A DRAMATURGICAL ANALYSIS

OF NURSES AND

AIDS-STIGMA

THESIS

Presented to the Graduate Council of
Southwest Texas State University
in Partial Fulfillment of
the Requirements

For the Degree

Master of ARTS

By

Clay J. Johnson, B.A.

San Marcos, Texas
May, 2003

ACKNOWLEDGEMENTS

I would like to thank Dr. Harold Dorton for being the chair of my thesis committee. Through his guidance, immeasurable contributions were made to this thesis. Without his resolve and dedication to high standards, I would not have been inspired to keep working toward my academic goals.

I would also like to acknowledge Dr. Barbara Trepagnier and Dr. Christopher Frost for encouragement and input as members of my thesis committee. Their comments and insights were invaluable.

In particular, I would like to thank my mother and father for all of their support and encouragement. None of my dreams would have been possible without them. I also would like to thank Pamela Oommen for always being there on the days when this thesis was overwhelming. Her patience and support enabled me to continue and finally complete this thesis.

TABLE OF CONTENTS

ABSTRACT

A DRAMATURGICAL ANALYSIS

OF NURSES AND AIDS-STIGMA

by

CLAY J. JOHNSON, B.A.

Southwest Texas State University

May 2003

SUPERVISING PROFESSOR: HAROLD DORTON

This thesis examines the interactions between nurses and AIDS-patients. Specifically, Goffman's dramaturgical analysis was utilized to understand impression management techniques employed in this interaction. Twelve AIDS-nurses from an AIDS-clinic in a large Texas city were interviewed to determine if AIDS-stigma was present interacting with AIDS-patients. Analysis of the interviews revealed AIDS-stigma was not present and corrective impression techniques were not employed. By providing unbiased care, the nurses fulfilled role-expectations. However, the nurses perceived nurses at general hospitals stigmatizing AIDS-patients not fulfilling role-expectations. Nurses at the AIDS-clinic perceived their facility a haven for patients stigmatized for having AIDS. This provided an individual and group identity that expected a quality of care perceived as uncommon in the general hospitals creating a tight-knit community

between nurses and patient. Such a community carried expectations where any presence of AIDS-stigma was not tolerated and reported if exhibited.

INTRODUCTION

Prejudicial attitudes concerning persons with AIDS are often informed by widespread misperceptions or misconceptions. AIDS is sometimes connected with irresponsible, deviant, and licentious practices and lifestyles (Devine, Plant, and Harrison 1999; Winslow, Rumbaut, and Hwang 1989). Consequently, fear and anxiety replace a collective understanding of AIDS. Furthermore, people often perceive those with AIDS suspiciously and negatively (Walkey, Taylor, and Green 1990). Given such a context, interactions with persons with AIDS may be affected, by stigma as well.

The nursing profession provides a role defined by caring, by providing holistic care, and by giving attention to the patient. However, popular beliefs concerning AIDS may be biased against AIDS patients. Through associating attributive qualities, persons with AIDS may become stigmatized. Such stigma may manifest in a role transgression for the nurse. Exhibiting stigma interrupts role expectations of the nurse whereby the patient may be further alienated and the subjective sense of blame and feelings of decreased worth buffered.

The role of the nurse is one of caring, a role expected by both patients and peers. Portraying actions contradictory to the role of the nurse would result in failed impression

management. This thesis examines the interactions and behaviors of nurses theoretically through a dramaturgical framework via qualitative methods.

In particular, the purpose of this study is to explore the interactions between nurses and patients with AIDS. I use Goffman's dramaturgical framework to understand impression management techniques nurses relative to AIDS and AIDS-stigma. I interviewed the staff of 12 nurses at an AIDS-facility in a large Texas city to gather data.

Data show that nurses from the AIDS-facility do not manifest AIDS-stigma in their interactions with patients. They perceive themselves and their peers as fulfilling role expectations. Perceptions emerged however that AIDS-stigma does occur in nurses at the general hospital in the same city when interacting with AIDS patients.

Any nurse exhibiting AIDS-stigma does not coincide with the expectations the facility and leaves voluntarily or is asked to leave. Nurses at the AIDS-facility provide a quality of care perceived to be lacking at the general hospital. The facility then is a place where persons with AIDS received care without stigma. The expectation in providing this quality of care formed the individual and group identity of the nurses at the facility.

A review of the existing literature on AIDS-stigma and relevance to nursing is presented in Chapter 1. Also included is a discussion of the theoretical structure upon which this study is based. A discussion of qualitative research and a description of the methodology utilized in the present study are presented in Chapter 2. Finally, results and a discussion of the key elements of this study are presented in Chapters 3 and 4.

CHAPTER 1

REVIEW OF LITERATURE AND THEORY

Globally, 16 million persons have died from AIDS and currently 50 million persons are infected with HIV (Levin, Bull, and Stewart 2001). To date, a reported 753, 907 persons infected with AIDS reside in the U.S. Engagement in homosexuality accounts for the primary means of exposure among men while women become infected primarily through heterosexual activity (CDC 2000). The epidemiological data does not reflect AIDS as a lived experience, particularly the dire physical, emotional, and social consequences.

CULTURE AND AIDS

A cultural and linguistic fragmentation besets AIDS discourse. Deemed the "epidemic of signification," (p. 19) the social terrain of AIDS challenges identity because it is not just defined by biomedical discourse, but in an array of social meanings (Treichler 1999). Moreover, members of marginalized groups, particularly the gay community, also became perceived as a primary cause of viral transmission (Panem 1988). For example, the media have portrayed AIDS as an easily communicable disease, which makes anxiety central to the discussion of AIDS.

Altheide and Michalowski (1999) argue that the media perpetuate a discourse of fear in part because they have presented selected misinformation, or information outside of its appropriate context. This creates a skewed vision of reality, reflected in public beliefs about AIDS. The media presented AIDS as an incurable disease. Fear and anxiety drove popular discourse, rather than a desire for information about everyday experiences with AIDS.

Sontag (1977) extends the concept of the social construction of illness identifying illness as socially metaphorical. Such a metaphor reflects those social elements relegated as deviant or morally suspect, particularly relevant in the social presence of a disease marked by potency and public ignorance. Standardization of such perceptions and interpretations become basis for AIDS-stigma. The cultural interpretation of illness and how the culture receives those that experience illness shapes one's construction of reality (Conrad 1986).

GOFFMAN AND STIGMA

For Goffman, stigma divides activity of the population into a dichotomy of stigmatized and those that stigmatize (1963). Those stigmatized rendered either as discreditable or discredited fall from the social parameters of the accepted. Being discreditable, the social agent may possess qualities that if exposed may result in stigma. Once exposed, the social agent becomes discredited. Stigma may result through physical abnormality, character defect, or tribal stigma where membership to a group provides the core of stigma. Every normal possessing a discreditable quality exists on the fringe of normalcy, close to being discredited.

The social actor not having discrediting attributes that deviate from social expectations may be considered one of the *normals* (Goffman 1959). Failing to conform to ritual and moral codes of conduct governing social interaction incurs the imputing of stigma (Creelan 1984). A symbolic morality defines social rituals retained and upheld by all members throughout the social order. Accordingly, interactants continually enact and reinforce codes of conduct. Every social actor then strives to act according to this symbolic morality. Failure to adhere to these codes of conduct produces unsuitable impression for others, but actors may engage in impression management or tactics that help produce a suitable impression. Impression management is the social actor's employment of social tactics in conveying this suitable impression.

IMPRESSION MANAGEMENT

Dramaturgical theory's focus is the analysis of activity, rather than knowledge (Hopper 1981). The dramaturgical process includes all social activity. Goffman uses the metaphor of performance and stage to both dramatize and understand this analysis (1959). All social settings act as a stage with actors who perform for the audience. People maneuver impression management tactics by adjusting them to the current frame of reference. The social world presents multiple stages where the actor daily engages in myriad role performances. Those stages that require particular performances are called *regions*. The actor may employ items, or *sign-equipment*, that coincide with the meaning of the region and the actor's performance (Goffman 1959).

Actors respond to both the setting and other actors on each stage. With varying frames, or the context of a social setting, every actor participates in role-playing

conducive to the implied meaning to the actions and props, or the surroundings involved in the performance. Actors must convince the audience of the performance's sincerity and authenticity. The impression the actor strives for is the legitimizing of the role being played, to attempt to present the ideals of that role. All performances must react "naturally" to the changing plots and story lines of daily interaction. Adaptation to these changes may require manipulation and even deceit for the act to be convincing.

Incorporating deceptiveness requires the actor to convince the audience of the naturalness in the actor's presentation in its *social front*, or social setting where the performance is enacted (Goffman 1959). Activity becomes drama that purposefully substantiates its reality. For this to occur, the audience must be convinced though the actor may need to believe in it as well. A presentation may be communicated through purposefully false impressions, which hides an actor's actual motives from an audience. Most social drama, however, requires the actor to be personally convinced of the act being performed (Goffman 1959). Belief in the role one enacts reinforces the role's validity and appropriateness. The actor who believes in the personal performance shares the audience's belief of the role requirements and the proper image that it should project.

Mismanaging impression management

Congruence with a script and referential social markers which guide a frame, is important for appropriate impression management. When an actor fails to create this congruence, impression management and role performance fails (Goffman 1959). Staying in role context safeguards the actor from suffering the humiliation of mismanaging the presentation of self. Safeguarding one's self from consequences require a consistency in role performance with certain poise. All social encounters are defined

by the perception of the actor. Preexistent rules govern the meaning and performance of these encounters (Goffman 1959). An actor's performance must abide by these social rules to successfully engage in the encoded script of everyday ceremonies. Self-perceived failures to meet expectations created in this ceremonial framework may generate shame or embarrassment.

The preexistent rules restrain such deviations and preserve the social consensus which allows social bonds to remain intact, albeit precariously. The rules attempt to maintain polite interaction and conformity over disruptive conflict and deviance. Without proper recognition and observance of the rules, the actor produces an inaccurate presentation. All social encounters will present challenges threatening the accurate presentation the actor attempts to engage. The actor will attempt to maneuver subjective impression management avoiding the risk of embarrassment (Gamson 1985; Schudson 1984).

Team Performance

Team behavior requires each participant's cooperation in supporting this collective impression that a group seeks to communicate (Goffman 1959). Upholding this impression requires the usage of back regions. Back regions are those areas allowing for the refining of an appropriate performance. This region allows the participant to regroup temporarily disengaging from the performance. An unfavorable response begins with associating negative attributes to others outside of the group. From this association the initial response is automatic. This reaction may be curtailed if present factors allow for the initial response to be reconsidered and replaced by one more appropriate (Pryor, Reeder, and Landau 1999). Back regions allow for this adjustment. By disengagement,

the back regions permit the expression of perceptions contrary to the actor's presentation (Goffman 1959). Referring again to the metaphor of the stage, the actor must go backstage for adjustments necessary for the next performance. Retreating to the back regions, one may adjust reactions more applicable to upholding the team's image. This retreat allows for a continuation of expressive control involved in a proper role performance.

Construction of meaning through activity

According to dramaturgical theory (Hopper 1981), reality and its meaning develop and are negotiated through interaction with others. Since it is not a stable facet of the social world the meaning of reality finds continuation in constantly establishing a constructed meaning. This process of establishment takes place through action, by shared activity. Other participants engaging in shared activity verify its meaning. The verification is ongoing scripting the necessary performances pertinent to our daily ceremonies. Any performance details the identity of the actor as we attach ourselves to the activity reciprocating the perception of self. Engaging in the activity allows us to identify with the script while interaction concurrently buffers our own identity as self (Hopper 1981). Construction of meaning occurs in this engagement where the actor garnishes prescribed roles with individual interpretations (Munch 1994).

AIDS-STIGMA

A growing body of literature details the prevalent stigmatization of persons with AIDS (Goodwin and Roscoe 1988; Herek 1999; Serlo and Aavarine 1999; Sheehan 1991; Walkey et al. 1990). Across campuses, students reportedly retained stigmatizing beliefs

and attitudes towards persons with AIDS (Goodwin and Roscoe 1988; Johnson and Baer 1996; McDevitt, Sheehan, Lennon, and Ambrosio 1990; Rozin, Markwith, and Nemeroff 1992; Serlo and Aavarine 1999). Expressions of stigma may be overt or sublime. For example, employees may be less likely to engage in social interaction with a peer known to have AIDS (Pryor, Reeder, and McManus 1991; Sheehan, Lennon, and Mcdevitt 1989). Stigma has been expressed in a range of environments and interpersonal relationships.

Subtle discrimination has included engagement in being overly cautious in interaction and job demotions. Direct forms of stigma have been companioned with manifest discrimination more hostile in intent through bomb threats and threats of bodily harm (Tewksbury and McGauhey 1997). AIDS-stigma may even be encountered in specialized communities where the care and concern of the individual is a primary concern. For example, social workers report "somewhat disheartening" (p.56) attitudes toward persons with AIDS (O'Hare, Williams, and Ezoviski 1996).

AIDS-STIGMA AND GOFFMAN

As previously noted, stigma is often associated with AIDS. Goffman (1963) defines stigma as biased or prejudicial labeling through a network of associations and categorization. Attachment of stigma occurs in those deemed appropriate candidates. Stigmatized persons are attributed *spoiled identities*, identities attributed stigma by a perceived fault or failing (Goffman 1963).

By social construction of AIDS, persons with AIDS may become recipients of AIDS-stigma. Less aligned with normals, persons with AIDS do not meet requirements

of normative expectations. AIDS-stigma then can be defined relative to negative social reactions.

