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A constructivist study of social work's involvement with HIV/AIDS

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A CONSTRUCTIVIST STUDY OF SOCIAL WORK'S INVOLVEMENT WITH HIV/AIDS

A Project

Presented to the

Faculty of

California State University,

San Bernardino

In Partial Fulfillment

of the Requirements for the Degree

Master of Social Work

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by

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ABSTRACT

This constructivist research project explored social work's involvement with HIV/AIDS. HIV/AIDS has disproportionately affected marginalized groups typically served by the social work profession. However, the social work response has been negligently slow, reticent and rhetorical. The goal of this project was to educate and empower social workers to comprehensively confront and contribute to the mitigation of the HIV/AIDS pandemic. The objective was to identify factors, which facilitate or inhibit social work practice in the field of HIV/AIDS.

Constructivism is a form of inquiry that recognizes subjective realities as defined or "constructed" within a social context. Participants were stakeholders from a myriad of agencies serving the HIV/AIDS populations in one Southern Californian community. Data was gathered through interactive interviews, as well as, a literature search and categorized through content analysis. Results indicated that many stakeholders have a "generic" perception of social work. Results also suggested that social workers suffer from the same fears, biases and ignorance of HIV/AIDS as the general population and that these issues inhibit social work practice with HIV/AIDS. Recommendations included social work title protection and HIV/AIDS education in schools of social work.

ACKNOWLEDGMENTS

IN MEMORY

OF MY BELOVED BROTHER, WHO DIED OF AIDS.

PATRICK JOSEPH HOGAN

1957 - 1990

His life inspired me to never give up.

His death inspires me to fight for

social justice and social change.

I also acknowledge:

All those who live with HIV and have died of AIDS.

May we all have such noble courage and lofty spirit!

PAULA JAYE HOGAN

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INTRODUCTION

Focus of Inquiry

The Center for Disease Control (CDC) declared Acquired Immune Deficiency Syndrome (AIDS) as the leading cause of death for adults age 25-44, as of January 1995 (Center for Disease Control, Surveillance Report, 1994). More adults in this age range died of AIDS than of cancer, heart disease, homicide/suicide, or vehicular accidents throughout 1994. Today, Human Immunodeficiency Virus (HIV), the virus that causes AIDS, has impacted a large cross section of the population. However, for the documented fifteen years of the pandemic and still today, HIV/AIDS has disproportionately infected and affected the marginalized, vulnerable groups social work has traditionally served.

The social work profession has been negligently slow in responding to the AIDS crisis, however. One might expect that a social services profession with an ethical mandate to intervene on behalf of socially disenfranchised, vulnerable groups would have been in the forefront of HIV/AIDS service provision; social casework, advocacy, education, primary prevention, social welfare policies and political action. Yet, as of 1991, over ten years into the AIDS crisis, Ryan (1991) in a National Association of Social Workers (NASW) editorial stated, "In addition

to failing to provide leadership and practice guidelines during the earlier stages of the epidemic, we are the only major national association that has not instituted an official policy advisory group on AIDS" (p. 4).

There have been some dedicated social workers involved in the AIDS arena since its inception. In the earliest days of the epidemic, when health care providers left AIDS patients food trays on the hallway floors, afraid to enter their rooms, it was social workers who took a stance against such deplorable discrimination. It was also a smattering of social workers who "pioneered the designing of the first psychosocial services for people affected by AIDS" (Shernoff, 1990, p. 5). Professionally trained social workers are visible in the fight against HIV/AIDS today, however, as a profession, social work remains underrepresented in the HIV/AIDS arena.

In very recent years, NASW, the professional organization for social workers, has become increasingly involved in the field of HIV/AIDS. NASW implemented an HIV/AIDS Task Force in 1991 and Social Work Speaks issued a policy statement on HIV/AIDS in 1993. The California NASW newsletter incorporated a new column "AIDS and Social Work" in 1994 and there is now an annual Social Work and HIV/AIDS conference at the national level. It appears that there is also some increase in HIV/AIDS specific

education in schools of social work. However, considering the devastation to lives and communities, the profession's response has been minimal and much remains to be done.

Over fifteen years into the AIDS pandemic the social work profession continues to tinker on the edge of comprehensively confronting and contributing to the mitigation of HIV/AIDS. The social work response continues to be negligently slow, reticent and primarily rhetorical, considering the staggering statistics of HIV/AIDS and the tremendous biopsychosocial ramifications for the marginalized groups social work is mandated to serve and advocate for.

The statistics are staggering and clearly demonstrate that HIV/AIDS has no biases and respects no boundaries. The cumulative year end statistics reported to the CDC as of December 1994, indicate that 267,479 adults/adolescents and 3,391 children under age 13, have died and another 435,319 adults/adolescents and 6,209 children have been diagnosed with full-blown AIDS, in the United States alone. Of the diagnosed and reported cases, 376,889 are male and 58,430 are female; of these cases, 6,209 are children. A breakdown of diagnosed adult/adolescent and pediatric cases by ethnicity indicates: Caucasians 214,146, African-Americans 146,283, Latinos 76,323, Asian/Pacific Islanders 2,991, American

Indian/Alaskan 1,065, have AIDS (HIV/AIDS Surveillance Report, Dec. 1994).

It should be noted that these statistics are only those reported to the Centers for Disease Control; many more cases go unreported or cause of death is listed as something else, due to the enormous stigma associated with AIDS. Furthermore, these figures do not account for the nonsymptomatic HIV cases, which the CDC estimates to be upward of 2.5 million; nor the numerous cases in which people are afflicted with AIDS related diseases, not yet fulfilling the diagnostic criteria for full blown AIDS.

Equally disturbing statistics clearly define AIDS as a social problem affecting disadvantaged groups demanding the attention of the social work profession's expertise in the provision of comprehensive, culturally and gender sensitive social services. "Of the reported cases, 61 percent are men who have sex with men and over 53 percent are ethnic minorities" (Social Work Speaks, 1994, p. 19). Women and children of color are the fastest growing population effected by AIDS. "Today, women of color constitute 72% of all women infected with HIV" and it is predicted that in the twenty first century, AIDS will be the leading cause of death of minority women and children (Land, 1994, p. 356).

HIV/AIDS: The Social Work Response

The Micro Level Response

Interestingly, a survey of the literature reflects social worker's continued reluctance to work with HIV/AIDS. In 1987, a Master of Social Work (MSW) student in a field placement agency refused to provide services to a client, who had been diagnosed with AIDS. This prompted the social work department at San Jose State University to initiate a policy of AIDS education (Merdinger et al., 1990, p. 32). A study by Dhooper et al. (1988), as quoted in Diaz & Kelly (1991) found that "80 percent of the 128 social workers surveyed would refuse to provide services to a person with AIDS" (p. 38). A survey of all MSW graduates working in twelve hospital centers (n = 406) as recently as 1990, found that 80 percent of these social workers stated "they would refuse an AIDS case" (Weiner & Siegal, 1990, p. 19).

Peterson (1991) in a survey of 379 NASW members employed in twelve different social work practice arenas found, "75 percent of respondents did not believe that they had a professional reason to learn about AIDS" (p. 32). Findings from this same survey indicated that only nineteen percent of mental health social workers, no school social workers and only fifty percent of social workers practicing in health care settings thought they had a

need for AIDS specific knowledge (p. 36). Finally, as recently as 1994, an NASW national survey of social worker's, knowledge, attitudes and comfort around HIV issues found "fifty-one percent of the respondents strongly or moderately agreed with the statement 'I believe a social worker should have the right to choose whether or not to work with a client with HIV/AIDS'" (NASW HIV Liaison Update, June 1995)

The Academic/Professional Response

It has become clear that the social work profession was slow to respond to people with HIV/AIDS during the onset of the crisis. Although unconscionable, the initial response is somewhat understandable considering the mysterious qualities of the disease and societal fears of contagion during the early eighties. However, today in 1995, we are well into the second decade of AIDS and the continued lagged response is incredulous. Fear of contagion through casual contact is clearly recognized as irrational and HIV/AIDS is a life threatening pandemic with enormous biopsychosocial ramifications for diverse populations demanding the attention of the social work profession. Yet, the social work response continues to be slow and primarily reactive.

In recent years, there has been a dramatic shift in the demographic characteristics of persons affected

by HIV/AIDS. There has been a decrease in the HIV seroprevalence among homosexual/bisexual males and HIV/AIDS is now disproportionately infecting and affecting women and children. The statistics indicate that HIV serpositivity in women has reached epidemic proportions. This is particularly true for women and children of color. "Significant increases in AIDS cases were noted among women of child bearing age, particularly African American and Hispanic women" (Land, 1994, p. 355). Additionally, a report published by the San Bernardino Public Health Department indicates, "Females under our care are significantly more likely to require crisis intervention or ongoing counseling on admission than our male patients" (AIDS Program Report, San Bernardino County, 1995). Yet, there are few social work models for culturally and gender sensitive HIV/AIDS service provision and crisis intervention with women and ethnic populations.

Until recently, the majority of models were developed primarily from work with gay, Anglo men early on in the epidemic. These models have been invaluable, however, they fail to account for the unique issues encountered by women, children, families, and people of color. Some social work academicians have begun addressing these issues (Land, 1994; Dicks, 1994; Gant & Ostrow, 1995), however, a review of the social work literature indicates there

is a dearth of information regarding these populations. So has the social work profession learned from the early experience of the AIDS crisis? One colleague stated, "you know how we are, we don't deal with things until they're piled at our door and we can't get out." It often seems we don't learn from history, but tend to take a reactive stance to social issues and crises. This appears to be true in the second wave of HIV/AIDS.

The current literature indicates that social work is continuing to lag in it's proactive, preventive response to issues such as: children rendered parentless by AIDS; foster and permanency placement for children with HIV/AIDS; and utilization of a systems approach to whole families infected and affected by AIDS. Statistics indicate that "By the end of 1995, maternal deaths caused by HIV/AIDS will have orphaned 24,600 children and 21,000 adolescents; by the year 2,000, 80,000 youth will be orphaned by HIV" (Michaels & Levine, 1992). This is not a new phenomenon. It was recognized as early as 1985 in large cities; New York, San Francisco and Los Angeles, heavily impacted by HIV/AIDS.

In 1991, Stuntzner-Gibson published a comprehensive article forewarning the profession of the emerging issues regarding ethnic minority women and children. Knowledge does exist, however, proactive attention by the profession

is certainly questionable. Recently, a social worker decided not to allow a mother dying of AIDS to see her children. The family never spent time together prior to her death and the children were then separated into different foster homes. In the same Social Work (1995) article, the authors question the preparedness of the social work profession to confront and comprehensively deal with this upcoming wave of HIV/AIDS issues. "As a consequence of [social workers] biases and ignorance, people with HIV/AIDS and their families are further victimized and are not provided with the appropriate social services" (Taylor-Brown & Garcia, 1995, p. 14).

The Macro Level Response

Finally, there remains a lagging response on the macro level of social work practice. The National Commission on AIDS was set up by the federal government in 1990 to study HIV/AIDS and make policy recommendations. The commission spent three years studying HIV/AIDS and it's impact on infected and affected communities. It completed it's mandate in September 1993 and published it's final report, "AIDS: An Expanding Tragedy." Interestingly, of the 217 participants providing testimony to the commission a mere six were social workers (National Commission on AIDS, 1993).

The NASW Task Force on HIV/AIDS was instituted in

1991, to examine the social work profession's involvement with HIV/AIDS. The group has recently completed it's inquiry and submitted it's recommendations to the NASW Board of Directors. Recognizing social work's lagging response, some of it's recommendations include: establishing HIV as a long-term association priority; creating a leadership group on HIV to include chapter liaisons, national leaders, and a social worker with HIV; continuing activity in the area of federal legislation and policy; and developing training projects related to HIV and social work practice. None of the recommendations have been implemented to date and task force members recently expressed apprehension that NASW would seriously consider and implement them (HIV/AIDS and Social Work Conference, May 1995, Chicago).

Conclusion

In summary, these findings present a curious phenomenon considering HIV/AIDS has reached pandemic proportions and the populations most affected by the disease are the vulnerable groups and impoverished communities, traditionally served by the social work profession. So why has social work lagged behind in responding to the overwhelming needs created by the AIDS epidemic? It appears that there may be a complex myriad of factors which inhibit social worker's presence and

leadership in the field of HIV/AIDS. These factors are worthy of exploration, since the pervasiveness and increasing incidence of HIV/AIDS across the population and at international levels, dictates that social workers in all arenas of social work practice will be called upon to demonstrate HIV/AIDS specific knowledge and skills.

Statement of Purpose

The purpose of this inquiry was to explore the factors which may inhibit and facilitate social work practice in the HIV/AIDS arena. The study was conducted in the Coachella Valley, a region of Eastern Riverside County in Southern California. There is a disproportionately high incidence and prevalence of HIV/AIDS in this area. According to Congressman Sonny Bono, "the Coachella Valley has a rate of incidence of diagnosed AIDS nearly equal to areas such as San Francisco and New York" (personal communication, April 7, 1995).

The Coachella Valley is comprised of several desert cities and has an average population of approximately 253,853 people. This region is of particular interest due to the diversity of the population and an economic base, which ranges from extreme poverty to the wealthiest per capita income levels in the United States. The economic base is dependent on construction, agriculture and tourism, which together attract the extremely

impoverished communities of farm laborers, as well as, extremely wealthy populations. The winter resort attracts populations falling at every point along the economic continuum from all parts of the country and the world. The area has also been a resort for gay men for many years and many living with HIV/AIDS have sought the solace and serenity of the valley. Although once a retirement community, over the last decade the valley has experienced a demographic shift, resulting in the growth of families and many single people. The community has become increasingly diverse as well. It's ethnicity make-up is as follows: Caucasian 71.9%, African American 2.7%, Latino 25.4%.

