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Aids in the workplace : how knowledge and homophobia influence interactions

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**AIDS IN THE WORKPLACE:
HOW KNOWLEDGE AND HOMOPHOBIA
INFLUENCE INTERACTIONS**

A Thesis

Presented to

The Faculty of the Department of Psychology

San Jose State University

**In Partial Fulfillment
of the Requirements for the Degree
Master of Science**

by

Meri-Sue Nuzum

August, 1995

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AIDS: Workplace Interactions

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AIDS IN THE WORKPLACE: HOW KNOWLEDGE AND HOMOPHOBIA INFLUENCE INTERACTIONS

by Meri-Sue Nuzum

HIV disease and AIDS are major health problems in the United States, and for organizations too. This research, using 3 measures, explores the relationships between willingness to interact with an AIDS infected co-worker, level of knowledge regarding transmission of HIV, and level of homophobia. Subjects were college students ($N=207$). Regression analysis tested the relationships between knowledge, willingness to interact, and level of homophobia. Results from the correlation's indicate that as level of knowledge rises and level of homophobia decreases, level of willingness to interact increases. The major conclusion drawn from this data is, there is a need to address the effect homophobia has on a persons willingness to interact with co-workers who have HIV disease or who have AIDS within the context of workplace education about AIDS. Actual workplace transmission risks need to be addressed as well as underlying biases and prejudices that affect co-worker attitudes.

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The Acquired Immune Deficiency Syndrome (AIDS) epidemic is affecting people of all ages, races, socio economic levels and sexual orientations. AIDS has become a major health problem in the United States and elsewhere. In order to be diagnosed as having AIDS an individual must test positive for the antibodies that indicate that the Human Immunodeficiency Virus (HIV) is present, and have one of the particular opportunistic infections that strike people with AIDS. Individuals who do not have AIDS but have been infected with HIV are said to be HIV positive, or to have HIV disease. Pozgar (1992) writes that "AIDS is a fatal disease that destroys the body's capacity to ward off bacteria and viruses that would ordinarily be fought off by a properly functioning immune system. Although there is no effective long term treatment of the disease, there are indications that proper management of the disease can improve the quality of life and delay the progression of the disease" (p. 425).

Since record keeping began in June 1981 there have been 220,871 deaths attributed to AIDS in the United States, including 2,819 children under the age of thirteen. The number of people who are currently known to have AIDS in the United States is 361,509 according to the Center for Disease Control (CDC) (hot line operator, personal communication, July 12, 1994). In the three months, between September 1993 and December 1993, 22,259 people died of AIDS in the United States. It has been estimated by the CDC that over one million individuals are carriers of the HIV virus that causes AIDS. This statistic involves the following: one in every 100 men and one in every 800 women are infected with HIV, for a combined number of one in every 250 individuals in the United States. The CDC also reports these statistics: in 1988 AIDS was

the third leading cause of death for men in the age range of 25-44 and the eighth leading cause of death for women aged 25-44. In 1989, AIDS became the second leading cause of death for men in this age group. According to the CDC, as of October 1, 1993 AIDS had become the fourth leading cause of death for women in the United States within this age group.

The demographics of the AIDS epidemic in America are changing. The rate of new infections of male homosexuals has leveled off, while more women and teenagers are becoming infected. Teenagers are currently the largest group of newly infected individuals. Approximately 90% of the people affected by HIV disease are between the ages of 25-49, their prime working years (Norton & Buch, 1993). People with HIV disease work in organizations of all sizes. They have co-workers who may or may not want to interact with them once they are known to have HIV disease or AIDS. Employers must maintain good working relationships with employees infected with HIV as well as their co-workers. Finding out what is involved in an employee's willingness to interact with an infected coworker is essential in order to create a comprehensive organizational response to this epidemic. The purpose of this study is to explore the relationship and to validate the need for comprehensive employer sponsored educational programs that will educate employees as to the risks involved in interacting with a coworker who has HIV disease or AIDS.

Impact of AIDS on Organizations

AIDS has become an issue of national health, and therefore has become an issue organizations must address. In a survey conducted by the National Association of People

with AIDS (NAPWA) it was found that out of 1,800 respondents (all individuals with HIV disease or AIDS), 30.9% of the respondents work full time and 10.5% work part time. The mean age of the respondents was 36 years, 93.3% were between 20 and 50 (NAPWA, 1992). As these numbers show, people with HIV disease are currently employed in American workplaces.

People who are infected with HIV are experiencing longer periods of time from infection to the development of diseases that render them incapable of working, and many individuals are now living a substantially longer amount of time than those who became sick in the early years of the epidemic (Anderson, Landy & Kerby, 1991). HIV disease has become a chronic illness. With appropriate medical management, individuals are staying healthy and active for years. Medical advances are enabling people to live longer and continue being productive members of society. In fact, most people keep working after testing positive for the HIV virus. Many individuals continue to work as long as possible even after they have been given an AIDS diagnosis. Work has strong meaning for most individuals, this is equally true for people with HIV disease who usually want to continue in their positions as long as possible, as long as their health situation is stable (Kastor, 1992).

Financial Impact

The exact financial toll the AIDS epidemic will take on the business community is an unknown amount. In one of the only projection studies of its kind, Scitovsky and Rice (1987) presented their findings of the indirect costs of AIDS based on CDC prevalence estimates for the years 1985, 1986 and 1991. These indirect costs represent the lost output because of cessation or

reduction of productivity due to the death rate caused by AIDS. These include morbidity costs (wages lost by people who are unable to work because of illness or disability) and mortality costs (the present and future earnings lost by people who die prematurely). Scitovsky and Rice estimated that the morbidity costs would be \$251 million in 1985, \$421 million in 1986, and 2.3 billion in 1991. They estimated the mortality costs to be between \$2.8 billion and \$3.5 billion in 1985, \$4.8 billion and \$6.0 billion in 1986 and \$28.6 billion and \$36.3 billion in 1991.

