THE ATTITUDES OF NURSES TOWARDS HIV POSITIVE PATIENTS

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SUMMARY

AIDS is increasing in South Africa at an alarming rate. Registered nurses consequently have more frequent contact with HIV positive patients. During this contact the nurses' behaviour are influenced by their attitudes. Negative attitudes may influence the quality of nursing care. In the light of this problem, the aim of this study was to investigate the attitudes of nurses towards HIV positive patients and to set guidelines for potentially changing these attitudes, in an attempt to improve the quality of care rendered to HIV positive persons. A qualitative design was used. An interview schedule was compiled after a literature study of the construct attitude, the components of attitude, differences between values and attitudes, the purpose of attitudes and the way in which attitudes can be changed. Nurses were identified for participation through purposive, voluntary sampling. Semi-structured interviews were conducted. The interviews were transcribed verbatim. The researcher and a co-coder analysed the data using a combination of Giorgi and Kerlinger's methods of coding. Consensus on the main categories was reached after discussion with the co-coder. The conclusion was made that the attitudes of nurses towards the HIV positive patient are mostly negative. Conflict between the personal and professional value systems of nurses exists. Nurses cope with the resulting discomfort by using defence and coping mechanisms, which hamper the development of a therapeutic relationship between them and HIV positive patients. Nurses entertain a biased view of their own risks, considering risks only from occupational exposure. According to these findings, general and specific guidelines for changing attitudes were set.

OPSOMMING

VIGS neem drasties toe in Suid-Afrika. Geregistreerde verpleegkundiges het gevolglik meer gereelde kontak met MIV-positiewe pasiënte. Gedurende hierdie kontak word verpleegkundiges se optrede beïnvloed deur hulle houdings. Negatiewe houdings mag die kwaliteit van verpleging beïnvloed. In die lig hiervan, was daar in die navorsing gepoog om die houdings van verpleegkundiges teenoor MIV-positiewe pasiënte te bepaal en om riglyne daar te stel wat potensiële houdingsveranderinge by die verpleegkundiges teweeg sal bring en sodoende die kwaliteit van verpleging van MIV-positiewe persone te verbeter. 'n Kwalitatiewe ontwerp is gebruik. 'n Onderhoudskedule is na 'n literatuurstudie van die konstruk-houding, die komponente van houdings, verskille tussen waardes en houdings, die doel van houdings en die wyse waarop houdings verander kan word, saamgestel. Verpleegkundiges is deur middel van 'n doelgerigte, vrywillige steekproef as deelnemers geïdentifiseer. Semi-gestruktureerde onderhoude is daarna gevoer. Die onderhoude is woordeliks getranskribeer. Die navorser en 'n

mede-kodeerder het die data geanaliseer volgens 'n kombinasie van Kerlinger en Giorgi se metodes van kodering. Konsensus oor die kategorieë in die data was bereik na gesprek met die mede-kodeerder. Dit blyk dat die houdings van verpleegkundiges teenoor MIV-positiewe pasiënte oorwegend negatief is. Daar bestaan konflik tussen die persoonlike en professionele waardesisteme van die verpleegkundiges. Die verdedigings- en hanteringsmeganismes van verpleegkundiges om die gevolglike interne ongemak te verminder, belemmer die opbou van 'n terapeutiese verhouding tussen hulle en MIV-positiewe pasiënte. Verpleegkundiges handhaaf 'n eensydige siening van die risiko om MIV-positief te raak deur slegs die moontlikheid van infektering deur hulle werk te oorweeg. Hierdie gevolgtrekkings het gelei tot die stel van algemene en spesifieke riglyne om houdingsverandering by verpleegkundiges teweeg te bring.

INTRODUCTION AND PROBLEM STATEMENT

The abbreviation HIV refers to the Human Immune Deficiency Virus, and AIDS refers to the Acquired Immune Deficiency Syndrome. When reference is made to HIV positive patients in this article, it implies people that are HIV positive, without any symptoms, as well as people with full-blown AIDS. When referring to the disease in general, the term AIDS is used.

