To the Graduate Council:

I am submitting herewith a thesis written by Cynthia Jean Day entitled "Attitudes Towards the Disease AIDS: A Survey of the Members of The National Therapeutic Recreation Society." I have examined the final copy of this thesis for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Master of Science, with a major in Recreation.

Gene A. Hayes, Major Professor

We have read this thesis
and recommend its acceptance:

Accepted for the Council:

Vice Provost and
Dean of the Graduate School

ATTITUDES TOWARDS THE DISEASE AIDS:
A SURVEY OF THE MEMBERS OF
THE NATIONAL THERAPEUTIC RECREATION SOCIETY

A Thesis

Presented for the

Master of Science

Degree

The University of Tennessee, Knoxville

Cynthia Jean Day

December 1987

DEDICATED

TO MY FAMILY

THANK YOU FOR YOUR PATIENCE AND SUPPORT

ACKNOWLEDGEMENTS

During the course of this research there have been several persons whose assistance has been invaluable. I would particularly like to thank Dr. Gene Hayes for chairing my committee. I appreciate the support and guidance of committee members Dr. Mary Dale Blanton and Dr. Doug McConatha. I also would like to thank Dr. Howard Pollio for assisting me with my questionniare and Dr. Michael Smith for his computer programming help.

ABSTRACT

Persons with AIDS (PWAs) suffer much discrimination, frequently loosing their jobs, homes, friends, and support systems. These changes lead to isolation, loneliness and feelings of helplessness. Therapeutic recreators are in a position to help alleviate the isolation and boredom that is an outcome of this disease.

The purpose of this study was to determine current attitudes of professional Therapeutic Recreation Specialists (TRS) with regard to working with AIDS clients. Questions considered were: Where did TRS received their information about AIDS? Had TRS encountered PWAs in their client population? Do they feel comfortable with AIDS clients. Do TRS perceive a responsibility for their care? and Would TRS refuse to work with PWAs?

For the study, a survey designed to assess the attitudes of the members of the National Therapeutic Recreation Society was mailed to 278 members. A total of 227 surveys were returned for a response rate of 82%. The results showed that 26% of the membership would refuse to work with PWAs; however, 70 % of the respondents who indicated that they would do so agreed with the statement, "The recreation profession has an obligation to treat AIDS clients." Reasons for refusal included concern over contact with the blood and other body fluids of clients with AIDS, feeling inadequately prepared for work with PWAs, lack of agency policies and procedures for work with PWAs and some moral concerns. Members who had previously worked with PWAs or had personally known a PWA (family member, friend or acquaintance) were significantly

more comfortable with PWAs than those without this contact. However, there was no significant difference in their decision to refuse to work with PWAs.

This study recommends: 1) Professionals continue to learn about the disabilities that affect their clients so they may effectively work with them, 2) Agencies establish policies and procedures for staff, and provide continuing education, and 3) The Professional Organization establish ethical position papers to guide the membership. Additional studies should be done to identify successful recreation programs and proven practical methods for working with AIDS clients.

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CHAPTER I

INTRODUCTION

Acquired Immune Deficiency Syndrome (AIDS) was first identified in the United States in Los Angeles in 1981. During the following six years it has become a feared epidemic. As of October 17, 1987 The Centers for Disease Control (CDC) reports 43,533 cases have been diagnosed and 24,947 of the victims have died for a fatality rate of 57 percent. Additionally, there are an estimated 1.5 million people infected with the virus, all of whom are capable of its spread (Koop, 1986). According to the February 14, 1987 Congressional Quarterly, "Experts anticipate an exponential spread of the disease over the next several years will lead to an estimated 270,000 cases diagnosed by 1991".

A diagnosis of AIDS can be catastrophic to its victims due to their poor prognosis and rapid downhill course. The quality of life is poor with up to 40% spending more than half their time from the date of diagnosis until death in the hospital (Pratt, 1986). The psychological adaptation to AIDS, like any severe life-threatening disease, depends

upon medical, psychological and sociocultural factors (Holland & Tross, 1985). The medical factors include general malaise, weight loss, vulnerability to opportunistic infections, fear of disfigurement from Kaposi's Sarcoma, central nervous system complications, and the response of the medical staff (Holland & Tross, 1985; Ryan, 1984).

Psychological distress includes depression, anxiety, anger and grief. The patients are preoccupied with the illness, feeling threatened with the impending loss of life, self esteem, and personal relationships. They experience anxiety over the attitudes of friends and family, with each new symptom which may or may not be related to the disease, and with the uncertainty of the disease process. Sadness, hopelessness, helplessness, guilt, loss of self-esteem, and feelings of worthlessness are common, often leading to social withdrawal and isolation. The isolation may be self imposed or imposed by others. Suicidal thoughts are frequent. The extent of psychological distress will be dependent on the individual's psychological adjustment prior to the diagnosis and the strength of his social support system (Alderman, 1987; Holland & Tross, 1985; Nichols, 1985; Ryan, 1984; Selzer & Prince, 1985).

Sociological stressors are compounded as AIDS is a highly stigmatized disease. Since it was first encountered in the United States among homosexuals, it is frequently referred to as the gay disease. It is also called the gay plague and often likened to leprosy. As the high risk populations include homosexuals, drug users, and now prostitutes, AIDS patients experience considerable discrimination. In addition to the medical and psychological components of their disease

they must confront their families who frequently are unaware of their life styles. AIDS patients have lost their jobs, their homes, their friends, and their right to confidentiality. They have been refused medical care, and the services of hairdressers, garbagemen, and undertakers. They lose the comfort of touch as friends and lovers fear contagion. Children with AIDS or living in a household with AIDS patients have been refused the privilege of school. The view that AIDS is deserved, is divine punishment is purported: 'Good Christians Do Not Get Aids'. The social impact on AIDS patients is tremendous (Cassens, 1985; Eickhoff et al., 1986; Flint, Turton, Goodwin, Bolger, & Neuberger, 1986; Holland & Tross, 1985; Marshall, 1987; Steinbrook, Lo, Tirpack, Dilley, & Volberding, 1985).

Rationale For The Study

The AIDS patient particularly needs the support of health care related professionals. There is an average of two years between the diagnosis and onset of severe illness. During this time AIDS patients suffer discrimination and frequently loose their jobs, homes, friends and support systems. There is a need to fill their time with quality activities. Additionally, many patients are spending more than half the time from date of diagnosis until death in the hospital (Pratt, 1986). While there, they may experience isolation from other patients and staff. Therapeutic Recreators are in a position to help alleviate the isolation and boredom that is an outcome of this disease, both within and without the hospital.

> The purpose of therapeutic recreation is to facilitate the development, maintenance, and expression of an appropriate leisure lifestyle for individuals with physical, mental, emotional, or social limitations (National Therapeutic Recreation Society, 1982).

The Code of Ethics of the National Therapeutic Recreation Society (NTRS) states:

> it is a professional organization committed to the provision of recreation services for <u>all</u> persons regardless of age, race, sex, national origins, religious beliefs, or physical, social or mental abilities.

The Code also subscribes to "principles of ethical conduct endorsed by all health related disciplines" (NTRS, 1984). It would appear that the professional Recreation Therapist has undertaken the responsibility of providing recreation services for the AIDS population. However a review of the literature concerning AIDS has failed to detect mention of either the services provided by this profession, or professional considerations to be contemplated while working with AIDS clients.

Purpose Of The Study

The purpose of this study was to determine current attitudes of professional Therapeutic Recreation Specialists (TRS) in regard to working with AIDS clients. Sub questions considered were:

1. Where have respondents acquired their information about AIDS?
2. Have TRS encountered persons with AIDS in their client population?
3. Do TRS feel comfortable with AIDS clients?
4. Do TRS perceive a responsibility for the care of persons with AIDS?
5. Would recreation professionals refuse to work with AIDS clients?