It was estimated by an economist for the CDC that in 1991 businesses spent \$66.5 billion on the direct and indirect costs of AIDS (Kastor, 1992). The annual cost of treating a person with HIV is estimated at \$5,150. The estimated annual cost of treating someone with AIDS is \$32,000 with a lifetime cost of approximately \$85,333 (Dane & Miller, 1992). All forms of benefits including insurance for employees or their dependents with AIDS is of serious consideration to the financial maintenance of organizations large and small. If organizations can avoid these future costs as well as the loss of human resources from HIV disease, it would be prudent to do everything possible to avoid such financial burdens in the future.

Legal Issues

Another major area of impact on organizations due to the AIDS epidemic is in the legal arena. It is important that organizations create a policy on AIDS in which steps that will be taken are viewed as ethical, and within current legal requirements (Puckett & Emery, 1988). Organizational policies must comply with federal, state and local regulations in order to be defensible should the need arise. If a company does not create an AIDS policy simply for humanitarian reasons, meeting the business necessity of complying with employment legislation

would be prudent. A well written AIDS policy is an organization's first line of defense against discrimination lawsuits. A documented AIDS policy is a way to avoid liability, letting managers know how they should respond as well as informing employees as to how the company will respond in this situation (West & Duity, 1991).

Organizations must act in compliance with laws that protect employees' rights to work even if they have HIV disease or AIDS. In 1987 the first federal appeals court ruling was made on the question of whether or not AIDS is a handicap within the meaning of section 504 of the Rehabilitation Act of 1973 (Turner, 1989). The Ninth Circuit district court ruled in Chalk v. United States District Court, section 504 is fully applicable to individuals who suffer from contagious diseases, including HIV. The federal government recently passed legislation that provides people with HIV or AIDS protection under the Americans with Disabilities Act (ADA). Individuals with HIV or AIDS are now specifically protected under Title I of the ADA. If organizations comply with the rules and regulations in Title I of the ADA, people with AIDS and HIV infection will be able to continue as productive members of society as long as it is reasonable for them to do so. Responding to this disease in a way that is both compassionate and legally sound should be a goal for society and organizations.

AIDS is now classified as a chronic disease, "victims are surviving long enough that their demands for fair treatment in the workplace need to be addressed formally" (Diamant, 1993, p. 191). The law states you cannot discriminate against people with HIV or AIDS. Herbert Lister, chairperson of Allstate Life Insurance Company also feels that top management should be involved in this issue. He states that AIDS "is going to be

around for quite some time. Anything we can do to make the work place and the people who inhabit it healthier and more productive is in the best interest of the company. AIDS can cost corporations a lot of money in, among other things, litigation and loss of productivity. There is a tremendous amount of misinformation that exists about AIDS among management as well as employees" (Quickel, 1988, p. 65). (NOTE: For a further discussion of the legal issues related to AIDS in the workplace see Burris, Dalton, Miller and the Yale AIDS Law Project (Eds.), 1992.)

Transmission of HIV: Casual Contact in the Workplace

Research has shown that the HIV virus is transmitted through specific modes of transmission: blood, semen, vaginal secretions, and breast milk (Norton, 1993). To be more explicit, according to the U.S. Public Health Service and the CDC, HIV disease is transmitted only through a) sexual contact where bodily fluids are exchanged, b) injection of contaminated blood or blood products, c) the exchange of bodily fluids between an infected woman and her baby during pregnancy, or d) from an infected mother to her child through breast feeding.

In a study conducted by the CDC, the US Department of Health and Human Services and other State Departments of Health and medical universities, the possibility of transmission of the HIV virus through casual contact was assessed (Rogers et al., 1990). Eighty-nine members of households where young children with HIV infection lived were tested for the presence of the HIV antibodies. The twenty-four children in the study had acquired HIV through blood transfusions and were of preschool age. All household members were found to be HIV negative. There were no cases of transmission, even though personal contact with the children, such as the

sharing of toothbrushes, nail clippers, eating utensils, toilets, baths, combs, towels, toys and beds occurred on a regular basis. Herek and Glunt (1988) propose that the tendency to overestimate the transmissibility of AIDS may be due to confusing the seriousness of the disease with its risk of infectiousness (cited in Rozin, Nemeroff, & Markwith, 1992). Therefore, casual contact with people who are infected with HIV does not place one at risk for transmission of the virus.

The HIV virus is not spread “through the air by coughing and sneezing or by sharing a desk, drinking fountain, computer or toilet seat with a person who has AIDS” (Feuer, 1987, p. 70).

There are no cases of transmission of the AIDS virus that have been linked to sharing typewriters, computers, telephones, tools, papers, water fountains, bathrooms, vehicles, uniforms, desks, toilet seats, coffee pots or eating facilities (Masi, 1990; Puckett & Emery, 1988; Sullivan, 1991).

In certain workplace situations the risk of transmission of the HIV virus is termed more than a minimal risk (Leonard, 1993). In the realm of emergency service workers (police, ambulance drivers, firefighters, and health care workers) there is an increased risk of becoming infected through exposure to the blood, or bodily fluids of an infected person. For the purpose of this research individuals in these occupations were not used in the sample and so discussion of the risks involved as well as safe guards within these occupations is beyond the scope of this project.

Roth (1993) reports there are very few studies that focus on perceived risk of transmission of HIV in the workplace. Sheehan, Lennon and McDevitt (1989) found that in hypothetical situations, subjects were less willing to interact with HIV positive coworkers than with coworkers who had a “controllable” disease like lung cancer. These

researchers suggest that this finding was due in part to a respondents' level of empathy towards affected individuals, attitudes and knowledge about HIV disease, and attitudes toward homosexuals. It was concluded from these findings that even though people are knowledgeable about the risks associated with HIV transmission they may prefer to not interact with coworkers affected due to other factors.

Many people either lack the appropriate knowledge (the knowledge that casual contact transmission does not occur) or they have some sort of belief about who contracts this disease. The issue of transmission of the HIV virus through casual contact in a workplace situation is one organizations need to address through education. Even though there have been no cases of transmission through casual contact, organizations need to educate their employees on this point because fear and misinformation continue to surround this issue. AIDS can evoke stigmatizing and prejudicial attitudes in respect to perceived lifestyles of people with AIDS, because of its association with homosexuality, drug use and sexual behavior (Dane & Miller, 1992).

