What's ignorance? The construction of knowledge, competence and risk in the areas of drugs and HIV/AIDS education

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ABSTRACT

This thesis is concerned with the manner in which the secondary school curriculum has responded to drugs and HIV issues. It focuses on pupils understandings of drug use and HIV/AIDS, demonstrated in questionnaire responses and classroom talk. Data was originally collected to provide the basis for an evaluation of education programmes in Cambridgeshire. This is subjected to a retrospective and reflexive analysis, which aims to contextualise the data and provide a substantive focus for the debate about quantitative and qualitative research methods.

Theoretical debates in sociology and psychology concerning the nature of knowledge and models of the subject are addressed, especially in relation to understandings of the educational process and pedagogic communication. The thesis raises methodological issues, opposing the complete rejection of positivist methods of research and the dichotomy between quantitative and qualitative approaches. The benefits of a paradigm based on their complementarity are suggested.

The influence of the following upon drugs and HIV/AIDS education are considered: assumptions and methods of the 'enlightenment' model of education; policy and public debates which reflect moral agendas, embedded within wider political frameworks; and the location and delivery of the Health Education curriculum. Results of a study of school-based drug and HIV/AIDS education, reflecting the dominant paradigms in research and education at the time (a positivist approach to research and the 'enlightenment' model of pedagogy), are presented. Findings are related to similar investigations, as an historical 'snapshot' and also discussed in terms of meaning construction and contextual regulation. The thesis ends by drawing conclusions from the above areas and focusing them upon possible future developments for both researchers and educationalists in this field.

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INTRODUCTION TO THESIS

Issues and approaches

> All diseases have social, ethical and political dimensions. Diseases affect individuals, not abstract entities or collectivities, and affects them in variable ways, according to their general social condition and bodily health. What makes disease culturally and historically important, however, is the way in which meanings are attached to illness and death, meanings and interpretations which are refracted through a host of differing, and often contradictory social possibilities. These shape the ways we interpret illness, and therefore organise the ways in which we respond.
> (Weeks, 1989a p1)

This work is concerned with Health Education in the areas of drugs and HIV/AIDS. My interest in drug education, here, is in terms of its relevance to HIV/AIDS issues and to related concerns with researching the educational process.

The topic of drugs and AIDS education brings into focus a set of broader theoretical concerns in the areas of social psychology and sociology, and in educational theory and practice. This reflects the special nature of AIDS as a socio-medical phenomenon of considerable *symbolic* significance within popular consciousness. How to approach this aspect of AIDS both as a teacher and researcher raises questions which relate directly to current theoretical debates in the social sciences and in the areas of educational research and practice. Therefore, there are three sets of inter-related concerns:

[1] the special character of AIDS as a *social* phenomenon,

[2] debates about the *educational* process.

[3] implications of and for current debates in the *theory and method* of the social sciences,

AIDS Discourse

As a number of writers in the AIDS area have pointed out, the condition carries with it a symbolic load which significantly affects how it is treated in the public sphere. AIDS cannot be treated 'objectively', simply as an 'illness' about which people can be more or less

well-informed. Thinking about AIDS is influenced by 'discourses' which are metaphorical or symbolic in character and which incorporate concerns and anxieties relating to the self, identity and moral order. Although to some degree, such public concerns and anxieties have been played upon and orchestrated by the mass media, it would be simplistic to see them as no more than a deliberately created 'moral panic' (Cohen, 1987). The symbolic aspect of the AIDS discourse reflects its capacity to bring together a wide range of social anxieties and 'ontological insecurities' (Giddens, 1991) which can be seen as deeply embedded in European culture and in the historical development of modern societies (Weeks, 1989b).

The contemporary position of AIDS as a symbol has to be placed within the broader context of the body and health and illness as sources of metaphor. As a number of writers have pointed out[1], 'the body' frequently serves as a symbol of society and as a metaphor of social order. Images of bodily health and illness function as images of moral order and disorder. There is a two-way transaction between thinking about the body and about the social. Images of the one are used to represent the other; as in the way, for example, that we talk of 'the body politic'.

Nations or communities are typically personified - the 'Fatherland', the 'Mother Country', *etc.* These personifications are 'fleshed-out' with personality characteristics, embodying the virtues of the people - John Bull (the 'British Bulldog'), Britannia, Uncle Sam, *etc* and relate self and culture through identity and membership. They also bring together images of the physical body and of geographical territory.

A key aspect of the argument of the anthropologist Mary Douglas is that the fusion of images of the body and the social is crucially concerned with *boundaries*. The physical boundaries of the body represent, metaphorically, the physical boundaries of the nation, community or group. As Sontag illustrates (Sontag, 1991), ways of talking about the one are translated into ways of talking about the other. Issues of health and illness are especially important, here, because of the way in which images of physical well-being of the body and its physical integrity come to symbolise states of moral integration, or well-being, in society. On the one hand, 'social images' are used in relation to illness and, on the other, 'health images' applied to society.

Numerous aspects of the social can come to provide images of illness and disease and shape society's reactions to them. Images are drawn, for instance, from science, technology, architecture and warfare.

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[1] For example, see Douglas (1970); Turner (1984); and Sontag (1991).

Sontag argues that the 'warfare' imagery has become increasingly significant and it can be seen as having important implications for perceptions of illness and those afflicted by them.

> It was when the invader was seen not as the illness but as the micro-organism that causes the illness that medicine really began to be effective, and the military metaphors took on a new credibility and precision. Since then, military metaphors have more and more come to infuse all aspects of the description of the medical situation. Disease is seen as an invasion of alien organisms, to which the body responds by its own military operations, such as the mobilising of immunological 'defenses', and medicine is 'aggressive', as in the language of most chemotherapies.
> (*ibid* p95)

The point about boundaries is that they create the difference between inside and outside and, by extension, *insiders* and *outsiders*. Sontag outlines the symbolic logic of the metaphoric association between the body and the social and the way in which it comes to construct the position of illness and its sufferers. 'Demonisation' of illness, leads readily to concepts of victims and guilt. The 'invasion' metaphor links the body and the social by presenting the origins of diseases as being outside the society in the way that the virus was initially 'outside' the person prior to infection.

The complex, metaphoric linkages explored by Sontag are well-illustrated by Watney (1987) when he quotes the Reverend Enrique Rueda, from the United States, who has written of homosexuality as '..."a reservoir of disease" and gay couples as "a form of cancer", whilst concluding that the "homosexual community could be considered a diseased portion of the body politic".' (p49).

In terms of the type of analysis offered by Sontag (and others), AIDS has to be located within the framework of a complex symbolic/cultural field and approached through an appropriate theoretical framework.

Sontag's essays (1991), *Illness as Metaphor* and *AIDS and its Metaphors*, are concerned with a number of basic themes which are addressed in this work and which surface in the empirical study which makes up the second section. These can be listed as:

[1] the *demonisation* of AIDS and the *stigmatisation* of sufferers.

[2] the construction of certain groups, in particular homosexuals, as *'alien'* or *'other'*.

[3] the tension between rationalistic or empirical discourses and metaphoric or symbolic ones.

[4] the 'overdetermination' of discourses of health and illness by concerns with identity, membership, and, especially in the case of AIDS, sexuality and moral order.

[5] the problematical construction of 'innocent' and 'guilty' categories and notions of risk and invulnerability.

A major argument in Sontag (*op cit*) is that this symbolic overdetermination or 'contamination' of illness by metaphor works against the interests of those suffering illnesses. This view reflects her own experience as a cancer sufferer. The symbolic load projected onto illness not only makes it harder to bear for the ill (*eg* intensified fear, irrational guilt feelings or loss of self-esteem) but also affects their treatment by others, including members of the medical profession.