Delimitations Of The Study

The delimitations of the study were:

1. A random sampling of National Therapeutic Recreation Society members chosen from the 1987 membership roster.

2. The survey instrument consisting of questions related to AIDS education, experience working with AIDS clients, and attitudes about working with these same clients.

Limitations Of The Study

The study was limited by:

1. The number of professionals belonging to the National Therapeutic Recreation Society.

2. The willingness of those surveyed to answer the questions.

Assumptions Of The Study

The assumptions of the study were:

1. The respondents provided accurate information when answering the survey questions.

2. The survey instrument provided data sufficient for conclusions to be drawn.

3. The respondents provided information representative of the National Therapeutic Recreation Society membership.

Definitions Of Terms

For the purpose of this study the following definitions were used:

AIDS Client: An individual who has been exposed to the AIDS virus, has AIDS Related Complex, or has active AIDS.

Attitudes: Disposition, feeling, and position with regard to a person or thing.

Health-Care Workers: "Persons, including students and trainees, whose activities involve contact with patients or with blood or other body fluids from patients in a health-care setting" (CDC, 1987).

National Therapeutic Recreation Society: The professional organization established to meet the needs of Therapeutic Recreation personnel.

Person with AIDS: (PWA) Individuals with AIDS prefer to be referred to as persons with AIDS rather than AIDS victims. In this paper PWAs is used to refer to the plural of PWA.

Therapeutic Recreation: "A process which utilizes recreation services for purposive intervention in some physical, emotional, and/or social behavior to bring about a desired change in that behavior and to promote the growth and development of the individual" (Ninth Southern Region Institute of Therapeutic Recreation, 1969).

Therapeutic Recreation Specialist: A professional who creates recreational opportunities for clients through referral, counseling, education or actual program involvement.

CHAPTER II

REVIEW OF THE LITERATURE

Introduction

The literature search failed to detect articles in recreation journals concerning AIDS or working with AIDS clients. Therefore, medical and psychosocial literature was utilized. This review was divided into four sections: 1) Etiology; 2) Transmission; 3) Health Care Personnel and AIDS; and 4) Attitudes of Health Care Personnel Towards AIDS Patients.

Etiology

AIDS is defined by the CDC as "a disease, at least moderately predictive of a defect in cell-mediated immunity, occurring in a person with no known cause for diminished resistance to that disease" (CDC, 1982). These diseases include Kaposi's Sarcoma, Pneumocystis carinii pneumonia and other serious opportunistic illnesses. Opportunistic diseases are those diseases the body could normally defend against, but in the presence of the AIDS virus it cannot.

AIDS is caused by a virus, which has been named HTLV-III for human T-lymphotropic virus, type 3 and LAV for lymphadenopathy associated virus (Connor, 1987). The virus invades many body cells but zeroes in

on those vital to the immune defense system. It then eliminates those cells, known as T-helper cells, that are crucial in resisting many kinds of infection. Therefore, the body becomes incapable of resisting many bacteria that would be harmless to an individual with a normal immune system leading to what are called opportunistic illnesses.

Transmission

The HLTV-III/LAV is transmitted through sexual contact (homosexual or heterosexual), by shared contaminated needles, through parenteral exposure to infected blood or blood products, across the placenta from mother to infant, and in one documented case in Australia, via breast milk (Cabane, Thibierge, Goodeau, Moreau, & Wattiaux, 1984; CDC, 1982, 1983, 1984; Eickhoff, Valenti, Perlmutter, Weil, & Johnson-White, 1986; Redfield, et al., 1985). Thus, the indications are that the individuals most at risk are homosexuals, persons with multiple sexual partners or whose sexual partner has many other sexual partners, hemophiliacs, and IV drug users.

The virus has been isolated from tears, blood, semen, breast milk, urine, cerebral spinal fluid, lymph nodes, brain tissue and saliva (CDC, 1985; Eickhoff et al., 1986; Fujikawa et al., 1985; Maynard, 1986; Pitchenik, Shafron, Glasser, & Spira, 1984; Stewart et al., 1985; Thiry et al., 1985). Transmission has not been documented from saliva and tears (CDC, 1985). Contagion through casual contact and airborne spread are not likely (CDC,1982). None of the known cases have been transmitted in the school, day-care or foster care settings or through

other casual person-to-person contact (CDC, 1985). Also, there are no documented cases of AIDS in family members, with no other identifiable risk factors for AIDS infection, who live in the households of persons with AIDS (Friedland et al., 1986).

According to CDC there is no need to fear transmission from HTLV-III/LAV-infected fellow employees in the work place as the virus is transmitted through sexual contact or contact with blood/blood products. Additionally, employees should not be restricted from using telephones, office equipment, toilets, showers, eating facilities, and water fountains (CDC, 1985). The AIDS virus is fragile, susceptible to the effects of detergents, bleaches and temperatures greater than 56 degrees C. (Spire, Montagnier, Barre-Sinoussi, & Shermann, 1984; Spire, Barre-Sinoussi, & Montagnier, 1985).

Health Care Personnel And AIDS

Prior to July 1983, there had been 1831 patients meeting the criteria for the CDC definition of the acquired immunodeficiency syndrome; four of these were reported to be health care personnel. None of the four had a history of caring for an AIDS patient, and none had known contact with the blood of an AIDS patient. However, accuracy of data concerning their sexual activity and IV drug use could not be verified (CDC, 1984).

In August 1983 CDC began surveillance of health-care workers (HCWs) with documented parenteral or mucous-membrane exposure to body fluids of patients with suspected or diagnosed AIDS. By December 31,

1985, 1,758 HCWs were involved in this or similar projects. Twenty six or 1.5%, were seropositive, i.e., showed serum antibodies to HTLV-III, but only three of these were not members of a group at high risk for AIDS.

In the CDC surveillance group of 938 HCWs the mean length of follow-up was fifteen months, with 531 (57%) of the participants followed for more than one year. As of April 24, 1986 none of the HCWs had acquired signs or symptoms of AIDS (McCray, 1986). The results of these studies suggest that occupational risk among HCWs is low (CDC, 1985; McCray, 1986; Napoli & McGowan, 1987). However, "Despite reports of low incidence after occupational exposure, seroconversion can occur after even a single superficial needlestick injury and the evidence suggests that at least 90% of seroconverters, will eventually have symptoms" (Goodacre, 1987; Mayer, Stoddard, & McCusker, 1986; Salahuddin, Groopman, & Markham, 1984). "As of June 30, 1987 three of 551 of the HCWs with needle stick exposures seroconverted. None of these three health-care workers had other documented risk factors for infection" (CDC, 1987).

According to CDC, as of July 10, 1987, 1,876 (5.8%) of 32,395 persons with AIDS, were reported to be HCWs. For comparison, in the U.S. work force there are 6.8 million persons (5.6%) employed as HCWs. Ninety five percent of the HCWs with AIDS engage in high risk behaviors for AIDS. The remaining 5% of the afflicted HCWs have acquired AIDS through undetermined means. For non health care workers the undetermined category remains at 3%. Of the 87 HCWs categorized as no identifiable high risk behavior 16 (18%) have died or refused to be

interviewed and 38 (44%) are still being investigated. The remaining 33 (38%) participate in the following occupations: five physicians, three of whom were surgeons (15%); one dentist (3%); three nurses (9%); nine nursing assistants (27%); seven housekeeping or maintenance workers (21%); three clinical laboratory technicians (9%); one therapist (3%); and four others (1.2%) who did not have contact with patients (CDC, 1987).