The HI virus, identified in 1983 as the causing factor of AIDS (Van Dyk, 1992:6), has taken on pandemic proportions (Lachman, 1995:5). Both Webb (1997:2) and Doyle (1992:53) agree that the disease is a major problem in South Africa. Doyle (1992:56) states that by the year 2010 the number of people in South Africa infected with HIV may be as many as 30% of the total population of 43 million. In the light of the above figures, it is clear that AIDS will have an enormous impact on the lives of individuals, families and communities (Doyle, 1992:53; Whiteside, 1992:65; Webb, 1997:1). One of these implications is an increasing number of patients seeking care causing increased pressure on health care personnel, including nurses (Doyle, 1992:53). It is during this expected frequent contact with HIV positive patients that the attitudes of nurses become important.

The attitudes of nurses towards HIV positive patients are described as predominantly negative in several international studies (Allender, Senf, Bauman & Duffy, 1991:341; Baylor & McDaniel, 1996:99-105; Bliwise, Grade, Irish & Ficarotto, 1991:289). In South Africa Metz and Malan (1988:29) found that negative attitudes of nurses towards HIV positive patients occur because of ignorance, the high mortality associated with the disease and the stigmatisation of persons with AIDS. Their negative attitudes cause reactions of fear, despondency, denial, blaming and unnecessary avoidance of HIV positive patients (Van Dyk, 1992:2-3). This may influence the quality of care rendered to HIV positive patients negatively, while positive attitudes may improve the quality of care (Baylor & McDaniel, 1996:103).

Although these studies indicate that the attitudes of nurses have an influence on the quality of care, no suggestions are made regarding how these attitudes may be changed. Therefore the questions raised are:

- What are the attitude of nurses towards HIV positive patients,
- What can be done to potentially change the attitudes of nurses towards HIV positive patients in order to improve the quality of care rendered to HIV positive patients?

In accordance with the research problem and questions, the purpose of this research was to determine the attitudes of nurses towards HIV positive patients and then to set guidelines that can potentially change these attitudes, in an attempt to improve the quality of care rendered to HIV positive patients.

RESEARCH METHODOLOGY

The qualitative design used in this research was aimed at exploring and describing the attitudes of nurses working in the context of hospitals in the North West Province of South Africa. A purposive voluntary sample was obtained. The criteria for inclusion in the sample was that the person:

- should be a registered nurse working in the North West Province;
- should have cared for an HIV positive patient in the past year;
- should be willing and available to participate in the

interview;
- could belong to any culture;
- should give informed consent to participate in the research and that the interview may be recorded on audio-cassette; and
- should be able to speak Afrikaans or English.

Nursing services managers at the hospitals were asked to select participants who met the criteria as supplied by the researcher. Further information regarding the purpose of the research and the nature of participation was provided to the selected participants. They were given a choice to participate or not, and informed consent was obtained from willing participants. They were assured of confidentiality.

The three components of attitudes provided the framework of the interview schedule, according to which semi-structured interviews were conducted. After seven semi-structured interviews were conducted according to the interview schedule, the data were saturated. Field notes were made after the interviews and were used during analyses to verify data found in the verbal and non-verbal communication of participants.

The framework of Guba and Lincoln (1989:236-243) for trustworthiness was integrated with the model of Woods and Catanzaro (1988:136), who set guidelines for reliability and validity in qualitative research.

DATA ANALYSIS

The interviews were transcribed verbatim and coding was carried out by using a combination of the methods of Kerlinger (1986:477-483) and Giorgi (as quoted by Omery, 1983:57-58). The service of a psychiatric nursing specialist as independent co-coder was utilised and a consensus discussion was held regarding the categories and subcategories present in the data.

LITERATURE STUDY

Before the interviews were conducted, a literature study was done in respect of the concept "attitude", as applicable in this research. The definition of attitude, the three components of attitude, differences between attitudes and values, the purpose of attitudes and how attitudes can be changed were the themes that gave direction to the literature study.

For the purpose of this research a definition of "attitude" was synthesised from the definitions by Plug, Louw, Gouws and Meyer (1997:149) and Middlebrook (1980:566), namely that it is a relatively stable, mainly learned tendency in an individual towards certain objects and it comprises a cognitive, an emotional and a behavioural component. When interpreting this three-component model within a nursing context, it can be argued that nurses maintain certain beliefs about AIDS, they then experience feelings towards HIV positive patients, and these then influence their behaviour.

The functions of attitude were also investigated. Triandis (1971:4) indicates four functions, namely that an attitude helps people to understand their environment, to protect their self-image, to adapt in a complex environment and it provides opportunities for them to pose their fundamental values. Triandis (1971:4) as well as Reich and Adcock (1976:7) are of the opinion that there is a difference in attitude and values, in that a person's values are taken into consideration when attempting to change the person's attitude.