Of particular significance for educators is the tendency whereby the cultural logics of symbolism mediate or refract the 'knowledge' which they attempt to impart and which they hope or expect to modify pupil behaviour. For instance, the logic which defines sufferers as 'other' and automatically assigns them to an 'alien' category also implies that those who are 'us' cannot be or become sufferers. This can lead to a sense of 'invulnerability' which encourages behaviour which subjects 'objectively' *know* to be risky but which is not perceived as dangerous for 'the likes of us'. Pupils in the qualitative part of the study reported in this thesis, for instance, did not identify drug-users *known* to them with the stereotypical (negative) image of 'the drug-user' ('junkie') which emerges from their responses in the more quantitative questionnaire survey (see Sections Two and Three). This is similar to the phenomenon whereby white individuals may declare themselves prejudiced against black people (as an 'alien' category) but admit to having black friends ('us') within their local community. Within the symbolic mapping of the social world, categories are related to and valued in terms of 'social distance' and intimacy and this

contextually embedded cultural calculus can override what is abstractly known to be the case.

The symbolic aspect of illness has also been taken-up by Weeks (*op cit*), but he argues that AIDS differs in significant respects from the cases considered by Sontag in *Illness as Metaphor*. In particular, AIDS has occurred in modern societies grown accustomed to the belief that scientific medicine could ultimately provide a cure for all known diseases.

The onset of AIDS coincided with a questioning of and developing scepticism towards the central values of 'modernity' - in particular the belief in the inevitability (or even, ecologically, the desirability) of 'progress'. The reasons advanced for this condition in the literature on 'post-modern' society are numerous and beyond the scope of this work to review. A number of writers, however, have pointed to the disillusionment of Left and radical thinkers after the failure of the cultural and political revolution of the 'sixties (Callinicos, 1989; Giddens, 1990; Norris, 1992). The failure of the radical movement to bring about significant and permanent social change resulted in a retreat from theory (especially from Marxism) and from 'grand narratives' of general historical advance and human betterment.

Under the influence of 'post-structuralist' thinkers such as Foucault, the idea of 'progress', or the possibility of using theory to understand society and change it, was debunked as an 'enlightenment' delusion (Sarup, 1988). In addition to its apparent resistance to medical understanding and cure, AIDS also appeared as a kind of retribution for the progressivism (or 'permissiveness') of the sixties. In this respect it fitted precisely into the agenda of the emerging cultural authoritarianism of the New Right with its emphasis upon 'traditional' values and heterosexual monogamy (Weeks, 1989b). The post-sixties debilitation of the libertarian left was countered in the ascendency of the radical right fuelled, in part, by a rejection of the 'permissiveness' of the sixties. As Weeks says'

> ...AIDS has become the symbolic bearer of a host of meanings about our contemporary culture: about its social composition, its racial boundaries, its attitudes to social marginality; and above all, its moral configurations and its sexual mores. A number of different histories intersect in and are condensed by AIDS discourse. What gives AIDS a particular power is its ability to represent a host of fears, anxieties, and problems in our current post-permissive society.
> (Weeks, 1989a p2)

The symbolic power of AIDS reflects, he argues, its capacity to focus "deeply rooted fears" (p9) created by an unprecedented rate of change in sexual behaviour and social mores over the previous two generations. Rapid social change and the problems this created for the sense of identity, membership and community were particularly associated with sexuality. The permissiveness of the sixties was seen not only in terms of sexual promiscuity but also as a deeper challenging of traditional gender identities and roles. The complex of symbols associated with moral order and physical disease came to be focussed upon sexuality, and AIDS became the bearer of this symbolic load through the logic of association. Weeks argues that,

> Culturally, the ground for the social reaction to AIDS was prepared before anyone noticed the range of illnesses afflicting gay men and others. In a sense therefore there was already an immanent problem awaiting a symbolic resolution. To this extent, AIDS was a crisis waiting to happen.
> (*ibid* p10)

In these terms, particular sections of society were psychologically predisposed, as a reaction against the rate of social change, to focus a wide range of fears and anxieties upon any likely contender presenting the appropriate symbolic features. In other words, it is not simply the case that AIDS *in itself* invoked a particular reaction but that broader social conditions were such that the advent of AIDS coincided with a situation predisposing it to be demonised in this way.

Weeks discusses the reaction to AIDS in terms of the concept of 'moral panic'. The idea of moral panic was used by Cohen (*op cit*) to describe popular reactions to youth sub-cultures such as mods and rockers. The process involves the demonisation of a group (their translation into 'folk devils') and an excessive public reaction to them amplified by media exaggeration and distortion (Young, 1973a, 1973b; Watney, 1987). The group in question becomes a focus, in the way discussed above, for social fears and anxieties *etc.* The concept is described by Weeks in the following way:

Moral panics occur in complex societies when deep rooted and difficult to resolve social anxieties become focused on symbolic agents which can be easily targetted. Over the past century sexuality has been a potent focus of such moral panics - prostitutes have been blamed for syphilis,

> homosexuals for the cold war and pornography for child abuse and violence.
> (*ibid* p5)

The point about such panics is that the 'symbolic agents' with which they are connected "...become the bearer of a number of political, social and moral anxieties, whose origins lay elsewhere, but which are condensed into a crisis over AIDS." (*loc cit*). Apart from the classic case of youth subcultures, drugs have periodically provided a similar source, especially when subject to the process of 'media amplification'. Early reporting on marijuana, for instance, tended to present users as 'dope fiends' who lose all self-control when 'under the influence', *eg*

> The marijuana user is a violent criminal, with an insatiable appetite for rape, homicide and mayhem. Eventually it renders the user totally insane.
> (Anslinger, 1937)

Weeks argues that under the impact of the process of moral panic AIDS acquired an 'expanded meaning' whereby it has become a 'potent symbolic agent in its own right' (*loc cit*). In the case of AIDS, the process of media amplification was associated with the Thatcherite New Right moral agenda of the eighties, especially in its targeting of 'loony left' local authorities and their support of gay and lesbian groups.

Within the framework of a 'moral panic' a process of 'displacement' occurs whereby issues not intrinsically connected with the group or phenomenon in question come to be associated with it by virtue of symbolic resonance for certain social groups. Like Sontag, Weeks deplores the effects of this for those afflicted with the condition.

For both Sontag and Weeks there is a distinction between illness understood 'simply' as illness and particular illnesses burdened by the load of symbolic overdetermination. For cases such as these, the key aspect to be addressed in research is the metaphoric character and logic of this process. For the educator, also (as I will discuss in more detail below), the *symbolic* dimension of meaning and understanding becomes the key focus of pedagogy.

The discussion of AIDS as a symbolic discourse has been extended by Watney (1987). Watney notes some limitations upon the concept of 'moral panic':

> ...it may be employed to characterise all conflicts in the public domain where scape-goating takes place. It cannot, however, discriminate between either different orders or degrees of moral panic. Nor can it explain why certain types of events are especially privileged in this way. Above all, it lacks any capacity to explain the endless "overhead" narrative of such phenomena, as one "panic" gives way to another, or one anxiety is displaced across different "panics". Thus one moral panic may have a relatively limited frame of reference, whilst another is heavily over-determined, just as a whole range of panics may share a single core meaning whilst others operate in tandem to construct a larger overall meaning which is only partially present in any one of its individual "motifs".
>
> (Watney, 1987 p41)

Hence, Watney suggests that 'moral panic' should be seen as a more complex phenomenon than the original usage suggests. Rather than limited, discrete 'episodes', they may represent an endemic feature of culture whose form, scope and specific content changes over time, but whose underlying causes and the functions they serve remain persistent.