The statistics of HIV/AIDS in Riverside County, and the Coachella Valley indicate that there is a need for social work involvement. As of August 1995, there have been 3,698 cases of AIDS in Riverside County; of these cases, 1,271 have died of AIDS (HIV/AIDS Program Report, Riverside County, April 1995). "Riverside County experienced a 321% increase in AIDS diagnoses between 1992 and 1993 and the Coachella Valley has one of the highest rates in the nation of per capita AIDS diagnoses" (Desert AIDS Project Census, 1994).

There is a substantial population of professionally trained social workers in the valley as well, however,

it appears few are involved in the HIV/AIDS arena. According to the NASW membership list, there are 97 professionally trained social workers in the Coachella Valley. There are many more who are non-members; approximately twenty known to this researcher alone. Curiously, an informal survey of the HIV/AIDS arena in the valley indicated that few social workers were involved in work with HIV/AIDS, other than in medical facilities where the HIV/AIDS population is integrated into the client base.

There are many dedicated and committed people organizing, administering and delivering services to the HIV/AIDS communities in the Coachella Valley. While some are social workers, the majority are either representatives of other helping professions or grass roots community organizers and agencies. The Riverside County Consortia on AIDS has been in existence for over five years and there are only two social work members. A recent NASW presentation of Community Social Work and HIV/AIDS only attracted the five consistent core members out of a potential 97 social workers on the mailing list. This trend in the Coachella Valley is consistent with the literature findings on social work's involvement with HIV/AIDS.

The goal of this project was to educate and empower

the social work community, educators, and profession in order that they may realize the vital necessity of a professional response to the HIV/AIDS crisis. The objective was to gain an awareness of the thoughts, beliefs and feelings of social workers and other key professionals working in agencies and organizations serving HIV/AIDS infected and affected communities in the Coachella Valley community regarding social work's involvement. The ultimate goal was to facilitate action and policies that will increase and enhance a social work response in all arenas of social work practice. This inquiry process revealed factors that are barriers to or enhance social work practice in the field of HIV/AIDS. The expectation is that social work profession will proactively respond to future waves of the pandemic, still very much in our midst.

METHODOLOGICAL CONSIDERATIONS

Research Paradigm

Constructivism is a form of inquiry that recognizes subjective realities as defined or "constructed" within a social context as important data or knowledge. There is little agreement on the definition of HIV/AIDS and the way in which it is approached will vary depending upon the context in which it is viewed. For example; the Department of Public Health may perceive HIV/AIDS

as an epidemic disease threatening the health of the populace, while the Department of Social Services may perceive it as a social problem threatening to deplete resources. ACT UP, a gay activist organization, may perceive HIV/AIDS as oppression and gay genocide requiring political action. The various constructions of HIV/AIDS will prompt society and its' professional gatekeepers to respond and approach the problem differentially, depending upon their construction of the problem.

A consideration of social work involvement in the HIV/AIDS pandemic, requires inquiry into the individual, subjective constructions of the involvement of social work with HIV/AIDS held by the many providers; line workers, educators, administrators, agencies and organizations, working in the AIDS arena. The constructivist paradigm facilitates inquiry into the myriad of ways HIV/AIDS and social work is perceived and approached in a full range of milieux.

Fox & Fee (1988), in a dissertation on the social construction of AIDS note, "the process of defining both the disease and the persons infected has been a process in which politics and social perceptions have been embedded in scientific and social policy constructions of their reality and meaning" (p. 309). The nature of HIV/AIDS and the diversity of the vulnerable, disenfranchised groups

thought of as most susceptible to the disease; gay males, intravenous drug users, ethnic minorities, women and children, leads to a multiplicity of definitions. HIV/AIDS has been differentially defined as a medical, social, moral, sexual, political, cultural, racial or socio-economic affliction. While most will agree that AIDS is a medical condition, few regard it solely as a biological disease.

Disease is medically defined as illness; an abnormal bodily condition that impairs functioning and can be recognized by signs and symptoms. A disease becomes an epidemic when it takes on qualities of contagion and affects a disproportionately large number of individuals within a population, community or region at the same time. An epidemic entails sudden development, rapid growth and spread of the disease, often with mystifying qualities, which elicit fear, panic and social disorganization. When a disease reaches epidemic proportions, it's definition usually expands beyond the realm of biological explanations and medical authority and is defined by powerful social, cultural, economic and political forces. Historically, this has been particularly true for sexually transmitted diseases and diseases which have struck during economically depressed periods. According to Brandt (1986), as quoted in Mack (1991), epidemics are "'socially

constructed'. . . . the manner in which a society responds to disease reveals it's most fundamental cultural, social and moral values" (p. 93).

In its earliest days, AIDS was considered the "gay plague" and given little consideration as a social problem (Shilts, 1988). Referred to as Gay-Related Immune Deficiency (GRID), AIDS was thought only to infect gay males and was socially constructed as the wrath of God; divine retribution for an immoral, homosexual lifestyle. As HIV/AIDS began to infect hemophiliacs and intravenous drug users, it was defined medically as a blood borne virus and socially, as a self inflicted disease of an immoral, indulgent lower class. HIV/AIDS was defined as a sexually transmitted disease with all the attendant moralistic judgments and societal reactions, as prostitutes and racial ethnic minorities became afflicted. In recent years, there is mounting evidence of its spread into the general population. As AIDS has begun to infiltrate the populations of "innocent" women and children and the white, heterosexual male, we are beginning to see it defined categorically as the "deserving and undeserving" sick and as a social problem. Most, however, still perceive HIV/AIDS to be a male, homosexual disease despite statistics that defy such constructions.

A positivist research paradigm, with its focus on

one true, objective reality, would not be adequate to address this issue, since it is clear there is no one reality of HIV/AIDS. Positivist forms of inquiry also build upon existing knowledge. There is ample knowledge about HIV/AIDS. As noted by Brennan (1994), "Our increased knowledge of HIV has not necessarily been translated into improved care . . . 60 percent of persons would benefit from early intervention services; far fewer receive treatment because they lack resources" (p. 386).

Action rather than the accumulation of knowledge and more rhetoric is imperative. Action by the social work profession may be one missing component in the fight against HIV/AIDS and may be more readily addressed through a constructivist paradigm than by a traditional, scientific form of inquiry. Constructivism is an educative tool and served as a functional method to uncover, discover and when necessary discard barriers to social work practice in the field of AIDS. Through open communication it may also empower social workers and the profession to enhance social work practice and make a significant contribution to the primary prevention and mitigation of AIDS in our society.

Participants

The initial identification of participants was made through a preliminary investigation of agencies providing

services to the HIV/AIDS communities in the Coachella Valley. Purposive opportunistic sampling was used in choosing participants relevant to this area of practice and research. This method also allowed the researcher to incorporate additionally identified participants, as the study progressed. Maximum variation sampling was utilized in choosing a variety of sites; some exclusively serving persons living with HIV/AIDS and some serving the general populace, integrating HIV/AIDS clients into their service delivery systems. Similarly, in an effort to identify both barriers and facilitative factors to social work practice with HIV/AIDS, this sampling method was employed in order to identify stakeholders from agencies, which employ professionally trained social workers, as well as, those that do not. All participants live and/or work in the Coachella Valley, except the stakeholders from the two university MSW programs serving this region.

The Hermeneutic Dialectic Circle

A hermeneutic dialectic circle is a visual construct of stakeholders and non-human sources of data, such as literature, involved in the total inquiry process. According to Guba and Lincoln (1989), the circle ". . . is hermeneutic because it is interpretive in character and dialectic because it represents a comparison and

contrast of divergent views with a view to achieving a higher-level synthesis of the all . . ." (p. 149).

The proposed hermeneutic dialectic circle included twenty one participants from the thirteen identified stakeholder groups. In order to maintain confidentiality, some agencies were combined into broad categories, such as Substance Abuse Programs. Stakeholders in this initial circle are represented in Figure 1.

Figure 1

The Initial Hermeneutic Dialectic Circle

AIDS Specific Agencies

Dept. of Social Services

Child Protective Services

Hospice Agencies

Home Health Agencies

Local Hospitals

Substance Abuse Programs

Medical Clinics

County Substance Abuse Programs

Research Literature

Universities

Researcher

Dept. of Public Health

The constructivist paradigm facilitates modification of the proposed hermeneutic dialectic circle in order to accumulate increasingly relevant, as well as, divergent data, as the study progresses. The emergent nature of the paradigm dictated that the researcher request

identification of additional key stakeholders by participants at the conclusion of each interview. Through this process, new respondents were identified and included in the modified circle. The inclusion of new stakeholders into the circle was based upon their availability to the researcher and their ability to provide new or divergent data to the emergent themes.

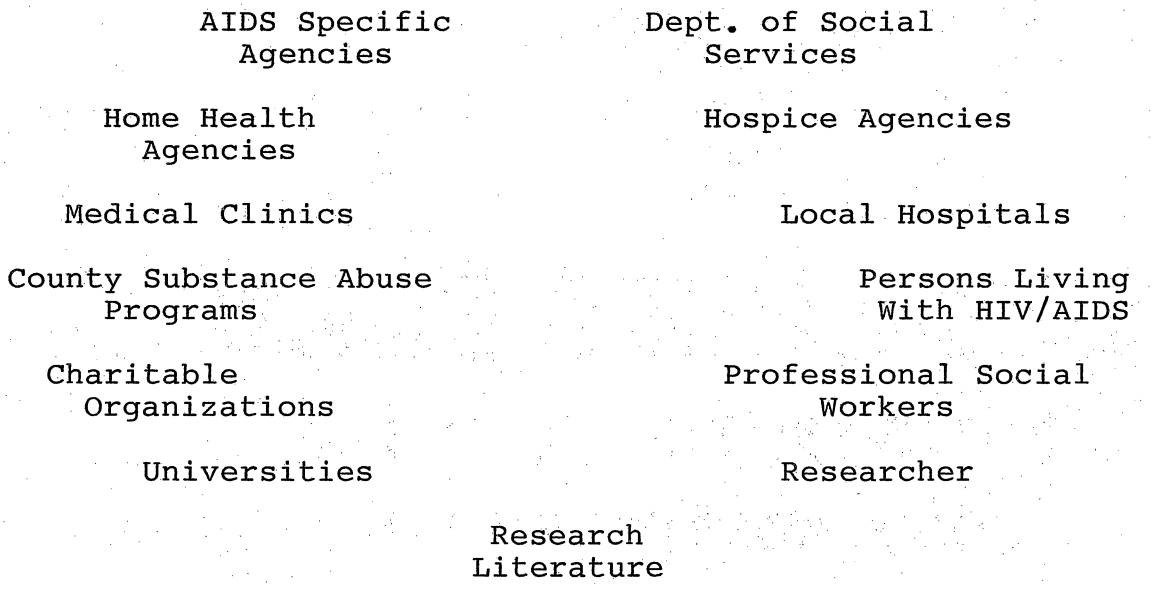
Likewise, some initial stakeholders were eliminated from the circle, due to limited or no contact with the HIV/AIDS population. Consequently, the following stakeholders were eliminated. Two substance abuse programs were eliminated, due to limited contact with the HIV/AIDS population, as well as, no professionally trained social workers on staff. A key informant stated that they have had HIV seropositive clients, however, few choose to disclose to peers and the entire staff. Consequently, referrals are made to AIDS specific agencies. Child Protective Services was eliminated due to limited known contact with the population. The Riverside County Public Health Department was also eliminated due to limited contact. An administrator indicated that primary service delivery is conducted by AIDS specific agencies in this region of the county and the Public Health Department now concentrates on testing, education and prevention services. Consequently, there is limited contact with

the inquired population.

The modified Hermeneutic Dialectic circle is depicted in Figure 2.

Figure 2

The Modified Hermeneutic Dialectic Circle



The modified circle involved twenty two participants, comprising thirteen stakeholder groups, including the constructs of the researcher and pertinent literature. Some identified stakeholder groups included more than one participant or agency but were combined, due to confidentiality constraints. The newly integrated group denoted as Charitable Organizations consisted primarily of volunteer agencies providing basic sustenance services, such as food, housing and vouchers. The group, Professional Social Workers included social workers who

are stakeholders in the HIV/AIDS community but not members of agencies. Social workers were also participants in the majority of other stakeholder groups. Social workers classified as Bachelors in Social Work (BSW), Master of Social Work (MSW), Licensed Clinical Social Work (LCSW), PhD in Social Work and Doctor of Social Work (DSW) were included in the study.

A full range of other professional representatives; line workers, case managers, health practitioners and administrators, as well as, members of the infected and affected communities of Persons Living With HIV/AIDS were also included. The majority of participants were service providers. The hermeneutic dialectic circle was considered complete when all stakeholders had participated.

Participation was completely voluntary and all participants were informed of their right to discontinue participation at any time. All were asked to read an informed consent form, delineating the purpose, methods and confidentiality commitment. Informed consent is labeled Appendix A. Participants were also given a debriefing statement containing names and numbers of the researcher, research advisor and agencies providing HIV/AIDS counseling should this become necessary. Debriefing statement is labeled Appendix B.

Instrumentation

The researcher is an integral instrument of inquiry in constructivist research. In contrast to traditional scientific research in which the researcher is considered objectively separate from the inquired, the naturalistic inquirer strives to be embedded into the social context and personally interact with the participants. It is therefore, essential that the researcher be knowledgeable about, sensitive to, and respectful of the context and the participants. The reflective journal kept by the researcher was one tool, which facilitated sensitivity and the accumulation of new constructions and knowledge. A journal of thoughts and feelings facilitated the researcher in maintaining an awareness of self in the interactive process of the research.

A literature review is pertinent for the accumulation of knowledge about the subject and serves as a source of information and constructions to be shared in the interactive process with participants. A thorough literature review was conducted prior to implementation of the study, as well as, an ongoing literature review as themes that were not previously considered emerged.

The researchers' own experience and background were also invaluable for implementing the naturalistic study. It enabled the researcher to "go native" due to familiarity

with the context and facilitated communication in a similar language. Personal experience also provided contacts in the field and facilitated conditions of entry, as well as, opportunities for preliminary interviews and persistent observations in some instances, prior to implementation of the study. These factors enhanced sensitivity of the human instrument and knowledge of the sites.