Different theories regarding how to change attitudes exist, namely the Yale approach (Zimbardo, Ebbesen & Maslach, 1977:56-62), the Michigan group dynamics approach (Kaplan & Sadock, 1988:149), the theory of cognitive dissonance, the accountability theory and the social learning theory (Zimbardo *et al.* 1988:66-72; 74-75; 80-84). From these theories it is apparent that attitudes can be changed through verbal and non-verbal communication with the aim of convincing a person. Group dynamics, the media and behaviour also play a role in changing attitudes.

All of these aspects were taken into consideration during the formulation of guidelines to potentially change the attitudes of professional nurses towards HIV positive patients.

RESULTS AND DISCUSSION

The results of the study are discussed below under the six main categories as stated in Table 1. (Table 1 on next page).

Table 1: The attitudes of nurses towards HIV positive patients

COGNITIVE COMPONENT	EMOTIONAL COMPONENT	BEHAVIOUR COMPONENT	DEFENCE MECHANISMS	COPING MECHANISMS	VALUE JUDGEMENT
* Points of view of nurses towards the progression, treatment and handling of AIDS * Points of view regarding the need of patients and the community for more information on AIDS *Points of view regarding social behaviour and AIDS * Points of view regarding confidentiality and HIV positive patients * Points of view regarding the risk to nurses of becoming HIV positive themselves * Points of view regarding the role of nurses during nursing care of HIV positive patients	* Sorrow as an emotional component of the attitudes of nurses * Anger as an emotional component of the attitudes of nurses * Fear as an emotional component of the attitudes of nurses * Uncertainty as an emotional component of the attitudes of nurses * Other emotions of a positive nature experienced by nurses * Other emotions of a negative nature experienced by nurses	* Supportive and therapeutic behaviour by nurses * Preventive behaviour and the safe nursing care of HIV positive patients * Controlled or forced interaction by nurses during the nursing care of HIV positive patients	* Denial as a defence mechanism used by nurses * Avoidance as defence mechanism used by nurses * Rationalisation as defence mechanism used by nurses * Intellectualisation as defence mechanism used by nurses	* Cognitive coping mechanisms used by nurses during nursing care of HIV positive patients * Emotional coping mechanisms used by nurses during nursing care of HIV positive patients * Behavioural coping mechanisms used by nurses during nursing care of HIV positive patients	* Value judgements regarding HIV positive patients * Value judgements regarding the behaviour of nurses towards HIV positive patients

The cognitive component of the attitudes of nurses towards HIV positive patients

Most statements made by participants about HIV positive patients are supported by literature, but a finding that was unique to this research concerned the statements describing HIV positive patients as pleasant people with the same needs and fears as other people. Another perception, which was confirmed in the available literature, was that the disease is spread because of ignorance and disbelief about the real existence of the disease. Statements about cultural habits influencing the spread of HIV and the behaviour of HIV positive patients were also confirmed in the available literature (Webb, 1997:32; Van Dyk, 1992:65; Saayman & Kriel, 1992; Eagle & Bedford, 1992:19; Mokhobo, 1989:20; Wood & Dietrich, 1990:324).

Confidentiality is seen as beneficial only to HIV positive patients, but detrimental to the community, and it is said that in fact it should be abandoned. In contrast to this belief, nurses are of the opinion that ignorance about patients' HIV status facilitates the development of a relationship between the patient and the nurse and the reduction of discrimination. This was a finding unique to the research. HIV positive patients are also considered to be dangerous and this idea was supported by authors like Berkowitz and Nuttall (1996:463-469), Newton (1995:128-129), Latman, Horton, Finney and Fenstermacher (1996:223). Nurses are unsure about the exact risk involved when nursing HIV positive patients, but it is clear from available literature that knowledge pertaining to an individual's HIV status leads to an increased use of universal precautions (Van Dyk, 1992:27).

Lastly, the rights of the HIV positive patients are considered to be in conflict with the rights of the nurse, as one participant mentioned: "*I have rights and the patients have rights, but I must consider my duty and pledge*". Statements regarding so-called "normal" behaviour towards HIV positive patients was unique to this research, but the influence of the attitudes of nurses on patients and the patients' dependence on nurses were confirmed by Mullins (1996:21) and Sims and Moss (1991:12-13).