In addition to these points, Watney raises a deeper issue relating to the relationship between a 'panic' and its apparent 'object' (*eg*, youth, drugs, AIDS). This has to do with the nature of 'representation' and has particular implications for both researchers and educators in this area.

> Moral panic theory is always obliged in the final instance to refer and contrast "representation" to the arbitration of "the real", and is hence unable to develop a full theory concerning the operations of ideology within all representational systems. Moral panics seem to appear and disappear, as if representation were not the site of permanent ideological struggle over the meaning of sciences. A particular "moral panic" merely marks the site of the current front line in such struggles. We do not in fact witness the unfolding of discontinuous and discrete "moral panics", but rather the mobility of ideological confrontation across the entire field of public representations, and in particular those handling and evaluating the meanings of the human body, where rival

> and incompatible forces and values are involved in a ceaseless struggle
> to define supposedly universal "human" truths.
> (*ibid* pp41-42)

Underpinning this criticism is a *semiotic* questioning of the relationship between the sign and that to which it refers. Both Weeks and Sontag can be seen as suggesting that the symbolic or metaphoric aspects of illness are an *additional* overlay which could be stripped away to reveal the 'real' illness simply as a thing in itself which both sufferers and society in general could understand and treat directly. Within the broader theoretical debate, such a stance would be termed 'empiricist' (and, in a more extreme form, 'positivist'). Watney is questioning the presumption that such a 'real' object exists. Illness (and the social perception of phenomena in general) is always mediated by signs which in various ways *construct* the object. Post-structuralists (Sarup, 1988) have taken this view to the relativistic extreme of denying any possibility of 'objectivity' in knowledge or distinctions between discourses such as those of science and, for instance, aesthetics or 'common-sense'. Deconstructionists in literary criticisms treat philosophy (and rational discourses in general) as types of literary text (Norris, 1982, 1992), denying the 'genre distinction' between types of discourse. This view raises fundamental philosophical problems and also issues for methodology and research.

More specifically, Watney's discussion points to the ongoing process of ideological representation and social construction of meaning. Such an approach to meaning construction (broadly within the symbolic interactionist tradition and more recently drawing upon semiotics and discourse theory (see ch 1 below)) stresses the manner in which meaning is continually negotiated within any social context, including the classroom or the research situation (*eg* in filling in a questionnaire or responding to an interview). The processes represented in the concept of 'moral panic' are not discontinuous with those involved in meaning construction in the routine contexts of 'everyday life'. They can be seen as an extension and intensification of such processes through the agency of the mass media through which they feed back into the everyday to inform notions of 'self', 'identity' and 'community'.

Summary

[1] AIDS has to be approached in terms of its complex *symbolic* role in society. This is part of a more general view of the way in which the human body and states of health and illness are metaphorically linked with images of society and notions of boundaries, identity, membership and exclusion.

[2] Although this symbolic dimension can be shown to be historically and anthropologically extensive (perhaps universal), AIDS can be seen as having a special position within *modern* societies. It has been depicted as the symbolic bearer of anxieties relating to the rapid rate of social change (especially in the post-war period) and also draws upon aspects of consciousness to do with the 'post-modern' condition of pessimism regarding the 'enlightenment' principles of historical progress and faith in the capacity of reason and science to solve human problems.

[3] The 'extended meaning' of AIDS can be seen as constituting an 'overdetermined' discourse constructed by a number of different currents and concerns. A displacement of a range of more general anxieties becomes focused upon AIDS as a condition and those groups identified as its 'carriers'. This aspect of AIDS requires a well developed theoretical model of the nature of symbolic discourses. Such a model requires a consideration of relevant debates in the social sciences and also has implications for methodology and the researcher and for pedagogy and the teacher.

[4] Although the concept of 'moral panic' is valuable in an analysis of the AIDS discourse and locating such an analysis within an established tradition of social research, the concept needs to be extended beyond its original form in the study of youth sub-cultures. Rather than seen simply as discrete and discontinuous episodes, moral panics should be viewed in terms of a continuous process of ideological struggle over representations, meanings and values in society, especially where they have to do with models of the self and constructs of 'normal identities'.

[5] Whereas moral panic theory has traditionally paid particular attention to the role of the mass-media in encouraging and orchestrating such panics, this more extensive model stresses the continuity between these processes and those occurring routinely in everyday contexts. Meanings and representations, from this point of view, are never simply given and complete, they are continually being negotiated, contested and transformed and the particular role of the mass-media (and groups such as health educators) is to mediate (or even 'police') this process.

On the basis of the above, it is clear that the topic of this study should be located within a framework which takes account of current debates within the social sciences concerned with the theory of social representation, meaning construction and discourse. My intention is to *raise and explore a range of issues* in terms of their implications for teachers and researchers in this area rather than to suggest definitive solutions. This position reflects

both the state of the current debate (which some writers have likened to a 'paradigm crisis' (see Chapter One)) and the history of my own changing involvement with these concerns as teacher, researcher and student over the period with which the study is concerned. This biographical aspect and its relation to the model of the 'reflexive practitioner' (both teacher and researcher) will be discussed more extensively in Section Two.

THE ORGANISATION OF THE THESIS

This work has been divided into three sections. Section One provides a theoretical discussion of a range of issues raised by the above review of AIDS as a complex social phenomenon and its implications for education and educational research. Chapter One considers the idea of a 'sociological social psychology' as a general theoretical approach. In looking at this debate in social psychology, the similarities with the earlier debate about 'positivism' in sociology are noted together with the problems presented by the relativism of the 'post-structuralist' influence upon advocates of a 'new' social psychology. It is argued that the topic of AIDS presents educators in particular with anxieties as far as a relativist position is concerned.

Chapter Two relates the discussion of 'sociological social psychology' to educational research and to the call by Pollard (1990) for a positive collaboration between psychologists and sociologists based around a common concern; the construction of meaning in the classroom. It is argued that a sophisticated understanding of these processes in research are paralleled by the need for more complex approaches to teaching around issues such as AIDS which have the degree of symbolic and discursive complexity discussed above. This entails a pedagogy which rejects the simplistic logic of the 'enlightenment' model of teaching. The New Sociology of Education of the 1970s is taken as a starting point for considering these issues and, again, parallels are drawn between that movement and current debates in social psychology.

The third chapter locates AIDS education issues within the context of the politics of education of the 1980s and the educational reforms of the New Right. Particular emphasis is placed upon the influence of the moral agenda of the 'neo-conservatives' and the implications of this for areas such as sex education and the presentation of topics such as AIDS and homosexuality in the schools. These ideological debates are related to changes in the control of schooling and the curriculum and their implications for teachers in the Personal Social and Health Education (PSHE) area. These issues are then related to the Health Education curriculum in Chapter Four.

The second section is mainly concerned with presenting the results of a survey of pupils' attitudes to and knowledge about drugs and HIV/AIDS in Cambridgeshire schools in 1986/7. Although the survey is allowed to stand in its own right as a 'snapshot' of the situation in that place at that time as presented by that particular method of data collection, it is also treated reflectively in terms of my own position, then, as an Advisory Teacher and researcher. Retrospectively, that study is relocated and discussed in terms of

my further professional development as a lecturer in psychology (with some additional involvement in sociology) within teacher training and now on a psychology degree course and which has led to the more fully developed theoretical position I explore in this thesis. The section concludes with a factor analysis which, in identifying a set of underlying themes within the survey data, acts as a bridge into the next section, which reports the qualitative data from that original research project.