This researcher has been involved in the HIV/AIDS arena and has networked with many stakeholders in the area. It was essential, however, that the researcher with personal and professional experience in the field remain openminded and humble, in order not to limit the data collection through an attitude of expertise. The use of the reflective journal and peer debriefing with a colleague engaged in a constructivist study guarded against these concerns. Owning and sharing ones own construction of the issue as part of the hermeneutic dialectic circle also established the researcher as learner and participant, rather than expert in the area.

Data Collection

Data was collected through face to face interviews with all but one participant. A telephone interview was conducted with one participant due to repeated scheduling conflicts. The exception was made for this participant because valuable data was proffered. Interviews were

loosely structured, open ended and interactive in nature in order to facilitate the emergence of subjective constructions of social work's involvement with HIV/AIDS.

Data was gathered by using both handwritten notes and a recording device. An audio recording device was the primary mode of data collection. This mode was utilized in order to provide more fidelity to data collection and to give the researcher more freedom to actively interact in conversation with the participants. It also served as an element of quality control, since the validity of the data is easily verifiable through the recordings.

Recording also provides an audit trail of the inquiry process. Recording of interviews was voluntary and permission to record was requested of each participant. All but one participant agreed to be recorded. The interview with that participant was recorded through handwritten notes. The telephone interview was also handrecorded and verified through the mail in writing, as well as, through additional calls. Handwritten notes were used minimally, to highlight key points or to be used later in the interview for clarification and elucidation of content.

The researcher engaged in interactive communication with participants, sharing personal constructions,

literature findings and emergent themes from prior interviews. Participants were instructed to include any information they felt relevant to the topic, which the questions may have failed to address. Data gathering and analysis is an interactive process in constructive inquiry and was enhanced by immediate attention. Immediately following each interview and observation, the researcher spent time reviewing notes and recordings, reflecting on the interview, and engaging in on going data analysis. The reflective journaling process was also employed at this time. Data was analyzed, structured into emergent themes and constructions, and shared with successive participants. Data collection was considered complete when all identified stakeholders had participated.

SUBSTANTIVE CONSIDERATIONS

Transactions

Research inquiry within the constructivist paradigm begins with the very broad definition of an arena to be studied. There are no definitive questions and no hypotheses to be proved or disproved. The constructivist researcher began exploring participants subjective constructions in their natural social context. Through this process, themes began to emerge and a more structured design and consensus developed. This process enfolded through a series of phases. Time constraints only allowed

for the first phase of constructivist inquiry in this research endeavor, therefore, this study explored beginning constructions. The hope is that another researcher will continue the study and conduct successive phases of inquiry.

Phases of Transactions

Overview and Orientation

This project consisted of a single round of interviews with stakeholders identified as involved with HIV/AIDS infected and affected populations in the Coachella Valley, as well as, area university educators. Broad, open ended questions exploring individual constructions of AIDS, opinions regarding social work's level of involvement in the HIV/AIDS arena and factors participants thought may inhibit and/or facilitate social work involvement with HIV/AIDS were utilized in this phase. The research questions are listed in Appendix C.

The constructivist paradigm recognizes that any human inquiry is value laden and subjective, therefore, allows for open, interactive communication between inquirer and participants. Inclusion of the researcher's own constructions in the hermeneutic dialectic circle addressed this reality of social work inquiry. Emergent themes and shared constructions, including the researcher's own construction of HIV/AIDS and social work and existing

literature, were identified, communicated and shared with stakeholders as the interviews progressed. The purpose of this communication was: to share constructed realities; to provide a vehicle for new constructions of reality to emerge; to enhance knowledge and facilitate empowerment of all participants serving the HIV/AIDS population. This included those working with and educating social workers, as well as, the social work profession itself.

Member Checks

Member checks served as a method to verify the data obtained from participants. The data from a constructivist study is a subjective account of reality and must be verified with the participant prior to being included in the report. Member checks were routinely conducted throughout the duration of the interview by verbally checking back with participants. During the course of the interview, this was achieved through an interactive process between the researcher and participant. The researcher reflected back to the informant what was heard for participant verification, when the information presented was not clear to the researcher. Clarification and further definition of statements by participants were solicited, as needed.

Data from each recorded interview was transcribed and mailed to each participant for further verification

prior to writing the final case report. All participants were also encouraged to include any additional data that came to mind. In some cases, particularly with respondents who participated early on in the inquiry process, the researcher also presented constructions, which emerged later in the process. Additional comments on these constructions were solicited. A self addressed stamped envelope was included in each mailing along with a request for verification of data, either verbally or in writing. Some participants altered some of their responses and these changes were integrated into the study prior to writing of the final report. Some also proffered additional comments and these were included as well.

Content Analysis

Data analysis, in the constructivist paradigm, is an ongoing process of analyzing and synthesizing the information obtained during data collection, rather than a discrete, linear task. As data was collected from each observation, interview and document, it was analyzed both during and immediately following the collection session. Through the ongoing analysis process, theoretical concepts and units of information were categorized, studied and synthesized, resulting in the emergence of reconstructions to be shared with successive respondents.

Data was induced from the interactive process between

inquired and inquirer with an emphasis on the social context. Therefore, data analysis began immediately upon the researcher's entry into the first site. According to constructivism, the constructivist researcher, as the human instrument, is capable of gathering and intuitively analyzing data during the interview, through observation of and interaction with the participants in their social context. This process facilitates formation of a tentative working hypothesis, which guides subsequent data collection and allows for the emergence of new constructions.

A formal qualitative method of data analysis, the Constant Comparative Method, developed by Glasser (1965), was employed at the end of each interview. The Constant Comparative method is a continuous process of categorizing information by properties and constantly comparing new information to these categories in order to determine whether they are similar or divergent. Brewer & Hunter (1989) suggest three steps to operationalize this process: unitizing, categorizing and member checking. These steps were utilized throughout the data collection and analysis process. This process is congruent with the Guba & Lincoln (1989) Hermeneutic-Dialectic Process as described by Erlandson et al., 1993 (p. 124).

Immediately following the initial interview with the first stakeholder in the circle, the unitizing process

was employed. This process entails the identification of discrete units of information, small enough to be understood by themselves. As each unit of information was identified, it was recorded onto a five by seven index card. The source of the information, the site from which the information was obtained and the type of respondent was coded on the back of the card. This coding served to protect the participants confidentiality, as well as, to facilitate an audit trail.

The cards containing units of information were then studied and analyzed in order to categorize the data. The initial categories were formed intuitively by the researcher's perception of "feel-alike" or "look-alike" properties. Each subsequent card was analyzed for similar or divergent concepts, themes and properties and categorized accordingly. As cards began to accumulate into piles, the researcher recorded memos about specific qualities and properties which defined the categories. At this point in the analysis process, the researcher made decisions regarding inclusion and exclusion, which served as tentative decision rules to focus, as well as, compare and contrast the categories. This process allowed new categories to emerge and old categories to be eliminated as was deemed necessary. Once the cards were categorized into both similar emergent themes and divergent

cases, they were studied so that content and emergent constructions could be shared with the next participant at the conclusion of that interview.

The constructions that emerged from interviews with prior participants, the researchers own constructions, and the literature findings were shared with each respondent. Comments on the constructions were solicited. Through this ongoing process, joint constructions began to emerge providing a thick, rich description of participants constructions. This entire data collection and analysis process continued until all identified stakeholders had participated.

SALIENCIES

The Researcher's Construction in Context

The researcher's interest in this project began with an informal inquiry into why HIV/AIDS was minimally, if at all, addressed in schools of social work in 1993-1994. The expectation was that the social work profession and consequently, the educational arena would have been in the forefront of tackling the AIDS crisis, since it is so devastatingly affecting marginalized groups nationally and globally. It became increasingly apparent, through discussions with and informal surveys of students and colleagues, that there was not only a lack of basic HIV/AIDS knowledge but fears and biases that were quite

surprising. Considering the NASW Code of Ethics, which drives the profession, and the exponential rates of HIV infection across the population, which dictates that all social workers will encounter HIV/AIDS issues in their practice, this became incredulous. The researcher, considering that this may be a phenomenon of the local area, conducted an extensive literature review of the field.

Amazingly, the literature indicated that social work has given minimal attention to HIV/AIDS throughout the duration of the epidemic. Furthermore, this professional trend has just recently begun to shift in the past three years to five years. As a result of this literature review, a preliminary construction emerged regarding social work's response to a pandemic with tremendous biopsychosocial ramifications for the disenfranchised groups, the profession is mandated to serve.

The researcher's initial construction, which guided the onset of the inquiry, was that the social work profession has indeed lagged behind other helping professions in it's response to HIV/AIDS in all practice arenas. It was thought that the reticent response and the minimal social work presence and leadership in the AIDS crisis, may be due to two factors; individual's constructions of HIV/AIDS and the lack of HIV/AIDS specific

education in schools of social work. This construction was based upon the researcher's ten year experience in the HIV/AIDS arena; observations of the social work educational and professional arenas; discussions with students, colleagues and professors; and a comprehensive review of the social work literature.

The Proposed Direction of the Research

True to the constructivist paradigm, there was no hypothesis for this study. Rather, the researcher was interested in respondents individual constructions of general, thematic areas. Since this was the first exploratory round of interviews in what could be a longitudinal constructivist study, a myriad of stakeholders from various professions were interviewed, in order to explore a wide range of opinions. These included; line workers, administrators, social workers, educators and people infected and affected by HIV/AIDS.

The inquiry process began with very broad, open ended questions exploring participant's individual constructions of HIV/AIDS, perceptions of social work involvement with HIV/AIDS, and issues that might inhibit or facilitate social work involvement. Very early on in the study, however, it became evident that shifts in the proposed direction of the research were required. Firstly, there was a consensus among participants regarding constructions

of HIV/AIDS. Secondly, it was discovered that the inquiry process must be refined in order to clarify the concepts of social work and social work involvement, prior to exploring opinions on the other issues.

The Construction of HIV/AIDS

The initial shift in the proposed direction of the research involved participant's definitions of HIV/AIDS. It was proposed that the slow response of social work may be due to perceptions and definitions of HIV/AIDS, since the way a problem is defined or "constructed" will determine the response. One objective of the inquiry process was to explore participant's constructions of HIV/AIDS, as a barrier or facilitative factor in willingness to work with this population. Initially the question "how do you define AIDS?" was posed in order to facilitate discussion regarding problem definition.

There was consensus among participants on this issue. All participants reported that they perceived HIV/AIDS as a virus, an infection, a medical disease. Some participants adamantly stated, "HIV/AIDS is not a gay disease." Others indicated they perceived it as a virus and a medical condition, however, they made repeated references to the gay, male population. This for the most part seemed to be a function of their work with gay males, as the primary client group.

Interestingly, only one participant, a social work educator, defined AIDS as a social problem. "It's a big social problem that requires our immediate attention." He went on to define the people infected and affected by HIV/AIDS as "an oppressed population" rather than defining them by cultural descriptors or typical high risk behaviors. "Persons, who have been diagnosed as HIV positive or have AIDS, represent a minority not just because of the numbers but because of their inability to impact the decision making process."

It may be that, due to these participants active involvement in the HIV/AIDS arena, they are more likely to be educated about the disease as a medical condition and have clarified their values, fears and biases. Since there was a general consensus among these participants that HIV/AIDS is a medical condition, this question was not pursued in depth.

The Construction of Social Work

The focus of inquiry then shifted toward exploration of participant's opinions on social work's involvement with HIV/AIDS. One unanticipated saliency, that began to emerge, was unclarity about the meaning and perception of social work itself. It became evident, through the data collection process, that opinions on social work's involvement with HIV/AIDS were difficult to determine,

because many participants held various constructions of the social work profession. The proposed direction of the research was refined toward a more focused exploration of participant's definitions of social work, prior to exploring other constructions regarding involvement.

The concept of professional social work seemed to be confusing for many respondents. Some participant's responses to general questions and statements regarding social work's response to and involvement with HIV/AIDS yielded a "generic" perception of social work. Consequently, it was essential to begin with a definition of social work. The researcher clarified that the focus of this particular study was on professionally trained social workers, particularly the Master of Social Work (MSW) degree. There was also interest in the Bachelor of Social Work (BSW), Licensed Clinical Social Worker (LCSW), Doctor of Social Work (DSW) or Doctor of Philosophy in Social Work (PhD). The focus, however, was on the MSW as the terminal social work degree.

The professionally trained social workers in the hermeneutic dialectic circle were understandably clear on the construction of social work. A few administrators, who were not social workers, also seemed to have a clear perception of the social work profession, as well as, experience with professionally trained social workers

in the arena of HIV/AIDS and/or medical settings. Some key stakeholders, however, did not seem to distinguish professionally trained social workers from a variety of other degreed professionals, who refer to themselves as social workers by virtue of their job role and/or agency affiliation.

Two issues emerged. Firstly, even when professional social work and the MSW degree were explained and clarified, some participants did not seem to be experientially familiar enough with the MSW degreed workers to distinguish them from other helping professionals; the Marriage, Family, Child Counselors (MFCC), various other counselors, or bachelor degreed workers. Some participants seemed to "have a sense" that there is a distinction between professionally trained social workers and other degrees. Many, however, did not seem to be able to clearly distinguish the MSW from the "generic" label social worker, which many helping professions claim as a title.

Secondly, once clarified, most respondents appeared to be familiar with the LCSW degree as a social work specialization, however, did not seem to know that an MSW degree is a pre-requisite for an LCSW. Some respondents perceived the MSW solely as a "wanna be" LCSW. Some virtually saw the MSW and LCSW as two separate degrees

rather than the LCSW as licensing of an MSW. A misconception of the MSW and it's qualifications could conceivably inhibit social work involvement.

Constructions regarding social work licensing and social work's image also emerged from professionally trained social worker's responses to the question, "What factors in your opinion, inhibit social work involvement with HIV/AIDS." In order to further explore this issue, participant's constructions regarding the image of social work, the profession's focused direction toward licensing and acquisition of the LCSW were posed to successive participants in the circle, when appropriate.