Stigma becomes associated with one who does not accurately portray the expectations of the working consensus (Falk 2001). According to Goffman (1963), normals do not consider the stigmatized fully human. Since multiple stigmas intertwine in AIDS-stigma defining perceptions of AIDS, individuals may rationalize and justify their actions through an informal stigma-theory (Goffman 1963). People operating according to these ideas justify and confirm the stigmatization with an informal social agreement. This argument justifies the collective perception in discrediting those deviant from the social consensus (Devine et al. 1999; Gilmore and Somerville 1994; Winslow et al. 1989).

Through spoiled identities, persons can experience stigma (Gardener 1991). A lessened AIDS-stigma, however, may be attributed to identities tenable to the social consensus. This would particularly occur through contraction of AIDS through blood transfusions, infidelity, or other innocent transmissions. Identities then that typify expectations within the social consensus may mitigate stigma than those perceived deviant.

AIDS-stigma and virtual social identity

Some women exhibiting symptoms of AIDS may not be diagnosed with the disease. Often, this is because they are white and middle-class, unaligned with traditional risk-groups like homosexuals and intravenous drug-users (Grove and Kelly 1997). In Goffman's terms (1963) these women possess a virtual social identity, or socially imputed characterizations consonant with expected codes of conduct. Such hesitancy to

diagnose the seropositive patient reflects a symbolic morality inherent in social expectations of other's performances.

Patients from this study by Grove and Kelly (1997) lacked association to stigmatized groups not commensurate to social expectations. Once discredited, medical staff perceived and treated the women as innocent victims. While stigma remained a part of their daily life, social reactions did not hold the same moral indignation.

CATEGORIES OF AIDS-STIGMA

Stigma and the social experience of AIDS are strongly related. The social construction of AIDS involves multiple variables. Acceptance of such perceptions can affect interaction with persons with AIDS. These elements forming our social construction of AIDS may be not separate, but combined.

Tribal Stigma

Homophobia is an important aspect of the literature of AIDS and AIDS-stigma. In particular, homophobia is a primary factor that attaches stigma to the social meanings of AIDS (Bouton, Gallaher, Garlinghouse, Leal, Rosenstein, and Young 1987; Cochran and Peplau 1991; Dowell, Presto, and Sherman 1991; Fullilove and Fullilove III 1999; Herek and Capitano 1999; McDevitt et al. 1990; Triplet and Sugarman 1987). Through an increase of homophobic attitudes, a greater degree of social distance reportedly occurred when in the presence of a person with AIDS (Leiker, Taub, and Gast 1995). Researchers Larsen, Serra, and Long (1990) found that attitudes toward AIDS are strongly associated with homophobic attitudes. Similarly, Pryor, Reeder, Vinnaco, and Kott (1989) found that AIDS' symbolic functions are stronger creators of AIDS-stigma

than its instrumental functions. AIDS' symbolic function acts as society's moral injunctions, while its instrumental functions are connected to potential consequences through contact with AIDS patients. AIDS-stigma, then, has stronger influence when associated with perceived infraction of expected behaviors.

Moral Blemishes of Character

Deviant behavior challenges moral identity because it may represent a lack of proper self-regulation. In particular, actions perceived as irresponsible and immoral do not create socially acceptable public images. Instead, such perceived character flaws produce stigma.

In the case of AIDS contraction, control over infection is linked with social responsibility. Acquisition through activities such as prostitution, IV drug use, and unprotected sex generate heightened stigma, because these are not only viewed as immoral activities, they are also avoidable activities (Cole and Slocumb 1993; Forrester and Murphy 1992; Hassin 1994; Leiker et al. 1995). Conversely, the implementation of blame increases by extension of perceived responsibility the victim retains in acquiring AIDS.

Transmission by "innocent" means mitigates blame and stigmatization. Hemophiliacs, children of seropositive mothers, blood transfusions, and wives who have contracted AIDS by result of a husband's infidelity have little control over their contraction. Consequently, they are not only less accountable for their disease, they are less stigmatized for moral reasons (Dowell et al. 1991; Goldin 1994).

Physical Abominations

Goffman (1963) designated external bodily deformities as stigmatizing. While persons with AIDS are not always deformed, their bodies are medically defective, which may be similarly stigmatizing, likewise the fear of contraction associated with the condition creates a stigma similar to external bodily deformities. Bishop, Alva, Cantu, and Rittiman (1991) found perceived risks of contagion may be stronger than homophobia in creating stigma, challenging other findings (Pryor et al. 1989). The potential of contraction remains a source of distress for medical practitioners (Treiber, Shaw, and Malcolm 1987).

Lack of or distorted AIDS-related knowledge may result in fear of contraction (Royse, Dhooper, and Hatch 1987; Winslow 1988). According to Caruso and Haig (1987) college students demonstrate an "alarming degree of ignorance and misunderstanding" (p. 32) of AIDS. For example, high-risk behavior is often defined in terms of engaging in unprotected sex. Beyond this knowledge is misinformation, especially relative to transmission. For example, myths about marginally risky behaviors like hugging and kissing persist (DiClemente, Zorn, and Temoshock 1986; Cline and Johnson 1992).

AIDS as Multi-stigmas

Through persons identified as having AIDS, certain carriers can be identified. Identifying the single cause or expression of AIDS-stigma is impossible since many social elements contribute to the genesis of AIDS-stigma. For example, membership in marginalized and stigmatized subpopulations can be a key factor in stigmatizing AIDS

carriers. A double stigma may arise where group membership becomes further stigmatized in the attachment of AIDS.

Socially, AIDS is attributed to out groups, perceived as transmitted by deviant behaviors and/or lifestyles, contagious, and terminal (Conrad 1986). Modes of transmission affect the meaning of AIDS, which may be transmitted by behaviors perceived deviant and immoral, particularly those behaviors involving sexual activity. Moreover, meanings may be more potent because AIDS has no cure or vaccine. Each element interconnects in a semblance of social meaning of AIDS.

Persons with AIDS occupy the unique position of being discreditable or discredited by the combined stigmas of physical abnormalities, moral defect, and group membership. As the patient progressively suffers from this debilitating virus the physical appearance declines. The result in this decline means the loss of a healthy visage. Such debilitation may be interpreted as a character deficit, if others feel the person with AIDS the disease through deviant activities or improper self-restraint. Contraction through membership in a socially deviant group can extend the stigma formerly attributed with that group. Since the discovery of such discreditable qualities discredits an individual, such a person has to acknowledge a potentially tarnished social identity.

THE ROLE OF THE NURSE

Nurses may be considered the axis of the healthcare community especially in their proactive functions in healthcare delivery (Godfrey and Kuehne 1997). Nurses have more daily patient contact and more intimate relations than any others in the healthcare professions. Identified as the "culture of caring," (p. 226) the intimacy in daily contact

with patients must remain without bias or prejudice (Fox, Aiken, and Messikomer 1990). Patient interaction should reflect attitudes and behaviors of nurturance and comfort, qualities with positive impacts on patient recovery and sustenance (Fox et al. 1990). Moreover, such care must be both professional and ethical.

Controversies and concerns in the healthcare professions may create ethical dilemmas for the nurse and AIDS patient. These may include the right to confidentiality of patient's prognosis, quality care regardless of the prognosis, and respect and aid in maintaining autonomy of patient (Herrick and Smith 1989; Kirkman and Bell 1989). By exposure of the patient's status as an AIDS patient, the nurse may provide a lessened quality care.

Nurses receive encouragement to adopt an ecological paradigm. In the context of this paradigm, the patient is perceived in relation to existing social inequities, oppression, and uneven power distribution (Kleffel 1991). Caring for the patient's autonomy involves addressing these issues (Zawid 1994).

ROLE PRESCRIPTION OF THE NURSE AND AIDS

Nurses' roles expect them to attend to both personal and medical situations of persons with AIDS. This expectancy requires medical and therapeutic attention to all persons without prejudice or bias, in accordance with the ideals of such professional documents as the ANA Code of Ethics and AHA Patients' Bill of Rights (Herrick and Smith 1989).

Role Duality, AIDS, Moral and Tribal Stigma

AIDS-stigma may interfere with enacting role expectations and professional ideals (Denmer 1999; Lawrence and Lawrence 1989; Gallop, Lancee, Taerk, Coates, and Fanning 1992; Reutter and Northcott 1994; Robinson 1998; Siminoff, Erlen, and Lidz 1991; Valimiki, Suominen, Peate 1998; Vermette and Goldin 1996). Outside cultural perceptions combine with those role expectations defining the nurse. While nurses possess a moral agent enabling moral decision and action in a context of caring (Wilson 1999), stigma coincides when interacting with a patient deemed deviant, particularly with patients with AIDS (Farrell 1987; Carveth 1995).

Role duality occurs in extension of certain attributions to the patient. For example, healthcare literature associates AIDS and homosexuality, increasing negative attitudes toward homosexuality and AIDS (Schwanberg 1990). Seropositive homosexuals were deemed responsible for their contraction and deserving of their condition (Kelly, Lawrence, Smith, Hood, and Cook 1987). Nurses hold intravenous drug users, sex-workers and homosexuals most accountable for weakened self-regulation (McCann 1999). Patients failing to maintain symbolic morality may cause this role duality. In particular, depersonalization of the AIDS patient may overshadow the actual patient (Klisch 1990).

Role Duality, AIDS, and Physical Abominations

While negative perceptions contradict nurses' role prescriptions, fear involved with contact of AIDS patients may completely violate traditional expectations of nurses. Researchers Green and Platt (1997) reported perceived risks of exposure prompted healthcare workers to exceed requirements essential to safeguard the self from exposure.

Patients described the insensitivity of healthcare workers appearing and interacting overly garbed to the extent where patient accounts described the workers' appearance resembling "spacemen" (p. 81). The unnecessary donning of excessive protective gear has been witnessed in situations involving little to no risk of exposure. Segregation reportedly occurred as AIDS patients had separate waiting rooms (described by one patient as being more like a "broom cupboard" (p. 81)) and restrooms isolating them from other patients.

The spatial proximity in regards to interaction and level of contact affect one's degree of contraction. Concerns about contraction increase with degree of contact, especially with respect to blood (McCann and Sharkey 1998). Nursing students asked to comment on personal desirability in working with patients with AIDS raised objection based primarily on the fear of contraction (Eliason 1993) which may gradually subside with increased interaction (Klisch 1990; Patsdaughter, Grindel, O'Connor, and Miller 1999).

KNOWLEDGE AND AIDS-STIGMA

Nursing students may understand the fundamentals of AIDS but demonstrate relative ignorance of the disease's complexities (Jemmott, Jemmott III, and Cruz-Collins 1992). Almost every school of nursing includes AIDS education in the curricula although it may not counter pervasive AIDS-mythology. According to Chitty (1989) 72% of 366 nursing schools spent only 1 to 5 hours of class time teaching about AIDS. Only 19% utilize a role model format that teaches students through observing direct care of AIDS patients, and only 24% teach through administration of direct care. AIDS-

related knowledge accrued most from media-formats as newspapers, magazines, television, and radio (Armstrong-Esther and Hewitt 1989; Goldenburg and Laschinger 1991; Lester and Beard 1989).

As a result of the limited scope of AIDS-centered education in nursing programs, and the massive media coverage that augments it nurses may retain some misinformation the general public accepts. While nurses have more extensive knowledge of AIDS than the general population this comprehension and understanding may not adequately facilitate quality care.

Those nurses with a higher degree of AIDS-related knowledge evidence a stronger and more positive perception of persons with AIDS (Brown, Calder, and Rae 1990; Ooermann and Gignac 1991). For nursing students, the more comprehensive one's AIDS-related knowledge the more objective the perception of homosexuals and intravenous drug users (Jemmott et al. 1992). Increase in knowledge familiarizes nurses with modes of contraction. Understanding these modes mitigates fear of contracting AIDS. Knowledge also creates tolerance decreasing social distance.

Impression Management and Nurses

Even through the cultural discourse concerning AIDS is often misguided, it remains a potent and potentially stigmatizing element in interaction between nurses and AIDS patients. Nurses confronted with AIDS come into contact with a discredited patient. Overt displays of stigma would discontinue a nurse's performance in as a caregiver. To have a convincing performance, impression management techniques have to be adopted. All actions that communicate perceptions of AIDS patients as anything

but normal must remain subtle or concealed. The resulting social front coincides with the region in which the nurse performs the required duties as caretaker.

This region would often be the hospital setting. The hospital setting acts as stage for the role of nurse to be enacted with nurses also utilizing the stage and using the backstage when possible adjusting the performance to meet the ongoing drama. Usage of medical instruments, or sign-equipment, reinforces the social front. Nurses must utilize this setting as a stage with props and enact the role that suitable to the existing frame.

In the literature of AIDS-stigma, nurses may perceive AIDS patients as discredited or discreditable. Through tribal, moral infraction, and physical abnormalities the patient becomes discredited. Limited research has focused on reactions of nurses to AIDS. Not all reactions manifested in a stigmatizing manner. Nurses have stigmatized, though many have performed the role of caretaker as prescribed without falter. The relatively sparse area of literature does not specifically relate to the dramaturgical techniques in which nurses engage to maintain the image of caretaker with discredited patients. Role duality with AIDS becomes a subject in need of being addressed and understood.

CHAPTER 2

METHODOLOGY

This research provides a dramaturgical analysis of nurses who work solely with HIV/AIDS patients. My research focuses on nurses and the interactions with AIDS patients. More specifically, the purpose of this examination was to understand the impression management techniques nurses use if a role duality emerges. A nurse exhibiting bias when caring for a patient with AIDS is not fulfilling role expectations. Breaches in role performances would indicate AIDS-stigma. This research asks the following questions:

1) Do nurses perceive AIDS negatively?
2) If so, does impression management occur in the role expectations between the ideal and practical role of the nurse?
3) What forms of impression management are employed in this conflict?