AIDS Education in the Workplace

Organizations that provide education on the prevention of transmission of the HIV virus in the workplace will create a work environment in which people know what to expect from their organization, and how the organization will respond if the need should arise. Careful planning is imperative since AIDS is a long term issue. Prevention of infection should be the main focus of an education project (Culpan, 1990; Masi, 1990). An organizations employees may also need additional education regarding their rights as co-workers (Culpan, 1990). Furthermore, supervisors or managers may need specific

education and training concerning how to respond to an employee with HIV disease or AIDS (Feldman, 1991; Koch, 1990; Nau, 1991; Sharpe, 1992). This should include how to handle issues of confidentiality, privacy, reasonable accommodation and other business related matters that may arise (Sharpe, 1992). Goals of a company education project might include slowing the epidemic through behavior change, expanding awareness regarding issues surrounding AIDS, reducing fear about the disease and informing employees about how the company will respond to a case of AIDS (Masi, 1990). All educational information should be based on current medical knowledge rather than on myths, stereotypes or stigmas about the disease or who is affected.

Organizations are in a unique position to offer education that can be given to large groups of people. Some feel that there is no better place in which to educate and inform masses of people about this disease than in the workplace (Puckett & Emery, 1988). Current updates on AIDS information can be easily offered to employees. Organizational communication networks may provide individuals with information they might not usually have access to. For example, using a company newsletter, monthly meeting or simply the grapevine could spread information about AIDS to a larger group. These would also serve the purpose of providing updated information on a continuous basis. Levi Strauss & Co. began an education program in 1982 in which they wanted employees to take the educational messages home and into their communities (Feldman, 1991). At Digital Equipment Corporation (DEC), education is thought to be the best and only defense against AIDS a company can offer (Feldman, 1991). "Survival of the best informed" is DEC's goal in presenting their employees with a comprehensive education

program. This program includes medical, legal and psychological aspects of AIDS.

Factors such as fear, panic and bereavement are also covered.

Organizations that take responsibility for protecting and educating their employees demonstrate a willingness to be involved in their workers lives. This is a hopeful sign. The human and the economic sides of work are joined when AIDS is addressed (Backer, 1988). Placing the emphasis on education about the transmission of the HIV virus is an intelligent business response. If organizations educate employees on how to avoid becoming infected with HIV, they will be contributing to the safety and health of their employees. Providing education and training about HIV in the workplace can also help and the prejudice and stigma that surround people who have this disease, replacing ignorance and fear with knowledge and compassion.

Willingness to Interact with a Coworker who has HIV Disease or AIDS

The need to address the issue of willingness to interact with an HIV infected coworker stems from the previously discussed fear of casual contact transmission that is often present when people encounter someone with HIV disease or AIDS in the workplace. The attitude behind an employees resistance to interact with a coworker who has HIV disease or AIDS may be due to their lack of knowledge of contracting the HIV virus through workplace contact and their level of homophobia.

Attitudes about HIV disease and AIDS

Attempting to explore attitudes about HIV disease has been the focus of many previous studies. Fischer (1986), Siegal (1986), and Kagay (1991) reported the existence

of harsh, judgmental and fearful attitudes towards people with AIDS found through large public opinion polls. Farnham (1991) prepared a review of several studies that focused on attitudes and behaviors towards the AIDS epidemic in American business. In the 1993 study titled "Employee Attitudes about AIDS: What working Americans think" carried out by the National Leadership Coalition on AIDS (NLCA), 67% of those polled predicted that their coworkers would feel uncomfortable working with someone who had HIV disease. Herold (1988) found that 66% of 2,000 workers in a national poll would be concerned about sharing a bathroom with a person known to have AIDS, and 37% would refuse to share tools or equipment with such a person. It is essential to address the needs of the employee who is infected with HIV or AIDS, it is also important to address the concerns of those who interact with the affected individual. Providing accurate information to co-workers of people with HIV disease regarding transmission risks, company policy and legal guidelines can help in this respect.

Waltz (1989) researched the question of whether or not being knowledgeable about AIDS would translate into a positive attitude toward people with AIDS, and if this positive attitude would correlate with a willingness to work with a person with AIDS. In one of the earliest studies of this type, Waltz found that greater knowledge of AIDS correlated significantly with positive attitudes toward people with AIDS. He also found that this attitude positively correlated with willingness to interact with an AIDS infected co-worker. The implications of these findings give support to the need for educational efforts that will raise the level of knowledge about AIDS, lower fear of transmission through casual workplace contact leading to improved relations between coworkers.

Knowledge about HIV disease and AIDS

Fear of contracting the HIV virus through workplace contact may be based on a lack of accurate knowledge about the known routes of transmission associated with this virus. Puckett and Emery (1988) state that “employers have the credibility to effectively communicate and objectively handle emotional and controversial subjects, and they have the financial motivation to take advantage of opportunities for disease prevention “ (p. 139). Therefore it would be advantageous for organizations to provide information to employees to increase knowledge about the transmission risks inherent in the workplace.

The study conducted by Barr, Waring and Warshaw (1992) focused specifically on the issue of knowledge of HIV disease in the workplace. The relationship between workplace AIDS education efforts about HIV transmission and attitudes held towards co-workers infected with HIV were the issues these researchers examined. They found that where worksite education programs are minimal, employees know less about casual contact transmission of HIV and hold more negative attitudes about people with HIV disease in the workplace. These researchers found that the level of knowledge a person had about HIV infection and AIDS correlated positively with their attitude toward the disease. They also cite two studies by Herold (1988, 1989) in which an association between strong workplace HIV/AIDS education efforts and positive attitudes about HIV and AIDS in the workplace were found. Another important indication from this research is that employees who have a higher degree of knowledge about the transmission of the HIV virus through casual contact are less likely to have negative attitudes towards infected coworkers. These researchers feel that workplace AIDS education programs can

reinforce workers knowledge about HIV transmission, thereby fostering more favorable views towards coworkers with AIDS.