An expanded or "reconstructed" theme emerged within the hermeneutic dialectic circle, as a consequence of this unanticipated result. The emergent construction was: the lagged response of social work to populations infected and affected by HIV/AIDS, at least in this region if not nationally, may be due in part to a clinical impetus within the social work profession. This reconstruction was shared with participants in pursuit of looking at social work's image as a possible emergent factor affecting the social work response.

The Image of Social Work

The apparent confusion about what a social worker is and who qualifies as a social worker, in many ways

seemed to relate to emergent themes regarding the image of social work. According to Meyerovitz (1988) as quoted in Ross (1993) "Social work still has an image problem, with some people still believing that anyone can practice social work and that no special training is required" (p. 93). Some respondents thought that a barrier to social work involvement may be the perceived image of social workers, however, a variety of divergent reasons emerged.

The Devaluation of Social Work

The debate over social work's role as clinical practitioners versus social change agents, leaders and advocates for the disenfranchised is as old as the profession itself. Since the beginning of the professionalization of social work in 1890, when Mary Richmond declared that both personal casework and social action were necessary to social work practice, the profession has often vacillated between the two (Day, 1989, p. 232).

Today, the debate still rages within the profession. A social work administrator stated, "We've devalued ourselves trying to be equivalent to other professions . . . we wanted to become clinicians because we were somewhat envious of other professions who had a higher standard than social workers." Another social worker

declared, "Social work is in an identity crisis! We don't want to own our identity; we want to be therapists rather than do the work we were called upon to do. Consequently, other professionals have taken our jobs." A medical administrator reports that the medical profession is questioning the necessity of social workers because they have limited their niche and rescinded from their traditional jobs, "Social workers have not asserted themselves to demonstrate the value of their contribution; administrators question whether they are needed." Finally, an agency administrator stated, "Social workers have an image problem; they need to mobilize as MFCC's did. MFCC's used to be seen as LCSW flunkies, now they are viewed as equivalent to LCSW's." She saw minimal, if any, difference between an LCSW and an MFCC except "perhaps a few different classes."

"We Did It To Ourselves"

In all direct practice arenas in the Coachella Valley, if not the state of California, a myriad of other helping professionals are competing for jobs typically held by professionally trained social workers. This appears to be exacerbated by the political and economic climate, particularly the Congressional efforts to reform welfare and devalue the contributions of social work. In addition, the managed care systems have seemingly pushed other

therapeutic professionals out of private practice and into the public social service arena. In the Coachella Valley, social work has become a generic profession and "everyone's a social worker." These issues do appear to be factors in the disjunction of social work, however, many respondents report that "we did it to ourselves."

A number of social workers expressed this thought. "We have abdicated the title of social worker and left it open to all professions." "Our focus on psychotherapy has given the impression that anyone can do what we do; we've lost our value." "We want to become LCSW's so we back out of position as MSW's and others come in." "The orientation of the profession has changed, it seems more people want to get licensed and go into private practice." "We have not been professionally assertive enough to protect the title." This concept was confirmed by some administrators, as well.

"You Did It To Yourselves"

In more than one agency, there were BSW's and LCSW's but no MSW's. Reportedly, unlicensed positions could easily be filled by BSW's for much less money than an MSW's. Some administrators stated: "BSW's do an exceptional job. There is no need for MSW's at a higher pay scale." "MSW's are in the middle and have been pushed out. There is a higher position (licensed) and a lower

position; nothing in between." Further, licensed MFCC's are generally seen as equivalent to LCSW's. One administrator stated, "There is no preference; the degrees [LCSW and licensed MFCC] are the same." This perception also seemed to make the unlicensed MFCC degree valuable and the MSW relegated to diminished status. It appeared that the MSW degree was devalued by virtue of licensure.

An administrator explained that government regulations now mandate that licensure is required for most clinical positions. "There has been discussion at the state level that MSW's would be more than sufficient for some of those positions and more cost effective. This however, requires a change in government regulations that have been in place for a long time, which is difficult." She went on to say "MSW's would need to mobilize the way MFCC's did and educate the government and agencies about the value, cost effectiveness and professional capabilities of the MSW degree." In this researcher's opinion, this is vital, however, poses a professional conflict. MSW's would be fighting against the LCSW's in their own professional realm. This may, in fact, be how the devaluation of the MSW began.

A social work administrator remarked, "We [social workers] have not had adequate public relations from local, state and national social work organizations to gain a

strong foothold." An LCSW social worker in practice for many years, stated he could see the effects licensure has had on the profession's image, "If you're a professional, you're definitely an LCSW probably moving toward private practice or associated with 'feel good', whatever that is."

An administrator also spoke at length about his observations of social work and made two salient points. He thinks "social workers are demonstrating a reluctance to participate and make a valuable contribution . . . they are trying to limit their niche, which is getting smaller and smaller." He went on to explain that in his experience "social work has rolled on it's back and become reluctant and unwilling to provide services they have traditionally been called upon to perform." As social workers have backed out of their roles other professionals are having to fill in the gaps. Nurses for example, are reportedly not receiving supportive services from social workers in the medical arena and additionally often end up doing work with patients that social workers have typically done. "The consequence is that professionals are thinking perhaps we can get by without them."

A social worker in health care confirmed this. "Social workers tend to only want to work with patients. Social workers need to get involved and do supportive

efforts; they need to build rapport with the staff and deliver supportive services for the system. It keeps your job!" A social work educator addressing social work's inadequacies in dealing with physical health issues stated, "We don't compete well with nurses; they have a serious edge on us and we are loosing our jobs to them. They know what we know and they know the body."

Social Work Leadership

A significant number of participants thought that social work's image has been denigrated by a lack of leadership in the field. It appears that in the Coachella Valley, public social services is the only arena, in which MSW degreed social workers are highly valued in administrative and leadership positions. Participants reported that this is not so in other states and that MSW degrees are visible in powerful leadership positions in the HIV/AIDS arena, as well as, other practice arenas.

According to social workers, who addressed this issue: "Social workers need to be much more aggressive and self assured in our approach and physical presence in the community." "We need to be leaders in educating other professionals." "We need to be leaders; the community looks to social work for leadership." A social work administrator stated, "We claim outreach is one of our most important functions, I'm not sure it is." A social

work educator added, "We are expected to be advocates for groups of people who are disadvantaged or who have been oppressed." An experienced social worker declared "We must be political, as well as, advocates!" And finally a social work administrator emphatically declared "The social work profession has failed. Some of the reason we have the political climate we have is that social work has failed by providing clinical programs and not organizing, advocating and becoming leaders."

Conclusion

In summary, the image of social workers, the generic label social worker, and the profession's clinical focus may be inhibiting social work's presence and leadership in HIV/AIDS, as well as other practice arenas affecting the disadvantaged. In this researcher's opinion, the MSW is an extremely valuable, comprehensive degree, within the field of the helping professions. The integration of both: direct service practice with individuals, families, groups (micro social work practice), and social work practice with groups, communities and government (mezzo and macro social work practice), involving social welfare policy, administration, law and community organizing, is vital for social justice and social change. The profession, however, appears to have become increasingly fragmented into two separate modes of

practice; a clinical, medical model and a social action model, with an overemphasis on clinical practice.

Specht & Courtney (1994) claim that social work's focus on psychotherapy as a cure for social problems has lead social work to abandon it's mission of being leaders and advocates for disadvantaged, vulnerable groups. According to Specht, "Psychotherapy translates into poor services for poor people, and the further down the psychotherapeutic path we go, the less effective we will be in achieving our true mission" (NASW California News, 1995, p. 4). This disjunction in professional social work and a focus on clinical practice may have lead to a devaluation of the MSW degree and indeed the profession. It may also be a significant factor in the lagged social work response to the AIDS crisis, since a response to oppressed groups requires an emphasis on social action and social change, rather than solely the intrapsychic dynamics of the individual. As a social worker in this study shared "It may be that a clinical emphasis has bypassed a major segment of the population and the work with the very vulnerable populace that needs service has been left standing in the background." As mentioned, this debate has persisted throughout the history of social work. Perhaps, in today's political and economic climate, social work will rise to reclaim it's mission.

Constructions of Social Work's Involvement with HIV/AIDS

A myriad of salient features specific to social work's involvement with HIV/AIDS were identified. It seemed that participant's perceptions of social work's involvement with HIV/AIDS were influenced by their own individual level of involvement, as well as, their perception's of social work. Individual constructions of social work's involvement with HIV/AIDS emerged as themes, that could be classified into three groups of stakeholders based upon participant's personal arenas of involvement. This grouping was not identified in the hermeneutic dialectic circle. Rather, these classifications emerged as themes regarding social work's involvement with HIV/AIDS, throughout the data collection process.

Stakeholder Groups

One group of stakeholders consisted of direct service workers and administrators from various professions, as well as, people of communities infected and affected by HIV/AIDS. The majority of this group are directly involved in the HIV/AIDS arena in various capacities. It became evident that most of these respondents did not have a clear definition of social work as a profession but viewed social work in global, generic terms. As mentioned, social work as a profession was clarified to the extent possible prior to pursuing other lines of questioning and

discussions regarding social work's involvement. This group tended to have a variety of thoughts on social work's involvement, however, due to unclarity regarding professional social work, it was difficult to accurately assess perceptions involvement.

A second group of stakeholders was comprised of professionally trained social workers. Those who have BSW, MSW and LCSW degrees and are involved with HIV/AIDS as part of their job description. The majority work in the medical field and two work in public social service agencies. HIV/AIDS infected and affected persons are integrated in their caseload as part of the client base served. Stakeholders in this group were understandably clear on the definition of the social work profession. However, there was not a clear consensus regarding social work's involvement with HIV/AIDS among this group.

The majority of these social workers initially seemed to think that the social work profession is involved with HIV/AIDS, which seemed to be a function of their own involvement through their job description. Most seemed to think that, because they are working with HIV/AIDS and they are social workers, the profession as a whole is adequately involved. As it became evident that opinions of involvement were constructed through limited personal experience, it was necessary to share the researcher's

construction of involvement and the literature's construction of the social work response to HIV/AIDS with these participants.

The majority of these workers were surprised by the literature's findings and this researcher's construction of social work's lagged response to the HIV/AIDS pandemic. Some said they had never thought about it. A few agreed that the social work profession is not adequately involved and felt that they were thrown into work with this population with little training and no education. As the interactive discussion continued and alternative constructions were presented, many agreed there was a lagged response.

The third stakeholder group was also comprised primarily of social workers from all degreed levels, including, DSW's and PhD's in social work. This group also included a few administrators, who were not social workers but had a clear perception of the social work profession and experience with professionally trained social workers. This stakeholder group was also clear on the definition of social work but in contrast to the previous group, chose to be involved in HIV/AIDS of their own volition rather, than as part of their job description.

Participants in this group were knowledgeable about social work's involvement with HIV/AIDS and it was not

necessary to share the researcher's construction and literature findings with them. As a result of their active involvement with HIV/AIDS, they voluntarily reported that social work has and continues to lag in it's response to HIV/AIDS. They also clearly delineated factors, which may inhibit a professional social work response to HIV/AIDS.

Social Work's Lagged Response

There was consensus among these participants that social work has failed in it's response to the AIDS crisis. One social worker, who was in San Francisco during the inception of the epidemic in the eighties reported, "Social work did not respond to the plight of the gay community; the community had to take it upon themselves to learn what they could about social work and fill in the gaps." An administrator agreed with this construction to some extent but also felt that the gay community is a self sufficient subculture and as such "rose up and took the lead quickly. This action on the part of the gay community may have locked social workers out."

A social work administrator thought that stereotypical views of social workers giving out food and clothing may have inhibited an early response. "Natural born advocates in cities got involved and didn't reach out to social work due to stereotypes; we (social workers) did not reach

out to them either." Another social worker shared, "We did not respond early on to the HIV/AIDS crisis because we were too concerned with developing a professional image and defining criteria for licensing, during the eighties." Finally, a heterosexual man with AIDS shared that the heterosexual community and helping professions still haven't responded adequately.

> The gay community still pulls the wagon . . . when this [AIDS] came about no one went near them, no one would do anything, they had to pool their resources and put something together for themselves. Now, here we [heterosexuals] come along and say we're here, we need help! It's time for us to get off the wagon and help them pull it.

In summary, unanticipated results of the initial phases of inquiry identified a myriad of possible factors inhibiting social work involvement with HIV/AIDS: generic constructions of social work, devaluation of the MSW degree, social work's image, licensing, and lack of leadership. Additionally, participants expressed a range of opinions on the level of social work involvement with HIV/AIDS. These opinions appeared to be a function of both, participant's perceptions of professional social work and their own experiences of involvement in the HIV/AIDS arena.

A variety of other factors, which may inhibit the social work response emerged, through data collection. Some participants disagreed with some of the findings

and identified additional inhibitory issues. These constructions did not develop into themes, but are recognized as individual, divergent constructions. Unexpected factors regarding social work's involvement with HIV/AIDS, not recognized in the literature but highlighted by numerous participants emerged, as well. These issues, economics and the role of agencies, are categorized as emergent constructions.

Divergent Constructions

Some respondents thought that opportunity was a factor. One social worker, who has been involved with HIV/AIDS since the early days of the crisis, disagreed with the construction of minimal social work involvement. In his opinion, "There are a lot of good, dedicated social workers involved with HIV/AIDS in the Coachella Valley. They tend to be concentrated in the medical arenas. There are limited opportunities for social work practice with HIV/AIDS." Another agreed, "There are not many opportunities for social workers in AIDS related programs, but 'we did it to ourselves'." A case manager also felt opportunities are limited, particularly in the Coachella Valley.

A social work administrator in public social services shared he did not observe a reluctance on the part of social workers to be involved, "I don't see phobias or

resistance around the disease. HIV/AIDS clients are viewed simply as a part of the client base." An educator indicated that "HIV/AIDS is a relatively new development and was not a primary concern ten or fifteen years ago." He went on to state, "We (the social work professionals) have been late in other responses as well. We are a profession that is supposed to advocate for and defend against gender discrimination and yet, we do it in our own profession."