Attitudes Of Health Care Personnel Towards AIDS Patients

A review of the literature failed to detect papers concerning the role of the therapeutic recreator in the care of AIDS patients in either clinical or community settings. However, there are many articles concerning the attitudes of HCWs, generally doctors and nurses, towards AIDS patients. A negative picture is painted by articles which describe avoidance of patient care, overreaction to patient behavior, verbal abuse, homophobia and prejudice towards homosexuals. In some medical centers AIDS has been nicknamed WOG, wrath of God. A British nursing journal relates an incidence during which a patient who had seroconverted to the virus was transported from Ireland to London in a cadaver bag with eyeholes cut into it (Alderman, 1987; Cummings, 1986; Douglas, Kalman, & Kalman, 1985; Moran, 1985; Reed, Wise, & Mann, 1984; Selzer & Prince, 1985; Steinbrook et al., 1985). In a January 1986 poll conducted by Nursing Life 16% of the 450 responding nurses stated they would refuse to take care of an AIDS patient.

It is suggested that this negativism may be the result of fear of the unknown, fear of contagion and death, concern with the possibility of latent homosexuality, and homophobia. The medical profession is also stressed by the burden of the intensive complicated care of the AIDS patient, and the need to cope with continual suffering and death (Pearson, 1986). There is frustration over the inability to cure and the demand to treat so many young terminally ill patients. Additionally, personal prejudices and transference of feelings may interfere with patient care (Douglas et al., 1985; Holland & Tross, 1985; McKusick, Horstman, Abrams, & Coates, 1986; Pearson, 1986; Reed et al., 1984; Rosse, 1985).

In a 1986 study of health professionals (doctors, dentists, and nurses) in London, Searle conducted a survey of health professionals' knowledge, attitudes, and behavior in relation to AIDS. Seven hundred and fifty out of nine hundred eighty-one questionnaires were returned and analyzed revealing a disparity between expert opinion about the contagion of AIDS and the view of clinicians. His recommendation was to continue staff education about HIV(HTLV) at all levels as the health professionals are the educators and role models for the public. A 1986 study by McManus and Morton revealed that attitudes toward AIDS and its treatment among preclinical students were related to attitudes in general concerning homosexuality, rather than to amount of knowledge about the disease. They recommended increased education about homosexuality as well as continuing education about the disease and routes of transmission. A similar study by Reed et al. (1984) indicated that nurses who believed homosexuality to be a psychiatric disorder or a

sin were more anxious about working with AIDS patients than the nurses who considered homosexuality a lifestyle.

Articles in Medical Journals comment on the ethical responsibility of caring for all patients and remind readers of historic risks taken with diseases like typhus and tuberculosis (Smith, 1987). The British Royal College of Nursing recommends disciplining nurses who refuse to care for AIDS patients (Smith, 1987). Frederick Abrams, director of the Center for Applied Biomedical Ethics at Rose Medical Center, Denver suggests that "because the disease is known to be transmitted only through blood and body fluids, no health care worker should ever refuse to care for a patient with AIDS--always taking proper precautions, of course" (Nursing Life, 1986). A similar position is taken by Volberding and Abrams (1985) in The Hasting Center Report. They write, "on the question of occupational contagion, we consider the risk of contracting AIDS from a patient to be negligible; and the risk should not be accepted as a reason to limit care". More recent papers describe mitigation of many of the unwarranted fears following increased staff education and counseling (Thompson, 1987).

The psychiatric literature suggests there will be an increase in the number of AIDS clients admitted to psychiatric facilities as more AIDS patients begin to need psychiatric hospitalization. These articles also indicate increasing comfort and decreasing anxiety, while working with AIDS clients, among experienced staff members (Amchin & Polan, 1986; Polan, Hellerstein, & Amchin, 1985). Amchin attributes this to experience and education and further reports decreased anxiety among

other hospitalized patients (without AIDS) which is positively related to the attitudes of the staff.

Summary

The literature suggests there will be an increase in persons with positive AIDS antibody tests, AIDS related disease and AIDS (CDC, 1985, 1986; Congressional Quarterly, 1987; Eickhoff et al., 1986; Selzer & Prince, 1985; Amchin & Polan, 1986). As the disease prevalence increases more AIDS victims will be utilizing clinical and community facilities staffed by Therapeutic Recreation Specialists. A review of the literature revealed no studies of the attitudes or actions of recreators in conjunction with AIDS clients. Studies involving other health care workers reveal fear of contagion, death, latent homosexuality, homophobia and in some cases insufficient knowledge about the disease to provide adequate patient care. Reed et al. (1984) and Searle (1986) recommend further studies with other health care personnel, who work directly with patients, in order to discover fears and techniques for dispelling those fears and increasing professional assistance for AIDS victims. This issue remains unaddressed in the therapeutic recreation literature.

CHAPTER III

METHODOLOGY

This chapter identifies the methods used to conduct this study of the current attitudes about working with AIDS clients among professional Therapeutic Recreation Specialists.

Development Of The Questionnaire

Instrumentation

The literature was reviewed to determine if an instrument existed that could be modified for the population of Therapeutic Recreation Specialists. As none was discovered, one was developed by this author (Appendix A). It was designed using concepts from the Total Design Method (Dillman, 1978) and from Educational Research: Competencies for Analysis and Application (Gay, 1987). A preliminary instrument was reviewed by graduate students in a research seminar, and by Dr. Howard Pollio, a research consultant at the University of Tennessee. Comments and suggestions were utilized in the revised questionnaire. After revision the questionnaire was pre-tested in Knoxville, Tennessee. It was given to area health care professionals including: a clinical psychologist; two psychiatric social workers; four psychiatric and medical nurses; and four recreators working in commercial and health

care agencies. The questionnaire was revised again to remove suggested ambiguities.

The final questionnaire had three sections and used both open ended and closed ended questions. The three sections covered: 1) demographic information; 2) questions concerning knowledge about AIDS and experience with AIDS clients; and 3) questions to determine attitudes. The first section, demographic information, contained six closed questions about birth date, sex, level of formal education, agency description, and job title.

The second section, knowledge about AIDS and experience with AIDS clients, contained four questions designed to discover where the respondent acquired his/her knowledge about AIDS, and personal and professional experience with persons with AIDS.

The final section, Attitudes Towards AIDS Clients, contained 17 questions to which the respondent was asked to indicate his level of agreement. Two final questions asked whether the respondent would refuse to work with a person with AIDS and under what circumstances, and for any comments the respondent might wish to make.

Population Selection

The population selected for the study consisted of 278 professional members of the National Therapeutic Recreation Society randomly selected from the 1987 membership roles. The society had 2662 professional members on September 16, 1987. Respondents were chosen using the Epistat randomizing program for IBM Personal Computer created in 1984 by

Gustafson. Seventy one males (25.5%) and 207 females (74.5%) were randomly selected.

Implementation

The confidential questionnaire was mailed on September 28, 1987. Each individual surveyed received an explanatory cover letter (Appendix A), a questionnaire (Appendix A), and an addressed prepaid envelope in which to return the questionnaire. Respondents were asked to return the questionnaire within two weeks. A follow up letter (Appendix A) and questionnaire were sent October 12 to those individuals who had not responded.

Analysis

The results of the questionnaire were analyzed by the Statistical Analysis System (SAS) package. The SAS package is capable of performing common statistical tests and/or functions, including correlation, probabililty, frequency and cross tabulation tables, and chi-square, the procedures used in this study.

The data were analyzed and organized to address the purpose of the study and its sub-questions. Findings in the demographic section were cross tabulated with the attitudinal section for primary information. The chi-square procedure was utilized to determine the statistical significance of the data. An alpha level was set at .01. The open ended questions were used to provide supplementary data.