Homophobia

Homophobia can act as a strong dimension in a persons willingness to interact with someone who has HIV disease or AIDS. The level of homophobia an individual possesses may affect their willingness to interact with an infected co-worker. According to Pryor, Reeder, and McManus (1991), AIDS is still strongly associated with homosexuality in the minds of the public. Quite often AIDS is stigmatized as a homosexual disease and not given corporate attention (Munyard, 1989; Feldman, 1991). Avoidance of the issue due to homophobia was found by Strohecker (1988), who promoted AIDS education and awareness in a small business community of Massachusetts. He stated that being prepared to deal with AIDS in the workplace is simple. What has made it complicated is the denial that AIDS is of concern to the business community. There is still a stigma of homophobia attached to AIDS, therefore this issue needs to be specifically addressed (Cohen & Cohen, 1989).

Morton and McManus (1986) found that attitudes about homosexuality were related to attitudes about AIDS and suggest that education about AIDS should include general information about homosexuality. This would be an effort to change attitudes towards people with AIDS by changing attitudes towards homosexuals. Previous studies have noted homophobia as a component in a persons attitude towards AIDS, but have failed to fully address this issue in the organizational setting. Through AIDS education in the workplace both these attitudes could be addressed with facts and purpose.

Current study

Business aspects as well as human aspects of work are affected when HIV disease and AIDS are in the workplace. Previous research has primarily focused on the connection between knowledge and attitudes about HIV disease or AIDS, and whether or not they influence each other. An individual's resistance to interact with someone who has HIV disease or AIDS, may be due to fear of contracting the HIV virus and may also be influenced by the level of homophobia they possess. Homophobia has been measured as a dimension of a person's attitude, but not specifically in relation to organizational issues. In this study, a person's level of homophobia is viewed in relation to their level of willingness to interact with an AIDS infected co-worker.

The purpose of this study is to investigate the willingness of a person to interact with a co-worker who has HIV disease or AIDS. This will be assessed by measuring an individual's knowledge of the risk of transmission (through casual and non-casual forms of contact) of the HIV virus, their willingness to interact with an infected co-worker and their level of homophobia. It is hypothesized that high levels of knowledge about HIV transmission risks will be positively associated with high levels of willingness to interact with a co-worker who has HIV disease or AIDS. It is also hypothesized that low levels of homophobia will be positively related to high levels of willingness to interact with an infected co-worker. Level of knowledge about HIV transmission risks and level of homophobia are not hypothesized to be strongly related.

This research builds on previous research and adds more data to the growing body of information on this subject. Further, it is an exploration of the need to include

information on unlearning homophobia as a part of education in the workplace about HIV disease and AIDS. Educating employees about the range of attitudes that may underlie behaviors in the workplace when a co-worker has HIV disease or AIDS may better serve all involved.

Methods

Subjects

Two hundred and eighteen college students served as the subjects in this study. Ten subjects indicated that they currently work in the medical field. These subjects were taken out of the analysis, because in these work settings interacting with HIV infected individuals poses a small risk of transmission which is greater than in the typical workplace setting. One survey was incomplete and therefore discarded. The total valid number of questionnaires was two hundred and seven for a response rate of ninety five percent. Fifty-three individuals (24%) were undergraduates at San Jose State University. The remaining one hundred and sixty-six individuals (76%) were students at West Valley college. Subjects volunteered to be involved in this research. Table 1 presents descriptive statistics and demographic variables. The typical individual was 23 years old, single, an undergraduate attending a community college, working part time and heterosexual.

Instruments

Three different scales were used for data collection (see Appendix B, C, D). Individuals received a total scale score on each scale. Their total score was designated as either high or low, according to specific criteria established. This categorizing placed

Table 1

Descriptive statistics and Demographic variables of Research Individuals

Sample size	207		
Gender	Females	107	51.2%
	Males	100	48.3%
Age	x = 22.95 years	std dev. 6.86	Minimum 17 Maximum 67
Marital Status	Single	172	83%
	Married	20	10%
	Domestic Partner	4	2%
	Divorced	7	3%
	Separated	2	1%
	Widowed	1	.5%
College Status	Undergraduate	198	95.7%
	Graduate	6	2.9%
Work Status	Currently working	162	78.3%
	Not currently working	39	18.8%
Amount Currently Working	Full Time	18	8.7%
	Part Time	143	69.1%
Sexual Orientation	Homosexual	5	2.4%
	Heterosexual	189	91.3%
	Bisexual	9	1.4%

individuals in either a high or a low sub-group on the scales content. The first scale (twenty two questions) measured the level of knowledge about the risk of transmission of the HIV virus (KNOWLEVEL) through casual and non-casual forms of contact. Questions on this scale asked how likely transmission of HIV is through: the air, donating blood, sharing a needle for drug use with a person who has AIDS or attending school with a child who has AIDS. Responses to the KNOWLEVEL scale were reported on a six point Likert type scale with anchors as follows: likely, somewhat likely, somewhat unlikely, very unlikely, not at all possible and don't know. The range of possible total scores on this scale was from 0 - 110. A larger score denotes a greater level of knowledge about the way that HIV virus is transmitted. An individual was labeled as having high knowledge if their total scale score was 88-110 and low knowledge if their score was 56-77. The internal consistency of the KNOWLEVEL scale was estimated with an alpha = .85.

The second scale (eleven questions) was an assessment of a subject's willingness to work with a co-worker (WILLEVEL) who has AIDS. Items on the WILLEVEL scale asked whether a subject agreed or disagreed with statements such as: I am afraid of contracting AIDS from a co-worker who has AIDS, If I learned a co-worker had AIDS I would quit my job, or I would treat a co-worker with AIDS just like any other co-worker. The WILLEVEL scale anchors were: strongly disagree, disagree, slightly disagree, slightly agree, agree and strongly agree. The range of scores was from 0 to 66. Scores on this scale indicate a persons level of willingness to work with a person who has AIDS. High willingness individuals had total WILLEVEL scale scores of 55-66 and low

willingness individuals had scores of 34-44. The internal consistency of the WILLEVEL scale was estimated with a coefficient $\alpha = .89$.