A variety of divergent views were expressed regarding medical social work with HIV/AIDS. Both a long time social worker and a medical administrator, thought that when social workers are involved they have a tendency to be over involved and not always balanced in their work. "Social workers seem to be on two sides of the fence; either not willing to be involved at all or are so immersed that their involvement is too intense and overwhelming to be productive." "Those who are involved, sometimes have a tendency to be overly involved. There is a potential for burnout, due to dealing with death and dying issues on a day to day basis."

A few social worker's in the medical arena held the medical profession as responsible for the lack of social work involvement. They thought that physicians either did not refer HIV/AIDS cases to the social workers enough

or tended to refer to a specific worker or agency. Another said, the nurses try to do it all." On the other hand, a medical administrator reports, "I see very little initiative on the part of social workers to be involved with the HIV/AIDS population." A medical social worker seemed to agree. "Teamwork is a necessity with HIV/AIDS. Some social workers only want to work with clients but don't provide supportive services to the team system."

One administrator, working in the HIV/AIDS arena disagreed with the lagged response construction. She enthusiastically declared, "Every social worker I've worked with in this arena has been dedicated, committed and hard working." However, she admitted she had limited exposure to professional social work. Finally, a person with AIDS emphatically insisted, "They are involved! They have helped me tremendously. I still stay in touch with one from my early diagnosis." It became clear he made little distinction between professional social workers and other helping professionals generically labeled "social worker."

Emergent Constructions

Economics

Economic issues emerged as a possible logistical factor that may be a barrier to social work involvement with HIV/AIDS. Participants, who identified economics as a factor felt strongly about it, however, there was

not a consensus regarding this issue.

The government has been slow in providing fiscal assistance throughout the AIDS crisis. According to the literature, the Center for Disease Control identified AIDS as an infectious, life threatening disease in 1981. Yet, research and funding did not begin at the National Institutes for Health until 1983. In 1982 and 1983, the Reagan administration did not budget any money for AIDS research. In 1984, President Reagan asked for thirty nine million; Congress chose to appropriate sixty one million. In 1986, Congress allocated two hundred thirty four million but the administration proposed cutting it to two hundred thirteen million, despite the fact that the incidence and prevalence of AIDS had been doubling every year (Fee 1989, p. 161-162).

There have been some strides since then. In November 1990, HR5257 was enacted, appropriating funds for the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act. These funds are targeted toward areas most severely impacted by the HIV/AIDS epidemic and are intended to improve the quality and availability of care for individuals and families with HIV disease, specifically, low income, uninsured or underinsured members of the population (AIDS Program Report, San Bernardino County, Dept. of Public Health). The 1995 Congress has failed

to reauthorize the Ryan White CARE Act to date and threatens to rescind appropriations. Threats of budget cuts and a return to a conservative political and economic climate, continue to threaten funding for HIV/AIDS related services and research.

For the duration of the HIV/AIDS crisis, AIDS service organizations have primarily been grassroots agencies operated by the gay community and funded primarily through community donations and some limited public funds. Some participants in this study thought that the lack of social work involvement could in part be attributed to these economic issues. "Few other than the those of the infected and affected communities, responded and they had to learn to take care of themselves." "Fundraising was a primary source of fiscal support throughout the eighties, however, has become increasingly difficult in recent years." "Fundraising has become more difficult; it takes a lot of time, energy and money." "The community has been supporting agencies for years and thinks the government should cover more." In contrast, a person with AIDS said the "community is sick of funding HIV/AIDS because they have not seen a significant change in high risk behavior."

One social work administrator stated "AIDS specific agencies, both private and public, are dependent on grants, government funding and donations that may vary from year

to year. Social workers don't want that kind of job insecurity." "The limited funding appears insufficient to hire MSW's. The salary range is such that agencies can hire two bachelor level case managers for the price of one MSW." A medical administrator, who felt that social workers are not demonstrating a valuable contribution in the medical setting stated, "Considering the economic climate, all disciplines are fighting for a place on top of the heap, if I were a social worker today I would be fighting for my place in the new arena."

One administrator, who is a social worker stated, "if I can get a good, competent advocate, who can deal with social services, social security and mobilize resources for $21,000.00, why should I hire a social worker at $30,000.00." When asked why economic issues are not addressed in the literature, this same social worker indicated, "We don't want to mention it because it sounds crass but it's an important element." One administrator, did not agree that economics is a factor. "A lot of money is going into HIV/AIDS and there are a lot of administrative positions with adequate salaries for MSW's. I disagree that economics inhibits social work involvement."

Agencies

Participants also spoke of agencies as affecting

levels of social work involvement with HIV/AIDS. Some participants thought that social workers would be more involved, if agencies prioritized involvement with HIV/AIDS through in service trainings, educational updates, risk reduction, and primary prevention. This line of discourse was primarily referring to agencies, which are not necessarily AIDS specific agencies, but provide services to people with HIV/AIDS as part of their client base. "Social workers will tend to be involved if the agency is interested and involved." "The agencies have a responsibility to facilitate social workers interest in HIV/AIDS." "By and large, social workers will not choose this as a population to work with." One administrator stated that she probably would not have chosen this work. "I got involved through work on policy and administrative positions at the agency. I'm glad I did now."

An administrator of a public social agency with a mandate to serve disabled adults reported, "social workers are able and willing to be involved because the agency is involved." An exception to any other agency, organization or individual in the study, this agency, serves a large HIV/AIDS population and is administered by and values MSW degreed workers. He reports seeing virtually no reluctance, unwillingness, fears or phobias on the part of workers to serve this population. This

informant thinks this is attributable to the fact that the agency's mission to serve disabled adults is inclusive of HIV/AIDS clients and integrates them into the client base with no distinction around diagnosis.

He suggests that an another factor is that the agency's structural and functional parameters are based on a social rather than a medical model. The agency also regularly provides current training and education to employees on HIV/AIDS issues. Admittedly this program does not offer comprehensive care but serves more as a safety net and provides linkage with AIDS specific agencies in the area. This administrator provided divergent views and an interesting perspective of the agency's role in influencing social work involvement.

Respondents also made comments related to agencies, which don't necessarily serve identified HIV/AIDS populations but by the nature of their work come in contact with populations engaged in high risk behaviors. These agencies include; substance abuse programs, mental health programs, children's services and most public social service agencies. Reportedly, these agencies don't appear to be addressing HIV/AIDS directly as a service, educational or primary prevention issue. One administrator, who works in a "non-direct HIV" agency, stated "Agencies have a responsibility to facilitate social

worker's interest in HIV/AIDS, if the administration is not interested, social workers will not be interested."

A direct service worker commented "the agencies inhibit social worker involvement, . . . the caseloads are huge, which limits time to get involved; social workers may not want to open a can of worms they don't have time to deal with." Interestingly, a public agency worker thought that client perceptions of social workers inhibited involvement, "Clients fear discrimination by social workers and fear they will not maintain their confidentiality and may disclose to their family . . . both clients and social workers avoid the issue."

Finally, a few participants thought that AIDS specific agencies themselves limit social work involvement. Some AIDS specific agencies in other regions do employ and are even currently recruiting MSW degreed workers to serve the HIV/AIDS infected and affected populations. A telephone call to one such agency revealed that "The director highly values the MSW degree and sees it as a more integral degree than any other." In this particular AIDS specific agency, economics also arose as a factor. This is a large agency that has been in existence for quite awhile and has incorporated a Medi-cal waiver program. This enables them to afford MSW salaries. It seems pertinent, however, that this respondent thought

the most important factor was the director's perception of the MSW degree.

Agencies in the Coachella Valley seemed to value and prefer the LCSW or licensed MFCC degree, due to both economics and the multi-dimensional problems associated with HIV/AIDS. Participants identified neuropsychiatric dementias, as well as, complex psychosocial issues; substance abuse, childhood abuse, suicidal ideation, depression and mental illness, as issues requiring licensed professional interventions. The perception is that employing a licensed person is also more cost effective because he/she has the ability to crossover and fill in gaps in other positions, as well as, confront these more serious psychological issues.

Interestingly, there were no MSW's known to be working in administration positions other than in some public agencies. A social work administrator stated, "most social workers have not been trained to administer programs except as a result of their experience." A social worker thought it was an issue of image once again, "Social workers are seen as soft scientists, nice people who are bleeding hearts and easy to talk to; not perceived as qualified in fundraising, budgets, economics and politics." "MSW's are seen neither as hard scientists nor true therapists . . . this inhibits involvement with HIV/AIDS." An

administrator added, "Considering the importance of economics in dealing with the AIDS crisis, social workers are perceived to be at a disadvantage."

Conclusion

The issues of economics and the role of agencies, were not identified in the literature but emerged as salient themes throughout the study. In essence, these factors and the previously identified saliencies are issues of the social work profession's relationships with government, agencies, other helping professions, community and societal structures.

A myriad of other factors inhibiting social work involvement were identified by both the literature and participants. These factors appear to be issues manifesting within the social work profession itself and are classified as convergent themes.

Convergent Themes

A number of convergent themes emerged from the interactive dialogues with participants. The following section includes responses from the entire hermeneutic dialectic circle: the researcher's constructions, direct quotes from participants, and quotes from the literature on salient factors within the social work profession itself, that may inhibit social work practice in the HIV/AIDS arena. Participants from stakeholder groups,

who were versed in and knowledgeable about professional social work, freely offered opinions on these saliencies. These opinions, often confirmed the literature findings and formed convergent constructions as the inquiry process was increasingly refined. These convergent constructions were presented to participants, from stakeholder groups less familiar with the social work profession, as constructions from the hermeneutic dialectic circle. In the following discussion, literature findings will be presented first, followed by thoughts and direct quotes from participants.

Two salient themes emerged. These broad thematic areas were fears of and biases against HIV/AIDS infected and affected populations, and the responsibility of schools of social work to integrate HIV/AIDS specific education and training into the curriculum. Central to these themes was the notion that social workers are not immune to the biases and fears surrounding HIV/AIDS. Some participants thought that many of these issues are amenable through education. There was consensus, that both social work educators and the social work profession, have a responsibility to address the social problem of HIV/AIDS

Fears and Biases

It appears that there may be a complex myriad of factors that inhibit social workers' presence and

leadership in the field of AIDS. One factor, which may account for social workers' apparent reluctance to work with persons with AIDS (PWA's), may be that they suffer from the same fears, biases and ignorance as the rest of the society. A reticence to deal with potentially threatening issues such as: human sexuality, homophobia, intolerance of intravenous drug abusers, lack of knowledge regarding etiology and transmission of AIDS, morality and death and dying may inhibit social worker's provision of services and development of policies needed to confront this pandemic.

Fear of Contagion

"AIDS evokes the most basic fears through it's association with sex, blood, drugs and death" (Sontag, 1989). A study evaluating attitudes and knowledge about HIV/AIDS among educated professionals in social work found, "among alumni from graduate level programs of social work, 67 percent reported being moderately or highly fearful of AIDS" (Peterson, 1991, p. 32). In a number of other studies (Scott, 1988; Fager, 1989; Batcheler, 1988), as quoted in Peterson (1991) findings confirmed that, "professionals are not immune to the fear, prejudice and misinformation found in the general public" (p. 32). The most comprehensive survey of social workers willingness to work with AIDS patients, Dhooper et al. (1987-1988)

found that out of 128 social workers, 37 percent had high scores measuring fear of AIDS and 31 percent had low scores on the scale measuring empathy.

In a study of more than 400 social workers surveyed in 12 major teaching hospitals, approximately 35 percent stated they were worried about the possibility of developing AIDS through direct patient contact (Wiener & Siegal, 1990, p. 23). Some of these social workers provided qualitative comments reflecting fear of contagion in working with AIDS patients in a hospital setting. "My basic fear is that maybe it is risky to have any physical contact with these patients." "There may come a time 'later' that being in the same breathing space may cause it to be spread" (p. 21). In a recent study of African American social work students attitudes toward AIDS, Owens (1995) found that fear of contagion is still prevalent. Responses to items that measure fear of AIDS indicated that two-thirds (65 percent) of the 48 students surveyed were unsure whether they might develop AIDS if they worked with people with AIDS (p. 112).

Some study participants discussed the issue of fear as a barrier to social work's involvement with HIV/AIDS. One medical administrator, involved with both HIV/AIDS and social workers over many years, indicated that fear of contagion was understandable for all professionals

throughout the eighties because modes of transmission and contagion were unclear. He went on to say, "Today we are sure about mode of transmission and contagion factors but still don't see social work involvement to support the HIV well population." A social worker long involved in the field of HIV/AIDS shared that other professional social workers ask him " . . . aren't you afraid you'll catch it?"

Another social worker admitted to her fears of contagion through breathing the same air or drinking from the same glass. "It's frightening when they offer you something to drink in their homes; even breathing the same air can be frightening because there's a lack of knowledge. It's like a foreign object we're dealing with and we don't know the parameters." She indicated it is stressful to always have to work at separating personal biases from her professional position. Another social worker addressed social work's lack of involvement in reference to fear, "It's comfortable to stay away; it alleviates fears and helps you believe it won't happen to you." A social work educator thought "There are irrational fears of diseases which tap into personal issues." Indeed, personal issues and biases appear to be some of the most powerful barriers to social workers willingness and comfort in working with HIV/AIDS.

Stigmatization

"AIDS is an epidemic of stigma" (Peterson, 1991, p. 31). Society perceives HIV/AIDS as a disease of the immoral, lower classes, particularly intravenous substance abusers and homosexual men. To the extent that society can classify an epidemic disease as affecting certain groups it can blame them and justify the lack of response. "The initial identification of AIDS with socially stigmatized groups affected the response . . . people with AIDS were ostracized, victimized, and discriminated against or treated as pariahs" (Ross, 1993, p. 94).

According to literature discussing the history of epidemics (Brandt, 1985; Fee & Fox, 1988; Day, 1989; Rosenberg, 1989; Mack, 1991), blame has been a means of psychologically separating oneself from the disease and making devastating epidemics more comprehensible and possibly controllable. The belief seems to be that by blaming a group and their deviant, immoral behavior for the disease, society can control it through isolation, discipline and prudence.