CHAPTER IV

RESULTS

Introduction

The survey was administered by mail during the time frame of September 28, 1987 through October 24, 1987. The 278 recipients were all professional members of the National Therapeutic Recreation Society (NTRS). Questionnaires were sent to 71 (25.5%) males and 207 (74.5%) females. Two hundred and eight persons responded before the October 24 cutoff date. An additional nineteen individuals answered after the deadline bringing the total number of respondents to 227 (81.7%). This level of response indicates solid interest in the subject matter of the study. A total of 25 of the 221 questionnaires were not used in the study as the recipients had: died (1); moved (1); returned an incomplete questionnaire (2); changed careers (2); or returned the questionnaire after the deadline (19). The total number of questionnaires used was 202 (72.7%).

Frequencies

The first section of the questionnaire is concerned with the demographic characteristics of the participants. A discussion of the frequencies of responses follows. As, on occasion a respondent would leave a question unanswered, the number (n) of respondents who answered each question is indicated in each table.

Fifty males and 151 females responded, table 1. One respondent did not indicate gender. There was no significant difference in the response rate of the respondents according to sex. Approximately 25% of the questionnaires were sent to males and 75% to females, and the response rate by gender was the same.

TABLE 1. Number of Respondents by Sex

	N=201			
SEX	FREQ	%	CUM FREQ	CUM%
MALE	50	24.9	50	24.9
FEMALE	151	75.1	201	100.0

Missing frequency = 1

The respondents ranged in age from 22 to 73, with a large majority (81.4%) under the age of 40. Three individuals chose not to report their age. Table 2 presents a breakdown of the respondents by age.

The majority of the respondents have earned a bachelors degree (46.5%) or a masters degree (27.2%). Seventeen percent have done post graduate work and 5.4 percent reported having doctorate degrees. Only

3.5 percent of the respondents did not have a degree. The most common degree held by those replying was in recreation. One hundred sixty five persons reported having a recreation degree. A complete report of the educational level reported by those responding is found in table 3.

TABLE 2. Number of Respondents By Age

	N=199			
AGE	FREQ	%	CUM FREQ	CUM%
22-29	69	34.7	69	34.7
30-39	93	46.7	162	81.4
40-49	21	10.6	183	92.0
50-73	16	8.0	199	100.0

Missing frequency = 3

TABLE 3. Educational Level of the Respondents

	N=202			
EDUCATION	FREQ	%	CUM FREQ	CUM%
HIGH SCHOOL	1	0.5	1	0.5
2 YEARS COLLEGE	6	3.0	7	3.5
BACHELORS DEGREE	94	46.5	101	50.0
POST GRADUATE WORK	35	17.3	136	67.3
MASTERS DEGREE	55	27.2	191	94.6
DOCTORATE	11	5.4	202	100.0

The respondents worked in a variety of agencies as indicated by table 4. The most common setting was a psychiatric hospital with 19.8% of the respondents indicating they worked in this area. This was followed by nursing home (11.9%), rehabilitation setting (10.3%), general hospital (9.9%), and educational setting (9.9%). Those working

in rehabilitation comprised a large portion of the "other" category. Additional agencies represented by the "other" category included adult day treatment facilities, childrens' hospitals, military recreation, manufacturing representatives and retired persons.

The agency positions held by the respondents are noted in table 5. The most frequent position listed was that of therapist/specialist (46.8%). This was followed by activity director (13.4%,) administrator (12.4%), supervisor (12.9%), educator (5.9%), and programmer (1.5%). The "other" category (7.4%) included consultants, acting chief, researchers, aquatic directors, family fitness coordinator, rehabilitation therapists, community relations coordinator and dance therapist.

TABLE 4. Number of Respondents by Agency

	N=202			
FACILITY	FREQ	%	CUM FREQ	CUM%
GENERAL HOSPITAL	20	9.9	20	9.9
PSYCHIATRIC HOSPITAL	40	19.8	60	29.7
MENTAL HEALTH CENTER	8	4.0	68	33.7
SUBSTANCE ABUSE CENTER	5	2.5	73	36.1
COMMUNITY RECREATION CENTER	8	4.0	81	40.1
NURSING HOME/LONG TERM CARE	24	11.9	105	52.0
PUBLIC PARKS AND RECREATION	12	5.9	117	57.9
EDUCATIONAL SETTING	20	9.9	137	67.8
DEVELOPMENTALLY DISABLED CENTER	15	7.4	152	75.2
CORRECTIONAL FACILITY	1	0.5	153	75.7
VOCATIONAL TRAINING	3	1.5	156	77.2
OTHER	46	22.8	202	100.0

TABLE 5. Number of Respondents by Agency Position

POSITION	N=202 FREQ	%	CUM FREQ	CUM%
ADMINISTRATOR	25	12.4	25	12.4
SUPERVISOR	26	12.9	51	25.2
THERAPIST/SPECIALIST	94	46.5	145	71.8
PROGRAMMER	3	1.5	148	73.3
EDUCATOR	12	5.9	160	79.2
ACTIVITY DIRECTOR	27	13.4	187	92.6
OTHER	15	7.4	202	100.0

The second section of the questionnaire, "Experience with AIDS and AIDS Clients", contained questions designed to discover where the respondent acquired his/her knowledge about AIDS, and personal and professional experience with persons with AIDS. The majority of those responding to the question requesting sources of information reported newspapers (31.4%) and television (30.0%) to be their primary source of information about AIDS. These were followed by agency education (28.4%) radio (4.5%) and workshops/conferences (3.9%). Four individuals (2.7%) cited clinical journals as their primary knowledge base. Sources listed in the "other" category included classes, research, pamphlets and discussions with the medical profession.

The question was confounded as 31 respondents indicated all the sources they utilized. However, their replies followed the same pattern as those indicating their primary source, as requested. The responses of those indicating one primary source are shown in table 6.

TABLE 6. Primary Source of Information

SOURCE	N=171 FREQ	%	CUM FREQ	CUM%
NEWSPAPERS	48	31.4	48	31.4
TELEVISION	46	30.0	94	61.4
RADIO	7	4.5	101	65.9
CLINICAL JOURNALS	4	2.7	105	68.6
AGENCY EDUCATION	38	24.8	143	93.4
WORKSHOPS/CONFERENCES	6	3.9	149	97.3
OTHER	4	2.7	153	100.0

Missing frequency = 31

In response to the question, "Have you known personally an individual with AIDS or AIDS Related Complex (a friend, family member, or acquaintance)?", 50 (24.8%) answered yes, and 152 (75.5%) replied no. The results are in table 7.

TABLE 7. Friend, Relative or Acquaintance with AIDS

RESPONSE	N=202 FREQ	%	CUM FREQ	CUM%
YES	50	24.8	50	24.8
NO	152	75.2	202	100.0

There was a wide variety of responses to the question regarding the number of persons with AIDS encountered through the respondent's work. The responses varied in number from zero to 60, with 61 (30.8%) individuals reporting experience working with AIDS clients. All types of agencies were represented by those individuals who had encountered

AIDS clients through their work. The responses are listed in table 8. Respondents from New York were unable to answer this question as they reported a state law which prohibited agencies from disclosing the names of persons with AIDS to their staff. Ten respondents reported they are currently working with persons with AIDS.

TABLE 8. Number of PWAs Encountered Through Work

N=198

# of PWAs	FREQ	%	CUM FREQ	CUM%
0	137	69.2	137	69.2
1	23	11.6	160	80.8
2	16	8.1	176	88.9
3	4	2.0	180	90.9
4	4	2.0	184	92.9
5	1	0.5	185	93.4
6	6	3.0	191	96.5
7	2	1.0	192	97.5
10	1	0.5	193	98.0
15	1	0.5	194	98.5
20	1	0.5	195	99.0
40	1	0.5	196	99.5
60	1	0.5	197	100.0

Missing frequency = 4

The responses to the question regarding refusing to work with AIDS clients are given in table 9. Fifty one individuals (26.0%) responded with a yes, they would refuse to work with a PWA and 136 (69.4%) replied no, they would not refuse. Nine persons pencilled in a response such as "maybe" or "I don't know". Five persons did not answer the question. A list of all the reasons for refusal and comments following this question are found in Appendices B and C.