The third scale (fourteen questions) was a measure of a subjects level of homophobia (HOMOLEVEL). Questions asked for agreement or disagreement on items such as: I would not like to work with a homosexual, sexual preference should not be a factor in employment opportunity, and job discrimination against homosexuals is wrong . The anchors for this scale were as follows: strongly disagree, disagree, slightly disagree, slightly agree, agree, strongly agree. In scoring this scale the values were reversed so that a high score would denote a non-homophobic answer. The higher total score on this scale the less homophobic an individual was rated to be. The range of possible scores was between 0 and 84. An individual was labeled as having a high level of homophobia if their score was 19-60, and having a low level of homophobia if their score was 70-84. The internal consistency of the HOMOLEVEL scale was estimated with coefficient $\alpha = .95$.

Procedure

Pilot study.

A pilot test was conducted in order to pretest the survey. Twelve graduate students from San Jose State University served as the sample population for the pretest. Minor unforeseen problems were brought to the attention of the researcher at this stage and simple corrections were made as needed. A “staple placement” error was corrected so that the instructions could be clearly seen, 2 of the 4 non-casual contact transmission questions were made more explicit, and family was added as a category for “How did you

first learn about AIDS” in the demographics portion.

Actual study

Participants were verbally informed that their participation was completely voluntary. They were also informed that they were free to withdraw from the research at any time. A questionnaire was then given to each subject. The questionnaire consisted of a one page instruction sheet which encouraged participants to answer all questions completely (so that a full set of data would be received from each person involved) (see Appendix A), the three scales (see Appendix B, C, D) and demographic questions (see Appendix E).

Results

Two hundred eighteen surveys were administered. Two hundred and seven were used in the data analysis. Out of the total of two hundred and seven completed surveys fourteen had missing data. In each case only one item had not been answered. For statistical processes the means sub command (the average response on an item over all the responses given by subjects), was used so that each set of data would be complete and could be used in the analyses conducted. The distribution of scores on the KNOWLEVEL scale was fairly symmetrical with a slight skew to the left. The mean of this scale was 92.40, with a standard deviation of 10.82. The distribution of scores on the WILLEVEL scale was moderately skewed to the left with a sharp rise at the upper end of the distribution. The mean of the WILLEVEL scale was 57.49 with a standard deviation of 7.66. The HOMOLEVEL scale scores skewed to the left with many cases having the maximum amount of points possible on this scale. The mean of the HOMOLEVEL scale

was 70.15 with a standard deviation of 14.00. All three scales had fairly high means.

Please see Table 2 for complete scale statistics.

Table 2

Scale Total Scores: Statistics for all Individuals

Scale Name	Minimum to Maximum Scores	$\bar{X}$	Median	Mode	SD
KNOWLEVL	56-110	92.40	94	94	10.82
Level of knowledge about transmission of HIV					
WILLEVL	26-66	57.49	59	66	7.66
Willingness to work with a co-worker who has AIDS					
HOMOLEVL	19-84	70.15	73	84	14.00
Level of homophobia					
Valid cases = 207 Missing Cases = 0					

A correlation matrix was generated to examine the relationship between the overall scores on the three scales. First, the KNOWLEVEL scale was correlated with the WILLEVL scale to test the hypothesis that high levels of knowledge about the transmission risks of HIV would be positively associated with high levels of willingness to interact with an infected co-worker. Results of the correlation between the KNOWLEVEL scale and the WILLEVL scale were $r(207) = .43, p < .01$. This can be

interpreted to mean that as an individual's level of knowledge increases so does their level of willingness to interact with an infected co-worker. The correlation between the WILLWORK scale and the HOMOLEVEL scale tested the hypothesis that having a low level of homophobia would be positively associated with a high willingness to interact with an infected co-worker. This relationship was found to be quite robust $r(207) = .63$, $p < .01$, which signifies that individuals with a low level of homophobia have a higher level of willingness to interact with an infected co-worker. The correlation between the KNOWLEVEL and HOMOLEVEL scales was not hypothesized to be strong, and while the relationship was significant it was relatively small $r(207) = .27$, $p < .01$. This finding implies that while there is a small relationship between knowledge of the transmission risk of HIV and an individual's level of homophobia it can not be inferred that as level of knowledge gets larger, level of homophobia necessarily gets smaller. Please see Table 3 for complete correlation statistics.

Table 3

Correlation's of Scale with Scale

	KNOWLEVEL	HOMOLEVEL
WILLEVEL	$r(207) = .43$ R Squared = .18 $p < .01$	$r(207) = .63$ R Squared = .39 $p < .01$
HOMOLEVEL	$r(207) = .27$ R Squared = .07 $p < .01$	

As mentioned earlier, the total scale scores had specific criteria that would place

an individual in a high or low subgroup based on their total scale scores. Crosstabulations between these subgroups of the scales were run in order to count the number of times different combinations of these subgroups occurred. Many cases were clustered in the high willingness by low homophobia group ($n = 107$). From this finding it can be surmised that these individuals were both highly knowledgeable about HIV transmission and had low levels of homophobia. The high willingness by high knowledge group ($n = 114$) contained even more cases. This implies that a large number of individuals were highly knowledgeable and highly willing to interact with AIDS infected co-workers. Please see Table 4 for complete crosstabulations results and criteria that designates membership in either a low or high level sub-group.

Discussion

The following section discusses the findings of this study, implications that may offer a greater understanding of the data gathered, strengths and weaknesses of the research and future research needs in this area. As stated earlier, the purpose of this study was to investigate the facets of a person's willingness to interact with a co-worker who has HIV disease or AIDS. This was accomplished by assessing an individuals level of knowledge of the risk of transmission of the HIV virus, their willingness to interact with an infected co-worker and their level of homophobia. It was hypothesized that high levels of knowledge, would be positively associated with high levels of willingness to interact with an infected co-worker. It was also hypothesized that low homophobia levels would be positively associated with high willingness to interact with an infected co-worker.