This ideology enables society to associate disease with "the other" class, race, sex, ethnic group, somehow exempting the rest from contagion. The "other" group become the victims of blame, as well as victims of the disease. The vulnerable groups have typically been from

the marginal sectors of society and reflect the ideology, social stereotypes, and moral and political biases that prevail in society at a given time.

This certainly has been true of AIDS. A barrier to social work involvement may be the belief that only certain, highly stigmatized groups are susceptible to contracting HIV/AIDS. Haney (1988), a social worker who lived with HIV and died of AIDS, referring to the high risk group mentality portrayed in the media shared "It is as if we are some fringe element 'out there' an element unworthy of compassion because of some character flaw or inappropriate behavior" (p. 251). In surveys of practitioners, Wiener & Siegal (1990) and Gillman (1991) found that social workers preferred not to work with people with AIDS because they didn't want to interact with homosexuals and drug addicts (Owens, 1995, p. 114). According to McDonell (1993) "Evidence that HIV may be spread through other means (that is, heterosexual transmission) has done little to diminish the presumption that infected people acquired the virus through socially disapproved acts" (p. 403).

According to Miller & Dane (1990) "AIDS is an illness surrounded by social ambivalence and stigma linked to sexuality and drug abuse" (p. 177). Haney (1988) shares his experience, "AIDS carries with it a stigma of shame

and a pointed finger of blame, suggesting those of us who are sick are at fault for being infected" (p. 251). Macks (1987) as quoted in McDonell (1993) noted, "that because of social stigma, many people with AIDS have been rejected by those around them or, fearing rejection have isolated themselves" (p. 404).

Some participants in this study thought that these risk group stigmas may inhibit social work involvement. "HIV/AIDS is so stigmatized by society that this may inhibit social work's involvement." "HIV/AIDS is still thought of as a gay or drug addict disease; social workers are not immune from these biases." "Person's with AIDS (PWA's) have come into chronic illness support groups but there is an unspoken stigma and they usually don't stay." A social worker stated "Social worker's fear stigma! The public view is you wouldn't work with this population unless you were gay. Social workers don't want that stigma." "Social workers fear the stigma of working with HIV/AIDS will hurt their career."

An administrator involved with HIV/AIDS for many years commented, "In the earlier days social workers were so reluctant to deal with the HIV/AIDS population, that one medical social services department had the R.N. assigned to the unit attend HIV/AIDS trainings. All the HIV/AIDS cases were then assigned to that nurse for

psychosocial as well as medical interventions." A person with AIDS shared his experience of stigmatization. "I was on an oncology ward. People were there that were my age, with a similar family situation and demographics. The only difference was that they had cancer. Due to the social stigma of my disease, I was treated like crap. That shouldn't be. I deserve the same treatment; my family deserves the same treatment, as anyone else." This was as recent as 1994.

The Public Health Service challenged social workers to move beyond the limiting beliefs of the society, stating, "By breaking out of the risk group mind set, social workers in a variety of settings will have much to contribute to public education and prevention" (Peterson, 1991, p. 36).

Sexuality

AIDS is most commonly transmitted through sexual practices. Social workers may feel inhibited or anxious in discussing sexuality with clients and consequently, avoid work with AIDS clients, as well as, risk assessment and primary prevention conversations with clients in their chosen practice arena. In addition, their own current or past sexual practices may put them personally at risk and they may avoid discussions of HIV/AIDS, due to fear, guilt or anxiety. "There is a generalized discomfort

in dealing with sexuality and with a disease that is usually sexually transmitted" (Ryan, 1990, p. 357).

Homophobia, an irrational fear of and prejudice towards homosexuals, may be a significant factor inhibiting social work practice with HIV/AIDS, according to the literature. Researchers, who assessed MSW degreed social workers attitudes toward sexuality found, "nearly one-third of the social workers had scores falling in the homophobic range" (Wisniewski & Toomey, 1987, p. 455). DeCrescenzo (1984) as quoted in Wiener & Siegal (1990) studied mental health professionals' attitudes toward homosexuality and found that homophobia was more prevalent among professional social workers than other caregivers and least evident among psychologists (p. 19). Respondents in a study of social workers comfort working with HIV/AIDS by Wiener & Siegal (1990) indicated "they felt significantly more sympathetic, non-judgmental, helpless and less angry providing counseling to the AIDS patient identified as hemophiliac, than one identified as homosexual" (p. 23).

Although the statistics clearly indicate that HIV/AIDS is not a "gay disease" limited to the male, homosexual community many, including social workers, still seem to perceive it this way. It stands to reason that, if HIV/AIDS is defined as a "gay disease" and people have homophobic biases, these attitudes may inhibit social

work involvement. "Homophobic attitudes can be a potential source of stress and discomfort among service providers and can interfere with the provision of quality care to persons with HIV/AIDS" (Ross, 1993, p. 95).

Many participants agreed. A social work educator stated "HIV/AIDS is an infection but we have to address homophobia because it's keeping people from seeing the reality of the disease." Another educator said "Some social workers refuse to work with gays because of their own homophobic feelings; it's too threatening." A social worker thought, "Social workers may fear catching homosexuality as well as catching HIV/AIDS." Another said "Social workers have a tendency to avoid problem areas or topics they are sensitive to."

A person with AIDS shared that a medical social worker didn't invite him to a support group on a hospital unit. "I'm sure some of it was because I have AIDS, but some of it was because I'm gay too. When you've lived life as a gay man, you can tell how people feel about you." An administrator shared his perception of the social work profession. "Social workers are more willing to understand urban black culture than urban gay culture or Hispanic subculture than gay subculture." A social work educator tended to agree stating "Given who we are as a profession with sexual diversity, it is unconscionable that we haven't

dealt with it."

Some social workers indicated they were surprised by the reported rates of homophobia among social workers. Others said they had never thought of this as an issue for social workers. One administrator didn't feel homophobia was the issue in social worker's reluctance to work with HIV/AIDS. "I don't think it's the driving force because social work is not present in other HIV populations like substance abuse either." A heterosexual man with AIDS perhaps summed up the issue best.

> Tell social workers my world has changed so much since getting AIDS. I used to make such a clear distinction between right and wrong and was so homophobic I didn't want gays near me. Today when I need help, when my family needs help it is the gay community that helps me. I'm embarrassed by my homophobia; I've met so many people just like me, they just choose not to sleep with women.

Morality

For centuries, plagues in Europe had been linked to morality. Disease was understood primarily in terms of man's relationship to God. Many thought this to be the only explanation for the randomness of epidemics. Divine retribution for an immoral, lazy, intemperate lifestyle was thought to account for why some were infected and others spared. "A frantic populace demanded scapegoats for God's curse upon the land and they were found in socially indigestible people---those unwanted by society." (Day 1989, p. 103). This connection between morality

and disease has maintained a long tradition in the history of social welfare in America. The fear of contagion and the threat of social disorganization in this country has generated moral and political pressure for decisive and visible action. People have looked to authorities; God, medicine and government to provide meaning, order and control.

AIDS has clearly been defined as a moral issue by many in society and social workers are not necessarily immune from such judgments. In a study on the influence that attributions of personal responsibility for AIDS have on service to AIDS patients, McDonell (1993) found, "social workers may experience a decreased willingness to engage HIV-positive clients in a social work process to the extent that the client is held to be responsible for their HIV status" (p. 408). Wiener & Siegal (1990) found, social workers with less negative moral attitudes toward people with AIDS had significantly higher levels of comfort in service provision and less fear of contracting AIDS (p. 22).

Many participants in this study referred to moral judgment as an inhibitory factor in social work practice with HIV/AIDS. A social work educator stated "If people see HIV/AIDS as a moral issue and people with AIDS as sinners, they will be reluctant to help or work with the

sinners." Indicating that reluctance may be the effect of prejudices and biases "If this person has AIDS some may think he/she must have done something terribly wrong." A social worker indicated "We tend to talk of AIDS as a medical disease but immediately move into moral judgment, 'If they hadn't been engaging in x or x they wouldn't have gotten it'." "Some think the disease is a result of sin; God's punishing them so why should I help them." Referring to moral judgment, one social worker said, "It's attributable to ignorance; if you see them as sinners they need to be punished; if you see them as sick they need treatment."

Some social workers also thought religion was a factor. "Religious biases may have a lot to do with the resistance to work with AIDS patients." "Religion promotes stigmatization of homosexuality." Referring specifically to the Coachella Valley, one social worker said "We live in a conservative community, wherein religion promotes the stigmatization of homosexuality."

Death and Dying

Issues of death and dying may also prevent social workers from working with people with HIV/AIDS. These clients encountering death, are often in the same age group as the worker, which may threaten their own sense of mortality. Additionally, most social workers aspire

to facilitate growth, hope and change in people's lives. There is no cure for AIDS and it is typically a death with incredible suffering and indignities. The sense of helplessness and powerlessness over a life threatening disease may also be unappealing to social workers.

Written comments offered by social workers in a study by Wiener & Siegal (1990) reflect these feelings. "The hardest part is the fear of getting close to someone who is dying." "It's too demanding and now leads to death with no hope of remission." "Even if symptoms can be controlled for awhile, the improvement is only temporary and eventually the syndrome will kill them." "This is the worst debilitating illness I've witnessed . . . complete helplessness" (p. 21). According to Ryan (1990) "Workers have often reported difficulty in working with patients who are chronically ill, have a poor prognosis for recovery or who are suffering from terminal illness." "In working with people with AIDS, providers have expressed feelings of powerlessness, depression and despair at not being able to influence the course of the disease and having the myth of professional impotence shattered" (Ross, 1993, p. 97).

Social workers in this study confirmed these literature findings. "Social workers may feel like they want to be involved but fear it'll be too depressing;

they don't want to see the wasting of AIDS in their clients." "Social workers may be afraid of working with clients who they know will die eventually." "Working with HIV/AIDS clients may awaken or re-awaken a fear of death." "When people think of HIV, they think of death."

"This society focuses on being alive, energetic, healthy, full of life; we as a society tend to deny the other side, we don't want to see illness; it makes social workers feel helpless." "You're looking death in the face; it's a relatively young adult who's going to die." "It's a horrendous death with real shock value; one of the most shocking death scenes to watch." "Social workers are not motivated to work with people at the other end of life issues; it goes against the grain of our socialization and education." "Social workers are sold a bill of goods; we don't want to see clients die, it hurts when you've invested your emotions." "It takes a special person to work with HIV/AIDS, in the same way it takes a special person to work in oncology or gerontology, because the end result is not a happy one."

Hospice workers and some other participants offered a different perspective on the issues of death and dying and HIV/AIDS. A hospice worker indicated that work with death and dying was part of the natural career progression. "Life experience is the most important factor in working

with death and dying issues. It can be overwhelming at times." "One needs to have an experiential background to cope with what comes to you day after day, and truly be present, empathic and still be functional, facilitative and helpful." An experienced social worker shared thoughts on spirituality and work with HIV/AIDS death and dying. "Social work doesn't deal with spirituality enough. We don't talk about the spiritual components of the disease. The release; the ability to let go as a result of spiritual contact."

In summary, participants in this study both confirmed and expounded upon the literature findings that fears and biases may inhibit social work practice with HIV/AIDS. Most identified social work education as necessary to clarify values and biases, as well as alleviate fears. Education, in fact arose both, as an inhibitory and facilitative factor in virtually all interviews and was addressed so extensively as to warrant an additional section.

Social Work Education and HIV/AIDS

Many of the identified fears and biases are potentially amendable through education. This leads to speculation about another possible factor inhibiting social work practice in the field of HIV/AIDS, the lack of HIV/AIDS specific education in schools of social work.

Numerous researchers (Merdinger et al., 1989; Royse et al., 1987; Wiener & Siegal, 1990; Riley & Greene, 1993) have clearly demonstrated that AIDS education alleviates fear, increases empathy and facilitates social workers' willingness to work with AIDS. Many organizations, including the NASW, have outlined the need for HIV/AIDS education for social workers. Students and practitioners themselves have requested HIV/AIDS specific education.

In a survey of students interested in working with AIDS, "overwhelmingly, 71 percent indicated that it was necessary and appropriate to initiate a new course focused on AIDS issues" in order for them to feel competent in their work (Miller & Dane, 1990, p. 178). Wiener & Siegal (1990) in a survey of social workers' comfort in providing services to AIDS patients found that out of the 264 respondents, 24 percent indicated more education would facilitate their willingness to work with AIDS patients (p. 21). Yet, today there appears to be minimal HIV/AIDS education in graduate level social work programs.

Schools of Social Work

The AIDS Task Force on Social Work Education (1988) called for AIDS content throughout general courses in undergraduate and graduate programs stating that "social work education has been slow to respond to the need for formal education and training for working with AIDS"

(Weiner, 1990, p. 162). Yet, a national survey by Diaz & Kelly (1991) three years later found a deficit of HIV/AIDS specific education in schools of social work.

They surveyed the curriculum of the ninety-nine schools of social work accredited by the Council on Social Work Education (CSWE) to determine the level of AIDS education. Out of the responding programs they found: less than half offered full courses on human sexuality, less than half offered courses on primary prevention and almost one fourth did not offer students any training on AIDS information. In considering AIDS-specific education; only 8 percent offered full courses on AIDS-specific topics, only 9 percent offered courses on clinical services to AIDS affected populations and one-third reported that they incorporated AIDS content into other courses (pp. 39-40). This lack of AIDS education in graduate programs, implies that students will not have the opportunity to gain the knowledge and experience required to feel comfortable and competent in their work with this population. This may be a significant barrier to social work involvement with AIDS.

Peterson (1991) in her national survey of social worker's knowledge about AIDS stated, "social workers in all fields have reason to be knowledgeable about this disease." She went on to conclude, "schools of social

work must take responsibility for educating all social workers . . ." (p. 36). Merdinger et al. (1989) referring to NASW's statement on the ethical responsibility of social workers to be involved at all levels with the AIDS epidemic stated, "If social workers are to be held accountable for multi-level interventions, schools of social work must be able to prepare the newest social workers to deal with the crisis of AIDS" (p. 32).