The emotional component of the attitudes of nurses towards HIV positive patients

As mentioned in Table 1 nurses feel sorry for HIV positive patients and these feelings are confirmed in the available literature (Crandall, Glor & Britt, 1997:98; Van Dyk, 1992:61; Leasure, Hawkins & Merril, 1996:235). Positive emotions that nurses experience are caring about HIV positive patients, worrying about them, an

absence of fear and a positive feeling about nursing them. The latter is supported by Bennet (1995:339) who mentions that nurses want to nurse HIV positive patients and the focus should be on the skills they need to enable them to do so.

Anger as an emotional component is based on feelings of being exposed to danger, universal precautions that are considered to be uncomfortable, unwillingness from patients to accept HIV as a diagnosis and aggression towards those that are perceived to deliberately spread the disease. One participant stated: *"I'm not feeling aggression towards the patient as a human being, but because he is infected, I can also become infected…".* These feelings make it very difficult to change the attitude of nurses toward HIV positive patients, as explained by Eagle and Brouard (1995:24). Denial of the disease by patients provokes the anger of nurses and they also feels angry because of the perception that other people are deliberately being infected. This is a finding unique to the research.

Many authors describe the fear that nurses suffer (Crandall *et al.* 1997:113; Latman *et al.* 1996:224), and certain nurses or doctors may even refuse to care for HIV positive patients because of the fear of contracting HIV through occupational exposure (Bliwise, Grade, Irish & Ficarotto, 1991:289). Nurses also feel unsure about their conduct towards HIV positive patients and Reutter and Northcott (1994:55) and Latman *et al*. (1996:224) support this insecurity in the literature. Other emotions of a negative nature mentioned by the participants include feelings of helplessness, negativity and considering the nursing of HIV-patients as unpleasant.

The behavioural component of the attitudes of nurses towards HIV positive patients

It is often mentioned in available literature how nurses ought to accept and treat HIV positive patients (Van Dyk, 1992:47-84; Evian, 1993:40-239; Sims & Moss, 1991:1-105), but according to participants HIV positive patients receive more attention and care than other patients. This behaviour of nurses is a finding unique to the research. Nurses also comfort HIV positive patients when necessary, as stated by a participant: *"If he is sad, I feel sorry for him and I'll comfort him".* Van Dyk (1992:64) mentions that this behaviour evolves out of empathy and a belief that HIV positive patients should be able to express their feelings. Nurses also touch HIV positive patients, in contrast with the findings of Baylor and McDaniel (1996:100), who state that fear leads to avoidance, over-emphasis of universal precautions and little respect for HIV positive patients.

Nurses' advocacy role concerning HIV positive patients often leads to conflict with doctors and colleagues. However, authors like Wilson and Kneisl (1992:608) and Anderson and Wilkie (1992:4) encourage nurses to speak up for HIV positive patients and their families because of the existing discrimination and stigmatisation attached to AIDS.

Regarding the use of universal precautions, it was found in the research that universal precautions permit the general nursing of HIV positive patients, and these precautions according to some participants are practised with every patient, whether they are diagnosed as HIV positive or not. Universal precautions are considered more important, and additional precautions are even taken when nursing a patient with a confirmed HIV positive diagnosis. Many authors consider universal precautions as important (Van Dyk, 1992:27; Evian, 1993:221; Meisenhelder & LaCharite, 1989:17), but Bennet (1995:345) argues that additional precautions when nursing HIV positive patients are not necessary. The latter may occur because of the fact that knowledge alone does not convince nurses that it is unnecessary. Reutter and Northcott (1994:56) mention that this occurrence might be a coping mechanism to make the risk of nursing HIV positive patients more manageable.

Controlled or forced interaction between nurses and HIV positive patients as a category in Table 1 is apparent from the careful behaviour displayed by nurses when nursing HIV positive patients and their sense of responsibility towards HIV positive patients. Reutter and Northcott (1994:54) are the only authors who mention that the thought of impending death and the possibility of being infected is always present in nurses who nurse HIV positive patients. These thoughts are encouraged because of nurses witnessing HIV positive patients dying. According to Van Dyk (1992:86-87), nurses employed by a hospital authority may not refuse to nurse HIV positive patients.