DATA COLLECTION

I conducted semi-structured interviews with the twelve nurses from an AIDS-facility in a large Texas city to collect data. In the interviews, respondents addressed issues related to AIDS-stigma. The relationship of AIDS-stigma, impression management, and interaction with patients was central.

I analyzed the interviews to better understand the nurses' impression management. After taping and transcribing the interviews, I established a categorical framework connecting empirical results with existing theory.

RATIONALE FOR USING QUALITATIVE METHODOLOGY

The social sciences have traditionally emphasized quantitative oriented research (Denzin and Lincoln 1998a). Data that can be measured in quantity, amount, intensity or frequency constitutes quantitative research. Such research generally finds wider acceptance since it is deemed more scientifically based, particularly with the common viewpoint that science mandates clarity and precision (Denzin and Lincoln 1994).

Quantitative research attempts to demonstrate the causality between two variables (Berg 2001). Inferred deductively, finding causality supports a research question and theory. From such support, researchers view finding causality can express future outcomes (Neuman 1997). The primary goal in demonstrating causality, however, is to discover a universal value which means this goal is furthered through the use of neutral methodology and neutral presentation of results (Katsuko 1995).

Qualitative research, on the other hand, does not attempt to measure social action or imply causality. The chief concern with qualitative research is the content and process of experience. Scholars reveal experiences by identifying emergent themes in social actions and the surrounding events in which they appear (Denzin and Lincoln 1998a; Denzin and Lincoln 1998b). This social context forms the core of qualitative methods.

Social situations create and house meanings. When research fails to account for social situations it cannot explain the meaning of social action (Neuman 1997).

Concentration on this context contributes to a broad understanding of certain social experiences through revealing the depths of social meaning and action that quantitative methods are relatively unable to find.

Criticisms of Qualitative Methodology

Perceived as a "soft science" (p.7), critics of qualitative research consider its methodology to be less reliable in researching social action with less precise measurement. Instead, qualitative research only provides a description of social action making qualitative methodology suspect for some critics (Denzin and Lincoln 1998b) because relying on interpretations of social context deduces objectivity. In addition, some contend that research bias can result in the selective process and recording of information (Johnson 1997). Moreover since the qualitative process is exploratory, this makes it open-ended and less rigid than quantitative research.

Despite these criticisms, this emphasis on context and process in social action made qualitative analysis more suitable for this research project. This thesis is concerned less with the magnitude of AIDS-stigma among nurses and more with how nurses identify with the nursing role when interacting with AIDS patients. Particularly, this analysis allow for shades of meaning in the social action to emerge. Such analysis also constructs and uses theory through assembling the breadth and depth of varied meanings.

SETTING AND PARTICIPANTS

The facility housed and treated HIV/AIDS patients. Care provided to patients was without expense and care continued on a 24-hour basis. Patients were sent to a general hospital when the facility was unable attend to acute medical needs. Nurses

instead tended to patients' basic medical needs, giving medication, and assisting the patients limited by AIDS in daily activity.

I contacted an AIDS-facility in a large Texas city to solicit participants. All 12 nurses at this facility allowed me to individually interview them for this project. The nurses' mean age was 42, with a mean of 10 years of nursing experience and two years of working directly with AIDS patients. There were 8 females and four males (See Appendix A). Fictional names were assigned to each participant for both identification and to retain a more human element in the data.

Purpose in Conducting Research at an AIDS Facility

Initially, I planned to conduct this investigation with nurses at a general hospital. I contacted several hospitals throughout three major Texas cities, but was unable to secure agreement for conducting a qualitative study because I needed to conduct half-an-hour to hour-long interviews. Nurses at general hospitals informed me they could only leave the floor for fifteen-minute increments, which discouraged any productive interview sessions. Having busy schedules, none volunteered their only days off to participate in the interviews.

Moreover, a few of the hospitals had minimal experience with AIDS-patients. Such hospitals typically were located in less urbanized areas making them unsuitable for research purposes. I concentrated on urban hospitals after encountering this dilemma.

Referred by a doctor from an urban hospital, I contacted the head nurse at the AIDS-facility. After explaining the purpose of this research project, I was granted permission to interview all 12 nurses working at the facility. Almost all of the nurses had previous experience working in the general hospitals before working solely with

AIDS-patients. Making this facility more ideal for this research, the nurses possessed previous nursing experience coupled with experience presently gained in working with AIDS patients.

Purpose in Conducting Individual Interviews

Central to this research are nurses' perceptions of their roles as caretakers of AIDS patients. Individual interviews that secure a more meaningful narrative are the most effective way to secure data. In a one-on-one interview, the participant engaged in more dialogue concerning personal perceptions, a dialogue that would have been more difficult to obtain in a group interview.

In addition, single interviews afforded a richer context by allowing the participant to contribute personal perceptions which observation would not allow. Moreover, adopting observation as this project's only methodological tool would only have yielded data on how the nurses socially interact with patients and other nurses, which does not address this research' focus on how nurses perceive AIDS patient and whether and how these perceptions affect the nursing role.

ANALYSIS OF THE DATA

Grounded theory develops through observations of the social world, particularly by reflection of the data and emergent patterns within (Glaser and Strauss 1967). Completing the interview processes and transcribing, this reflection occurred through a saturation of the data. Perceptions and behaviors became clear creating concepts and theoretical ideas having a basis in the collected data. In turn, the concepts and ideas have validation in the data itself.

The interview format guided the research participants to relate particular qualities and aspects of their daily performances and general perceptions. Interview sessions typically contained the standard questions used to understand the narratives as related to the research questions. Though semi-structured, I used eight of these standard questions for the interviews (see Appendix B). Where I maintained that a participant's particular answer to a question added new understanding or development to this project, I asked other questions I felt relevant.

The Interview Process as Protocol Development

This research hinges on the interview questions. Role duality can occur whenever stigma involves the patients, particularly those who have AIDS (Klisch 1990; Green and Platt 1997; McCann 1999). The first three interview questions (see Appendix B) sought to reveal social actions, the definition of role, and whether social actions occur that do not abide by this definition. Third in this group of questions ("Do your coworkers exhibit these ideals?") was utilized for the purposes of understanding how nurses at the AIDS-facility perceived his or her peers. This question was also added for participant reliability in the event that the interview participant exaggerated subjective claims. The nurses may not claim to personally stigmatize the patient, though coworkers may note differently.

The following three questions (see Appendix B) I used to understand interactions the nurses have with AIDS patients. Asking interview participants about initial experiences with AIDS patients engaged the interview participant into discussing personal experiences and perceptions regarding AIDS patients. By further asking how they perceived how both actions and perceptions have changed since these first

experiences with AIDS patients, I was able to procure additional data useful in detailing nurses' perceptions.

In particular, such questions focused on the basis of these perceptions. The questions sought to determine whether AIDS-stigma was present in interactions and perception relating to the patients. Based on Goffman's stigma categorizations (1963), questioning involved perceptions regarding the patient's physical abnormalities (Green and Platt 1997; McCann and Sharkey 1998), moral defect (McCann 1997), and group membership (Kelly, Lawrence, Smith, Hood, and Cook 1987).

My last two questions directly asked the interview participants about any personal feelings and perceptions regarding AIDS and the AIDS patients. These questions I included to allow for additional comments and allow the interview participant to summarize personal perceptions. Asking direct questions allowed the nurses to be openly direct as well. The previous questions sought to indirectly reveal perceptions but did not provide opportunity to discuss subjective beliefs, feelings, and perceptions, particularly in relation to common cultural and social beliefs and perceptions (Walkey et al. 1990). The final questions allowed this opportunity.

Through the interviews I asked other questions to guide the interview process itself. Typically related to one of the standard interview questions, miscellaneous questions usually served to elaborate a certain comment or answer. This provided a more probing understanding of the interview participant's answer. Following the second interview, I began asking how interview participants perceived the care of AIDS patients by nurses at hospitals. This allowed me to understand the further dynamics in how the nurse perceived his/her own role as nurse, coworkers' roles, the AIDS patients, and the

role of the facility within the community. Through the interview process of probing, I began to recognize patterns in these dynamics contributing to determining a scheme for the interviews.

Determining Patterns within the Data

In developing a scheme in the interview questions, narratives emerged focusing on a particular social phenomenon. Examining the data after being fully transcribed revealed certain patterns. Goffman's dramaturgical framework forming the theoretical basis, I coded my data by breaking down these patterns into meaningful components (Bailey 1996). Listening to the interview tapes prior analysis, reading over transcribed interviews (a transcriptionist was hired for transcribing interviews), drawing maps and diagrams, and writing memos and notes aided in the development of categories and relationships (Bailey 1996; Maxwell 1996).

These components were separated into five related categories. The first two categories related to qualities nurses perceived in portraying the ideal nurse and nurses' self-identified qualities. Portrayals of the ideal nurse revealed the emergent themes indicating role-expectations within the AIDS-facility. Contrasting these role-expectations to self-identified qualities allowed for me to assess how the nurses perceive themselves acting out these expectations. Both ideal nurse and self-identified qualities contained subcategories detailing the context of these expectations and how nurses perceive they fulfill them.

Providing a similar function, the next two categories isolated those sections of the narratives where nurses discussed group-identity. How nurses perceived this identity in relation to nurses at the general hospital formed the other category. Through nurses

discussing how they perceived themselves and coworkers, identities emerged forming subcategories of particular identities.

I contrasted this category to the perceptions nurses had of other nurses at the general hospital. This contrast emerged perceptions in how nurses at the facility supported how they identified themselves and the clinic's role in the community. Coding those perceptions and comments by the nurses at the facility on the type of care administered by other nurses provides understanding to why the nurses retained this identity.

To provide a dramaturgical basis to these perceptions, I formed a separate category where nurses cited personal examples of interaction with nurses and AIDS patients. In coding, I did not discriminate in these examples of social action by forming subcategories. Instead, dramaturgical ideas emerged through explanations of particular situations and perceptions.

Generalizing Findings to Other Facilities

Quantitative analysis generalizes its findings through a set statistical parameter. Through a survey of a small sample, the results are extended to be suggestive of the larger population (Feagin, Orum, and Sjoberg 1991). Qualitative research however focuses less on generalizing from a sample and more on providing insights into a particular social phenomenon.

Reliability of generalizing qualitative data can be a concern as the research does focus only on a single social phenomenon. Focus on this singularity allows for depth of meaning within the phenomenon. Statistical surveys must assume that they reflect the attitudes of the sample population. In-depth interviews provide stronger insights into the

attitudes of the participants revealing shared meanings (Feagin et al 1991). A shared phenomenon is created by shared activities. These shared activities create a shared meaning (Denzin 2001). The shared meanings may be assumed to reflect other facilities more accurately than statistics (Feagin et al 1991).

CHAPTER 3

RESULTS

The nurses perceive their facility much differently than the general hospital staff. Nurses at this facility perceive the care they provide higher quality than the nurses at the general hospital. While stigma defines AIDS care at hospitals, a lack of stigma defines care at the facility. Nurses at the facility are expected to conform to this form of care. Abiding by these expectations, nurses form an *identity construct*, or role-identities shaped by these expectations and projecting a particular impression management. The collective effort by the nurses in maintaining these expectations and impression management form an *identity concentration*. Any exhibiting AIDS-stigma within the facility by not conforming to this identity concentration may either leave voluntarily or are asked to leave.

THE GENERAL HOSPITAL AND THE AIDS-FACILITY

Differences in perceptions of the AIDS-facility and hospitals emerged from the interviews. The emergent general evaluation of nurses and medical staff at hospitals was not favorable. Esther reported a lessened respectability since working with AIDS

patients: "I guess my perceptions about people in healthcare has changed and not for the better"

These differences involve quality of care in interaction with the AIDS population. AIDS care specialists (ACS) at the facility provided different care than hospital nurses. Some differences stem from hospital nurses treating AIDS patients unequally to the general patient population. Anthony described this difference in treatment:

> Oh my, um, night and day. Night and day. Um-I've worked in nursing homes where there's been HIV patients and there's certain nurses' aides when you come-I mean you couldn't get enough robes, gowns, gloves, hats, mittens on this staff that worked there.

AIDS-stigma was not manifest at the facility. Esther made the same observation in noting this difference:

> So listening to my patients, listening to their stories of care received in other facilities here in (a large Texas city)... Yeah, I don't see this an issue in this facility. I see it as an issue in the hospitals in (a large Texas city). And I'm sure it's pretty indicative of what the hospitals across the nation are like.

Sandra perceived the difference between the facility and the general hospital manifested in the level and types of care each provides remarking on a high level of care lacking at other hospitals: "I guess that's what's special about each and everyone one of these staff members is that we can go beyond all that."

While care is crucial, the facility staff strove to create an atmosphere unlike a general hospital. In particular, the staff strove to eliminate stigma and the threats of spoiled identity. With Terence, the facility resembled a safe haven for patients with spoiled identities: "That's the great thing about this place, it's a very safe atmosphere for everyone that comes in these doors." In short, ACS perceived their facility better from

general hospitals. This perception included an intimacy in interpersonal relationships not found in the hospitals. Patients can expect a better delivery of care without concern of a discredited identity.

Patients taken to other medical facilities returned to the AIDS-facility with stories of care received from both nurses and healthcare professionals. These reports became indicative of the types of care AIDS patients received while at the general hospital. Workers at the AIDS-facility perceived this care as lessened in quality. Care for AIDS patients at the facility, however, included respect and concern for patients' autonomy.

Types of Stigma and the General Hospital

AIDS-stigma created for the patients unfavorable reactions during interaction with healthcare workers. In accordance with Goffman (1963), stigma emerged in three categories: moral blemishes, tribal stigma, and physical abominations. Moral blemishes of character, tribal stigma, and physical abominations categorically formed these stigma types.