Participants in this study unanimously agreed that schools of social work have a responsibility to provide HIV/AIDS specific education to students. Many also thought that lack of education may be a factor inhibiting social work practice in this arena. They expressed a range of reactions to the literature findings that many schools of social are not adequately addressing HIV/AIDS issues. A social work administrator stated "schools of social work are negligent on the issue of HIV/AIDS; they are ivory towers." A social worker commented, "It's unbelievable that HIV/AIDS is not addressed adequately in schools of social work." A social work educator stated, "Biases and reluctance to work with any population needs to be addressed in the educational arenas." Another educator commented "HIV/AIDS should be addressed more directly and pervasively."

A social worker stated, "Social work education has

a huge responsibility to educate social workers in HIV/AIDS on all levels." An administrator commented, "I'm not surprised social workers are not involved. They have not been trained, issues of HIV/AIDS have not been addressed." A social worker agreed, "Social workers would get involved if they were educated and felt more knowledgeable about HIV/AIDS." In defense of social work education, an administrator commented that schools of social work contend with many demands. "Everyone is pounding at their door saying we need to look at this issue." An educator agreed stating "The dilemma becomes, with all these important issues we are not dealing with adequately how do we get it all done."

Factors Inhibiting HIV/AIDS Social Work Education

Participants, including literature constructions, offered a variety of opinions on factors that may inhibit HIV/AIDS specific social work education. There were also a range of opinions on facilitating social work education in this arena.

Educating the Educators

A factor inhibiting HIV/AIDS specific education may be that the AIDS epidemic is relatively new, emerging after the majority of educators completed their education and chose their specialization. A survey of AIDS related training in U.S. schools of social work found, only 2

percent of the faculty were conducting research, providing clinical services to clients affected by AIDS or engaged in other AIDS related activities. Only 1 percent had pursued extramural funded grants on AIDS. (Diaz & Kelly, 1991, p. 40). Faculty may be reluctant to provide instruction in areas where they feel inexperienced and underinformed.

Some participants offered similar opinions. One participant thought exposure was a factor. "Faculty may not have been exposed to this population." Another commented "This is a new area for faculty; they have not been educated so we can't assume they're prepared to teach." An educator commented, "Programs are usually set up around major issues to educate faculty, however, none have been set up around HIV/AIDS, as far as we know."

Another factor may be that many social work educators are not geared toward traditional, social casework and communal social work models required to deal with the magnitude of biopsychosocial issues of AIDS. "The large majority of teachers in graduate social work education have developed their careers around clinical work and are deeply committed to psychotherapeutic modes of practice" (Specht & Courtney, 1994, p. 150).

According to the literature, educators may also experience the same fears and inhibitions as the rest

of the population, which may limit interest in teaching AIDS related courses. Commentating on the potential conflicts professors may have dealing with AIDS as a socially unacceptable and stigmatized chronic, fatal illness, Weiner (1990) encourages instructors to confront their personal feelings in order to "facilitate and permit students to examine and communicate their own fears and anxieties about sexual behavior and drug use contributing to AIDS and death" (p. 179).

AIDS requires discussions of human sexuality and death, which may be an added difficulty for faculty, due to personal reasons and/or lack of AIDS specific education. David Kagan, Dean of Academic Affairs for the California State University system aptly challenged the academic profession to confront the AIDS epidemic stating, "Higher education must do a better job reaching students. There are two things we don't deal well with - human sexuality and death. The tragic situation with AIDS is that it involves both. We can't ignore it" (Weiner, 1990, p. 173).

Some participants offered opinions, which tended to confirm the literature but many also thought that social work educators have a responsibility to be leaders and as one participant stated "Social work educators should be a step above the social work community." "Social work

educators have a great responsibility; they're the ones that train clinicians, administrators and policy makers." "Educators should be leaders in eliminating bias." "Social work educators should be the leaders, in the forefront; out there researching determining what we need to be providing and doing." Finally, according to Weiner (1990)

> Social work educators possess the sensitivity and practice skills to help students deal with the difficult issues that are the reality of AIDS, either as persons at risk or as care providers. This can be social work educators' unique contribution to their students, their universities and their profession during the AIDS crisis (p. 174).

Institutional Factors

Some participants thought that institutional issues and biases may inhibit higher education on socially sensitive subjects such as HIV/AIDS. According to Weiner (1990) there may be conflicts in colleges with religious affiliations. "The public stance of certain religious organizations may make discussions of sex and sexual activities of students difficult" (p. 165). An educator explained that resources are necessary to teach subject specific courses and they may be restricted by the institutional climate. "The institutional climate is a factor, which sometimes blocks issues that are socially sensitive." An educator commented "How much an institution does to address a problem depends on institutional biases, as well as, individual biases." "Most universities require

a course in ethnic diversity; how that is presented varies greatly depending upon institutional attitudes and biases." "The same may be true of AIDS."

The Council on Social Work Education (CSWE), the accrediting body for schools of social work, may also be an institutional factor inhibiting HIV/AIDS specific social work education. The CSWE sets the standards mandating content to be integrated into the curriculum. If they do not prioritize HIV/AIDS, schools of social work, realizing so many other pertinent issues, may not prioritize it either.

Political Factors

The issue of stigmatization and values emerged in reference to social work education, as well as, the disease. Some participants thought that political agendas and funding priorities restrict social work education. "The groups most impacted by HIV/AIDS are socially stigmatized and arouse little sympathy from decision makers." One participant drew an analogy with funding for school lunch programs. "Let's look at who needs a lunch. If it's illegal immigrant children then let them not have a lunch." "Similarly, if it's homosexuals and drug addicts that get AIDS then let them die because we don't like them." "U.S. decision makers resisted seeing AIDS as a social problem; a national problem; a collective

problem because affected populations were people they did not like." Some participants thought that these political issues determine what social issues are addressed in schools of social work.

One participant explained that years ago when the deinstitutionalization of the state hospitals occurred funding became available to educate social workers in community mental health. He was provided an educational grant to study mental health in the same way that students today are given child welfare stipends. "When there's funding and a call for expertise, schools of social work learn fast!" "It's inevitable for us to look at politics; I'm pretty sure if we said we had lots of funding here for schools of social work to respond to HIV/AIDS, there would be whole tracks established."

Constructions of HIV/AIDS Education

Virtually all participants agreed that some level of HIV/AIDS specific education should be provided in social work education. The many divergent opinions on how this should be addressed are as follows. A medical administrator thought, "Social workers lack core medical knowledge. The lack of basic medical knowledge may in itself be a factor in social worker's fear of AIDS." Another administrator thought exposure to be essential and suggested a site visit to AIDS specific agencies.

A number of social workers commented that schools of social work have a responsibility to at least teach the basics about HIV/AIDS. "Social workers should at least be educated about the basics of HIV and the resources available for clients." "Basic education about HIV/AIDS should definitely be addressed in schools of social work." "Social work education is important. A whole class may not be necessary, but basic HIV/AIDS information is essential."

Participants also offered other suggestions. "Human sexuality and substance abuse classes should be educating social workers about HIV/AIDS." "I think that social work education has the responsibility to provide both undergraduate and graduate students with classes which focus on the individual person with AIDS and the family systems involved." "The schools should emulate public agencies with regular updates and education on all disabilities, one of which happens to be AIDS. An inclusive approach is suggested and is more palatable to clients and workers. It may prevent stigmatization." "There is a need for an administrative specialization."

Interestingly, educators offered very different constructions of ways schools might integrate HIV/AIDS education into the curriculum. One professor perceived it as an issue of sexual diversity. "Sexuality involves

a wide range of issues, one of which is HIV/AIDS. The social work profession has not adequately addressed sexuality and sexual diversity." Another educator saw HIV/AIDS as an issue of oppression. "Content on minority populations and special group issues is required by CSWE in order to meet accreditation standards. This automatically includes HIV/AIDS populations, since they are an oppressed group." Once again, it is evident that the way a problem is defined will determine if and how it is addressed.

Conclusion

A review of the literature and participant's responses indicated that both, the social work profession and social work education, have lagged in responding to the AIDS crisis. It appears there are many factors, which inhibit HIV/AIDS specific education in schools of social work. It is vital that the profession confront these barriers since, education was identified as the essential factor to facilitate social work involvement with HIV/AIDS and to mitigate this devastating pandemic.

Factors Facilitating Social Work with HIV/AIDS

Many participants also addressed other factors, which may facilitate social work practice in the HIV/AIDS arena. In addition to education and exposure, they identified changing perceptions of HIV/AIDS, benefits of working

with this population, and personal experience.

Living with HIV/AIDS

A significant number of participants in this study thought that changing the perception of HIV/AIDS from a "death sentence" would facilitate social work involvement. A social worker commented, "Actually, work with HIV/AIDS entails involving clients in their living rather than dying; living with the limitations the disease might place on them." A case manager shared, "There is no cure, but there is still hope; there is still life with HIV." A social worker, actively involved in the field, stated, "HIV/AIDS is perceived as death; no hope. It is vital to change perceptions from HIV as a fatal disease to living with HIV. People can live a long time with HIV. Quality of life may change and there may be limitations but they can live a comfortable life." "Education and empowerment are necessary to change the profession's perceptions from HIV/AIDS as a hopeless, fatal disease to the perceptions of living with HIV in order to support clients."

Benefits of Social Work with HIV/AIDS

A number of social workers also shared some of the benefits they have experienced as a result of this work. Most felt that if workers recognized the personal value, they may be more willing to work with infected and affected

populations. "Social workers can get so much gratification by working with HIV/AIDS; making a difference in the lives of people who are so fragile and so ill, people who are often rejected." "Work with HIV/AIDS facilitates the worker's personal development." A case worker stated, "Clients with HIV can inspire workers. The work with HIV can be difficult sometimes but is often rewarding." Another social worker stated, "This work helps value clarification. It's really changed my value systems: life is short, value life, make everyday valuable."

Personal Experiences with HIV/AIDS

An interesting finding was that the vast majority of professionally trained social workers involved with HIV/AIDS had been exposed to the disease on some level in their personal lives. Many thought this to be the most significant facilitative factor. Their responses are as follows. "The disease is so stigmatized that it almost takes getting touched by it to be open to confronting and working with it." "Social worker's primary motivation to work with HIV/AIDS is that they've been touched by it personally; your mind expands when you're touched personally by the disease." "Especially when family members are infected and affected, you have to get involved." "My motivation to get involved, includes the fact that friends have died of the dis-ease."

"Gerontologists have generally been the first to jump in and work with HIV/AIDS in social work circles." Among other reasons, this educator stated, "Gerontology has lost some significant social work members to the disease and seems to have a special commitment to carry on their work with HIV/AIDS." Another educator shared his experience. "It is difficult to ignore the problem if you belong to an ethnic community that has been harshly impacted by it."

Finally, participants offered some valuable comments on exposure as a facilitative factor. An educator stated "Exposure to HIV/AIDS populations, for example through working with a substance abusing population, may sensitize one to HIV/AIDS." Another educator shared, "We need to think about ways to systematically expose students to populations they have fears of, such as an intern rotation through hospital emergency rooms." A social worker stated, "Educators need to allow students every opportunity to be exposed to HIV/AIDS."

DISCUSSION

Summary

HIV/AIDS is a complex disease with tremendous biopsychosocial ramifications. Results from this research project indicated that an equally complex myriad of factors have affected the response of the social work profession.

Firstly, the construction of HIV/AIDS may be a significant factor in the response of the social work profession. There was participant consensus that HIV/AIDS is a medical disease. This is an educated construction, as compared to, the common societal constructions defining the disease according to high risk behaviors or groups. However, only one participant immediately responded that "It's a social problem impacting oppressed groups." There is little doubt, that if this construction were posed to these dedicated participants, toiling on the frontlines of the AIDS crisis on a daily basis, there would be consensus. It is afterall, those working directly in the AIDS arena, who witness the devastating biopsychosocial impact of the disease. Unfortunately, this construction emerged at the end of the data collection process and it was impossible to present it to the other participants.

It is interesting to note, however, that the immediate responses were "it's a virus, infection, medical condition." While social workers may perceive HIV/AIDS as a medical problem with social ramifications, this construction may imply they do not necessarily define it as an issue of social oppression. This may be a factor inhibiting the response one might expect from the social work profession. If the social work profession perceives HIV/AIDS as a medical condition, the result may be an

expectation that the medical profession will respond and social workers will fill in the direct service gaps, as needed. If HIV/AIDS isn't prioritized as a problem of social oppression, the social work may not be motivated to confront it anymore than we confront other medical conditions, such as cancer or diabetes. While social workers are providing social services to cancer patients in medical settings, they are also providing ancillary services to HIV/AIDS patients, as part of the client base in medical arenas. Although these are vital social work services, they fail to address the powerful socio-political forces impacting disenfranchised communities, infected and affected by the epidemic of HIV infection. Perhaps, the construction of HIV/AIDS as an issue of social oppression would facilitate a comprehensive social work response.

Dr. Jonathon Mann, former director of the World Health Organization during the first decade of AIDS and current Chair of Harvard School of Public Health spoke of this issue at the National HIV/AIDS and Social Work Conference (1995). Addressing the lagged response of the social work profession, he spoke of the global perspective of HIV/AIDS, as a problem of social oppression. He suggested a shift from thinking of HIV/AIDS as a medical disease or public health issue. He constructed the socio-political

treatment of HIV/AIDS communities, as a basic violation of human rights worldwide.

The unanticipated results regarding social service provider's perceptions of social work as a "generic" profession is pertinent. Few participants, other than social workers, recognized the Master of Social Work (MSW) as a terminal and comprehensive social work degree. This may also be a significant inhibitory factor for professional social work practice with HIV/AIDS since administrators, program developers and government may fail to recognize the valuable contributions of MSW's in the HIV/AIDS arena.

