUTCHCROFT, LARASON, LASSITER, LITTLEFIELD, THOMPSON, WILLIAMS (Freddye), HOBSON, SNIDER, LEWIS, HARRIS (Robert), GLENN, MORGAN (Jim), HOLT, VANATTA, ROSS, ANDERSON AND STOTTLEMYRE of the HOUSE

and

STIPE, HERBERT, TAYLOR, BROWN, CAIN, HANEY, HORNER, RIGGS and DICKERSON of the SENATE

AN ACT RELATING TO EDUCATION; MANDATING AIDS PREVENTION EDUCATION FOR STUDENTS; PROVIDING PROCEDURES AND REQUIREMENTS FOR SUCH EDUCATION; PROVIDING; FOR CODIFICATION; PROVIDING AN OPERATIVE DATE; AND DECLARING AN EMERGENCY.

BE IT ENACTED BY THE PEOPLE OF THE PEOPLE OF THE STATE OF OKLAHOMA:

SECTION 1. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 11-103.3 of Title 70, unless there is created a duplication in numbering, reads as follows:

A. Acquired immune deficiency syndrome (AIDS) prevention education shall be taught in the public schools of this state. AIDS prevention education shall be limited to the discussion of the disease AIDS and its spread and prevention. Students shall receive such education:

1. at the option of the local school district, a minimum of once during the period from grade five through grade six;

2. a minimum of once during the period from grade seven through grade nine; and

3. a minimum of once during the period from grade ten through grade twelve.

B. The State Department of Education shall develop curriculum and materials for AIDS prevention education in conjunction with the State Department of Health. A school district may also develop its own AIDS prevention education curriculum and materials. Any curriculum and materials developed for use in the public school shall be approved for medical accuracy by the State Department of Health. A school district may use any curriculum and materials which have been developed and approved pursuant to this subsection.

C. School districts shall make the curriculum and materials that will be used to teach AIDS prevention education available for inspection by the parents and guardians of the students that will be involved with the curriculum and materials. Furthermore, the curriculum must be limited in time frame to deal only with factual medical information for AIDS prevention. The school districts, at least one (1) month prior to teaching AIDS prevention education in any classroom, shall conduct for the parents and guardians of the students involved during weekend and evening hours at least one presentation concerning the curriculum and materials that will be used for such education. No student shall be required to participate in AIDS prevention education of a parent or guardian of the student objects in writing to such participation.

D. AIDS prevention education shall specifically teach students that:

1. engaging in homosexual activity, promiscuous sexual activity, intravenous drug use of contact with contaminated blood products is now known to be primarily responsible for contact with the AIDS virus;

2. avoiding the activities specified in paragraph 1 of this subsection is the only method of preventing the spread of the virus;

3. sexual intercourse, with or without condoms, with any person testing positive for human immunodeficiency virus (HIV) antibodies, or any other person infected with HIV, places that individual in a high risk category for developing AIDS.

E. The program of AIDS prevention education shall teach that abstinence from sexual activity is the only certain means for the prevention of the spread or contraction of the AIDS virus through sexual contact. It shall also teach that artificial means of birth control are not a certain means of preventing the spread of the AIDS virus and reliance on such methods puts a person at risk for exposure to the disease.

F. The State Department of Health and the State Department of Education shall update AIDS education curriculum material as newly discovered medical facts make it necessary.

SECTION 2. This act shall become operative July 1, 1987.

SECTION 3. It being immediately necessary for the preservation of the public peace, health, and safety, an emergency is hereby declared to exist, by reason whereof this act shall take effect and be in full force from and after its passage and approval.

Appendix B

Interview Questions

1. Please tell me about yourself--your personal story. (If the participant leaves out age, school information, and family situations, additional questions will be asked to determine this information).
2. Did you attend school in Oklahoma from 5th to 12th grades?
3. What do you remember about the AIDS education you received in school? (Depending upon the response to this question, other questions can be asked which deal with the models for successful AIDS programs. The participant will be asked about the amount of time the school spent on the program, the use of outside speakers, the use of famous spokespersons, the use of peer coaching, and the interaction with speakers and teachers which was permitted by the school.)
4. Do you remember any AIDS education which you received which did not come from school?
5. How old were you when you first engaged in at risk behavior?
6. Please describe the behavior you engaged in which put you at risk for AIDS.
7. What were your reasons for engaging in this at risk behavior?

8. In thinking about the AIDS education you received in school, what changes could have been made that would have affected your behavior?