Table 4

Crosstabulation results between high and low level sub-groups and criteria for membership in each scale sub-group

<u>Crosstabulations results sub-group with sub-group</u>	
Low Willingness By Low knowledge	4 cases
Low Willingness By High knowledge	5 cases
High Willingness By Low Knowledge	9 cases
High Willingness By High Knowledge	114 cases
Low Willingness By Low homophobia	1 case
Low Willingness By High Homophobia	11 cases
High Willingness By Low Homophobia	107 cases
High Willingness By High Homophobia	12 cases

Criteria designating membership in low or high level sub-group

<u>Score</u>	<u>Sub-group</u>
Total scale score of 34 - 44	Low level of Willingness to Interact
Total scale score of 55 - 66	High level of Willingness to Interact
Total scale score of 56 - 77	Low level of Knowledge
Total scale score of 88 - 110	High level of Knowledge
Total scale score of 70 - 84	Low level of Homophobia
Total scale score of 19 - 60	High level of Homophobia

The first hypothesis was supported since knowledge was found to be positively associated with level of willingness to interact with an AIDS infected co-worker. The more knowledge concerning the routes of transmission of HIV disease, the individual has, the lower a persons resistance to working with an infected co-worker seems to be. Waltz (1989), hypothesized that a lower fear level would reflect a greater willingness to interact with a person who has AIDS without concern about contracting AIDS. An appropriate path to overcoming fear about something is to gain accurate and complete knowledge about it. A person who knows that the transmission risks involved in a normal casual contact workplace situation are extremely low will not be fearful of contracting HIV from a co-worker; and therefore, may be more willing to interact with such an individual than someone with less knowledge.

The second hypothesis was also supported. Individuals with a low level of homophobia also were found to have higher levels of willingness to interact with infected co-workers. People who did not hold strong prejudicial attitudes against homosexuals were more inclined to have a higher willingness to interact with an infected co-worker. As the level of homophobia increased the level of willingness to interact with an infected co-worker decreased. These results highlight the importance of including information on unlearning homophobia within workplace education about the transmission of HIV. Education that is aimed at prevention of transmission of HIV disease may need to be broader in scope, in order to fully address underlying attitudes that affect a person's willingness to interact with a co-worker who has AIDS. Unlearning homophobia can help address these issues with facts about who is affected and how, attempting to erase

the stigma and prejudice that has historically accompanied this disease. Green (1992) developed a workshop entitled *Unlearning Homophobia: A workshop for AIDS service providers*, that could be modified for use in almost any workplace setting. Green found that even in a workplace where there was constant interaction with, and provision of support to people infected with HIV, prejudicial attitudes among the service providers still existed. Therefore, it cannot be assumed that simply because people have knowledge awareness about HIV disease and AIDS, they will not have homophobic attitudes.

Individuals with a high level of knowledge about transmission risks did not necessarily have a low level of homophobia. This supports the third hypothesis that level of knowledge and level of homophobia were not hypothesized to be strongly related. This finding conveys the idea that knowledge of the transmission risk of HIV does not appear to be the only influence on a person's attitude about interactions with an infected co-worker even in a casual contact setting like the work place. This is similar to what Platt and Katz (1991) found in their research which addressed the double stigma of being gay and having AIDS. They found that anti-gay attitudes strongly predict negative attitudes towards individuals who have AIDS.

Strengths and Weaknesses of Research

The main strength of this research was in the instruments used to gather data. The high validity and reliability of all three scales was demonstrated by the strong alphas produced. The questions were clearly and explicitly written, the responses easy to understand. There was an adequate number of items on each scale thus boosting the confidence level of the data received. The sample size was large enough to have

confidence in the results and the fact that there was very little missing data meant that complete sets of data from each participant could be gathered. The high response rate may be due to the quality and clarity of the instructions, the fact that all subjects were college students “trained” to answer questions of this type, or it may be due to the seriousness of the topic. After completing the survey many people approached the researcher and commented on the valid and important nature of this work. All participants were currently college students and as such they are all potential future employees who will more than likely face this issue in their careers. Therefore, it is vital to find out what their attitudes and knowledge are so that appropriate educational programs can be created to meet their needs. One possible weakness of the research is the fact that since these three scales might seem to be controversial or sensitive in content, individuals might respond in a manner that is socially appropriate than true to their own beliefs.

Implications of research

It is encouraging to note that the level of knowledge most of these individuals have about transmission of HIV is quite high. This indicates that information regarding how HIV is transmitted is understood by individuals in this society. However, there were questions that focused specifically on casual contact transmission which a few individuals answered either with don’t know or somewhat likely. These answers denoted that the individual considered it a possibility to contract HIV or AIDS from eating in a restaurant where the cook has AIDS, from a mosquito, or from using public toilets. These all have been established by the medical community as non-routes of transmission of HIV,

because they are forms of casual contact through which the virus does not pass from one individual to another. An individual answering that it may be likely to be infected with HIV through one of these types of contact, is revealing that they are not knowledgeable about the risk involved in casual contact with an infected individual.

This information should alert public health educators to the fact that while people now know the transmission routes of sexual or blood to blood contact quite securely, they may not be as knowledgeable or confident about the zero risk involved from casual contact. Perhaps the message from education and training sources on this subject is not being given clearly enough. The message that needs to be absolutely clear is that casual contact transmission of HIV does not occur. A primary message of any organizational education project on HIV disease and AIDS should focus on actual transmission risks in the workplace through casual contact. This may need to be stressed just as succinctly as the importance of having safe sex.

This same design could be used to study other groups of individuals. There may be regional, state, or occupational differences on levels of all three scales. Are people in Southern California equally knowledgeable about casual contact transmission? Are people in East Texas more or less homophobic than this sample? Would groups of individuals in the high tech industry have similar responses as bankers or lawyers? Research on these, as well as a myriad of other possible questions would add even greater richness to the discussion of attitudes about AIDS in the workplace.

Future research

Future research should involve developing educational material that includes

unlearning homophobia information. An assessment of the effect this information has on lowering homophobic attitudes verses presenting this education without the unlearning homophobia information would be ascertained through experimental conditions. This would be an attempt to further isolate homophobia as an aspect of a person's attitude about AIDS, and to explore whether or not education makes a difference in this regard. More specifically, by measuring the impact homophobia has on a person's level of willingness to interact with an infected co-worker, the value of including unlearning homophobia in educational efforts would be made evident. This research design may be appropriate for those developing training programs for organizations or consultants working specifically on this issue with organizations.