Defence mechanisms used by nurses while caring for HIV positive patients

Nurses deny that they feel negative towards HIV positive patients and according to Wilson and Kneisl (1992:92) denial is a blocking out of painful or stressful events or feelings. Avoidance is also apparent from the point of view of the nurses that it is not their fault that patients are HIV positive, which may be indicative of the perception among nurses that HIV positive patients are responsible for their own disease condition (Bennet, 1995:343; Leasure *et al.* 1996:235). Reutter and Northcott (1994:62) differ here by describing avoidance rather as a coping mechanism for the negative emotions associated with the risk of contracting AIDS to the nurses themselves.

Rationalisation also occurs in respect of the nurses' need to protect themselves, as apparent from the following quotation: "*It is human to protect yourself against any person who wishes to harm you"*. Wilson and Kneisl (1992:92) mention that rationalisation is a distortion of an experience by logically or socially acceptable explanations for behaviour, and Perkel, Strebel and Joubert (1991:150) state that rationalisation is used particularly by persons who are aware of their own risk of contracting AIDS. With regard to intellectualisation as defence mechanism, AIDS is regarded as an unavoidable disease, as one participant states: "*If I am going to contract it [AIDS], it will happen even if I try my best to avoid it…".*

Coping mechanisms used by nurses during nursing of HIV positive patients

It is apparent from the research that nurses are aware of the contribution that their occupation makes in society, and furthermore nursing brings sense and meaning to their existence. According to Sherman (1996:211) nurses are busy, with little fear of death, or increased spirituality, or spiritual awareness, and with willingness, to care for HIV positive patients, to actualise their nursing potential and to accept their social responsibility in respect of AIDS. Reutter and Northcott (1994:63) mention that awareness of duty in respect of the providing of patient-centred care of HIV positive patients ("required helpfulness") reduces fear, and the acceptance of risk is according to Bailey and Clarke (1989:57) an effective coping mechanisms in this case. A participant mentioned: "*Ons aanvaar sielkundig die risiko, ek moet myself beskerm". (We psychologically accept the risk, I must protect myself).* Nurses do not regard it as their right to judge the patient, but the finding in this research that nurses do not blame HIV positive patients is contrary to literature where blaming of the patient has indeed been documented (Leasure *et al.* 1996:235; Bennet, 1995:343).

The emotional support of HIV positive patients is regarded as the Christian duty of nurses and although the attitudes of some nurses are moralistic and judgmental, others plead for acceptance, no judgement and emotional support. Some nurses are of the opinion that HIV positive patients had committed a sin, and this point of view, together with the conviction that AIDS is a disease that people bring on themselves (Pantanowitz & Connel, 1996:102), influence the behaviour of nurses towards HIV positive patients. Nurses discuss HIV positive patients with colleagues as a behavioural coping mechanism, and Newton (1995:131) mentions that the sharing of a common experience, such as a needle-prick injury, is experienced as positive.

Lastly the symptoms that the patient with AIDS experiences are compared with those of other diseases and the occurrence of this phenomenon is mentioned in literature (Van Dyk, 1992:47). Nurses also use emotional coping mechanisms when feelings such as anger and aggression towards HIV positive patients are suppressed, and guidance and emotional support are given instead. This is a unique finding, together with the bottling-up of feelings, which is also described by nurses.

Value judgement regarding HIV positive patients

AIDS is sometimes regarded as a punishment for sin and a value judgement is expressed regarding the HIV positive person as not guilty or guilty, based on the method of transmission. Some participants are of the opinion that HIV has been contracted by "irresponsible" action, and this is a unique finding in the research. Further value judgements include that nurses feel that their Christian convictions give rise to a feeling of pity for those patients, but no confirmation hereof could be found in the literature.

According to participants the professional role of nurses and the Nurses Pledge of Service prevent them from discriminating against HIV positive patients. One of the participants stated: *"I took a pledge that I would nurse these patients and I can not discriminate against them"*. Although participants in the research do speak out against direct action that is indicative of discrimination, it happens and is confirmed by authors such as Joubert (1991:25) and Van Dyk (1992:1-3). The religious convictions of nurses play a positive role in how they act towards HIV positive patients, and Sherman (1996:210-212) shows the relationship between spirituality and the willingness among nurses to care for HIV positive patients. Nurses also ask God to protect them during the nursing of HIV positive patients, and according to Bailey and Clarke (1989:123), praying and reading the Bible are active direct coping mechanisms used by nurses to relieve stress. Newton (1995:129) mentions that nurses use prayer as a coping mechanism when they are exposed to HIV by a needle-prick injury.

Lastly nurses are of the opinion that high-technology care should be withheld from HIV positive patients, but a direct reference to this point of view of nurses could not be found in the available literature.