Moral blemish of character and tribal stigma. ACS perceived that nurses in other medical facilities did not deliver quality care to AIDS patients describing accounts of patients reported being snubbed or treated rudely. Patients have responded to hospital stays with strong hesitancy all the way to a refusal to go to the hospital. Esther explained reactions patients have when sent to another hospital for treatment:

> So I have patients that beg me not to send them back to a hospital because of the kind of care and the way they were treated at those facilities. And that makes me very sad that I have somebody that could benefit from a hospital stay and actually walk out, instead of laying there and dying, because of the way they were treated.

The stigma experienced at other hospitals may influence interactions between nurse and patients ranging from responding negatively to no response. The same participant describes personal frustration with this form of interaction:

> Having dealt so many years with this population and sending patients to the hospital when they're very sick and having them come back telling you stories about the care they received where they were never bathed, they were never changed, the nurses would not answer their call lights, they would not come in their rooms, the doctors would talk ugly to them, 'Well you have AIDS-you're going to die anyway.'

Hospital nurses stigmatize patients who contract AIDS through perceived deviant behaviors, interpreting this behavior and the disease as a moral infraction (Goffman 1963). These tarnished identities influence interactions negatively when nurses treat patients as deviants instead of patients. Terence perceived nurses in other hospitals dehumanize the patient:

> I feel a lack of compassion in most places by the nurses. I see a lack of concern. I see them doing a job just to get the job done. I see them looking upon the patients not as people. It's just somebody occupying a bed that space, for a day. That's their patient, you know.

Anthony acknowledged that hospital staffs understand AIDS medically but they perceive the patient to be irresponsible and deviant, even attributing less than human qualities to these patients:

> I think there's more of a...they know how you get it, how you don't get it. I think it's more of a look down on the person. I think by and large, the hospitals are not nice to AIDS patients, I've heard. I've had friends who have been in the hospital who-that they're cattle herds, this is how it's going to be.

The stigma of perceived moral failings are often exacerbated by membership in the gay community. Tribal stigma, or even its threat, can influence AIDS patients in hospitals to mask their membership to the gay community. AIDS and homosexuality

conjoin in AIDS-stigma so the patient must obscure personal membership to the gay community when at the general hospital. According to ACS, hospital nurses stigmatize AIDS patients according to both moral and community bases. More importantly, patients recognize this stigmatization and differential treatment. Consequently, both stigma and patients' knowledge of it influence interactions between patients and hospital staff, as well as the social environment of the hospital. This process, while disenfranchising and dehumanizing to the AIDS patient reaffirms the fragile symbolic morality of both the hospital and its staff (Goffman 1963). Yvonne recognizes that homosexual patients remain very discrete about sexuality in hospitals: "You won't see a lesbian or gay man going into a hospital to a floor, most of the time, and let it be known what their sexuality is." Patients assume they will receive deferential treatment and so remain discrete.

Fear of contagion. ACS perceived fear to be central to hospital nurses' interactions with AIDS patients. Reactions ranged from overdressing before contact with a patient to a lack of contact. Such reactions derived from a lack of knowledge or fear of the contagion. Sandra observed a lack of contact by staff and even by the hospital in connection with fearing AIDS:

> In the hospital, they'll come back and tell us 'We didn't get a hug' and 'They're afraid to come towards us.' There was still fear out there versus how they feel here... We use precautions, but I guess the fear isn't here as much as other outside staff at other facilities. Because like I said, it's not just one patient that says it, it's each and every one. They go to the hospital or to a different nursing home or whatever, they come back and they see the difference.

Terence described unnecessary overreacting in hospital treatment of AIDS patients. An insufficient AIDS-related knowledge may contribute to fear of this disease:

> I think that I've heard from people here that they treat them literally like walking diseases, you know. We had one patient and they put isolation tags on the door, you know. You need to wear a mask going in, everybody's gowning and gloving. And you know, here you don't need that. It's not something she's going to give you, she doesn't have anything contagious on the skin. And these guys, they go overboard. And I think it's a lack of knowledge or fear of the disease.

The medical facilities encourage this aversion to contact, a rejection often based on ignorance or fear (Bishop et al 1991). Again, Terence described this rejection: "So I think if people were better educated, you know, they'd know better. But most hospitals don't want to deal with AIDS patients. They'll send them somewhere else, you know. It's a shame."

The perception that nurses at hospitals feared patients with AIDS emerged from the participants. The contagious nature of the disease is the primary factor that creates this fear, which leads hospital nurses to treat patients "like walking diseases." According to participants, nurses in these facilities react from an incomplete AIDS-related knowledge base and consistent with research (Treiber et al 1987) are distressed by their potential for contraction.

GENERAL GROUP IDENTITY CONCENTRATION

In contrast to hospitals and their nurses, ACS at the AIDS-facility viewed both coworkers and patients in terms of greater intimacy in relationships than traditional occupational roles. ACS spoke about their peers and patients as if they have a collective identity, again what I call "identity concentration." During the interviews, four categories of group identity and interpersonal relationships emerged from the text: friend, team, family, and community.

The friend identity shows that the role of ACS extended beyond attending to the medical needs of the patients. AIDS patients at the facility experienced various emotional difficulties in connection with having AIDS. For example, Yvonne identified herself in relation to the patients as "a friend, an advocate, someone they can trust."

The group setting of the facility creates a need for the friend identity in this community:

> (As their nurse) you're their shoulder, you're everything to them. You're there when they fall no matter how they fall or been treated, it might be medically, emotionally, physically, you're there for them at all times.

According to Yvonne, coworkers sometimes remain past their shifts in order to "do something special with the patients." Patricia describes how the patient may respond to this treatment in kind:

> Um…if there's anything I can do like if there's a patient who runs out of money, I'll be like 'You want a soda?' and he's 'Okay.' So, I'll buy him a soda and he in return will pick some flowers for me or he'll make a drawing and give it to me.

Any ACS enacting the friend identity role does not react primarily to the patient's physical condition but to social and emotional needs as well. In Goffman's terms (1963), they offer acceptance in an environment that does not involve stigmatic interaction. Offering acceptance, patients have less concerns about spoiled identities. In response, the patient identifies to the friend identity by reacting to ACS in a context not limited to the patient role.

While patient relationships are central to ACS, peer relationships are also important. Reflective of this are the team identities that emerge from relationships with peers, rather than patients. As interrelationships and teamwork are basis for this identity,

cohesion creates it. Patricia described this cohesion by claiming that the facility possesses a "link" that runs throughout it. This link becomes basis for relationships that comprise this bond. Maria credited this link in buttressing group effort: "We all do our best around here. I don't know if I would be here this long if we weren't a team."

In team identity, a hierarchy of roles with subsequent assigned responsibilities does not emerge. Felecia describes the absence of a hierarchy in these terms:

> We're all on the same level here. We're all LVN's and nurses' aids. So we all know each other, you know. We're a pretty close group and we work well together, you know. Everybody pitches in and helps everybody. So it's no 'I can't change him, I'm a nurse.' You have to go change him.

The team identity the ACS created resembled a congruent team with a common goal: the patient. This absence of a hierarchy occurs through providing quality care. Providing the most effective care requires this absence where all ACS must participate in the care, regardless the task. ACS enacted roles with the goal of providing patient care. This goal resulted in a group expectation where members contribute in multiple roles, not just the occupational nursing role. The meanings in the roles formed a collaborative goal. ACS impression management coincided with these goals. Reflecting this meaning, Terence commented: "We tend to band together and help each other out and that's what makes this place really cool. I was offered other places to work but this place had a feeling." In interactions, impression management reinforces the collaborative goal.

Within team identity, the linking of ACS roles took focus providing an examination of the collaborative occupational meaning. Family identity focuses on participants' perceptions of the relationship between ACS and patient. The collaborative meaning within team identity is the patient. The actor's presentation focuses around the

patient. The extension of collaborative meaning develops in the relations among staff and patients. Yvonne asserted identity to this familial bonding: "It's like family." Enacting multiple roles around patients creates a familial cohesion in the facility. As stated by Terence, AIDS creates role synthesis in the facility: "It's like a big family, but its got this disease, you know. And I guess it's a common bond."

Lacking outside support, bonding becomes expected by the patients. As a result, Terence makes this observation: "Their families won't come in...so we're their families." With the absence of their families, patients may need to identify with a family structure. Staff becomes the family structure. To the ACS, the patient may also become a family member. Interrelationships with patients involve caring for the patient with the context of one's personal family. Sandra located this caring in the care of the AIDS patients: "So I think you just gotta care for them. You've got to treat them as you would want one of your family members to be treated." This family identity becomes a support for the patients. Anthony described this setting as a place where the patient may find emotional and social reinforcement: "This isn't so much a nursing group, it's...more like a support group. You know you need somebody here to talk to, to release their fears to."

For the same participant, this setting can also resemble the same tensions experienced in a regular family:

> Sometimes you feel you're the partner role to these guys. They have nobody, no partner, no wife, no husband, so to speak, to yell at, so you're being scolded for this or that. And it's like, 'I'm not your wife' you know, that's stuff that either your husband or wife would yell at you for.

Patterns in interaction begin to create scripts that influence family-like roles. Involved in these scripts are reactions are support and tensions encountered in the family setting.

Friend, team, and family identities all suggest a community identity within the facility and certain narratives defined the facility as a community collective. Yvonne described the facility "more like they're own community." A staff member who was not ACS defined the facility a subculture since the facility has been a stage for drag shows and other events not typical in the workplace setting. The community identity did not emerge as distinctly in relation to other group identifications. However, a community is assumed in friend, team, and family identities.

Frustration, AIDS Patients, and Blurring of Roles

Providing too much care to the patients created some frustration among ACS, especially when the patients relied too heavily on ACS. ACS can become frustrated not just with the patients, but also with peers. Frustrations arose from staff pampering certain patients creating patients' expectation for such treatment from all ACS. Anthony describes the process of this frustration:

> Everybody reaches breaking points here. Some have a lower threshold, a breaking point than others would have. I mean, everybody is used and and abused at some point. Some staff get frustrated with other staff... You do this and they (the patients) want this thing, you know, everybody all the time..

Some patients come to expect continual servitude, which blurs the roles between patient and ACS. The authority vested in the role of ACS is reduced to role of service. Frustrations involve those ACS who continual provide these services as described by Joseph: "There's one nurse, she baby's everybody...It's just so frustrating for me, she's always, 'Poor baby,' you know." Through constantly submitting to such expectations, patients come to expect such treatment from all ACS. The frustrations created by demands for patient attention challenges identity construction, because the separate roles

of ACS and patient begin to blur. While ACS provide care, demands become unnecessary when patients begin expecting to be pampered. Expecting to be pampered, patients partake less in caring for themselves.

Despite some patients' capability to perform certain tasks, expecting ACS to perform the task for them prevents ACS attending to patients needing greater attention. These expectations begin with those ACS who continually perform such tasks, as described by Anthony:

> We have a patient here who, well we have a number of similar patients that you need to get them up in a wheelchair and bring them out, you know, taking them to the bathroom. They're capable of doing it. Anyway, this patient he'd get up in the morning, get in his wheelchair and wheel himself to the dining room. He won't do it though because somebody says, 'Oh, I'll be here to get you' or you're basically standing beside the bed while he gets up, gets in the wheelchair, but if this nurse doesn't go-he stays in the bed, he won't get up in his wheelchair-he won't go to breakfast, he he won't go to lunch. He'll just skip a meal as opposed to going to it. So that nurse isn't always here and it's not a floor nurse, it's one of the administrative nurses who's here for some days. So the staff-the floor staff-that's always pushed to the limit with meds and other patients at meal times. Well, this is somebody who can do for themselves but won't do for themselves because they want someone else to stand there...It's like some baby this patient and now, I don't have time to do it, but I've got to stand there while this person gets up you know. It's a mess

ACS must be firm when confronting these demands by establishing limits. Not establishing limitations, patients continue making unnecessary demands and craving further attention. Particularly with Maria, patients become dependent in this attention even demanding decreasing authority in the nursing role:

> We do like everybody and we're firm, and really it's bad, they need so much attention and we just don't have time to baby them... if you don't set limits, and you're not firm and you don't follow through with what you're gonna do, it's like they'll walk all over you. They'll, you know, take advantage of you and this and that. Um—and you know, we just set limits for them.

Frustration manifests with both patients and peers when certain ACS are overly attentive to patients. Patients expect this attention from all ACS, even when other patients require more immediate attention. Frustrated, ACS must be firm with patients to reestablish the role boundary between nurse and patients. Setting limitations also allows for impression management to continue by reaffirming roles. Reaffirmation also reestablishes expected behaviors in upholding identities that comprise the identity construct (Goffman 1959).

AIDS patients, ACS, and Identity Concentration

Impression management (Goffman 1959) was used to uphold identities of friend, team, family and community. Strong social interrelation, with a primary concern for the patient, creates the identity concentration. This concern includes quality care for the patient's medical, emotional, and social needs. Emphasis on teamwork in all tasks enabled this care, and fostered stronger bonds between ACS.

Bonds also tightened between ACS and patients' because of the social support ACS provide to patients. The absence of AIDS-stigma allowed patients to experience social interactions difficult to obtain outside of the facility. For this system to continue, ACS conformed to particular expectations providing cohesiveness throughout the facility. These role expectations emerged in a pattern outlined by the ACS through qualities identified in the composition of the ideal nurse.

IDENTIFIED QUALITIES OF AN IDEAL NURSE AND SELF-IDENTITY

I asked participants to compare themselves to the ideal nurse. This allowed me to assess whether nurses' self-identity coincided with nursing ideals they identified. In

comparing self-identified qualities, participants enacted identities resembling the ideals fulfilling the role expected by both peers and patients. Participants' self-identified qualities correspond to ideal nurse qualities.