And what about the people who are actually affected by this disease? What type of research could help them continue in their places of employment as employees of value? What will alert organizations to the genuine concerns and needs these individuals have? Documenting experiences and viewpoints of what it is like to be HIV positive or to have AIDS and to be a working individual would be very informative. Researching how AIDS affects issues of organizational commitment, group dynamics, stress in the workplace, (the psycho immunological issues of stress on people with AIDS), employee motivation, job satisfaction, work related attitudes, and productivity would be valuable.

An assessment of organizational culture may be worthwhile in order to evaluate how an organization responds to it's employees. What does how you treat an employee with AIDS say about the corporate culture of the organization? How safe do people feel to expose their HIV status? What kind of reaction from the organization and or their

fellow employees do they perceive will be given them? Information on these questions and many others will add to the depth and breadth of information on this subject.

Conclusion

It is essential for organizations to provide an environment in which all employee's are responded to and their basic rights and needs are met. Puckett and Emery (1988) state that employees who contract AIDS have the right to assume that their employer will fulfill its contract to provide medical care and disability benefits, will give them a chance for reasonable accommodation, and will continue to regard these employees as part of its work family (1988). It is vitally important to continue discovering what is involved in a co-worker's discomfort or unwillingness to interact with someone who has HIV or AIDS in order to develop appropriate policy and educational efforts. It is not only of utmost importance to educate in order to help those already affected by this disease, but to act now in order to avoid future problems between employees from occurring. By creating sound organizational policies as well as providing accurate factual workplace education about HIV and AIDS, organizations can become part of the solution to this disease, rather than adding to the problem. Policies should describe appropriate employee behavior rather than relying on employee attitudes to dictate actions in the workplace regarding co-workers.

Organizations are always affected by and have an effect upon the environment in which they exist. In today's business environment, the AIDS epidemic in the United States will be one of the largest human resource challenges faced. The response to this disease must come from a place of empathy and be purely human. However, it can be

presented by organizations and businesses as a business necessity and a cost effective management strategy by viewing it in the appropriate context of keeping employees from becoming infected. Puckett and Emery (1988) state that "to a large degree, management is the art of dealing effectively with the environment in which the organization finds itself" (p.3). Choosing to take a proactive stance against a preventable disease is the path that organizations and management within them must take. Dr. C. Everett Koop, who served as Surgeon General for the United States when AIDS began to be diagnosed in this country, reminded the public again and again that "we are fighting a disease, not people." Organizations can help join in this fight against a nondiscriminatory disease by educating employees on the true risks and non risks of casual contact transmission of HIV in the workplace. The employers of today should not fail in this crucial task, on the business or the human side of this issue.

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Appendix A

Instructions for AIDS in the Workplace study

Thank you for participating in this study. Your time and input are appreciated very much.

In order for your answers to be most helpful to us, it is important that you try to be as accurate as you can. Since we need complete and accurate information from this research, we hope you will think hard to provide the information asked for. Please answer all questions, it is important to have a complete questionnaire from each participant. This is an anonymous survey. Please do not write your name or any other identifying mark on the questionnaire.

You can make any type of mark to indicate your answer to each question.

For example:

☒	☐	☐	☐	☐	☐
☐	☐	☒	☐	☐	☐
☐	☐	☐	☐	☒	☐

Thank you.

Please begin the questionnaire

KNOWLEVL scale
Knowledge of the transmission risks of the HIV virus

Please read the following questions carefully and mark your answer clearly.

	Very likely	Somewhat likely	Somewhat unlikely	Very unlikely	Not at all possible	Don't Know
Touching or hugging a person with AIDS	O	O	O	O	O	O
Taking care of a person with AIDS.	O	O	O	O	O	O
The air.	O	O	O	O	O	O
A classmate who has AIDS.	O	O	O	O	O	O
A family member (not spouse or partner) who has AIDS.	O	O	O	O	O	O
Getting bitten by a mosquito or other insect.	O	O	O	O	O	O
Eating in a restaurant where the cook has AIDS.	O	O	O	O	O	O
Having unprotected sexual activity with a person who has multiple sex partners.	O	O	O	O	O	O
Sharing plates, forks, or glasses with someone who has AIDS.	O	O	O	O	O	O
Using public toilets.	O	O	O	O	O	O
Shaking hands with or touching someone who has AIDS.	O	O	O	O	O	O
Donating or giving blood.	O	O	O	O	O	O
Kissing, with exchange of saliva, a person who has AIDS.	O	O	O	O	O	O
Sharing needles for drug use with a person who has AIDS.	O	O	O	O	O	O

KNOWLEV1 scale
Knowledge of the transmission risks of the HIV virus

	Very likely	Somewhat likely	Somewhat unlikely	Very unlikely	Not at all possible	Don't Know
Receiving a blood transfusion.	O	O	O	O	O	O
Kissing, on the cheek, a person who has AIDS.	O	O	O	O	O	O
Working near someone with AIDS.	O	O	O	O	O	O
Living in the same house as a person who has AIDS.	O	O	O	O	O	O
Being coughed on or sneezed on by someone who has AIDS.	O	O	O	O	O	O
Living near a hospital or home for AIDS patients.	O	O	O	O	O	O
Having unprotected sexual activity with a person who is in a group with a high incidence of AIDS.	O	O	O	O	O	O
Attending school with a child who has AIDS.	O	O	O	O	O	O

Appendix C

WILLEVEL SCALE

Willingness to work with a co-worker who has AIDS

Section II

Please read the following questions carefully and mark your answer clearly.

Please indicate the degree to which you agree or disagree with each statement.