TABLE 9. Would You Refuse to Work with an AIDS Client?

	N=196			
REFUSE?	FREQ	%	CUM FREQ	CUM%
YES	51	26.0	51	26.0
NO	136	69.4	187	95.4
MAYBE	9	4.6	196	100.0

Missing frequency = 6

Crosstabulations

The frequencies of several questions were crosstabulated with those items regarding whether the respondents were comfortable working with PWAs, and whether they would refuse to work with AIDS clients. A chi-square test was utilized with several of the crosstabulations to determine the significance of the difference between the expected frequencies and the observed frequencies.

The first crosstabulation was sex with refusal to work with AIDS clients (table 10). Of the 138 women responding to both questions 35 (25.4%) indicated they would refuse to work with AIDS clients, while 103 (74.6%) indicated they would not refuse. Sixteen (33.3%) of the 48 men answering both questions indicated they would refuse, while 32 (66.7%) indicated they would not refuse. One man and three women answered the statement by writing in "maybe" or "I don't know". Although the refusal rate was slightly higher for men, the chi-square value was not significant.

Table 10. Comparison by Sex of the Percentage of Responses Indicating Potential Refusal to Work with AIDS Clients

N=186

	Male		Female		Total	Chi	Prob-
REFUSE	n	%	n	%	n	Square	ability
YES	16	33.3	35	25.4	51	1.137	0.286
NO	32	66.7	103	74.6	135		
Total	48	100.0	138	100.0	186		

Missing frequency = 16 DF = 1

A comparison of respondents who indicated encountering PWAs through their work was crosstabulated with the attitude statement, "I am comfortable working with AIDS clients", table 11. Eight (13.1%) of the respondents with prior work experience indicated they strongly agreed with this statement. Twenty one (34.4%) indicated they agreed for a total of 29 (47.4%) agreement. Seventeen (27.9%) of the respondents in this category remained neutral while 14 (23.0%) disagreed and one (1.6%) strongly disagreed. Of those respondents who had not encountered AIDS clients through their work 7 (5.1%) strongly agreed, 28 (20.4%) agreed, 63 (46.0%) remained neutral, 26 (19.0%) disagreed and 13 (9.5%) strongly disagree. The chi-square value, 14.34, is significant at the 1% level.

TABLE 11. Comparison of Respondents Having Worked with PWAs with the Attitude Statement, "I Am Comfortable Working with AIDS Clients".

N = 198

Work	Strongly Agree %	Agree %	Neutral %	Disagree %	Strongly Disagree %	Chi Square	Prob-ability
YES	13.1	34.4	27.9	23.0	1.6	14.34	0.006
NO	5.1	20.4	46.0	19.0	9.5		

Missing frequency = 4 DF = 4

The responses to the question, "Would you refuse to work with AIDS clients were compared with responses to the question determining prior experience working with PWAs, table 12. Respondents who had worked with one or more clients were contrasted with those with no experience in this area. No significant difference in response was discovered,

regardless of work experience. Thirty four persons (27.2%) of the 125 respondents with no experience said they would refuse to work with AIDS clients. Seventeen (28.8%) of the 59 persons who had worked with PWAs indicated they would refuse to do so again. Three of the respondents who indicated they would refuse had worked with six or more AIDS clients (6, 15, and 40 patients/clients).

TABLE 12. Comparison, by Work Experience, of Respondents Who Would Refuse to Work with PWAs

N = 184

	No Experience		Experience		Total	Chi	Prob-
	n	%	n	%	n	Square	ability
REFUSAL							
YES	34	27.2	17	28.8	51	0.052	0.819
NO	91	72.9	42	71.2	133		
Total	125	100.0	59	100.0	184		

Missing frequency = 18 DF = 1

The attitude statement, "I am comfortable working with AIDS clients", was compared with the question, "Have you known personally a PWA (a friend, family member or acquaintance)". Of those respondents who had personally known a PWA, 7 (14.0%) strongly agreed that they felt comfortable working with AIDS clients. Twenty (40.0%) agreed, 15 (30.0%) remained neutral, seven (14.0%) disagreed and one (2.0%) strongly disagreed. Of those who were not acquainted with a PWA, eight (5.3%) strongly agreed, 31 (20.5%) agreed, 66 (43.7%) remained neutral, 33 (21.8%) disagreed and 13 (8.6%) strongly disagree. The value of chi-square, 14.695, was significant at the 1% level (table 13).

Table 13. Comparison of Respondents Having Personally Known a PWA with the Attitude Statement, "I Am Comfortable Working with AIDS Clients"

N = 201

Work	Strongly Agree %	Agree %	Neutral %	Disagree %	Strongly Disagree %	Chi Square	Probability
YES	14.0	40.0	30.0	14.0	2.0	14.695	0.005
NO	5.3	20.5	43.71	21.85	8.61		

Missing frequency = 1 DF = 4

Question number eight which asked participants if they had personally known an individual with AIDS or AIDs Related Complex was compared with question 12 concerning refusal to work with a PWA. Individuals who had personally known a PWA were less inclined to refuse to work with an AIDS client/patient; however, the chi-square value was not significant. Nine (18.8%) of the 48 respondents who had personally known a PWA responded yes, they would refuse, while 42 (30.2%) of the 139 who did not have personal acquaintances indicated they would refuse. The results are shown in table 14.

Table 14. Comparison of Having Personally Known a PWA with Refusal to Work with PWA

N = 187

	Personally Known PWA YES		NO		Total	Chi	Probability
REFUSE	n	%	n	%	n	Square	
YES	9	18.8	42	30.2	51	2.365	0.124
NO	39	81.2	97	69.8	136		
TOTAL	48	100.00	139	100.00	187		

Missing frequency = 15 DF = 1

The agencies were divided into two groups, clinical and community, in order to determine if those persons working in more medically oriented organizations (clinical) were more comfortable with AIDS clients than those in community agencies. The agencies considered to be clinical were:

1. General Hospital
2. Psychiatric Hospital
3. Mental Health Center
4. Substance Abuse Center

Those categorized as community were:

1. Community Recreation Center
2. Nursing Home/Long Term Care
2. Public Parks and Recreation
4. Educational Setting
5. Developmentally Disabled Centers
6. Correctional Facility
7. Vocational Training
8. Other

There were no significant differences detected through the use of these categories. Eighteen (26.5%) of the 68 persons working in a clinical setting reported they would refuse to work with PWAs while 33 (27.7%) of those working in Community Agencies gave the same response. The results are depicted in table 15.

TABLE 15. Comparison of Clinical/Community Agencies with Refusal

N=187

	Clinical		Community		Total	Chi	Prob-
	n	%	n	%	n	Square	ability
REFUSE							
YES	18	26.5	33	27.7	51	0.035	0.852
NO	50	73.5	86	72.3	136		
Total	68	100.0	119	100.0	187		

Missing frequency = 15 DF = 1

The responses to the question indicating whether or not an individual would refuse to work with PWAs, were compared with replies indicating level of agreement to the statement, "The recreation profession has an obligation to treat AIDS clients." The results demonstrate the confusion felt by many persons when confronted with the possibility of working with AIDS. Thirty five (70.0%) of the respondents who indicated they would refuse to work with AIDS clients strongly agreed or agreed with the statement about obligation. Only 6 (12%) disagreed or strongly disagreed. Those respondents who indicated they would not refuse strongly agreed/agreed with the statement 85.0% of the time. Only nine persons (6%) who stated they would not refuse disagreed/strongly disagreed (table 16).