Compassion

ACS identified compassion as the most important quality of an ideal nurse. While compassion involves a general concern for the patient, selflessness in interactions with patients is even more significant.

Dramaturgically, impression management patterns that created this quality are related to selflessly assuming a caretaker's role. Role mannerisms included providing care, meeting patient needs, and attempts to create optimum comfort. Terence described how anticipating patient needs reveals this quality:

> Well, compassion and concern would be up there at the top. I think having a sense of what they need, before they actually call you for it. And seeing-you know if they're not doing particularly well, or if they're feeling nauseous , you're expecting that. So, you try and prevent that from getting that way of just looking out for them.

Compassion becomes essential in successfully enacting the other role qualities associated with the ideal nurse. A nurse must interact with a variety in patients. Patricia emphasized compassion regardless the patient's qualities: "Compassion (when caring for the patient) and lots of it. And being nonjudgemental." For the nurse to be compassionate, acceptance became second in importance.

Compassion connects participants most strongly to nursing ideals and the ideal nurse identity. Patricia directly linked herself to meeting this role requirement comparable to the ideal nurse: "I have the compassion, that's part of being the ideal

nurse." She further commented compassion makes her eligible for working with AIDS patients: "I'm compassionate, that's why I'm here."

This identification became extended in the care of AIDS and seeing its deleterious impact on patients. Suzanne noted this extension in her comment:

> So-I think it just opened my eyes more and to appreciate how devastating this disease is and how that, you know, people need love and compassion. Um-I think it did open my eyes more. And I'm still here two years later so that says something, you know.

Expressed daily, compassion was common between the ACS and patients. Esther explained this in her coworkers expressing affection to patients daily: "A lot of staff telling a lot of patients 'I love you.' And that's on a daily basis patients when patients know they're loved."

Terence described concern for the patients outlining the concern even when the patient no longer resided at the facility:

> This staff here is a great crew. Everyone here just looks out for the patients and—and there's times when one of the patients is sent to the hospital and it's not unlikely one of us will call, 'Hey, how's so and so'? Or to actually go to the hospital and find out how they're doing. We had one guy that was in--all he wanted was someone to take him clean socks and underwear, you know. We'd flip for it—not that it wasn't a matter of not wanting to do it, but just okay let's see who's going to do it.

ACS' identity constructs found meaning in the enactment of compassion. The purpose in the meaning meant being the caretaker for any patient. For the AIDS patients, this purpose emerged in a change of perception for those with spoiled identities, disregarding discreditable qualities or discredited identities. This change of perception Goffman (1963) calls a "heart changing personal experience" (p. 28).

Acceptance

Acceptance of the patient allows for continuation in the caretaker role. The nurse must be open to a variety in patients allowing for the role to remain in forefront. Suzanne emphasized this not just for the nurse interacting with the patient with AIDS, but for all patient identities:

> Not just for these types of patients but for every patient... You have to be open-minded. Not judgmental, you can't be judgmental. I mean-you know, you're going to run into very different people.

Compassion and acceptance often emerged together. Yvonne placed particular emphasis on the mixture of these qualities: "Well, I believe compassion and being nonjudgmental about anything involved in nursing. That is extremely important." Esther agrees emphasizing that both qualities make a nurse, and without the compassion and acceptance the nursing role is greatly diminished:

> Those are two very important things, because when you're talking about being caretaker and caring for other people, if you don't have the ability to be compassionate and nonjudgmental, you're not going to be a very effective or kind caregiver.

Nurses must fulfill their duties of patient care, despite patient identity. Such acceptance involves being open to both patients and many unique situations involved in patient care. Suzanne directly defined this: "You have to be able to adapt to whatever the situation is."

Anthony directed this definition more to both situation and AIDS patients:

> Ah, so I think in this group of people you have to, if you're gonna get any kind of cooperation from them you're gonna do their regardless that the doctor said three times a day, well, they're gonna do it twice a day. And you just fit into the—and so like if you're the ideal nurse if you're gonna achieve anything is to—you've got to work with them.

The ability to be flexible allows the ideal nurse to continue providing care in any situation and with any patient, including AIDS patients, who always require special care. On fully accepting the patient requires nurses to interact with patients without focusing on their status and background, ignoring potentially discreditable qualities of patients. This includes accepting the diversity of patients in the facility who have contain a broad range of backgrounds.

Patients' virtual social identity, or socially imputed characterizations consonant with expected codes of conduct, (Goffman 1963) may not coincide with their real identity. Anthony described certain patients having unexpected identities, particularly those potentially discreditable:

> There's people here who are prostitutes who blow you away to know that they are prostitutes, you find out later... You don't know what you think that person would have been, but it's the person you're seeing now; you're saying, 'You don't look like the type of person who would ever get it.' I see people here that could not stay off drugs to this very day, and they speak five languages and have a PhD.

More importantly, patients' identities are not spoiled by their modes of AIDS contraction. Patients still find acceptance even if their identities are spoiled. Anthony continues:

> We've had prostitutes, gay men-um-mothers who got it from their husbands that were drug abusers; he became infected, infecting them...There's a lot people that come through here and they're here the whole time. If they're here long enough, eventually they'll start talking, you know, about the personal things and you find out things about them. Um-I guess that's one thing never hear here...the question never comes up, like 'How did this person get this?'

Likewise, for Joseph patients were regarded without spoiled identities: "I interact with (the patients), you know. No problems. They're just like normal people, I interact with them." For the ACS then, interaction does not involve AIDS-stigma.

In social exchange, ACS and patient may interact with affection. Lydia explained her actions by accepting the patient without responding to the virus:

> I'm not scared to, you know, give them a hug. I'll give them a kiss on the forehead or the cheek, you know, just a hug. I'm not afraid of anything like that. I treat them kindly, with respect...see how they're doing and stuff.

Encounters with patients are with disregard to patient background and status. ACS treated the patients as individuals.

Being "wise" (Goffman 1963), or those with access to a stigmatized population and being sympathetic to their needs, ACS do not identify the patients' in terms of spoiled identities. Patients then are not concerned with spoiled identities, since ACS are wise to their backgrounds and status.

Creating a Trusting Atmosphere

The ideal nurse in being compassionate and accepting should attend not just to the patient's medical needs, but also to emotional needs. This quality creates an atmosphere where the patient's needs may be addressed to the nurse by the patient. Trust is conducive to creating a trusting atmosphere. Developing trust requires role intimacy between nurse and patient. Role intimacy is establishing trust and relaxing any formalities that may emerge through the roles of nurse and patient. Yvonne described this process of establishing trust by the nurse permitting a deeper sense between the two roles: "You have to treat that person and let them be comfortable before you treat them medically."

The ideal nurse must display care when patients express concerns, both medical and personal. After establishing role intimacy, the ideal nurse must also be trusted to address these concerns. Anthony described the ideal nurse as one available when the patient addresses personal concerns: "Um-an ideal, I guess in this-working especially with this group of people …(someone) who can listen."

Establishing a trusting atmosphere, patients must then come to trust in the ACS in all situations. Patients may then know they can rely on ACS as reflected by Thomas: "So whenever they need anything just being there, knowing that someone's there".

So in creating a trusting atmosphere, the ideal nurse brings a trusting presence for patients becoming both caregiver and confidante. As both caregiver and confidant, the ideal nurse creates role intimacy by being more involved in patient care. Lydia described this trust involved in this level of care: "Be able to counsel them and just sit and talk for a minute. Not just go in, take your medicine, and rush off."

Creating a trusting atmosphere involves performing the role of counselor. According to Thomas, this role assumption occurs frequently: "There's normally like 25% nursing here, but most of it's like counselor, aid." Consequently, role performance requires availability and willingness to counsel the patient. This identity assumption extends responsibilities of patient care. According to Sandra:

> Like for instance—um-you know, one of the patients this morning wasn't eating. He's usually one of the first ones to get to the dining room to eat. So you know we took him aside, talked to him to see what the problem was, if he was hurting. Just you know, hear them, let them know that we're there for him treatment and medication wise, but also we're there for them.

Displaying openness to patients can allow the patient to reconfigure impression management. Here, Terence maintained the identity as counselor while the patient foregoes a typically "harder" self-portrayal:

> I had one patient last week who always appearing that, you know, he's going to talk down to you in front of everyone and everybody fears him. He broke down in front of me the other day and said 'I'm really depressed, I went to my partner's house because he had all my clothes boxed up. I sorta think he knew something that I didn't know.' And I told him, 'Well,' I said 'Have you ever figured that maybe he was just boxing them up to put in storage? Now why are you gonna think the bad things?' He said 'Why would he do that?' And I said 'Well I don't know. Maybe you need to ask him. But you can't let something like that get you without knowing you know.' And that's, you know, it's-when you see somebody break down, you know, it hurts because there's nothing you can really do other than lend them a shoulder, you know, or give them a hug or something.

Portraying a counselor role casts an environment reciprocating allowance where patients do not have to abide by the script of patient, a script defined only by health problems. Instead, Goffman suggests unidimensional scripts defined by discreditable qualities that influence ACS and patient interaction. ACS, however, broaden the script and address emotional, spiritual, and social needs.

Empathy

The ideal nurse must also have empathy. Nurses should truly attempt to understand things from a particular patient's point of view. This helps the ideal nurse treat both the patient and the person. Yvonne broadly described this type of treatment: "It's instilled in the nurse to do what is best, as far as nursing goes. You have to be able to put yourself in their shoes and see how you would like to be treated, as a person."

Anthony narrowed this definition to the ideal nurse and the AIDS patient. The ideal nurse identifies the self with the daily routine of the patient particularly with patients' growing wariness in the systematic responsibilities involved in daily care:

> Um- (a nurse) who can understand where these patients come from. Because some of these people (AIDS patients) are sick and tired of pills. They're sick and tired of treatment. They're sick and tired of schedules.

The ideal nurse should be attuned to the internal experiences of the patient, attempting to understand frustrations involved.

Empathy can require a role-reversal between ACS and patient to understand the patient's experiences with AIDS. Terence described relocating self-identity by conceiving the patient's identity:

> I think I tend to put myself in their shoes a lot of times and just wonder what they are thinking about. How can I make them feel better? What can I say or do to make them forget they have this disease for a few minutes? What can I do? It's always the staff, you know, how can I make life easier?

Understanding the patient's experiences with AIDS makes role performances more meaningful to ACS. Patricia expressed her concern in witnessing AIDS and the patient: "You just want to see their quality of life get better. It's horrible. And I can only imagine what they're going through." By relating to the patient's experiences, the ACS can subjectively justify the type of care provided, again broadening what could be unidimensional script.

Knowledge

Knowledge also emerges as a quality of the ideal nurse and is particularly important for nurses who work with AIDS patients. The optimum of AIDS-related knowledge consists of understanding the medical aspects of AIDS and AIDS as a lived

experience. Until acquiring such knowledge, the nurse remains marginally effective. For Yvonne, the ideal nurse must have this knowledge to be most effective in working with the AIDS population.

> So once you learn what these people are all about which could be any length of time, you're just a nurse doing nurse duties until you've earned it. And when they ask question, you need to be prepared because the patients at this facility are very knowledgeable.

Even when acquiring such knowledge, the ideal nurse should always be open to continually learning. While emphasizing this knowledge, Suzanne notes the importance in learning since a nurse's knowledge of AIDS is never complete: "Be knowledgeable with what you're doing. You know, you know what you're doing. At least have most of it down because you are always learning-everyday you learn something." HIV/AIDS not being completely understood by the scientific community, the ideal nurse should remain abreast of current medical knowledge. The ideal nurse may provide the best care and information helping patients understand their conditions.

ACS identified themselves as having an adequate medical understanding to perform their roles. Some, like Anthony, saw it as a personal goal: "I want to be an advocate and a good nurse and knowledgeable for these people." Having AIDS-related knowledge, Patricia recognized a need for public awareness adding to the ACS identity construct: "I can discuss with people and I think I'm educating people about it a lot more. So if I can help one or two people realize, maybe I'm in the right field."

ACS educated not just the public, but also patients. Patricia saw knowledge as an enabler, encouraging patients to be healthier. However, all patients do not take advantage of what they learn:

> If somebody comes here initially, they're coming from the hospital or they're-they've come in because they're sick from home, they're not able to care for themselves. Um-there's a lot of compassion, a lot of attempt to get the person to-to hope, as much information as there is out there, a lot don't avail themselves of it. They just kind of go along doing the same old thing. They get sick. A lot of education...just trying to get this person to become aware. Many do, many don't. Some do...many do, many don't.

The ACS identified themselves as being educators and, consequently, sources of empowerment. Through personal knowledge, others outside the facility were informed about AIDS. For the patients, information was provided so the patient would become self-efficacious, even though some patients would sometimes ignore this knowledge creating frustration among ACS.

Patience

Participants emphasized patience when assessing the ideal nurse. For Yvonne, the nursing would possess an almost unwavering patience: "It requires 120% patience." Anthony referred to this quality of patience in definitive terms as a necessity for providing patient care: "Patience, you have to have patience." For Joseph, even frustrating patients should be treated with patience:

> You do get frustrated, you know. If somebody's constantly getting the light and you know-uh-you try to understand. For—for example, you—go down to help them out, and then you leave the room and you were just in the room, they cut the light on again. You know, and you come back to the room and you help them out and you go back to your desk, and they cut the light on again. You know—and so you get frustrated that way. And a lot of people do get frustrated that way. And so I guess...the ideal nurse would just keep going back into that room and helping them and helping them and not get frustrated, you know. See what am I saying?

The ideal nurse thus must perform duties without displaying frustration, particularly when interacting with frustrating patients and staff. Not partaking in the

process of improving their state of health, patients relied on ACS to provide complete care. This reliance sometimes involved continuing in behaviors not beneficial to this process. ACS experienced frustration when interacting with such patients.