	Strongly Disagree	Disagree	Slightly Disagree	Slightly Agree	Agree	Strongly Agree
If I would treat a co-worker with AIDS just like any other co-worker.	O	O	O	O	O	O
If a co-worker (who was a close friend) had AIDS I would continue our friendship.	O	O	O	O	O	O
I would be uncomfortable eating lunch with a co-worker who has AIDS.	O	O	O	O	O	O
If a co-worker had AIDS I would avoid contact with him/her.	O	O	O	O	O	O
People with AIDS should be treated like anyone else at work.	O	O	O	O	O	O
I am afraid of contracting AIDS from a co-worker who has AIDS.	O	O	O	O	O	O
My employer should screen out prospective employees who have AIDS.	O	O	O	O	O	O
If a co-worker of mine had AIDS I would neglect my work-related responsibilities to avoid interacting with them.	O	O	O	O	O	O
If I found out a co-worker had AIDS I would ask to be transferred to another department.	O	O	O	O	O	O
If I knew a co-worker had AIDS I would take advantage of as much sick leave and unpaid days off as possible to avoid interacting with them.	O	O	O	O	O	O
If I learned a co-worker had AIDS I would quit my job.	O	O	O	O	O	O

Appendix D

HOMOLEVL scale
Subjects level of homophobia

Section III

In this final section, please read the following questions carefully and mark your answer clearly.

Please indicate the degree to which you agree or disagree with each statement.

Statement.	Strongly Disagree	Disagree	Slightly Disagree	Slightly Agree	Agree	Strongly Agree
Homosexuals should not be discriminated against because of their sexual preference.	O	O	O	O	O	O
Homosexuals do not corrupt the youth of America.	O	O	O	O	O	O
Homosexuals should not hold high government offices.	O	O	O	O	O	O
I would not like to work with a homosexual.	O	O	O	O	O	O
If I found out one of my friends was a homosexual, our friendship would be severely damaged.	O	O	O	O	O	O
Homosexuals should not hold leadership positions.	O	O	O	O	O	O
Sexual preference should not be a factor in employment opportunity.	O	O	O	O	O	O
Job discrimination against homosexuals is wrong.	O	O	O	O	O	O
Apartment complexes should not accept homosexuals as renters.	O	O	O	O	O	O
Homosexuals are a danger to our young people.	O	O	O	O	O	O
I would not want a homosexual to live in the house or apartment next to mine.	O	O	O	O	O	O
Homosexuals should be isolated from heterosexuals.	O	O	O	O	O	O
I would never have anything to do with a person if I knew he or she was a homosexual.	O	O	O	O	O	O
Homosexual acts should be illegal.	O	O	O	O	O	O

Appendix E
Demographic questions

Age (in years): _____ **Gender:** Female _____

Male _____

Marital Status:

Single _____
 Married _____
 Domestic Partner _____
 Divorced _____
 Separated _____
 Widowed _____

What is your major in college?

What is your future intended occupation?

What is your status in college?

Undergraduate _____

Graduate _____

How much do you feel you know about HIV and AIDS?

(please place an X in the appropriate box)

A Lot	A Little	Very Little	Nothing

How did you first learn about AIDS (sources?) Please check all that apply

TV _____
 Elementary school _____
 Junior high _____
 High school _____
 College _____
 Religious organization _____
 Family _____
 Workplace _____
 Newspapers and Magazines _____
 Health Clinic _____
 Your Doctor _____
 Friends _____
 The Surgeon Generals
 1986 pamphlet _____
 Other, please specify _____

Appendix E (cont.)

Do you currently know someone who is HIV positive but has not developed AIDS?

Yes _____

No _____

If yes, what is your relationship? (If you know more than one person in this situation, please think of the person with whom you have the most contact.)

An acquaintance _____

A friend _____

Family member _____

Spouse or partner _____

Someone at work _____

Someone you know through religious or civic activities _____

Someone you know through recreational activities _____

Someone you know from school _____

A child or relative of someone you know at work _____

A child or relative of someone you know at school _____

Other _____

Do you currently know someone who has AIDS?

Yes _____

No _____

If yes, what is your relationship? (If you know more than one person in this situation, please think of the person with whom you have the most contact.)

An acquaintance _____

A friend _____

Family member _____

Spouse or partner _____

Someone at work _____

Someone you know through religious or civic activities _____

Someone you know through recreational activities _____

Someone you know from school _____

A child or relative of someone you know at work _____

A child or relative of someone you know at school _____

Other _____

Have you known someone who has died of AIDS?

Yes _____

No _____

Appendix E (cont.)

How often do you attend religious services? (Please place an X in appropriate box):

Regularly	Occasionally	Rarely	Never

Have you received any formal education about AIDS?

Yes _____
No _____

If yes, of what type? Check all that apply.

School _____
Workplace _____
Local Organization _____
Church _____
Government pamphlets on AIDS _____
TV _____
Other _____

Do you currently work?

Yes _____
No _____

If yes, do you work:

Full time _____
Part time _____

Do you work as an emergency service worker (police, firefighter, ambulance driver, paramedic) or in the health care field (doctor, nurse, surgical technician, etc.)?

Yes _____
No _____

If yes what is your position: _____

Has your company, organization, or business provided any education, training or information about AIDS or HIV in the workplace? Please describe.

If yes, was it presented by:

Company personnel _____
A community group _____
Other _____

What is your sexual orientation?

Homosexual _____ Bisexual _____
Heterosexual _____ Asexual _____

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TO: Meri Sue Nuzum
220 Forest Ave.
Santa Cruz, CA 95062-2215

FROM: Serena W. Stanford *Serena W. Stanford*
AAVP, Graduate Studies and Research

DATE: May 19, 1994

The Human Subjects-Institutional Review Board has approved your request to use human subjects in the study entitled:

"Interacting with an HIV Infected CO-Worker: Knowledge of Transmission Risk and Attitudes Towards Individuals Affected"

This approval is contingent upon the subjects participating in your research project being appropriately protected from risk. This includes the protection of the anonymity of the subjects' identity when they participate in your research projects, and with regard to any and all data that may be collected from the subjects. The Board's approval includes continued monitoring of your research by the Board to assure that the subjects are being adequately and properly protected from such risks. If at any time a subject becomes injured or complains of injury, you must notify Dr. Serena Stanford immediately. Injury includes but is not limited to bodily harm, psychological trauma and release of potentially damaging personal information.

Please also be advised that each subject needs to be fully informed and aware that their participation in your research projects is voluntary, and that he or she may withdraw from the project at anytime. Further, a subject's participation, refusal to participate or withdrawal will not affect any services the subject is receiving or will receive at the institution in which the research is being conducted. If you have questions, please contact me at (408) 924-2480.