TABLE 16. Comparison of Refusal with the Statement, "The Recreation Profession has an Obligation to Treat AIDS Clients"

N=186

REFUSE	Strongly Agree %	Agree %	Neutral %	Disagree %	Strongly Disagree %	Chi Square	Prob-ability
YES	26.0	44.0	18.0	8.0	4.0	5.797	0.215
NO	37.5	47.0	8.8	5.2	1.5		

Missing frequency = 16 DF = 4

Discussion

This section summarizes the data in order to address the subquestions of the study. The results of the final section of the questionnaire designed to determine the respondents attitudes towards working with AIDS clients are also recorded in this section and are seen in tables 17 and 18.

Five basic impressions concerned with these questions emerged from the data.

Subquestion 1. Where have respondents acquired their information about AIDS?

Newspapers (31.4%) and television (30.0%) were the sources listed most often by the respondents. This was followed by agency education (24.8%), while clinical journals, workshops/conferences, and radio made up the remaining 13.0%. Thirty nine percent of the respondents strongly agreed or agreed that their agency has provided them with quality information about AIDS. Only 26 percent indicated they believed they have adequate training for working with AIDS clients. Fifty six percent of the respondents reported they did not believe they were adequately trained for working with AIDS clients. Eighty four percent either disagreed or strongly disagreed with the statement, "You can get AIDS by handling equipment used by an AIDS clients", indicating an understanding of the basic concept regarding transmission of the AIDS virus.

One hundred nineteen respondents took the time to write comments on their survey forms. Fifty six (47.0%) of those related to a need for more education about AIDS in general. Eleven (9.2%) spoke of a need for

education focused on the field of therapeutic recreation. Forty nine percent of the persons indicated they would refuse to care for AIDS clients citing a deficiency in training and information as one of the reasons they would refuse. Respondents specified lack of procedures for working with PWAs, and/or lack of proper supplies necessary to initiate and support good infection control procedures as reasons for refusal. Additionally, persons were concerned with contact with bodily fluids, particularly through open cuts and wounds, and what to do with aggressive acting out patients who may bite (psychiatric settings).

Subquestion 2. Have NTRS members encountered persons with AIDS in their client population?

Sixty one respondents (30.8%) reported having one or more PWAs in their client population. At least one respondent from each type of agency listed in the study had encountered AIDS clients through his/her work. More PWAs were seen in clinical situations as would be expected; however, respondents working in community centers and parks and recreation positions also reported working with AIDS clients. Three of the twelve respondents employed in educational settings reported working with PWAs.

Twenty three percent of the respondents strongly agreed with the statement that persons with active AIDS should be allowed to use recreational facilities. Forty one % agreed, 24 percent remained neutral, eight percent disagreed, and three percent strongly disagree. When the statement was changed to read AIDS carriers rather than persons with active AIDS the reported agreement was higher with 32 % strongly agreeing and 45 % agreeing. Only three percent of the

respondents agreed with the statement, "Since I have a responsibility to other clients I cannot include persons with AIDS in group activities." Seven percent agreed while 31 percent remained neutral, 44 % disagreed and 15 % strongly disagreed.

Subquestion 3. Do therapeutic recreation specialists feel comfortable with AIDS clients?

Thirty three percent of the respondents indicated they agreed/strongly agreed with the statement, "I feel comfortable working with AIDS clients". Twenty seven percent disagreed/strongly disagreed with the same phrase. Respondents who had personal acquaintance with PWAs were more comfortable with AIDS clients, as were respondents who had prior work experience with PWAs. The latter finding is supported by Amchin and Polan (1986) who found anxiety incurred as a result of working with AIDS clients decreased as staff members became more experienced in working with AIDS clients.

Subquestion 4. Do members of NTRS perceive a responsibility to work with AIDS clients?

As presented in a 1984 issue of the Therapeutic Recreation Journal (TRJ) the code of ethics of the National Therapeutic Recreation Society states:

> it is a professional organization committed to the provision of recreation services for all persons regardless of age, race sex, national origins, religious beliefs, or physical, social or mental abilities" (Therapeutic Recreation Journal, 1984).

According to the code of ethics the therapeutic recreation profession "equally subscribes to those general principles of ethical conduct endorsed by all health related disciplines" (TRJ, 1984).

The respondents appear to subscribe to their code of ethics. There was a total of 81% agreement with the statement, "The recreation

profession has an obligation to treat AIDS clients". Thirty four percent of the 200 responding strongly agreed and an additional 47.0% agreed.

Affirmation was slightly stronger in support of the statement, "The medical profession has an obligation to treat AIDS clients." Sixty nine percent of the respondents indicated they strongly agreed with the latter statement with an additional 23.0% indicating they just agreed for a total of 92.0% agreement.

Eighteen percent of those writing in the comment section of the survey conveyed the belief that we have an ethical commitment to care for all humans including AIDS clients. One individual queried, "Who gives us the right to separate AIDS clients?" The respondent with the most experience with PWAs stated, "Recreation therapy is very important for PWAs; we serve as a resource person, support, leisure counsellor, thanantologist, and friend." Other respondents remarked on the critical importance of recreation and leisure for a PWA, and that PWAs deserve the same respect and have the same recreation needs as others.

Subquestion 5: Would recreation professionals refuse to work with AIDS clients?

Twenty six percent of the respondents indicated they would refuse to work with PWAs. Five percent wrote in, "I don't know", indicating potential for additional refusals. All individuals wrote explanations for their probable refusal. The most common reason cited for refusal was a concern with lack of knowledge about the disease process and the proper procedures to follow while working with AIDS clients. Forty nine percent of the reasons cited were due to feeling a need for more education in some facet of care of AIDS clients.

Twenty percent of those respondents who indicated that they would not work with AIDS clients cited moral reasons as the basis for their refusal. Specific comments included: "I am against homosexuality, lesbianism and drug use" and "Those contracting it through transfusions should be allowed to participate fully in the recreation spectrum." Conversely, some of those who indicated that they would not refuse stated: "People who refuse have homophobia or sexual hangups" and "Discrimination or bigoted behavior [is] shameful."

Another reason for refusal was "dislike working with chronic and or terminally ill patients." Unfortunately, PWAs are chronic patients with much spare time on their hands due to loss of jobs, decreased energy, and isolation from society and they may need the services of therapeutic recreation specialists.

Thirty one respondents cited potential situations for transmission (client with open cuts, possible contact with bodily fluids, and aggressive acting out patients) and pregnancy as reasons for refusal. Aside from the ethical responsibility to provide services to all persons, epidemiologic data do not suggest that concerns about transmission of AIDS from clients to health care workers justify an unwillingness to work with PWAs. Medical and allied health personnel can protect themselves adequately by following recent Public Health Service guidelines and the 1987 CDC recommendations for the protection of health care workers.

TABLE 17. Response to Attitudinal Statements (Number of Respondents).

Statements	N	FREQUENCY 1	2	3	4	5
A. My agency has provided me with quality information about AIDS.	(200)	30	48	43	37	42
B. I Have adequate training for working with AIDS clients.	(201)	13	40	35	53	60
C. The idea of working with AIDS clients interests me.	(201)	11	42	88	38	22
D. I am comfortable working with AIDS clients.	(201)	15	51	81	40	14
E. I help AIDS clients deal with their illness.	(199)	10	58	77	24	30
F. I communicate effectively with AIDS clients.	(199)	13	71	83	18	14
G. I feel sorry for AIDS clients.	(200)	31	68	73	17	11
H. I am fearful working with AIDS.	(201)	8	53	62	58	20
I. My family is comfortable with my working with AIDS clients.	(199)	3	23	81	53	39
J. My co-workers are comfortable working with AIDS clients.	(199)	1	21	84	68	25
K. The recreation profession has as obligation to treat AIDS clients.	(200)	67	94	23	11	5
L. The medical profession has an obligation to treat AIDS clients.	(199)	137	46	6	6	4
M. I believe other clients would be willing to participate in agency activities with AIDS clients.	(201)	6	27	78	76	14
N. Since I have a responsibility to other clients I cannot include persons with AIDS in group activities.	(200)	6	27	15	62	87
O. Staff members can acquire AIDS by touching materials used by an AIDS client.	(201)	4	11	17	64	105
P. Persons with active AIDS should be allowed to use recreational facilities.	(199)	47	82	48	16	6
Q. A person who is an AIDS carrier, but not an active case, should be allowed to use recreational facilities.	(200)	64	90	31	9	6

1 = Strongly Agree
2 = Agree
3 = Neutral
4 = Disagree
5 = Strongly disagree

TABLE 18. Response to Attitudinal Statements (Percentage of Responses).