Section Three presents data collected from the same group of school pupils, using qualitative methods. This data is discussed in terms of the effects of 'context' as a regulator of discourse. It is argued that changes in context produce different types of 'talk' because of the ways in which they reorder the relationships between sets of discourses and discursive principles. The influence of these principles is explored in the three different contexts in which pupil talk was observed. This analysis explores the character of the symbolically complex, 'overdetermined' discourse of AIDS and drug use and the dynamics of its situational location. The implications of this for both research and teaching are discussed.

It is important to stress that the original study was not conceived and implemented within the theoretical framework in terms of which it is now being analysed. It was not designed in order to test the theoretical and methodological positions developed in this thesis. Although it can be fairly seen as typical of research in this area at that time, the theory which is being applied reflects the development in theoretical discussions in the AIDS field over the intervening period. In particular, it reflects the application of increasingly sophisticated theoretical resources to the topic - *eg* as with Watney's discussion of the concept of moral panic (see above). At the biographical level this is reflected in my own professional development over that period.

These more sophisticated theoretical debates are combined in this thesis, with the adopting of the methodological position that positivist and qualitative approaches should be treated as complementary rather than mutually exclusive. In this respect, my argument parts company with those advocates of sociological social psychology who are drawing upon discourse theory and post-structuralism in order to criticise positivist social psychology in a way which reproduces the type of fundamental distinction between paradigms which was typical of the earlier debate about positivism in sociology.

Hence, the concern of this work can be described as being with the problems of developing theoretical understandings appropriate to the complexity of AIDS as a social phenomenon and with exploring the implications of such understandings for researching the area and for the pedagogy of Health Education in schools. These concerns are explored through the

critically reflexive analysis and presentation of an empirical study which was originally conceived and carried out in terms of an earlier theoretical, methodological and pedagogic paradigm. In part, my own development over this period of time reflects the changes and developments in terms of which AIDS has been discussed within the social sciences. Essentially, the thesis is concerned with exploring possibilities of a theoretically developed approach to researching these issues in education, rather than aspiring to present a fully worked out model.

SECTION ONE

CHAPTER ONE

AIDS DISCOURSE AND THEORETICAL DEBATES IN THE SOCIAL SCIENCES

The purpose of this section is to outline the general theoretical position to be adopted. This will be undertaken with reference to current developments and debates in the theory of education in sociology and psychology. As will be developed in detail in this section, the theoretical perspective of this work will be 'social psychological'.

A 'social psychology' approach to the issues of Health Education is appropriate because, historically, social psychology developed out of a concern with attitude measurement and change (Howitt *et al*, 1989) - a basic concern in the Health Education area. It also takes 'small group' interaction as its central focus and is therefore well-suited to studies of the classroom and the teaching-learning process. However, precisely how such studies should proceed is a contentious issue. Currently, this debate is being pursued within the context of what has been defined as 'the crisis in social psychology' (Parker, 1989; Parker and Shotter, (eds), 1990).

I will use the issues debated in 'the crisis' literature as a basis for defining the theoretical position of my study. I will also argue, in Chapter Two, that there are parallels between the current crisis in social psychology and an earlier episode in the late sixties and early seventies which led to the emergence of the 'New Sociology of Education' (Young, 1971). This comparison allows for a focus upon both social psychological explanation and concerns specific to the sociology of education.

I will draw upon both sets of literature in order to demonstrate the continuities and breaks between the two periods and debates. In the case of 'continuities' the key issue is to do with 'positivism' and its implications for explanation and method in the social sciences. I will consider the way in which interpretive sociologists and constructivist psychologists have criticised positivism in their respective disciplines. As far as the breaks are concerned, the contemporary literature in social psychology is drawing upon developments in post-structuralism, semiotics and discourse theory which post-date the New Sociology of Education.

The basic issue is the character of the human and social sciences. The debates with which I am concerned often invoke the idea of a crisis at a fundamental level within the discipline.

Harre says that crises of this type are "usually the result of two closely connected troubles":

> The methodology is inappropriate to the nature of the phenomena under investigation, but this is a consequence of a more fundamental disorder. The metaphysical basis, without which no science could begin to exist, is awry.
> (Harre, 1985 p13)

In the case of psychology, these problems are associated with the discipline's commitment to a positivistic model of inquiry and the associated models of the subject and agency, and the consequences for social explanation. I will be concerned , in particular, at a later point in this study, with the implications of these for understandings of the teaching-learning process.

The crisis in social psychology

The central feature of the 'crisis in social psychology' is the debate around the nature of social psychological understanding and methodology. The key issue here is how far these should be 'scientific' in character. In general terms this has to do with the relationship between social psychology and a positivistic model of scientific method and explanation. The main problem is how to accommodate and define 'the social' in social psychology in a non-positivistic fashion.

It can be argued that psychology in general experiences an endemic tension through the positioning of its subject between 'the biological' and 'the social'. Squire has written that psychology is interested in 'the subject as a social being' (Squire, 1990 p34). Yet it also,

> ...centres on an ultimately biological subject, and biological theories remain most powerful in it. Sometimes, biological explanations are offered for phenomena, like gender-specific play and excessive drinking, which could be much simpler to account for socially. More generally, social factors are reduced to modifying influences on a biological foundation, and are treated as if they all belong to the same category. Psychologists are continually trying to improve this situation by becoming more socially aware, but are continually unable to do so. And so, psychology's crisis is a crisis of its relation with the social world. This crisis of 'the social' emerges with particular force and persistence in social psychology, where the objects of investigation are

> social behaviour and experience, and where the methods are close to those of sociology .
> (*loc cit*)

This tendency to biological reductionism is associated with a positivistic, experimental method and model of explanation.

The historical influence of positivism can be accounted for in terms of the period in which psychology and sociology were establishing themselves as academic disciplines. In the first half of this century 'logical' positivism held a powerful position in defining the nature of science, and therefore the model to be adopted by any discipline wishing to acquire the status of an academically respectable and scientifically rigorous area of study and research. Eggleston has written that:

> The establishment of research in sociology has been a necessary condition of the establishment of the discipline itself. Only by demonstrating, empirically, that there are laws governing human behaviour in societies could sociology substantiate its claim for a legitimate separate existence...The battle for scientific recognition was first fought by the psychologists, successfully, but at considerable cost to the development of the subject - where the crudities of behaviourism, having the manner of approved scientific method, were tolerated, while the exciting, but largely untestable hypotheses in the field of psychoanalysis presented continual embarrassment. The rigorous formalism of the British Psychological Society, still largely modelled on the prestigious pure science organisations, points to a continuing belief in a need for scientific respectability.
> (Eggleston, 1974 p2)

The distinction between positivist and non-positivist understandings of 'the social' is reflected in Howitt *et al*'s distinction between 'psychological social psychology' and 'sociological social psychology' (Howitt *et al*, 1989 p165). The former, they divide into 'atomistic' and 'holistic' types; the first represented by behaviourism and the second by gestalt theory. Although it is the former which is strictly positivisitic, both are reductionist.

Sociological social psychology is traced back to the influence of George Herbert Mead and 'symbolic interactionism' (Craib, 1984).