PATIENCE, IDEALS, AIDS-STIGMA, AND IMPRESSION MANAGEMENT

These characteristics provide a measure by which all nurses may judge personal qualities. The typical nurse will likely not exemplify the ideal nurse, but may endeavor to enact in a manner approaching these ideals. By being aware of those ideals, specifically in working with AIDS, ACS felt that they delivered better care than general hospital nurses. Despite having awareness, ACS were susceptible to certain frustrations even the stigmatizing of AIDS attributed to nurses at the general hospital. In mismanaging a certain enactment, the nurse may risk not representing the expectations nurses hold for each other.

Impression management (Goffman 1959) begins when nurses do not represent expectations of peers, despite knowing the ideals. Caring for difficult patients can be challenging for ACS. For instance, Esther noted certain patients who are gay are quite difficult to care for:

> We have a lot of homosexual patients in here that many people call 'queens' that are very accustomed to being cared for in extravagant ways, or they themselves are very extravagant and very labile and very emotional. And they treat the staff like servants and want every little want and desire carried out immediately in the manner they want it done and so that gets a little hard sometimes.

Identity construct becomes challenged when ACS endeavor to act in a compassionate manner, particularly in a manner perceived different from nurses at the general hospital. When the patient responds differently than the expected script by failing to respond to

those compassionate endeavors, ACS may require a backstage (Goffman 1959), or those regions where the actor may retreat to reconfigure a mismanaged impression management, to recollect the expected role identity. Such recollection attempts to disallow breaches in continuation of quality impression management. Yvonne explained this in performing the script in front of the patient but allows a breach once in private. In dramaturgy, backstage are those regions where the actor may retreat to reconfigure a mismanaged impression management (Goffman 1959). Backstage permits the actor to reconstruct the act to safeguard against an inadequate dramaturgical response to patients and peers:

> We have to just constantly bite our tongues...I never to this day let myself go in front of patients. I will walk away and I will go into a room and I'll scream and holler or I'll say God knows what just to steam off but I never take my anger out on the patients. So, I've done real well because sometimes you just wanna choke them.

By not going backstage, the ACS may not abide by set standards identified in the ideal nurse. Failed impression management results in the patient not reciprocating expected or desired responses. ACS identify themselves to the caretaker role meaning the nurse identifies self to the caretaker role. A breach not only challenges patient relationships but also personal identity. Patricia provided this personal account:

> I don't want them to, you know, think I am or in any way that I hold it against them because I don't...because I feel if they feel it or sense it they're gonna resent me or not want me to be their caregiver and I want to do everything I can to have them comply and confide in me.

Moments at the facility where the nurse contacts difficulties with a patient can manifest a latent AIDS-stigma, or stigmatizing attitudes not typically displayed in interaction (Breault and Polifroni 1992). Stigma involves perceiving some patients at

fault for participating in deviant behaviors. Blame manifested in Suzanne described being angry that one of her patients died:

> I had a patient who…was a young mother and she had no history of drug abuse, alcoholism, or you know, prostitution, nothing like that. She just got together with the wrong guy…I felt angry at that time. Like why? You know, she had a little baby. And why did God let this happen? Um---the best one when I found myself mad---um—I don't know what to do. Just angry at the situation, why did this young mom have to die like that? And she had no…by no fault of her own.

This patient's virtual social identity did not coincide with other patients who contracted AIDS through deviant behaviors. Virtual social identities are socially assigned expectations to a role and expectant codes of conduct (Goffman 1963). Assigning "innocence" to some patients relegates deviance to other patients (Grove and Kelly 1997). By assigning deviance and blame though, the same participant acknowledged the nursing role and endeavored to sustain set ideals within:

> I know I've fought within myself 'Whose fault is it?' You know, something like that but I keep those things to myself…That puts myself in that situation, you know they're sick. Somehow or another they ended up this way and I chose to follow this profession. So now you know, I need to stand up to the plate and take care of them the best I can.

To continue with role performance, Joseph described a necessity retreating backstage to retain a portrayal of patience:

> The frustration leads to anger so, yeah, I did get angry at him but I tried to—before I go in their room, you know, I have to kind of calm down and talk to myself and say, 'This is a patient. I'm treating a patient.' You know, that little, that type, that little talk you have to give yourself.

Regaining composure after going backstage, the same participant describes a sense of sympathy for the patient:

> It's frustrating and then, you know, you have actually have to feel sorry for them. And then you wonder why did they use drugs or have sex with, you know, you take these chances. So you still wonder why, you know, and I feel sorry for them, you know.

ACS attempt to display patience during frustrating encounters with patients. Providing uninterrupted impression management becomes too difficult, however, requiring the ACS to adjust reactions backstage.

Despite frustrations, though, the ACS still attempts to retain compassion and acceptance in giving care. Maria describes this need for going backstage in order to continue providing these qualities:

> I guess also to be a good nurse you need to say 'Hey, wait a minute, time out." You know, I need to take----I need a health break, you know. Because if it is just work all the time, like a lot of the times catch myself doing, you know, you're not giving the quality care you could be, I mean if you just slow things down a little....I guess if you literally started to get to you, like when you start off your day and, you know, it's just crazy. And you just can't keep up because you're so frustrated or angry at something that happened earlier on, you know, that would be a good time to just, you know, get away, and get off the floor.

Quality of care helps each other maintain successful impressions. This is achieved through communicating with the patients and peers. Maria continued with this account:

> You then come back and see how you could have handled things differently, or what I should've done. And reevaluate the entire situation and then you could come back and, you know, go back and talk to whoever you need to talk to. Talk to your patient. Talk to the other nurses about whatever happened and then go on.

Readjustment of impression management occurs through not just an individual effort, but cooperative as well. By cooperative effort, ACS are enabled to be more patient especially in attempting to understand the cause of the frustration to reduce any potential reoccurrence. Through cooperative effort, ACS aids each other in lessening

occurrences of frustration. Maria also illustrates this in her own experience with one of her patients dying:

> I guess when one of our patients when one of our patients died, he'd been here for a long time and I had gone through a lot with him...he was so witty and so funny and so cute. I mean you really enjoyed around him. And when he died I got very angry...because a lot of the patients were crying, they're bickering about whatever. And I can't remember exactly how, but I was snapping at everybody because I was so mad he passed away. And then whatever else came up with my other patients that were having problems or whatever...that's when I knew I need to take a break, I needed to go for a walk...And we all get frustrated...you can't do this if you're not a team, There's no way. There's no way. It's not fair to you, it's not fair to those you work with, if you're not a machine. You know, because this is gonna make or break.

Both individual and group strive to produce proper impression management. The cooperative effort not only expects, but also helps each other in maintaining a successful impression. Exhibiting a successful impression marks the primary aim of this identity concentration since the identity concentration provides performance standards which ACS are expected to perform by.

IDENTITY CONCENTRATION AND THE IDEAL NURSE PROJECTION

The composite ideal nurse established by the ACS represent the perceptions of what defines the model nurse. In establishing this definition, I could understand the set standards ACS themselves abide by dramaturgically. Analysis of self-identified qualities revealed a pattern where ACS identity constructs maintained suitable behavior for their roles. Each ACS defined their roles by this projected code of conduct enacting it to complete their identity construct.

Maintaining this identity construct forms the survival of the identity concentration. The established standard set by the ACS in the ideal nurse forms the basis

of identity concentration. Abiding by these standards, the ACS role-identity becomes constructed in the process of fulfilling duties and interacting with patients and peers. The self-identified qualities involved in outlining this construction. Impression management must meet audience expectations (the patients and peers). Any ACS who fails in this impression management does not project a suitable identity construct.

The ACS ideal nurse projection represents the daily prescriptions for proper impression management for nurses at the facility, which is the ACS stage. The ideal nurse projection has become such an important part of all interactions on this stage, that many interactions become scripted, if not ritualized. This scripting influences with their colleagues and patients alike. No role duality emerges, despite the many competing and scripted demands of role performance, because all center on managing AIDS-stigma in interactions, and more importantly in patient care.

This becomes important since only a minimal disruption emerged in the actors' parts. ACS not only perceived their parts in terms of occupation, but also believed in the parts they enacted. By belief, the meaning in the roles became not just part of the identity construct, but part of the perceived reality. This perceived reality perpetuates identity constructs perceived as valid. There is authenticity then in the roles and actions of the ACS at this facility. Belief in one's role and performances does not create a role duality in interaction with AIDS patients. Stigma then does little to interrupt this role-identity continuation.

IDENTITY CONCENTRATION

ACS viewed themselves capable of caring and interacting with patients with AIDS. Expected by both patients and peers, all ACS attempted to remain capable. Expectations of maintaining this projected image preserve role functions. This image conveys itself in a concentration of identity.

Identity Concentration and Intimacy Level

Four interlinking identities emerged from the narratives: the identity of friend, team, family, and community. I use these terms to classify the identities that denote the intimacy in relationships and in interaction between ACS and patients. Intimacy levels define role functions, and let patients and ACS share in both relationships and interactions. These intimacy levels generate an emphasis on quality care from both patients and nurse's shared expectations. Dramaturgically, the shared expectations create an audience familiar with ideal nurse projections. This outlines a script, which keeps role duality from permeating the facility. This script consists of overlapping expectations of friendship, teamwork, family treatment, and community membership.

Identity Concentration and Meaning

These scripts influenced ACS identity constructs and associated behaviors. Consequently identity concentration helped ACS make sense of the facility's mission, as well as their place in this mission. Moreover, the establishment of identity concentration became part of the facility's indoctrination. Yvonne described those who become a part of this concentration that find function and meaning in participation at the facility: "We've gotten a few from the nursing schools, now, and they come in and love it."

Performance and meaning merge as ACS become convinced in the validity of their own personal performances (Goffman 1959).

While the strengths of identity concentration and constructs produce occupational definitions, they also create self-definitions. Anthony spoke of merging of self and occupation: "I could go somewhere else and make more money, but it's a thing of choosing to do...um---you're doing more of what you want to do, even though you can make more money." Opportunities to achieve higher salary exist, though participating in this identity concentration provides meaning to one's performances. Remaining part of this identity concentration may provide a meaning other occupations would be less able to provide.

The merging of self and occupation prohibits the ACS from stigmatizing AIDS patients in personal lives. Instead of stigma, quite the opposite emerges from identity concentration, especially when ACS find personal and valued meanings in their interactions and relationships with patients. Caring for AIDS patients produces both identity construct and concentration. Lydia found this meaning in the facility and through the patients:

> After a while, you know, I got to where I needed to be in here and I was like 'Well, I'm not going to quit. I like this job.' You know, I like the patients. Sometimes, I wish I could come back and see them more.

Working at the facility provides not just a role but also an identity. The merging of self and identity manifests through the strong interrelations among patients.

Identity Concentration and Deviation

Some nurses cannot manage identity issues and demands of working with AIDS patients. Yvonne commented on nurses who could not adapt their identity construct within the identity concentration:

> I don't what it is, you know, they come every time through this door gung-ho. I mean you'd thought they won the lottery and in the next few days they're all 'Hell no'...We had one particular man who was military. You could tell he was hard-core military, retired. He was here one or two nights and never came back. I think he had a very difficult time dealing with the portion that is homosexual...he was so homophobic.

Role-duality occurs in any presentation incongruent with the identity concentration. Intimacy levels hold little tolerance for such presentations. The function of intimacy produces predictability and cooperation in performances (Misztal 2001). When an ACS delivers an improper response, that person gets reported. Throughout this identity concentration, ACS perceived their relations in fairly intimate terms in the interactions among caregivers and patients. This intimacy exudes pressures to conform to the ideal nurse projection with failure to conform resulting in being reported as explained by Sandra: "I've seen a lot of nurses come and go. If you don't have compassion it gets told by either staff or patients." If an ACS identity construct becomes unsuitable for working primarily with this stigmatized population, that person will not remain long at the facility. She continued in explaining: "They'll either say 'This place isn't for me' or they are asked to leave."

If one's identity construct does not coincide with facility's identity concentration, that person will probably leave voluntarily. In display of role-duality where responses convey stigma, the ACS may also be asked to leave the facility.

Identity Concentration, AIDS, and the General Hospitals

When an ACS does not provide a proper visage conducive to the ideal nurse projection, role-duality occurs. Occurrences signal AIDS-stigma that does not parallel the group-perception compounding the facility's identity concentration. ACS unable to construct a self-identity in alignment with working with AIDS patients becomes filtered through the identity concentration. They may either leave voluntary or be told to resign. In this context, the facility dramaturgically becomes stage for a particular actor to assume particular roles and to abide by particular scripts.

The identity concentration reveals a particular quality of care delivered to the stigmatized population. This facility provides a function to this population that general hospitals are perceived as not providing. The function provided is the type of care AIDS patients know they will receive by the ACS. Without the threat of AIDS-stigma, the facility also functions as a buffer zone for the patients. The facility's identity construct shares the perception of the patient in relation to care at general hospitals.

AIDS-stigma heightens the intimacy level among patients and nurses. Providing care and acceptance to a stigmatized population forms the identity concentration and perceptions within. One engaged in working at the facility abides by the script enlaced in the identity concentration. These performances react to AIDS-stigma by not replicating reactions that indicate stigma. Performances involved do not reflect perceptions of AIDS exterior to the facility. From the intimacy levels at the facility, its identity concentration becomes a tighter-knit structure. The actors involved believe in the roles they perform and do not perceive the patients in contexts medical staff at other hospitals do. ACS do

not perceive their identity constructs as experiencing role-duality. Instead, role-performances are perceived in being authentic in relation to patients with AIDS.