Statements	PERCENT 1	2	3	4	5
A. My agency has provided me with quality information about AIDS.	15.0	24.0	21.5	18.5	21.0
B. I Have adequate training for working with AIDS clients.	6.5	19.9	17.4	26.4	29.9
C. The idea of working with AIDS clients interests me.	5.5	20.9	43.8	18.9	10.9
D. I am comfortable working with AIDS clients.	7.5	25.4	40.3	19.9	7.0
E. I help AIDS clients deal with their illness.	5.0	29.1	38.7	12.1	15.1
F. I communicate effectively with AIDS clients.	6.5	35.7	41.7	9.0	7.0
G. I feel sorry for AIDS clients.	15.5	34.0	36.5	8.5	5.5
H. I am fearful of working with AIDS.	4.0	26.4	30.8	28.9	10.0
I. My family is comfortable with my working with AIDS clients.	1.5	11.6	40.7	26.6	19.6
J. My co-workers are comfortable working with AIDS clients.	0.5	10.6	42.2	34.2	12.6
K. The recreation profession has an obligation to treat AIDS clients.	33.5	47.0	11.5	5.5	2.5
L. The medical profession has an obligation to treat AIDS clients.	68.8	23.1	3.0	3.0	2.0
M. I believe other clients would be willing to participate in agency activities with AIDS clients.	3.0	13.4	38.8	37.8	7.0
N. Since I have a responsibility to other clients I cannot include persons with AIDS in group activities.	3.0	7.5	31.0	43.5	15.0
O. Staff members can acquire AIDS by touching materials used by an AIDS client.	2.0	5.5	8.5	31.8	52.2
P. Persons with active AIDS should be allowed to use recreational facilities.	23.6	41.2	24.1	8.0	3.0
Q. A person who is an AIDS carrier but not an active case should be allowed to use recreational facilities.	32.0	45.0	15.5	4.5	3.0

1 = Strongly Agree
2 = Agree
3 = Neutral
4 = Disagree
5 = Strongly disagree

CHAPTER V

CONCLUSIONS AND RECOMMENDATIONS

Introduction

This chapter contains the conclusions reached by the author and recommendations for future studies.

Conclusions

Professionals must be able to conquer their anxieties, prejudices and fears in order to effectively perform their tasks, and it appears that with experience and education individuals will be more comfortable and secure if and when they encounter PWAs among their clientel. Those respondents who have personally known AIDS clients and/or encountered them in the work environment were significantly more comfortable with PWAs than respondents with no experiecnce.

One conclusion developed from this survey is obvious. The respondents require more AIDS information and more support in working with AIDs clients. The indications are that this disease will be with us for some time. With its continual spread and increase in carriers (1.5 million persons in the United States are said to be carriers), it is likely that many TRS working in clinical and community setting are going to have PWAs in their client population.

Educational goals will be difficult to define, let alone meet, due to the uncertainties that surround the disease. The absence of a consensus among medical experts complicates the task of education. "There are too many unanswered questions about AIDS", is an idea that was expressed by respondents.

No area is exempt from the possibility of encountering PWAs in their work situation; therefore, all agencies should plan to educate their staff. Policies and procedures that will enable personnel to be proactive rather than reactive in regard to the AIDS issue must be formulated. The education that is provided has to combat more than ignorance, it must deal with emotion, prejudice, and irrational fears about AIDS.

Attitudes towards refusal to work with AIDS involve highly volatile issues. Unfortunately these needy clients are frequently patients that many persons have difficulty accepting. Dislike of homosexuals, the largest category of PWAs is as common in health care institutions as it is elsewhere. A study by Douglas et al. (1985) has documented homophobia to have a strong correlation with refusal to care for AIDS clients. This survey, however, did not address the homophobia issue and was in fact designed to avoid it.

The recreation profession is in a position to assist AIDS clients to find new suitable activities that will enhance their quality of life. These persons have a need to feel accepted for who they are, and therapeutic recreators have an inevitable role in this issue. Recreation experiences can serve as a relief from illness, pain, and

social isolation. Activities may provide a new focus away from the stress and fears of the illness.

As difficult as it may be to arrive at a consensus, these issues require position papers from the National Therapeutic Recreation Society Ethics Committee. We need answers to the questions: Is a TRS ethically obligated to care for a client with AIDS? and What does the care of PWAs do to the practice and quality of life of those persons involved in the care of AIDS clients.

Recommendations

After considering the results of this research, and the conclusions based on this research, the following recommendations were made:

1. Recommendations Based on Research:
   A. TR professionals should continue to learn about the disabilities that affect their clients so they may work with them as effectivly as possible.
   B. Agencies should establish policies and procedures for staff, and provide opportunites for continuing education.
   C. The TR professional Organization should establish ethical position papers to guide its membership as well as conduct workshops at conferences.

2. Recommendations for Further Research

   A. Conduct a study to determine proven practical methods of working with AIDS clients.

   B. Survey programs established for PWAs to identity what specific recreation programs are in effect for AIDS clients.

   C. Create a manual to be used in leisure counseling with AIDS clients.

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APPENDICES

APPENDIX A

The University of Tennessee
KNOXVILLE TENNESSEE

September 25, 1987

Dear NTRS Member:

Recently I have worked with clients who have been exposed to the AIDS virus, have AIDS Related Complex or are ill with active AIDS. Since that time I have studied Aids and the attitudes of professionals whose work dictates that they interact with AIDS clients.

Enclosed is a questionnaire which has been designed to assess the sentiments of members of NTRS regarding their role in the care of AIDS clients. This effort is a requisite for my Masters degree in Therapeutic Recreation at The University of Tennessee.

I need your cooperation in responding to this questionnaire. I know your time is valuable so the questions have been designed for completion in approximately ten minutes. Please answer the questionnaire even if you have not yet worked with AIDS clients.

The procedures followed in this study adhere to the guidelines and ethical standards of human subjects research at The University of Tennessee. All replies will be received in confidence, and the data accrued will be reported as group information in my thesis.

I will be glad to answer any questions you have concerning the project and its outcome. A summary of the results will be sent to you if you wish.

Thank you for being part of this study. Your opinion is valued. Please mail your response by October 10 in the envelope provided.

Sincerely,

Cindy Day

The University of Tennessee
KNOXVILLE TENNESSEE

October 12, 1987

Dear NTRS Member:

Two weeks ago I sent you a questionnaire designed to assess the sentiments of members of NTRS regarding their role in the care of AIDS clients. This effort is a requisite for my Masters degree in Therapeutic Recreation at The University of Tennessee.

If you have completed and returned it to me please accept my sincere thanks. If not, please do so today. Because it has been sent to a small, but representative sample of NTRS members, it is extremely important that your response be included in the study if the results are to accurately represent NTRS.

The procedures followed in this study adhere to the guidelines and ethical standards of human subjects research at The University of Tennessee. All replies will be received in confidence, and the data accrued will be reported as group information in my thesis.

I will be glad to answer any questions you have concerning the project and its outcome. A summary of the results will be sent to you if you wish.