> ...symbolic interactionism gave sociologists an approach to social life which was predominantly social psychological rather than psychologically or socially deterministic in its explanations. The symbols of interaction do not exist in an individual's psychological make-up, but only through relationships in the social world.
> (*ibid* p168)

Symbolic interactionism became increasingly influential in the sixties with the shift of emphasis away from macro functionalist and Marxist perspectives towards micro analysis, intersubjectivity and 'meaning'. Over this period, further developments occurred within the symbolic interactionist perspective - 'labelling theory', 'ethnomethodology', 'phenomenology' - which are often referred to in contemporary anti-positivist social psychology (Howitt *et al, op cit;* Potter and Wetherell, 1987).

As positivism is the central concern of the debates which I am considering here, I will look at the concept in more detail and the way it is treated as a problem in social science.

The critique of positivism

During the late sixties and seventies, there was considerable debate around the notion of positivist sociology and its implications. Critics of positivism were located within the interpretive sociological tradition (Douglas, (ed), 1971; Filmer *et al*, 1972; Guba and Lincoln, 1991) and within humanist Marxism (reflecting the influence of thinkers such as Lukacs, Gramsci and the Frankfurt School (Keat and Urry, 1975)). Positivist sociology was seen as the dominant paradigm of that time and its critics were concerned to demolish its claim to define the character of the social sciences.

The aspect most relevant to this study is the focus of the anti-positivists upon what they saw as the dehumanising implications of positivist sociology and the limitations of its method for explaining and understanding the social. Interpretive sociologists made the following points:

1] By insisting upon the unitary character of science and giving priority to natural science, positivism treats human beings like things. This process is referred to as 'reification'.

2] It excludes that which is most distinctive of human beings, namely, their subjectivity.

3] By ignoring meaning and subjectivity, it imposes its own categories upon social actors, thus denying the integrity or independence of their own experience.

4] By virtue of the above and because of the commitment to a causal predictive model of explanation, it, in effect, produces systems of social control (Fay, 1975).

Positivism was seen as dehumanising, objectifying , absolutist and politically reactionary.

Historical background

The term 'positivism' has its modern roots in the philosophy of science and is associated with the influential views of the philosophers known collectively as the Vienna Circle or logical positivists (late 19th, early 20th century) (Cook, 1991; Kolakowski, 1972).

Armistead, in an influential collection in the early seventies, attacking positivist psychology, summarises the positivist position as follows:

> Logical positivists maintained that the sciences, physical, natural and social, are all one and that the same basic approach was applicable to them all, namely the approach of the physical scientists; they also maintained that abstract statements that do not refer to concrete, verifiable physical entities should be inadmissible in scientific discourse - the meaning of a statement consists in the method by which it is verified. This was interpreted to mean that psychology should proceed by formulating specific predictions about observable behaviour that are falsifiable empirically; usually by doing an experiment. Scientific laws should be deduced gradually from the results of many such experiments.
> (Armistead, 1974 p12)

The language of science is seen to be non-theoretical and presuppositionless. The positivists saw themselves as purging knowledge of the distortions of metaphysics, ideology and theory, all of which are seen as being based in concepts which are not open to empirical verification. Crucial to this position was the 'mirror-theory' of language - words simply reflect what is the case.

Critics of positivist sociology have described this position as 'absolutist'. Douglas, for example, says that:

> ...the early social scientist adopted a conscious policy of studying man (*sic*) the same way that one would study any physical object. Having presupposed these methods, they adopted the stance most in accord with them. They adopted the absolutist perspective on man and society. That is, they viewed man as an object, causally determined (totally) by forces outside himself. In accord with this perspective, they adopted an *absolutist* (or *objectivist*) stance toward everyday life. They assumed that the phenomena of everyday life could and should be studied only in terms of clear and distinct (scientific) formal categories defined by them in advance of their studies.
> (Douglas, 1971 p13)

Fundamental to this positivist model of science is the view that the observations used to evaluate theories are independent of the theories themselves. This involves the claim that observation statements are theoretically neutral.

The implication of the positivist view was that any discipline aspiring to the status of science had to be able to demonstrate that it could employ the 'scientific method' so-defined - only on this basis could it be said to be producing knowledge. An important principle of the positivist approach was the idea of the unitary character of science - all sciences use the same scientific method. This obviously has important implications for the idea of social science , because it implies that social sciences, in order to be sciences, must have the same basic form as natural sciences. It was a this point that social scientists operating within the interpretive tradition took issue with positivism within sociology.

The interpretive response

In the late sixties, sociologists began to question the idea of a unitary scientific method derived from the natural sciences. Drawing upon the Weberian tradition of interpretive sociology, they argued that the social sciences must necessarily be qualitatively different from the natural sciences. This reflected the fundamental difference between people and

things. In an explicitly anti-positivist work, written from a phenomenological perspective, Filmer *et al* argue that

> The social world, then, is a world constituted by the taken-for-granted meanings which its members use as a common scheme of reference by which appearances (events, actions, settings and so on) are interpreted and explained. Social structure, therefore, refers to the members' sense of social structure which is the product of the common scheme of reference that constitutes a set of socially standardized and standardizing, seen but unnoticed, background relevances by which members make sense of their world.
>
> The important point is this: we cannot take for granted, as a natural scientist does, the availability of a pre-constituted world for investigation because the process by which a social world becomes available (*ie* is constituted) must itself be the problematic object of investigation. It follows, then, that the task of sociology is to examine the processes by which the social world is constructed. This, in turn, necessarily entails suspension of belief in the existence of that world as an objective reality.
>
> The primary problem of positivistic sociology resides in its failure to suspend such a belief.
> (Filmer *et al*, 1972 p19).

Interpretive sociologists believed that social scientific knowledge was possible on a different basis. This 'paradigm crisis' in sociology in the early seventies is being repeated today in the area of social psychology.

However, as Eggleston has pointed out, the positivistic model of natural science should not be treated as the definitive account:

> An important critique by Kuhn (1970) suggests that natural scientists themselves are limited by their paradigms of scientific knowledge which have an important influence on their choice of problems, research methodology and their analysis of results. For Kuhn the development of scientific knowledge comes largely through scientific revolutions when the old paradigms were discarded and the new ones

> adopted. In the opinion of many sociologists it is just such a revolution that is now taking place in sociology.
> (Eggleston, 1974 p3)

In this first, sociological phase of the debate about positivism, interpretive sociologists argued that the human sciences should have a form distinct from that of the natural sciences, because they are centrally concerned with *the problem of meaning*. As Sharp and Green point out 'a number of strands and subcategories' contributed to this anti-positivist position. They say that

> ...what seems to be held in common by all of them are, first, their common heritage in German Idealism, developed in social science in the work of G H Mead, M Weber, and A Schutz, and second, their substantive concern with the problem of subjective meaning as basic for an understanding of the social world.
> (Sharp and Green, 1975 p3)

This concern with subjective meaning refers to the argument that human beings differ quite fundamentally from the objects of natural science in that they possess subjectivity. Positivism rejects subjectivity, because it is not empirically available and attempts to 'operationalise' subjective conditions by translating them into empirically available overt behaviours.

This principle was strongly denied by anti-positivists who saw observations as embedded within the theoretical paradigms (Barnes, 1985; Guba and Lincoln, 1991) whose propositions they were meant to be independently testing. Interpretive sociologists argued that observation is socially constructed and therefore intrinsically theoretical. In a similar fashion, they rejected the positivist claim that scientific knowledge was value-neutral.

Anti-positivists (*eg* Gross, 1974) argued that the claim to value-neutrality had invidious political implications in that it suggested that technical solutions to social problems were ideologically neutral (Fay, 1975; Henriques *et al*, 1984).