CONCLUSIONS

In the research the conclusion was drawn that the attitudes of nurses towards HIV positive patients were mostly negative due to a lack of knowledge and a lack of the internalisation of knowledge, which lead to the experiencing of negative feelings towards the patient. Furthermore, there is conflict between the personal and professional value systems of nurses. Although they state that their behaviour towards HIV positive patients does not differ from their behaviour towards other patients, it is nevertheless apparent that the defence and coping mechanisms displayed by nurses to decrease the internal discomfort which they experience are detrimental to the establishment of a therapeutic relationship between them and HIV positive patients. Nurses also maintain a unilateral view of the risk of becoming HIV positive by only considering the possibility of infection through their work, while they deny the risk of contracting AIDS in their private lives.

RECOMMENDATIONS

The possible applications of this study in *nursing research* include the potential for further research regarding the needs of HIV positive patients in respect of nursing, and the needs of nurses during care of HIV positive patients. The possible applications of this study in *nursing education* include the possible incorporation of guidelines established in this study in the curriculum of the course that leads to registration as a nurse. Furthermore, values should be cleared out with nursing students and ethical decision-making with regard to AIDS as a topic should be dealt with. Teaching techniques may also focus more on the attitude of students towards HIV positive patients, because during their training they already do practical work and come into contact with HIV positive patients.

With regard to the possibilities of application of this research in *nursing practice*, guidelines have been established to effect a potential change in the attitudes of nurses. General guidelines were established for a) the persons who attempt to change attitudes, b) the content of the message aimed at changing attitudes, and c) the receivers of the message, namely nurses.

The persons who attempt to change the attitudes of nurses must be regarded as credible. These persons must have self-confidence and nurses must be able to trust their motives. With regard to the message that is conveyed, it must be clearly understandable, non-judgmental and in line with the nurses' personal value systems. Furthermore it should also be beneficial to the persons whose attitudes must be changed, it should not cause fear, and active participation in the process of conveying information may effect a change in attitudes. The ego involvement of nurses in the subject with regard to which an attitude change must occur must be kept in mind and nurses must be allowed at their own pace to collect information that may potentially change their attitudes. Lastly, group membership may be an influential aspect with regard to a change in attitudes of nurses.

With the above in mind, specific guidelines were established for a potential change in attitude in nurses.

Guidelines to effect a change in attitude with regard to the treatment and handling of HIV positive patients by nurses

- Expansion of knowledge of the treatment and handling of HIV positive patients could possibly lead to an attitude change in nurses.
- The persons who convey the knowledge must preferably be experts in the field of AIDS and must themselves have a positive attitude regarding the nursing of HIV positive patients.
- Persons who themselves are HIV positive but are reasonably healthy because of effective treatment, could address nurses regarding the value of treatment.
- Knowledge conveyed must not only include information on treatment and handling, but also information on the value of extending by treatment the quantity and quality of life of HIV positive patients.
- The principles of "psychoneuro-immunology" could be explained to nurses.
- More than one method of attitude change can be used and media could be utilised to reinforce the message.
- Training of nurses in the counselling of HIV positive patients provides an opportunity to nurses to mean something to the HIV positive patient and reduce the perception that "nothing can be done for HIV positive patients"
- A change in the attitude of nurses could possibly also change the attitudes of them towards the treatment and handling of HIV positive patients.

Guidelines for an attitude change with regard to the consistent use of universal preventive measures

- To promote internalisation of knowledge regarding universal preventive measures by nurses, credibility of the sources of knowledge is essential.
- Attractiveness, which plays a role in credibility, could possibly be increased by effective verbal and non-verbal communication skills, personal neatness and self-confidence.
- Similarity increases the attractiveness of the sources (Middlebrook, 1980:202), and it may make sense if the presenters are as similar as possible to the group.
- Information regarding universal preventive measures must preferably not be conveyed by a person in authority, but rather by an external person.
- Role modelship is important when attempts are made to change attitudes of nurses, and own attitudes, values and meanings with regard to the consistent use of universal preventive measures may be conveyed.
- These persons must also be enthusiastic regarding the use of universal preventive measures, be certain of the risk attached to providing nursing care for HIV positive patients, convey information with self-confidence and be able to put forward logical arguments with regard to universal preventive measures.
- The mere cognitive transfer of information on universal preventive measures must be avoided.
- Group discussions may be used because a change in group norms could possibly also give rise to a change in attitude (Zimbardo *et al.* 1977:64).
- Contrasting opinions of universal preventive measures may be addressed by conducting debates.
- The reward that the consistent use of universal preventive measures may have for nurses and the consequences of inconsistent use may be shown to nurses.
- The consequences of cognitive dissonance for both nurses and HIV positive patients may be shown to nurses, and they could be assisted in changing their attitudes so that dissonance can be reduced and internal discomfort alleviated.