9. If you had the opportunity to talk to a group of young people today, what would you tell them about at risk behavior?

10. How do you think an effective AIDS education program for young people should be structured?

11. Would you have listened to advice from a movie, sports, or television star?

12. Would the advice from a young person your age who had AIDS have made a difference for you?

13. What grades did you make while in school?

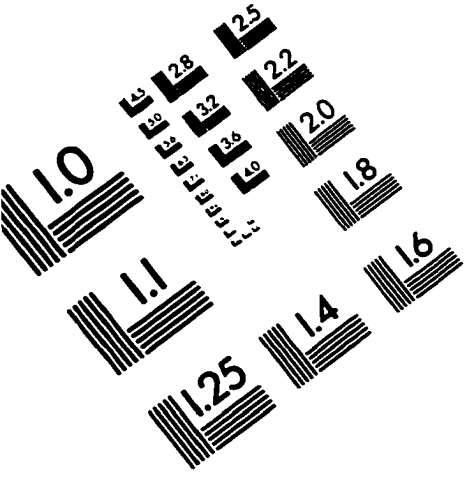
14. What extra-curricular activities did you participate in in school?

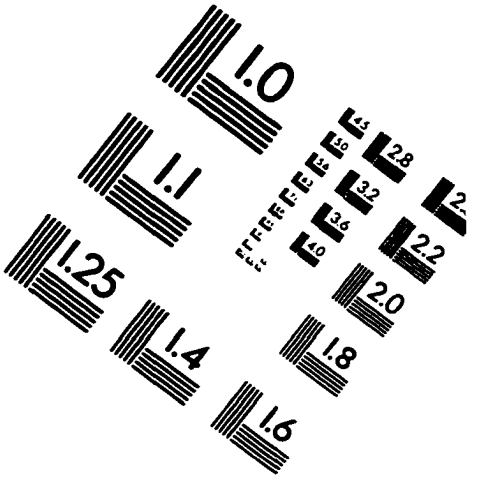
15. What was your religious upbringing?

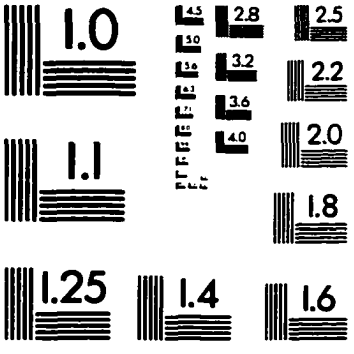
16. Did you participate in community service activities while growing up?

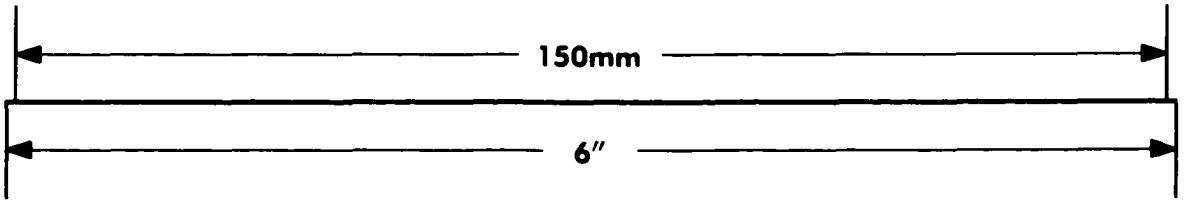
17. Describe your adolescent peer group.

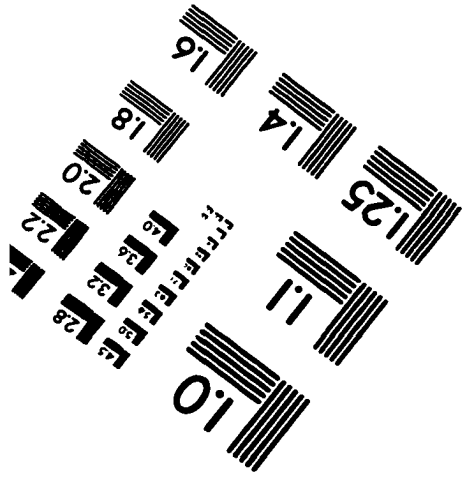
IMAGE EVALUATION TEST TARGET (QA-3)

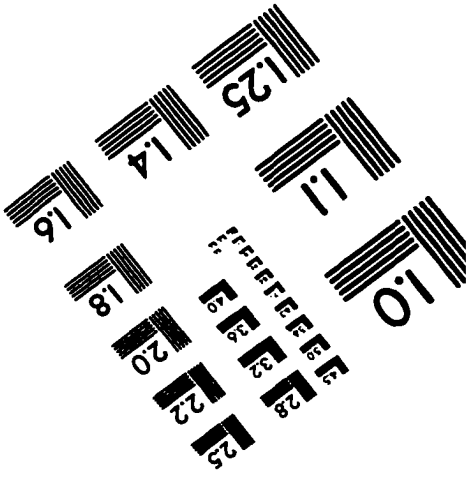












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