Meaning and action

Within the interpretive tradition a fundamental distinction is made between behaviour and action. Whereas things (*ie* the objects of natural science) merely behave, human beings act - *action is meaningful behaviour*. This implies that the significance of any example of human behaviour is not immediately available through simple observation. Its significance can only be ascertained through discovering its meaning to those involved. Meaning is both subjective in the sense of belonging to a particular individual, but also intersubjective in the sense that the meanings of social action are (a) socially produced and (b) shared. Consequently, social action becomes intelligible in terms of the socially produced and shared meanings current within a society or group at any particular time.

A major implication of this approach was that social scientists must necessarily operate with a method which differs fundamentally from that attributed by positivists to the natural sciences. It also follows that social scientific explanations will differ from those of natural science. The most significant aspect of this being that social scientific explanations will not necessarily be predictive in character. Interpretive sociology seeks to understand meaning rather than produce quantifiable, law-like statements.

It is this concern with subjectivity and with the active model of the social actor that the current approaches upon which this work will draw have developed.

Meaning and the active subject

The critique of positivism reiterated a number of well-established principles within the interpretive sociological tradition associated in particular with the influence of Weber. However, a radical break was seen as occurring within this tradition with the emergence of phenomenological sociology. Phenomenological sociology drew its inspiration from the work of Alfred Schutz (Craib, 1984; Giddens, 1974). This perspective was particularly associated with Berger and Luckman's work on the 'social construction of reality' (1967).

Drawing upon the earlier insights of symbolic interactionists (*eg* labelling theorists such as Becker), ethnomethodologists pointed to the flexibility and variability of meaning within social situations. They investigated the every day common-sense processes through which individuals made sense (or 'produced accounts') of social situations. They also saw these sense-making procedures as being themselves constitutive of social reality. In this manner, they radically challenged the model of the concept of context within symbolic interactionism and role theory. Rather than seeing context and its meaning as pre-given

and simply awaiting correct identification by the individual, they saw it as emerging out of social interaction and therefore being provisional and continually renegotiable (Douglas, 1971; Filmer *et al*, 1972).

They produced a radical critique of sociological work itself, denying any independent or privileged status to concepts such as class or social structure. They argued that such things exist only in so far as they are found within the common sense of 'members'. The role of the sociologist was not that of producing second-order concepts which purport to explain social action, but to recover the procedures within every day life whereby individuals actively construct social reality.

Symbolic interactionism and ethnomethodology provide important reference points in the current debate in social psychology, as well as being central to the sociological critique of positivism in the early seventies. I will now consider in more detail the differences between symbolic interactionism and ethnomethodology and their contemporary relevance.
In an influential essay published in 1971, Denzin says that

> Both perspectives take some variant of the individual and interaction as the unit of sociological analysis. Their methods are similar to the extent that the perspective of the acting person is given primary importance. Fundamentally, then, they posit a link between the person and the social structure that rests on the role of symbols and common meanings.
> (Denzin, 1971 p260)

Despite this similarity, symbolic interactionism, can be seen as associated with a simplification of the relationship between meaning and social structure. As Armistead (1974) points out, this is the result of the association between symbolic interactionism and structural functionalism based on the concept of 'role'. Role theory, although linking meaning and structure, came to be seen by anti-positivist sociologists as leading to an 'absolutist' approach to meanings and a passive model of the subject. In this respect, it was characterised by Wilson (in the same volume as Denzin) as the 'normative paradigm'. Wilson describes this in the following way

> The major current theoretical approaches in sociology, the relevant features of a pattern of action are accounted for ultimately in terms of dispositions that have been acquired by the individual, such as attitudes, sentiments, conditioned responses, and need dispositions, on

> the one hand, and sanctioned expectations, on the other. In common sociological terms, such sanctioned expectations are called role expectations, and an organised set of role expectations applying to a particular actor is termed a status.
> (Wilson, 1971 p59)

Phenomenology and ethnomethodology rejected this approach to meaning by problematising the processes of meaning construction as such. Wilson contrasts 'the normative approach' with the 'interpretive paradigm'. In contrast to the absolutism of role theory, ethnomethodologists argued that roles are provisional and subject to multiple interpretations, including retrospective reinterpretation by the social actor. Therefore, in any social situation, the meanings and purposes attributed to others are the product of an interpretive act by the individual.

Roles, therefore, are not 'given' in an absolute and unambiguous fashion, but are 'constructed' through interpretive interactions between people. Ethnomethodologists refer to these processes as 'accounting procedures' through which individuals make sense of the social world. They stress the negotiated character of these interactions and the emerging social realities or accounts. Ethnomethodologists took as a matter of principle the idea that sociologists could not improve upon the actor's own individual interpretations and understandings. As Armistead summarises this position

> Ethnomethodologists then try to study how these 'accounting procedures' make sense of the social world for participants by providing a sense of order and social structure. In doing this, a process of negotiation goes on between different participants' accounts of what is going on and what should be done, in social situations.
> Ethnomethodologists study these processes and hope thereby to arrive at the basic rules of everyday life - however, this involves a certain amount of interpretation, which ethnomethodologists recognise is just their interpretation of what is going on, rather than any final explanation of reality.
> (Armistead *op cit* p23)

It was this relativism that was the basis for the reservations expressed by radical sociologists of education. These reservations were to do with the provisional and ultimately relativistic status of ethnomethodological analyses.

Sociological social psychology

The principle continuity between these earlier debates and contemporary social constructivism is the idea that social reality *is* socially constructed and, therefore, in significant respects provisional, open to reconstruction/deconstruction and is an ongoing accomplishment of active social subjects.

The current 'crisis in social psychology' can be seen, in these terms as the attempt to develop a non-positivistic sociological social psychology (Howitt *et al*, 1989) drawing upon both the interpretive sociological influences in the earlier 'crisis in sociology' (symbolic interactionism, phenomenology, ethnomethodology) which underpinned the New Sociology of Education and the more recent contributions of semiotics, discourse theory and post-structuralism. More specifically, the interest of this work can be seen as applying this set of theoretical concerns to the classroom and the teaching learning process.

Howitt *et al* develop an eight point typology of approaches in social psychology, on the basis of their associated 'referents', 'concepts' and 'perspectives' (p172-173):

[1] Referent: social/non-social - this has to do with the nature of 'the thing to be explained' (p172). They give as examples of social referents: friendships, attitudes and language; and non-social include things such as perception, intelligence and reaction times.

[2] Concepts: social/non-social - essentially this distinction is concerned with whether or not explanatory concepts are reductionist. Here, leadership, for example could be explained in terms of social mechanisms to do with group attitudes or 'non-socially' in terms of intelligence and motivation.

[3] Perspectives: individual/group - this refers to whether the 'things to be explained' are an individual or collective phenomenon. They illustrate this distinction through the example of how conformity to group pressure could be accounted for in terms of a particular individual's degree of gullibility. The alternative group perspective would be to focus upon characteristics of a group or category rather than the special characteristics of particular individuals.

Sociological social psychology is their Type Two (referent social/concepts social/group perspective (*ibid* p173)) which they illustrate with reference to 'roles and rules'.

> Clearly this describes a social referent (the conduct of interactions between people); the concepts are social since roles and rules emerge out of interactions between people; and it involves the groups perspective since roles and rules are things which people share a common perspective on.
>
> (*ibid* p174)

Sociological social psychology, whilst carrying over insights of phenomenological sociology, has also incorporated post-structuralist concerns with discourse and the decentring of the subject. It is, however, important that this paradigm does not lapse into the extreme subjectivism and voluntarism of phenomenology.