Thank you for being part of this study. Your opinion is valued. Please mail your response by October 19 in the envelop provided.

Sincerely,

Cindy Day

ATTITUDES TOWARD THE DISEASE AIDS

DEMOGRAPHIC INFORMATION

1. Please list your age_____.

Circle the number of the correct response for the following questions.

2. Sex 1. Male 2. Female

3. What is the highest level of education you have achieved?

1. High School
2. 2 years of College
3. College Graduate
4. Post Graduate Work
5. Masters Degree
6. Doctorate

4. In which field(s) do you hold degree(s)? If more than one, please * the highest achieved degree.

1. Recreation
2. Psychology
3. Sociology
4. Physical Education
5. Business
6. Other(s)_____

5. Which of the following best describes the Agency where you are employed? Circle only one response.

1. General Hospital
2. Psychiatric Hospital
3. Mental Health Center
4. Substance Abuse Center
5. Community Recreation Center
6. Nursing Home/ Long Term Care
7. Public Parks and Rec.
8. Educational Setting
9. Dev. Disabled Center
10. Correctional Facility
11. Vocational Training
12. Other_____

6. What is your position? Circle only one response.

1. Administrator
2. Supervisor
3. Therapist/Specialist
4. Programmer
5. Educator
6. Activity Director
7. Other_____

EXPERIENCE WITH AIDS AND AIDS CLIENTS

7. What is the primary source of your information about AIDS?

1. Newspapers
2. Television
3. Radio
4. Clinical Journals
5. Agency Education
6. Workshops/Conferences
7. Other_____

J	My co-workers are comfortable working with AiDS clients.	1	2	3	4	5
K.	The recreation profession has an obligation to treat AIDS clients.	1	2	3	4	5
L.	The medical profession has an obligation to treat AIDS clients.	1	2	3	4	5
M.	I believe other clients would be willing to participate in agency activities with AIDS clients.	1	2	3	4	5
N.	Since I have a responsibility to other clients I cannot include persons with AIDS in group activities.	1	2	3	4	5
O.	Staff members can acquire AIDS by touching materials used by an AIDS client.	1	2	3	4	5
P.	Persons with active AIDS should be allowed to use recreational facilities.	1	2	3	4	5
Q.	A person who is an AIDS carrier but not an active case should be allowed to use recreational facilities.	1	2	3	4	5

12. Would you ever refuse to work with AIDS clients?
    1. Yes 2. No

    If you answered yes, please describe the circumstances under which you would refuse.

13. Is there anything else you would like to say which might help me understand how you feel on this issue?

All replies will be received in confidence and results will only be reported as group data.

8. Have you known personally an individual with AIDS or AIDS Related Complex (a friend, family member, or acquaintance)?
   1. Yes 2. No

9. How many persons who are known to have AIDS have you encountered through your work? Please estimate below.

   _____.

10. Are you currently working with AIDS clients?
    1. Yes 2. No

ATTITUDES TOWARDS AIDS CLIENTS

11. Indicate your level of agreement with each statement. If you have never worked with AIDS clients please indicate how you believe you would feel if the situation occurred.

1 Strongly agree
2 Agree
3 Neutral
4 Disagree
5 Strongly disagree

A.	My agency has provided me with quality information about AIDS.	1	2	3	4	5
B.	I have adequate training for working with AIDS clients.	1	2	3	4	5
C.	The idea of working with AIDS clients interests me.	1	2	3	4	5
D.	I am comfortable working with AIDS clients.	1	2	3	4	5
E.	I help AIDS clients deal with their illness.	1	2	3	4	5
F.	I communicate effectively with AIDS clients	1	2	3	4	5
G.	I feel sorry for AIDS clients.	1	2	3	4	5
H.	I am fearful of working with AIDS	1	2	3	4	5
I.	My family is comfortable with my working with AIDS clients.	1	2	3	4	5

APPENDIX B

REASONS FOR REFUSAL

Medical:

"If a client had open cuts" (7).

Concern about contact with bodily fluids. (4)

"I wouldn't work with aggressive/acting out clients/patients" (14).

"If I were pregnant" (6).

Moral:

"I am against homosexuality, lesbianism, drug use" (3).

"Persons with AIDS made their own choice" (2).

" I am not willing to jeopardize my life".

"Because it is a moral issue" (4).

"Those contracting it through transfusions should be allowed to participate fully in the recreation spectrum".

Education/proper procedures and supplies:

"I don't have enough training to work with AIDS clients" (18).

"There is a lack of proper supplies to follow good infection control procedures" (4).

"Because the agency doesn't give enough information on PWAs" (3).

Miscellaneous:

"Fear for my family" (4).

"For the same reasons I would refuse any other client."

"I don't work with chronically ill, terminally ill, burns, children."

"I don't work with chronic or terminal patients" (3).

"Because there is no cure".

"Most any circumstances".

"Any physical contact".

"There are too many unanswered questions about aids" (3).

APPENDIX C

COMMENTS

Comments made by respondents are listed below. The numbers indicate a tally of individuals expressing similar thoughts.

Education:

More education is needed (40), particularly geared to TR. (5)

"Too much is unknown" (3).

"Educators need to be more aware of the clinical situations to which they send their students" (2).

More research is needed in regard to TR and AIDS (4).

"I am tired of reading about AIDS and tend to take risks because of it and I'm not keeping current."

"The energy of too many people is directed at avoidance rather than understanding."

Ethics:

PWAS deserve the same respect and have the same recreation needs as others (9).

Ethical commitment to care for AIDS clients (10).

Commitment to care for all Humans (4).

"Who gives us the right to separate AIDS clients?"

"How do we maintain the rights of PWAs without sacrificing the rights of residents and the community we serve?"

"As in any profession the professional selects the type of clientel he desires to work with", [the same person continued] "RNs hysterical, there should be equal services for all clients".

Moral Issue:

"We need a moral approach together with medical."

"People who refuse have homophobia or sexual hangups."

"Discrimination/bigoted behavior shameful" (2).

"I do not discriminate."

"Persons with AIDS made their own choices" (2).

Therapeutic Recreation:

"I don't know that having aids would mean the person needs TR."

"Recreation Therapy is very important for PWAs, we serve as resource person, support, leisure counsellor, thanantologist and friend. There's no danger to us!!!"

"The importance of recreation/leisure in an AIDS person is critical and it is our responsibility to help meet these needs."

Miscellaneous:

"Difficult to answer these questions as I have not worked with PWAs" (7).

"I worked with TB patients, related to this in answering questions."

"As it is transmitted in only very specific ways recreation is open to all patients" (2).

Poor communication in agency about who has AIDS (4).

"Obligation on part of PWAs to say they have disease."

"Perhaps with more experience I will feel comfortable working with them" (2).

"Only a matter of time before we are all involved."

"I had a relative with AIDs and feel more open."

Reference to hysteria in general public (4) and in staff (2).

"Hospital staff threatened to leave if we treated AIDS clients and patients threatened to leave."

"You can run but you can't hide." "Sooner or later."

VITA

Cynthia Jean Day became a Registered Nurse in 1963 after graduating from Queen's Hospital School of Nursing in Honolulu, Hawaii. She is experienced in working in both medical and psychiatric settings. Additionally she has worked for the International Committee of the Red Cross and the League of Red Cross Societies in both Cambodian and African refugee camps.

She returned to school in 1982 and received a Bachelor of Science Degree in Psychology from the University of Tennessee in 1984 and a Master's Degree in Recreation in December 1987.

Mrs. Day is a member of the National Recreation and Parks Association, the National Therapeutic Recreation Society, the American Therapeutic Recreation Association, and the Tennessee Recreation and Parks Association, Therapeutic Section. Additionally, she is a certified Psychiatric and Mental Health Nurse. Her particular area of interest is recreation for the mentally ill.