CHAPTER 4

CONCLUSION

AIDS care specialists' care is characterized by tolerance and an active push to diminish the social stigmas associated with AIDS. Not surprisingly, AIDS-stigma is not tolerated anywhere in the AIDS-facility. Those nurses who allow stigma to enter their interactions with patients eventually leave the facility either voluntarily or by being asked to leave subtly forced out by those nurses who see themselves as AIDS care specialists.

In answer to the first research question ("Do nurses perceive AIDS negatively?"), strong biased perceptions did not emerge. ACS instead perceived patient in intimate terms, creating tight social knitting among patients and peers. This knitting created group identities. These identities emerged in four categories: friend, team, family, and community. The emergent categories combined indicated an overall group identity lacking in stigma and bias.

While ACS failed to see AIDS-stigma in their facility, they perceived that nurses at general hospitals were biased in their interactions with AIDS patients. Moreover, ACS used these contrasts with other nurses to reinforce their own self-perceptions, which contributed to a higher quality of care at the facility. By differentiating themselves from the nurses at the general hospital, ACS attempted to provide a higher quality of care without the presence of AIDS-stigma.

Providing higher quality of care means providing care *different* from the care by nurses at the general hospital. This quality of care indicates a type of care that does not encompass any of Goffman's (1963) stigma types: moral blemishes of character, tribal stigma, and physical abominations, although ACS reported the presence of these stigma types in the care provided to AIDS patients at the general hospital. This contrast creates the perception that the facility is a haven from AIDS-stigma. Being a haven, group identities emerged from the tighter-knit social environment.

This social environment necessarily disallows the presence of AIDS-stigma. Expectations among patients and peers create pressure on ACS to provide a quality of care that lacks AIDS-stigma. Being such a tight-knit social environment, any infraction of these expectations would not be left unnoticed, because they challenge group identity. Those unable to abide by these expectations either left voluntarily or were asked to leave.

Those abiding by these expectations managed impressions and identities properly which keeps the group identity intact. This group identity involves both the intimate relations among patients and peers and the perception of the facility as a haven for AIDS patients. Such collective impression management by ACS acts to further maintain this group identity. This collective effort of impression management within the facility is called *identity concentration.*

An outline of these expectations emerged in ACS detailing the characteristic of the ideal nurse. When ACS compared the perceived qualities of the ideal nurse to their own self-perceived they revealed the extent to which they followed these complex expectations. From the second research question, if nurses perceive AIDS negatively, does impression management occur in the role expectations, data emerged to show that

ACS perceived themselves abiding by those expectations. Conforming to the identity concentration they created, ACS described themselves as employing proper impression management. Conforming one's impression management by identifying with these expectations form the *identity construct.*

Employing this impression management strategy, ACS did not report role-duality when the identity construct of the ACS is perceived as conforming to the identity concentration. ACS then do not perceive themselves as using impression management in resolving role conflicts. For the third research question (What forms of impression management are employed in this conflict?), some impression management was utilized in situations described in potentially threatening proper impression management.

ACS when too attentive to patients threatens role boundaries between ACS and patients. By being too attentive or "spoiling" the ACS creates an expectation of servitude for the patients. Any ACS unable to perform this expectation can create frustrations with patients. This blurs distinction between roles. ACS no longer have the authority their role prescribes. When the patient becomes demanding ACS must focus on these demands taking away from attending to patients with more immediate needs. Restoring boundaries and preventing frustration from causing impression management to fail, ACS must be firm with patients, set limitations, and demonstrate what behaviors will be tolerated.

In dramaturgy, producing the proper group image requires members to cooperate in impression management efforts. In the company of other members, however, this cooperation is no longer necessary (Goffman 1959). For the identity concentration,

cooperation must be present with those outside the facility and peers and patients in the facility. Patience must be present so this cooperation may be achieved.

Patience may emerge as one of the most important forms of impression management. In particular, patience emerges as the quality of tolerating behaviors unaligned with expectations, particularly those behaviors that can be disruptive to one's perception of control. Utilizing patience requires the actor to remain self-controlled in spite of the disruptive behaviors.

ACS needed patience as they described having difficult patients. For an identity construct to remain intact, patience must be enacted as not to project a visage incoherent with the identity concentration. Even though enacting patience, AIDS-stigma may momentarily emerge through blaming the patient for contracting AIDS. Through blaming, ACS assigns deviance to the patient. These references to momentary emergence seldom occurred in the narratives, though manifested regardless.

To regain a proper identity construct, ACS can retreat backstage to temporarily forgo proper impression management. While backstage, ACS can release frustrations allowing for regaining one's composure. Remaining patient also allowed for the ACS' identity constructs to continue providing the quality of care expected.

Frustrations emerged when ACS felt a loss of control in the situation. This loss of control involved patients being frustrating themselves. Patients tended to become challenging when relations between patients and ACS became too close, blurring the distinction between the role of patient and role of ACS. ACS may remain patient when interacting with the patient, going backstage when necessary. When the blurring of role boundaries became too much, ACS had to be firm to reestablish the role boundaries and

communicating that certain behaviors will not be tolerated. Frustrations occurred, though inferring from ACS perceptions, these frustrations, however, did not interrupt providing quality care.

Within the facility, intimacy among the patients and ACS discouraged AIDS-stigma. This intimacy was central to the identity concentration. The facility was a particular stage for a particular actor to abide by a particular script. Nurses at the general hospital did not work with a particular illness. Caring for AIDS patients was primary to the facility. Those working there did so by identifying themselves by the identity concentration. Since the general hospital hosts multiple illnesses, intimacy between patients and nurses is lessened. Lacking identity concentration among these nurses, AIDS-patients may be more susceptible to AIDS-stigma.

Dramaturgy situates the social actor performing a variety of roles, each with a particular script relevant to the social situation. Incorrectly performing the script may complicate social interactions for the actor (Goffman 1959). Stigma can be a complication as stigma discredits the actor's performance (Goffman 1963). The facility creates a stage where actors are not discredited requiring a script with intact performances for both the facility and other outside the facility.

Caring for AIDS patients being its sole function, the facility becomes a particular stage. Those that do not attribute stigma to AIDS form the particular actors. Providing quality care lacking stigma provides the basis for the particular script. By focusing on similar stages, future research can identify the shared qualities that provide both intimacy and level of care. Understanding these shared qualities, research may outline the type of care essential to the AIDS patient.

APPENDIX A

Participants' Information and Demography

Participant #1:
Name: Esther
Age: 46
Sex: Female
Number of Years as Nurse: 23
Years Working with HIV/AIDS: 10

Participant #2:
Name: Yvonne
Age: 44
Sex: Female
Number of Years as Nurse: 8
Years Working with HIV/AIDS: 2

Participant #3:
Name: Terence
Age: 39
Sex: Male
Number of Years as Nurse: 3 months
Years Working with HIV/AIDS: 7 months

Participant #4:
Name: Patricia
Age: 27
Sex: Female
Number of Years as Nurse: 5
Years Working with HIV/AIDS: 2 years and 3.5 months

Participant #5:
Name: Suzanne
Age: 33
Sex: Female
Number of Years as Nurse: 2.5
Years Working with HIV/AIDS: 2

Participant #6:
Name: Maria
Age: 35
Sex: Female
Number of Years as Nurse: 2 months
Years Working with HIV/AIDS: 2 months

Participant #7:
Name: Joseph
Age: 51
Sex: Male
Number of Years as Nurse: 10
Years Working with HIV/AIDS: 1

Participant #8:
Name: Anthony
Age: 40
Sex: Male
Number of Years as Nurse: 4.5
Years Working with HIV/AIDS: 2.5

Participant #9:
Name: Lydia
Age: 40
Sex: Female
Number of Years as Nurse: 15
Years Working with HIV/AIDS: 1

Participant #10:
Name: Felicia
Age: 63
Sex: Female
Number of Years as Nurse: 28
Years Working with HIV/AIDS: 6 months

Participant #11:
Name: Thomas
Age: 38
Sex: Male
Number of Years as Nurse: 2.5
Years Working with HIV/AIDS: 2.5

Participant #12:
Name: Sandra
Age: 44
Sex: Female
Number of Years as Nurse: 24
Years Working with HIV/AIDS: 3

APPENDIX B

Research Questions

1) How do you define yourself professionally as a nurse?
2) What are the qualities of an ideal nurse?
3) Do your coworkers exhibit these ideals?
4) What was your first experience working with AIDS patients?
5) How has your perceptions changed since working with your first AIDS patient?
6) How has your actions changed since working with your first AIDS patient?
7) How do you feel about AIDS?
8) How do you feel about the AIDS patient?

REFERENCES

Altheide, David L. and Michalowski, R. Sam. 1999. "Fear in the News: A Discourse of Control." *The Sociological Quarterly.* 43(3): 475-503.

Armstrong-Esther, Chris and Hewitt, W.E. 1989. "Knowledge and Perception among Canadian Nurses." *Journal of Advanced Nursing.* 14: 923-938.

Berg, Bruce L. 2001. *Qualitative Research Methods for the Social Science.* 4ed. Needham Heights, MA: Allyn and Bacon.

Bailey, Carol A. 1996. *A Guide to Field Research.* Thousand Oaks, CA: Pine Forge Press

Bishop, George D., Alva, Albert L., Cantu, Lionel, and Rittiman, Telecia, K. (1991). "Responses to Persons with AIDS: Fear of Contagion or Stigma?" *Journal of Applied Social Psychology.* 21(23): 1877-1888.

Bouton, Richard A., Gallaher, Peggy E., Garlinghouse, Paul Arthur, Leal, Terri Rosenstein, Leslie D., and Young, Robert K. 1987. "Scales for Measuring Fear Of AIDS and Homophobia." *Journal of Personality Assessment.* 51(4): 606-614.

Breault, Allison J. and Polifroni, Carol E. 1992. "Caring for People with AIDS: Nurses' Attitudes and Feelings." *Journal of Advanced Nursing.* 17: 21-27.

Brown, Yvonne, Calder, Barbara, and Rae, Donna. 1990. "The Effect of Knowledge on Nursing Students' Attitudes Toward Individuals With AIDS." *Journal of Nursing Education.* 29(8): 367-372.

Caruso, Barbara Ann and Haig, Joseph R. 1987. "AIDS on Campus: A Survey of College Health Service Priorities and Policies." *Journal of College Health.* 36: 32-26.

Carveth, Judith Ann. 1995. "Perceived Patient Deviance and Avoidance by Nurses." *Nursing Research.* 44(3): 173-178.

Centers for Disease Control and Prevention. *HIV/AIDS Surveillance* Report, 2000; 12(1).

Chitty, Kay K. 1989. "A National Survey of AIDS Education in Schools of Nursing." *Journal of Nursing Education.* 28(4): 150-155.

Cline, Rebecca J. Welch, and Johnson, Sarah J. 1992. "Mosquitoes, Doorknobs, and Sneezing: Relationships Between Homophobia and AIDS Mythology Among College Students." *Health Communication.* 4(4): 273-289.

Cochran, Susan D. and Peplau, Letitia Anne. 1991. "Sexual Risk Reduction Behaviors Among Young Heterosexual Adults." *Social Science and Medicine.* 33(1): 25-36.

Cole, Frank L.and Slocumb, Elaine M.1993. "Nurses' Attitudes Toward Patients with AIDS." *Journal of Advanced Nursing.* 18: 1112-1117.

Conrad, Peter. 1986. "The Social Meaning of AIDS." *Social Policy.* 17(1): 51-56.

Creelan, Paul. 1984. "Vicissitudes of the Sacred: Erving Goffman and the Book of Job." *Theory and Society.* 13: 649-662.

Denmer, Craig.1999. "AIDS Attitudes and Attitudes Toward Caring for Dying Patients." *Death Studies.* 23(5): 433-443.

Denzin, Norman K. 2001. *Interpretive Interactionism.* Thousand Oaks, CA: Sage Publications, Inc.

Denzin, Norman K. and Lincoln, Yvonna S. 1994. *Handbook of Qualitative Research.* Thousand Oaks, CA: Sage Publications, Inc.

Denzin, Norman K. and Lincoln, Yvonna S. 1998a. *The Landscape of Qualitative Research: Theories and Issues.* Thousand Oaks, CA: Sage Publications, Inc.

Denzin, Norman K. and Lincoln, Yvonna S. 1998b. *Strategies of Qualitative Inquiry.* Thousand Oaks, CA: Sage Publications, Inc.

Devine, Patricia J., Plant, E. Ashby, and Harrison, Kirsten. 1999. "The Problem of 'Us' Versus 'Them' and AIDS Stigma." *American Behavioral Scientist.* 42(7): 1212-1228.

DiClemente, Ralph J., Zorn, Jim, and Temoshock, Lydia. 1986. "Adolescents and AIDS: A Survey of Knowledge, Attitudes, and Beliefs about AIDS in San Francisco." *American Journal of Public Health.* 76(12): 1143-1145.

Dowell, Kathleen A., Presto, Charles T., and Sherman, Martin F. 1991. "When are AIDS Patients to Blame for Their Disease? Effects of Patients' Sexual Orientation and Mode of Transmission." *Psychological Reports.* 69: 211-219.

Eliason, Michele J. 1993. "AIDS-Related Stigma and Homophobia: Implications for Nursing Education." *Nurse Educator.* 18(6): 27-30.

Falk, Gerhard 2001. *Stigma: How We Treat Outsiders.* Amherst, New York: Prometheus Books.

Farrell, Barbara 1987. "AIDS Patients: Values in Conflict." *Critical Care Nursing Quarterly.* 10(2): 74-85.

Feagin, Joe R., Orum, Anthony R., Sjoberg, Gideon (1991). *A Case for the Case Study.* Chapel Hill, NC: The University of North Carolina Press.

Forrester, David Anthony. 1990. "AIDS-Related Risk Factors, Medical Diagnosis, Do-Not-Resuscitate Orders and Aggressiveness of Nursing Care." *Nursing Research.* 39(6): 350-354.