Semiotics and discourse theory

As far as social psychology is concerned the significant feature is the move away from an individual cognitivism towards a concern with the collective representations which subjects hold of the social world. Corinne Squire, for instance, has defined a position which challenges

> the mainstream's dominant cognitivism by addressing the structure and contents of subjects' collective representations of the social world, rather than their individual cognitions of it; or by exploring mainstream social psychology's own concepts, and their historical and social determinance; or by adopting some combination of the two... These initiatives are influenced by structuralist and post-structuralist concerns with signification's uncertain meanings, authority, and materiality, and by social psychology's own history of treating language as an index of the social relations which it neglects.
>
> (Squire, 1990 pp36-37)

In their review of 'the foundations of discourse analysis', Potter and Wetherell (1987) discuss both ethnomethodology and semiotics. Semiotics rejects the view that meaning is

located in the direct relationship between a term and its object (the so-called 'mirror-theory' of language or truth in positivism).

> First, structuralists view language as a sign system. Any sign has two elements: the signifier (word/letter/sound), and the signified (the meaning, idea, concept). Structuralists hold that the relationship between the signifier and the signified is arbitrary. There is no necessary or obvious connection between word and meaning. Post-structuralists seize on this arbitrary connection of the signifier and signified and employ it to destroy any hope of objectivity, secure truth or certainty. If language, or literature, or personal identity are functions of differences within a system (having no intrinsic being), and if within those systems the relationship of signifiers to signified is arbitrary, then all meanings are unstable and shifting. As a result, language refers only to itself (the signifier) not to the concept (signified) - or even the world (referent).
> (Gibson, 1986 p93)

These ideas have their origins in the work of the linguist Ferdinand de Saussure. Meaning is derived from the relationships between signs within symbolic systems. Their scientific study constitutes the field of semiotics. In the sixties and seventies, this approach was further developed in the work of the anthropologist Claude Levi-Strauss and the critic Roland Barthes. This approach was known as structuralism. As Gibson says,

> The characteristic is the notion of *relationships*. Structuralism asserts that no 'thing' has meaning in itself. Rather, it is defined and given meaning by its relationships within a system or structure. This idea arises from Saussure's notion that language has no positive terms, only differences. A word is known only through other words, through its setting in the structure of language.
> (*ibid* pp92-93)

In the work of structuralists such as Levi-Strauss, 'structures' are seen as having a definite form, which can be revealed through analysis (as in his studies of myth). Post-structuralism, however, questions the 'givenness' of these relationships. As Madhan Sarup says

> While structuralism sees truth as being 'behind' or 'within' a text, post-structuralism stresses the interaction of reader and text as a productivity. In other words, reading has lost its status as a passive consumption of a product to become performance.
> (Sarup, 1988 pp3-4)

In this way, post-structuralists could be seen as working with an active model of the subject. However, in its decentring of the subject, post-structuralism is often regarded as dehumanising in its denial of the human subject based on a unified consciousness (Sarup, *loc cit*). Following Gibson, the basic principles of the post-structuralist developments in semiotics are that society, meaning and identity are constructed, rather than being natural or given and fragmented, contradictory and without a 'stable essence'. Consequently, the self is not seen as the subject, actively constructing meaning, but as a product of discursive practice.

The individual, the social and the subject

The post-structuralist influence that Squire (*op cit*)mentions marks the distinctive difference between the 'crisis in social psychology' and the earlier episode in sociology. The key concerns, here, can be related to the quote from Harre at the beginning of the chapter. He refers to the 'closely connected troubles' of an 'inappropriate methodology' and the 'metaphysical basis' of social psychology being 'awry'. The model of the subject is central to both. The contemporary literature focuses upon 'the model of the subject' in terms of the post-structuralist critique of the 'unitary subject' which is held to have underpinned both positivist and interpretive approaches.

Potter and Wetherell say that

> It is taken for granted that this self, the object to be discovered, is the *centre* of experience, an initiator of action, a coherent whole, separate from other distinct selves. These aspects are crucial to psychology's conception of the individual person and the human subject. They make

it possible, for example, to contrast the *individual* with *society*, as natural pairs in a balanced dichotomy. The individual can be posed as the causal unit the researcher retreats to when explaining social phenomena, and represented as the possible origin point for society and, indeed, of any knowledge about the world ... It is presupposed that the self is a unitary entity, a relatively autonomous agent in the world and thus a source and explanation of the kind of phenomena which interests the psychologist. In fact this assumption comes to define what the psychologist should study and the prominence given to the laws of motivation, for instance, or the cognitive structure of the person. Even for the role theorist, the self is seen as bounded in this sense, and as the origin point of experience.
(*ibid* p101)

Whereas the debate about positivism constructed the crucial distinction as that between passive and active models of the subject, post-structuralism introduces a distinction between a unitary and a de-centred subject. In the positivist tradition, this unitary subject is presented as a *determined* being to be 'explained' through the scientific method. In the humanist or interpretive tradition, it is presented *voluntaristically* as an agent to be understood subjectively in terms of meaning construction.

As Potter and Wetherell point out, this unitary subject is contrasted with 'society' leading to the 'individual-society' dualism (Henriques *et al*, 1984). In psychology, this dualism has been classically understood in terms of how a biological organism is modified by social influences through socialization. Henriques *et al* (1984) see the basic terms of the 'individual-society dualism' as circumscribing developments in psychology (p13). It is the critique of the dualism *as such* which they see as the necessary condition for developing a radically new approach. The 'de-centring' of the subject aims to dissolve the dichotomy between the individual and society.

The main object of the critical movement has been to displace attention from the self-as-entity and focus it on the methods of constructing the self. That is, the question becomes not what is the true nature of the self, but how is the self talked about, how is it theorised in discourse ... It is suggested that methods of making sense are the key to any kind of explanation of the self, as people's sense of themselves is in fact a conglomerate of these methods, produced through talk and theorizing. There is not one 'self' waiting to be discovered or uncovered but a

> multitude of selves found in the different kinds of linguistic practices articulated now, in the past, historically and cross-culturally.
> (Potter and Wetherell, *op cit* p102)

In terms of this 'critical movement', anti-positivist sociology can be seen as a humanist attempt to regain a sense of the individual as agent (Henriques *et al, op cit* p93). Henriques *et al* associated this humanist model of agency with the type of 'voluntarism' which led the New Sociology of Education writers to move away from phenomenology in the mid-seventies. However, simply by moving back in the direction of Marxist types of structuralism (*eg* Bowles and Gintis, 1976), they remained within the individual-society dualistic framework.

From this point of view, the post-structuralist 'decentring of the subject' can be seen as transcending these 'classic dichotomies' and providing a new type of solution to the 'dilemmas' they created in the past. The key issue for this work, is how this approach can provide an understanding of 'the social' in a sociological social psychology which can be applied to the classroom and the teaching-learning process.

Discourse and meaning

I now want to look in more detail at the concept of 'discourse'. Potter and Wetherell (1987) point out that the terms 'discourse' and 'discourse analysis' have an extremely wide range of meanings. They suggest that it is easily possible for two books on 'discourse analysis' to have no shared content or mutual referencing (p6). A broad distinction can be made between 'discourse analysis' which focuses upon 'discourse' as in conversation or talk and looks at the structuring, construing and sharing of meanings in natural settings, and 'discourse analysis' which looks at 'fields of discourse' in the sense of structured and structuring systems of meaning which exist prior to specific texts or conversations actually produced by given subjects. The former draws upon earlier traditions of work in interactional sociology, especially ethnomethodology (Silverman, 1985) whereas the latter comes out of the structuralist/semiotic tradition (Eagleton, 1991) and, more recently, draws on the work of Foucault (Ball, 1990). These two types of 'discourse analysis' could be seen as complementary in the sense that the discursive fields are the basis (or 'deep structures') of actual texts, conversations, *etc*. For the sake of convenience, I will distinguish between the two by referring to the first type as 'conversation analysis' (Silverman, *op cit*), and the latter as 'discourse theory'. My main concern, now, is with the latter.