There also appears to be a significant issue regarding social work's image. The lagging professional response to populations infected and affected by HIV/AIDS seems to have given the impression that we as a profession have failed to answer our calling. Many participants thought that the profession's focus on clinical practice and licensing have shifted the image of social work. Many thought that as a result, we no longer prioritize a response to disenfranchised and marginalized groups. Other professionals, governments, and communities may not call upon us to respond, due to a negative image of "failing to get the job done." One administrator shared that administrators of a hospital, instituting a

specialized AIDS unit, did not see the need for a social worker. "I don't see them making a valuable contribution and don't want them around if they're uncomfortable. There is potential for greater social work involvement, but they need to get out and create a niche for themselves."

It appears that the esteem of clinical licensing in California has contributed to a biased image of social workers, solely as clinicians. Along with generic labeling, this seems to have led to devaluation of the MSW degree. Informal discussions with social work professionals, who have worked in other states, indicate a very different picture. While licensing of social workers is valued, it is not emphasized to the same degree as in California and MSW's are highly regarded professionals. As a result of attendance at the national HIV/AIDS and Social Work conference '95 in Chicago this month, this researcher had the privilege of seeing many MSW's in leadership positions in organizations, providing a range of services to communities impacted by HIV/AIDS. This may indicate that the overemphasis on licensing is an issue specific to California state licensing regulations and California NASW.

A myriad of factors related to fears and biases were also identified as barriers to social work involvement

with HIV/AIDS. Education was clearly identified as a factor to remedy these issues and facilitate a social work response to HIV/AIDS. While some of these fears and biases may be irrational and intractable, research has repeatedly demonstrated that most are amenable through education. Both social work education and the social work profession, have a responsibility to prioritize HIV/AIDS education. HIV/AIDS content should be integrated into the curriculum. There is also a need for continuing education and trainings, to teach basic etiology and epidemiology of HIV/AIDS and facilitate social workers in clarifying values and biases against HIV/AIDS infected and affected populations.

Limitations of the Study

This was only the first phase of inquiry in what might be a longitudinal constructivist study. As such, it involved a single round of interviews and was exploratory in nature. The proposed direction of the research was a focused exploration of factors inhibiting and facilitating social work involvement with HIV/AIDS. The scope of the study was vastly expanded by the unanticipated emergence of issues related to social work's image and participant's lack of clarity about professional social work. This detracted from an in depth exploration of the other issues.

This study was also limited by it's microscopic focus on one small community in Southern California and is by it's qualitative nature not generalizable to other populations, communities, states or nations. The results of this research project were constructed through a compilation of salient features reported by the researcher and stakeholders participating in this one area. The literature constructions were derived primarily through social work literature from the United States. The results are not meant to be exhaustive in nature and may be relevant only to this region and the participants.

HIV/AIDS is a global pandemic. Africa, for example, has approximately seven million cases of primarily heterosexually transmitted AIDS. Some Euroupean cities have a high incidence of HIV/AIDS transmitted through intravenous drug abuse and heterosexual behavior. Louisianna reportedly highly values the MSW degree and HIV/AIDS specific agencies are administered and operated by MSW's. Consequently, a similar study in other national and global communities may yield dramatically different results.

Suggestions for Future Research

The constructivist paradigm suggests three phases of inquiry. Each phase becomes increasingly focused and refined as saliencies continue to emerge through the

interactive dialogue. A suggestion for future research is to continue the next two phases of constructivist inquiry. Additional stakeholders were identified during this phase of the study. They could be included into the hermeneutic dialectic circle for further inquiry. This case report should be shared with participants in advance for examination of the identified issues, which would add to the depth of inquiry. Factors, which inhibit and facilitate social work practice with HIV/AIDS, could be studied more in depth, once the concept of professional social work is clearly defined at the outset of the study. Future research might also focus more comprehensively on the construction of HIV/AIDS as social oppression and an issue of human rights violations.

Recommendations

The short term goal of this project was to educate and empower the social work community, educators and profession, so that they might realize the vital necessity of a professional response to the HIV/AIDS crisis. The ultimate goal of this project was to facilitate action and policies, which would enhance a social work response to HIV/AIDS in all arenas of social work practice. This study yielded results, which pose a significant challenge to the profession in restoring social work's image. The study also yielded findings regarding fears and biases

that one might not expect from professionally trained social workers. Remedying these issues may require action and policies, which demand that NASW and CSWE prioritize social work practice and education with HIV/AIDS.

As a result of this study, the following recommendations should be considered:

1. The title social worker must be protected. Social workers should advocate NASW to develop policies and take legislative action to protect the image of social work. Other helping professionals and para-professionals should not be allowed to use the title social worker by virtue of their job description or agency affiliation.

2. The NASW Board of Directors should fully and immediately implement the recommendations for a professional social work response outlined by the NASW HIV/AIDS Task Force.

3. The CSWE should immediately mandate schools of social work to integrate HIV/AIDS content into the curriculum by revising accreditation standards.

4. Schools of social work should take the initiative to integrate HIV/AIDS specific issues and education into content addressing issues of oppressed groups. HIV/AIDS specific education must be available to students in order for new professionals to adequately respond to HIV/AIDS in this second decade of the epidemic.

5. Social work educators should be educated on HIV/AIDS issues, in order to adequately educate students to respond to this crisis. Professional training and education is available for educators at the National AIDS Training and Education Centers. Contact: Dr. Nathan Linsk at the Midwest AIDS Training and Education Center (312) 996-1426.

6. NASW should launch a major educational campaign to assure that all professionally trained social workers are prepared and willing to respond to HIV/AIDS in all practice arenas. The association should also strictly enforce the Code of Ethics and sanction any social workers refusing to respond to HIV/AIDS infected and affected populations, when called upon to do so.

7. All social workers should read the modern human rights manual and integrate the issues of social oppression and basic human rights into our work with HIV/AIDS.

It is this researcher's expectation that these recommendations will be seriously considered by all social workers. Further, all concerned social workers should take immediate action in advocating these organizations to prioritize HIV/AIDS on all agendas. Contact the National Social Work AIDS Network (N-SWAN) for support in actualizing these recommendations. Willis Green, Jr. (212) 491-9000 or Mary Jean Weston (713) 520-1414.

Implications For Social Work Practice

A report by the Social Workers Task Force on HIV/AIDS indicates that "many practitioners who identify themselves with one field of practice do not recognize that the insidious nature of the AIDS epidemic has implications across all arenas" (Peterson, 1991, p. 32). Reamer (1993) in a discussion of AIDS and social work ethics, states "no social service setting will be able to avoid the stark reality of AIDS; social workers who a decade ago had scarcely heard of the disease can now expect to encounter it regularly" (p. 412). Yet, today in 1995, with all the medical advances and scientific knowledge about the epidemic of HIV infection and AIDS, there is evidence of social worker's continued reluctance to respond to the impacted populations.

Jack Stein, chair of the NASW Task Force on HIV/AIDS, expressed concern about the apparent belief of many social workers that they can choose whether or not to work with a client with HIV/AIDS.

> Refusing to work with a client on the basis on HIV infection is clearly a violation of both the NASW Code of Ethics and federal anti-discrimination law. Every social worker has the responsibility to develop the skills and comfort levels to work with HIV infected clients as they may present in their setting. Referring clients on to colleagues who are more willing to work with people with HIV is pure and simple discrimination (NASW HIV/AIDS Liaison Update, June, 1995, p. 2).

Suggestions For An Ethical Social Work Response

The NASW Code of Ethics mandates all social workers to respond to the social impact of HIV and AIDS (Social Work Speaks, 1994, p. 20).

Direct practice skills and social casework are directly transferable to the myriad of systemic psychosocial problems encountered by HIV/AIDS infected and affected persons, families, groups and communities. Clinical social workers have an opportunity to identify needs and develop culturally and gender sensitive intervention models to serve populations of women, children and racial and ethnic minorities.

Case management models that address the myriad of specific needs unique to each of these populations including; caregiver support, respite care, foster homes, adoption services for AIDS orphans are needed, since the majority of current models are specific to the gay, white male. At a minimum, all direct practice workers have a responsibility to acquire epidemiological knowledge including the etiology, transmission modes and early intervention techniques, in order to provide risk assessment, education and primary prevention services to all clients.

Social workers in administrative positions are confronted with occupational, educational, fiscal and

supervisory issues. "The World Health Organization (WHO) has estimated the 90 percent of people with AIDS are employed at the time of diagnosis" (Social Work Speaks, 1994, p. 20). Work can be one of the most vital components enabling a person with HIV/AIDS to maintain a sense of autonomy, dignity and social support, yet the workplace continues to be an area of discrimination, stigma and alienation. Social workers must take an active position in the workplace to advocate for clients and co-workers in order to prevent discrimination, maintain confidentiality and sensitivity and provide education, counseling and support for all workers.

Social work administrators and educators have a responsibility to provide education and supervisory support for social workers contending with HIV/AIDS in their work. Ethically, no social worker has the right to refuse services to persons affected by HIV/AIDS. Workers and students must be provided education and supervision and "should be subject to disciplinary action, including dismissal, if necessary" if they fail to maintain performance mandated by the NASW Code of Ethics (Social Work Speaks, 1994, p. 23).

Social workers in policy practice arenas can have a tremendous impact on the multidimensional legal, ethical and political dilemmas encountered by this vulnerable

population. All people, regardless of their ethnic, racial, social, financial, sexual orientation, age, gender or immigrant status have a right to medical, legal, economic and social supportive services. Social workers must advocate for legislation and funding to promote social and economic justice and ensure that people are provided the necessary services to live with HIV/AIDS and die with dignity free of stigma, discrimination, civil and human rights violations.

Community social workers have an incredible task of organizing comprehensive service delivery systems and advocating for scarce resources. The most successful agencies and organizations serving those affected by HIV/AIDS have been the grass roots, community organizations, developed primarily by the work of the gay community. Social workers must support these agencies and work toward the formation of comparable models and organizations in order to develop, comprehensive, models specific to the needs of an increasingly multi-cultural and multi-generational populations of people with HIV/AIDS in all communities.

Researchers and social work educators have a responsibility to be on the cutting edge and provide innovative and creative information to facilitate students and society in seeking ways to support those afflicted

and affected. To date there is no cure for AIDS and the only method for arresting the disease is through primary prevention. All social workers have a responsibility to impart the unique knowledge, skills and values of the profession to educate society in an effort to prevent further devastation and loss of lives.

AIDS has been a great teacher for many. It has challenged both people affected by HIV/AIDS and the workers serving them, to contemplate profound existential questions of life, death, values and relationships. AIDS continues to challenge us personally and professionally. Ryan (1991), in her discussion of social work's lagging response to the AIDS crisis succinctly states,

> Social work as a profession can make enormous strides in healing the massive social disruption and pain brought about by the AIDS epidemic. If we view this catastrophe as a test of our ability to plan, react, and rapidly reassign priorities, we could learn a great deal. Then perhaps during the next social crisis, social work could lead the way (p. 4).

APPENDIX A - Informed Consent

INFORMED CONSENT

The study in which you are about to participate is designed to explore the factors, which facilitate and inhibit professional social work involvement in the HIV/AIDS arena. This study is being conducted by Paula J. Hogan under the supervision of Dr. Majorie Hunt, professor of Social Work. This study has been approved by the Institutional Review Board of California State University, San Bernardino.

In this study, you will be asked to share your knowledge and opinions of the AIDS epidemic and your perception of professional social work's involvement in the field. The constructivist design of this research project is such that, data gathered will be analyzed throughout the course of the project and may be shared with other study participants. At no time will your identity be reported with your responses. At the conclusion of the project, results will be compiled into a case study to be shared with participants, universities and community agencies in the form of a written report. The identity of participants and agencies will be held in the strictest confidence.

Potential benefits of participating in this interview may include: improved services to populations infected and affected by HIV/AIDS, community networking with the individuals, agencies and organizations working in the AIDS arena and new insights into clinical, policy and advocacy perspectives of people from a myriad of backgrounds. The potential risks of participating might include the surfacing of unwanted or unforeseen feelings surrounding HIV/AIDS. Another risk may be the awareness

of acute differences in the perceptions, treatment and prevention of AIDS, which may conflict with your personal or professional opinions and beliefs.

Your participation in this research is completely voluntary and you are free to terminate your participation at any time without penalty. You are also invited to change or revoke any information or data provided by you at any time during this study. At the conclusion of the research project, you will receive a report of the results. Please, be assured that at no time will your identity be revealed to anyone other than the identified researchers, through any form of communication, including the case study or any of the written reports.

I acknowledge that I have been informed of, and understand, the nature and purpose of this study, and I freely consent to participate. I acknowledge that I am at least 18 years of age.

_____ _____

Participant's Signature Date

_____ _____

Researcher's Signature Date

APPENDIX B - Debriefing Statement

DEBRIEFING STATEMENT

California State University, San Bernardino, and the researcher conducting this study have responsibility for insuring that participation in any research sponsored by this university causes no harm or injury to its participants. In fulfilling this responsibility, contacts for counseling are made available to any participant who, due to his/her participation in the present study, experiences psychological or emotional repercussions. The following contacts are provided in the event counseling should be required as a result of the above participation: Desert AIDS Project (619) 323-2118, AIDS Hotline of Southern California (800) 922-2437, National AIDS Hotline (800) 342-2437.

Any questions or concerns regarding this research, or its findings, may be directed to:

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Palm Desert, CA 92260
(619) 568-9647

OR

Dr. Marjorie Hunt
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California State University, San Bernardino
5500 University Parkway
San Bernardino, CA 92407
(909) 880-5501

APPENDIX C - Interview Questions

1. How would you define AIDS?
2. In your opinion, what causes AIDS?
3. In your opinion, how might the helping professions best contribute to the field of HIV/AIDS?
4. Have you ever had MSW social workers on the staff?
5. Are you aware of any factors that may be barriers to social work practice with HIV/AIDS?
6. Are you aware of any factors that may facilitate social work practice with HIV/AIDS?
7. How do you see the social work profession making a contribution to the field of HIV/AIDS?

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