Forrester, Anthony D. and Murphy, Patricia A. 1992. "Nurses' Attitudes Toward Patients with AIDS and AIDS-Related Risk Factors." *Journal of Advanced Nursing.* 17: 1260-1266.

Fox, Renee C., Aiken, Linda H., and Messikomer, Carla M. 1990. "The Culture of Caring: AIDS and the Nursing Profession." *The Milbank Quarterly.* 68(2): 226-248.

Fullilove, Mindy Thompson and Fullilove III, Robert E. 1999. "Stigma as an Obstacle to AIDS Action: The Case of the African American Community." *American Behavioral Scientist.* 42(7): 1117-1129.

Gallop, R.M., Lancee, W.J., Taerk, G., Coates, R.A., and Fanning, M. 1992. "Fear of Contagion and AIDS: Nurses' Perceptions of Risk." *AIDS Care.* 4(1): 103-109.

Gamson, William A. 1985. "Goffman's Legacy to Political Sociology." *Theory and Society.* 14: 551-604.

Gardener, Carol Brooks. 1991. "Stigma and the Public Self: Notes on Communication, Self, and Others." *Journal of Contemporary Ethnography.* 20(3): 251-262.

Gilmore, Norbert and Somerville, Margaret A. 1994. "Stigmatization, Scapegoating and Discrimination in Sexually Transmitted Diseases: Overcoming 'Them' Versus 'Us.'" *Social Science and Medicine.* 39(9): 1339-1358.

Glaser, Barney G. and Strauss, Anselm L. 1967. *The Discovery of the Grounded Theory: Strategies for Qualitative Research.* New York: Aldine Publishing Company.

Godfrey, Nelda S. and Kuehne, Dale S. 1997. "In the Care of a Nurse." *Hastings Center Report.* 27(5): 23-25.

Goldenburg, Dolly and Laschinger, Heather.1991. "Attitudes and Normative Beliefs of Nursing Students as Predictors of Intended Care Behaviors with AIDS Patients: A Test of the Ajzen-Fishbein Theory of Reasoned Action." *Journal of Nursing Education.* 30(3): 119-126.

Goldin, Carol S. 1994. " Stigmatization and AIDS: Critical Issues in Public Health." *Social Science and Medicine.* 39(9): 1359-1366.

Goffman, Erving. 1959. *The Presentation of Self in Everyday Life.* New York: Doubleday.

Goffman, Erving. 1963. *Stigma: Notes on the Management of Spoiled Identity.* New York: Simon & Schuster, Inc.

Goodwin, Megan P. and Roscoe, Bruce. 1988. "AIDS: Students' Knowledge and Attitudes at a Midwestern University." *Journal of College Health.* 36: 214-222.

Green, Gill and Platt, Stephen. 1997. "Fear and Loathing in Health Care Settings Reported by People with HIV." *Sociology of Health and Illness.* 19(1): 70-92.

Grove, Kathleen A. and Kelly, Donald P. 1997. "'But Nice Girls Don't Do it': Women, Symbolic Capital, and the Social Construction of AIDS." *Journal of Contemporary Ethnography.* 26(3): 307-328.

Hassin, Jeanette. 1994. "Living a Responsible Life: The Impact of AIDS on the Social Identity of Intravenous Drug Users." *Social Science and Medicine.* 39(3): 391-400.

Herek, Gregory M. 1999. "AIDS and Stigma." *American Behavioral Scientist.* 42(7): 1106-1116.

Herek, Gregory M. and Capitano, John P. 1999. "AIDS Stigma and Sexual Prejudice." *American Behavioral Scientist.* 42(7): 1130-1147.

Herrick, Charlotte A. and Smith, Joseph E. 1989. "Ethical Dilemmas and AIDS: Nursing Issues Regarding Rights and Obligations." *Nursing Forum.* 23(3,4): 1989.

Hopper, Marianne. 1981. "Five Key Concepts of the Dramaturgical Perspective." *Free Inquiry in Creative Sociology.* 9(1): 47-52.

Jemmott, Loretta Sweet, Jemmott III, John B., and Cruz-Collins, Madeline 1992. "Predicting AIDS Patient Care Intentions Among Nursing Students." *Nursing Education.* 41(3): 172-177.

Johnson, Mark E. and Baer, Alice J. 1996. "College Student's Judgments and Perceptions of Persons With AIDS from Different Risk Groups." *The Journal of Psychology.* 130(5): 527-536.

Johnson, Burke R. 1997. "Examining the Validity Structure of Qualitative Research." *Education.* 118(2): 282-293.

Katsuko, Hara. 1995. "Quantitative and Qualitative Approaches in Education." *Education.* 115(3): 351-356.

Kelly, Jeffery A., St. Lawrence, Janet S. Smith, Steve, Hood, Harold V. and Cook, Donna J. 1987. "Medical Students' Attitudes Toward AIDS and Homosexual Patients." *Journal of Medical Education.* 62: 549-556.

Kirkman, Mary B. and Bell, Shirley K. 1989. "AIDS and Confidentiality." *Nursing Forum.* 23(3,4): 47-51.

Kleffel, Dorothy.1991. "An Ecofeminist Analysis of Nursing Knowledge." *Nursing Forum.* 26(4): 5-18.

Klisch, Mary Lou.1990. "Caring for Persons with AIDS: Student Reactions." *Nurse Educator.* 15(4): 16-20.

Larsen, Knud S., Serra, Matt, and Long, Ed. 1990. "AIDS Victims and Heterosexual Attitudes." *Journal of Homosexuality.* 19:3: 103-116.

Lawrence, Sally A. and Lawrence, Rena M. 1989. "Knowledge and Attitudes About Acquired Immunodeficiency Syndrome in Nursing and Nonnursing Groups." *Journal of Professional Nursing.* 5(2): 92-101.

Lester, Lula B. and Beard, Betty J. 1989. "Nursing Students' Attitudes Toward AIDS." *Journal of Nursing Education.* 27(9): 399-404.

Leiker, Jason J., Taub, Diane E., and Gast, Julie. 1995. "The Stigma of AIDS: Persons With AIDS and Social Distance." *Deviant Behavior.* 16: 333-351.

Levin, Bruce, Bull, J.J., and Stewart, Frank M. 2001. "Epidemiology, Evolution, and Future of HIV/AIDS Pandemic." *Emerging Infectious Disease.* 7(3): 505-551.

Maxwell, Joseph A. 1996. *Qualitative Research Design: An Interpretive Design.* Thousand Oaks, CA: Sage Publications, Inc.

McCann, T.V. 1999. "Reluctance Amongst Nurses and Doctors to Care for and Treat Patients with HIV/AIDS." *AIDS Care.* 11(3): 355-359.

McCann, Terence V. and Sharkey, Ron J. 1998. "Educational Intervention with International Nurses and Changes in Knowledge, Attitudes, and Willingness to Provide Care to Patients with HIV/AIDS." *Journal of Advanced Nursing.* 27: 267-273.

McDevitt, Teresa M., Sheehan, Eugene P., Lennon, Randy, and Ambrosio, Anthony L. 1990. "Correlates of Attitudes Towards AIDS." *The Journal of Social Psychology.* 130(5): 699-701.

Mistzal, Barbara A. 2001. "Normality and Trust in Goffman's Theory of Interaction Order." *Sociological Theory.* 19(3): 312-324.

Munch, Richard. 1994. *Sociological Theory: From the 1920's to the 1960's.* Vol. 2 Chicago, ILL: Nelson-Hall Publishers.

Neuman, W. Laurence. 1997. *Social Research Methods: Qualitative and Quantitative Approaches.* 3d ed. Needham Heights, MA: Allyn & Bacon.

O'Hare, Thomas, Williams, Cynthia L., Ezoviski, Alan. 1996. "Fear of AIDS and Homophobia." *Social Work.* 41(1): 51-58.

Ooermann, Marilyn H. and Gignac, Debra.1991. "Knowledge and Attitudes About AIDS Among Nursing Students: Educational Implications." *Journal of Nursing Education.* 30(5): 217-221.

Panem, Sandra. 1988. *The AIDS Bureaucracy.* Cambridge, MASS: Harvard University Press.

Patsdaughter, Carol A., Grindel, Cecilia Gatson, O'Connor, Catherine, and Miller, Kathleen H. 1999. "Students' Decisions to Select HIV Services for Clinical Experiences." *Nurse Educator.* 24(3): 35-39.

Pryor, John B., Reeder, Glenn D., and Landau, Steven. 1999. "A Social-Psychological Analysis of HIV-Related Stigma: A Two Factor Theory." *American Behavioral Scientist.* 42(7): 1193-1211.

Pryor, John B., Reeder, Glenn D., and McManus, Julie A. 1991. "Fear and Loathing in The Workplace: Reactions to AIDS-Infected Co-Workers." *Personality and Social Psychology Bulletin.* 17(2): 133-139.

Pryor, John B., Reeder, Glenn D., Vinnaco, Jr. Richard, and Kott, Teri, L. 1989. "The Instrumental and Symbolic Functions of Attitudes Toward Persons With AIDS." *Journal of Applied Social Psychology.* 19(5): 377-404.

Reutter, Linda I. and Northcott, Herbert C. 1994. "Achieving a Sense of Control in a Context of Uncertainty: Nurses and AIDS." *Qualitative Health Research.* 4(1): 51-72.

Robinson, Nicola. 1998. "People With HIV/AIDS: Who Cares?" *Journal of Advanced Nursing.* 28(4): 771-778.

Royse, David, Dhooper, Surjit Singh, and Hatch, Laurie Russell. 1987. "Undergraduate Graduate Students Attitudes towards AIDS." *Psychological Reports.* 60: 1185-1186.

Rozin, Paul, Markwith, Maureen, and Nemeroff, Carol. 1992. "Magical Contagion Beliefs and Fear of AIDS." *Journal of Applied Social Psychology.* 22(14): 1081-1092.

Serlo, Kaijaleena L. and Aavarine, H. 1999. "Attitudes of University Students Toward HIV/AIDS." *Journal of Advanced Nursing.* 29(2): 454-462.

Schudson, Michael. 1984. "Embarrassment and Erving Goffman's Idea of Human Nature." *Theory and Society.* 13: 644-648.

Schwanberg, Susan L. 1990. "Attitudes Towards Homosexuality in American Health Care Literature 1983-1987." *Journal of Homosexuality.* 19(3): 117-136.

Sheehan, Eugene.1991. "University Students' Response to AIDS: A Review of Research with Recommendations for Education." *College Student Journal.* 25(4): 417-426.

Sheehan, Eugene, Lennon Randy, and Mcdevitt, Teresa.1989. "Reactions to AIDS and Other Illnesses: Interactions in the Workplace." *The Journal of Psychology.* 123(6): 525-536.

Siminoff, Laura A., Erlen, Judith A., and Lidz, Charles W. 1991. "Stigma, AIDS, and the Quality of Nursing Care: State of the Science." *Journal of Advanced Nursing.* 16: 262-269.

Sontag, Susan. 1977. *Illness as Metaphor.* New York: Random House.

Tewksbury, Richard and McGauhey, Deanna.1997. "Stigmatization of Persons with HIV Disease: Perceptions, Management, and Consequences of AIDS." *Sociological Spectrum.* 17: 49-70.

Treiber, Frank A., Shaw, Darlene, and Malcolm, Robert. 1987. "Acquired Immune Deficiency Syndrome: Psychological Impact on Health Personnel." *The Journal of Nervous and Mental Disease.* 175(8): 496-499.

Treichler, Paula A. 1999. *How to Have Theory in an Epidemic: Cultural Chronicles Of AIDS.* Durham, NC: Duke University Press.

Triplet, Rodney G. and Sugarman, David B. 1987. "Reactions to AIDS Victims: Ambiguity Breeds Contempt." *Personality and Social Psychology Bulletin.* 13(2): 265-274.

Valimiki, Maritta, Suominen, Tarja, and Peate, Ian. 1998. "Attitudes Toward Professionals, Students and the General Public to HIV/AIDS and People With HIV/AIDS: A Review of the Research." *Journal of Advanced Nursing.* 27: 752-759.

Vermette, L. and Goldin, G. 1996. "Nurses' Intentions to Provide Home Care: The Impact of AIDS and Homosexuality." *AIDS Care.* 8(4): 479-488.

Walkey, Frank H., Taylor,Antony J.W., and Green, Dianne E. 1990. "Attitudes to AIDS: A Comparative Analysis of a New and Negative Stereotype." *Social Science and Medicine.* 30(5): 549-552.

Wilson, Feleta L. 2000. "Measuring Morality of Justice and Care Among Associate, Baccalaureate and Second Career Female Nursing Students." *Journal of Social Behavior and Personality.* 14(4): 597-606.

Winslow, Robert W. 1988. "Student Knowledge of AIDS and AIDS Transmission." *Society and Social Research.* 72(2): 110-111.

Winslow, Robert W., Rumbaut, Ruben, G., and Hwang, Jimmy. 1989. "AIDS, FRAIDS, And Quarantine: Social Responses to Pro-Quarantine Initiatives in California." 19(17): 1453-1478.

Zawid, Carole S. 1994. *Sexual Health: A Nurse's Guide.* Albany, New York: Delamr Publishers, Inc.

VITA

Clay Johnson was born on January 23, 1973 in Webster, Texas, the son of K.W. Johnson and Joye Johnson. After completing his work at Temple High School, Temple, Texas, in 1991, he entered University of Mary-Hardin Baylor in Belton, Texas. He received his Bachelor of Arts from University of Mary-Hardin Baylor in 1996. In September 1997, he entered the Graduate School of Southwest Texas State University, San Marcos, Texas.

Permanent Address: 4501 Hickory
Temple, Texas 76501

This thesis was typed by Clay J. Johnson