Guidelines for changing the attitude of nurses in respect of confidentiality

- A workshop with the theme: "AIDS, my rights and duties as a nurse" may be presented, and by focusing on the rights and duties of nurses, feelings of having been wronged may be reduced in nurses.
- Adequate opportunity for the verbalisation of feelings regarding confidentiality and HIV positive patients is necessary because emotions are controlled by being aware of them, accepting them, giving direction to them and verbalising them (Johnson, 1993:139). An environment of unconditional positive acceptance may facilitate this process.
- A change in attitude can be encouraged by a change in behaviour when systems are implemented where patients' rights are respected. If

nurses are of the opinion that the patients' right to confidentiality do not conflict with their own rights and those of the community, they may act as spokespersons for the patients. In this way they express their attitudes and commit themselves in public, all of which, according to Zimbardo *et al*. (1997:55) bring about a change in attitude.

Guidelines to change nurses' attitudes by equipping them to deal with internal discomfort by them learning more effective coping mechanisms

- Existing coping mechanisms may be identified and evaluated for effectiveness.
- Information regarding the expansion of coping mechanisms can be offered.
- It may also be of value to identify support systems and then to suggest ideas regarding their optimal utilisation.
- A healthy self-image and the promotion of rational thought may increase self-confidence.
- The learning of effective problem-solving skills and relaxation techniques may also be of value.
- According to the learning-theoretical approach, nurses may be made aware of the consequences of their behaviour.
- Effective coping mechanisms may be strengthened by positive feedback and ineffective coping mechanisms discouraged by ignoring them.
- The presenter may act as a role model by active participation in the expansion of existing coping mechanisms.

Guidelines for changing the attitude of nurses towards a therapeutic relationship with HIV positive patients

- A relationship of familiarity as described by Johnson (1993:16) may be developed between nurses and HIV positive patients by increasing contact between the parties involved.
- Trust may be promoted by respecting patients' right to confidentiality and by acting consistently.
- Effective communication, mutual acceptance and support are also essential skills for interpersonal relationships (Johnson, 1993:16) and a course in interpersonal skills may be of great value to nurses.
- Effective conflict management and problem-solving are necessary in order to build up therapeutic relationships with HIV positive patients, and these skills can be practised by means of role-plays.
- It could also be of value if nurses attend AIDS training in order to equip them to give guidance to the patients.
- The persons who attempt to change the attitudes of nurses towards HIV positive patients may act as role models by showing positive attitudes towards HIV positive patients in both their verbal and non-verbal behaviour.

Guidelines for potential changes in attitude in nurses in order to promote a more realistic consideration of the risk of contracting AIDS in their professional and private lives

- The denial of own risk may be addressed by conveying knowledge of each form of transmission and the risk attached to it. Emphasis may be placed on high-risk versus low-risk events.
- It may also be sensible to encourage nurses to identify the implications of AIDS in their personal lives, and group discussions may be held on how to protect themselves in all areas.
- The use of first names and comfortable private clothing during training may help nurses to view AIDS also from a personal perspective.
- Humour may be used to encourage relaxation, and an environment in which nurses feel comfortable to share personal aspects with the group can be created. The presenter must therefore be thoroughly familiar with group processes and dynamics.
- During role-play nurses may be encouraged to be "patients" who are more or less in similar positions as they are, and this could possibly bring home to the nurse the idea of personal risk.
- HIV positive speakers with whom nurses can identify could be invited to address them regarding their experiences of being HIV positive.
- Lastly, the persons who attempt to change the attitudes of nurses in respect of this aspect could possibly make themselves available, should nurses indeed become aware of their risks of contracting AIDS in their private lives and require counselling.

SUMMARY

The aim of this research was achieved because knowledge of the attitudes of nurses towards HIV positive patients has contributed to the establishment of guidelines that have the potential of changing the attitudes of nurses towards HIV positive patients. In this way the quality of nursing care of HIV positive patients may be improved.

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