Ball, in a discussion which relates the ideas of Foucault to education, defines 'discourse' as follows:

> Discourses are about what can be said and thought, but also about who can speak, when, and with what authority. Discourses embody meaning and social relationships, they constitute both subjectivity and power relations...Thus the possibilities for meaning and for definition are preempted through the social and institutional position held by those who use them. Meanings thus arise not from language but from institutional practices, from power relations. Words and concepts change their meaning and their effects as they are deployed within different discourses. Discourses constrain the possibilities of thought. They order and combine words in particular ways and exclude or displace other combinations. However, in so far as discourses are constituted by exclusions as well as inclusions, by what cannot as well as what can be said, they stand in antagonistic relationships to other discourses, other possibilities of meaning, other claims, rights, and positions.
> (Ball, 1990 p2)

In a similar fashion, Eagleton writes about 'discursive formations' as follows:

> A discursive formation can be seen as a set of rules which determine what can and must be said from a certain position within social life; and expressions have meaning only by virtue of the discursive formations within which they occur, changing significance as they are transported from one to the other. A discursive formation thus constitutes a 'matrix of meaning' or system of linguistic relations within which actual discursive processes are generated.
> (Eagleton, 1991 p195)

The term 'discourse' can be taken as refering to a structured symbolic field which selectively orders meanings. This ordering is associated with power relations in that it gives priority or 'authority' to some meanings over others and affirms and reinforces the positions of dominant groups. Terms within discourses do not have fixed or given meanings. They vary according to the contexts in which they are operating and the power relations which regulate the ordering of discourses between categories of agents within the context (*eg* teachers/pupils, men/women, *etc*).

There are two major problems associated with 'discourse theory', especially in its 'post-structuralist' form (Sarup, 1988). The first is that of relativism associated with 'deconstructionism' and the idea of 'intertextuality' (Norris, 1982), and the second that of 'the death of the subject'; that is, the 'anti-humanism' (Silverman 1985 pp90-91) of post-structuralism in which the human subject as a social agent is dissolved. These two features of post-structuralism are interrelated in that meaning is seen as having no basis other than that derived from its location within discourses (as opposed to originating in the ideas or intentions of individuals) and 'the subject' as such is a product of discourses.

I want to register the following two points that are fundamental to the general position I wish to adopt in this study. First, regarding relativism: relativism in both its cognitive and moral forms is untenable and undesirable. Norris, in a strongly mounted attack on post-modernist relativism, argues that it removes the distinction between truth and falsehood and bars rational debate about ethical issues, reducing it to " a mere play of competing 'discourses' devoid of any warrant beyond what is supplied by the current conversational rules of the game." (Norris, 1992 p69)

Although Norris is deeply critical of relativism, he does not totally reject 'deconstructionism'. His book on this movement (Norris, 1982) is concerned with defending Derrida against the charge of relativism and with understanding discourse theory and analysis as part of the critical tradition whereby the implicit assumptions of historically produced knowledge are articulated. On this basis, discourse theory remains within the broad 'enlightenment' tradition which is concerned with the conditions for the authorising of 'truth-claims'. Despite contrary tendencies within postmodernism, discourse theory and post-structuralism do not necessarily or inevitably lead into relativism.

The area of concern in my own work raises crucial issues about cognitive and moral truth-claims. From the educators' point of view, the accuracy of pupils' knowledge about drug use and HIV are obviously crucial issues. Similarly, as far as ethical values are concerned, it is again crucial that pupils should be able to think in an informed and responsible way about the ethical consequences of their attitudes and behaviour. Drugs and HIV issues have important ethical implications for the individual, for others (*eg* sexual partners) and towards others (*eg* AIDS sufferers). In areas of this type, the implications of relativism are more sharply focussed than they might be in philosophy or literary criticism, for instance. For Health Educators, the slogan 'anything goes' does not necessarily have the same appeal as it might to those whose radical concerns are more abstractly defined within academic debates. As Gellner has said, 'Relativism, basically an affectation, is most attractive in places where it is least relevant...' (Gellner, 1992 p79)

As far as 'the model of the subject' is concerned, the anti-humanist, post-structuralist position indicated by Sarup, above, would make the previous points highly problematical. If 'the subject' is no more than a product of discourses, then concerns with truth claims and choices are meaningless. However, an alternative approach can be constructed by further developing the idea of 'discourse' itself. In a critical discussion of Foucault, Turner has made the following points:

> Some forms of discourse analysis reduce the individual agent/speaker to the level of a socialised parrot, which must speak/perform in a determinate manner in accordance with the rules of language. There are alternatives to this form of structuralism which do not entirely obscure the role of human agency...Discourses are not linguistic machines which routinely and invariably produce the same effects, but possible modes of social construction the consequences of which contain a large element of contingency...Another way of expressing this criticism is to argue that there is always resistance to discourse - an argument which Foucault recognises but frequently neglects. The contemporary notion of beauty as slimness has become the object of feminist criticism and of women's groups which simply reject such norms of beauty as commercialism...Foucault's theory of knowledge has in many respects the weaknesses which characterise any dominant ideology thesis; it conflates the logic of discourse with the issue of its social effects. We cannot assume that because, for example, modern advertising is based on a discourse of cosmetics that consumers invariably embrace its rules of production. Discourses are never uniform in their effects or unified in content.
> (Turner, 1984 pp175-176)

Rather than seeing 'the subject' as a product of discourse, it can be treated as an agent active within discourses. The anti-humanism of discourse theory can be seen as resulting from an over-consensual view of discourse. In addition to the fact that there will always be a number of competing discourses available to individuals, discourses themselves are internally contradictory. As Billig *et al* (1988) argue, discourses are 'dilemmatic' - that is, through their contradictions, they present individuals not with unambiguous subject positions and prescribed ways of acting, but with 'dilemmas' which require constant negotiation and reconstruction. As Turner's reference to 'resistance' indicates, individuals and groups can deconstruct, contest and create discourses. The women's movement can be seen

as a notable example of this in recent times. These comments can be related back to the earlier discussion of Watney's approach to AIDS discourse and moral panic. Again, this has important implications for teachers: the point of education is to produce *active subjects*, *ie* pupils or students who can *use* knowledge in an aware and self-determining way.

I will now briefly consider the methodological implications of the preceding discussions. There are two main issues to be discussed. First, in keeping with the rejection of relativism and the view that the 'truth claims' of knowledge can be meaningfully discussed, I see methodology as concerned with ways of establishing 'facts' about the world. Secondly, following writers such as Silverman and Hammersley, I will reject the view that methods should be seen in terms of a mutually exclusive opposition between 'positivist' and 'interpretive' or 'qualitative' paradigms. In this respect I will take issue with recent discussions of 'discourse theory' in social psychology which are based around the idea that discourse analytic approaches are incompatible with (and constitute a critique of) more traditional 'scientific methods'. I will argue for the approach that Silverman terms 'analytic induction' which aims for a 'non-sectarian' (p115) fusion of quantitative and qualitative methods.

Conclusion

The purpose of this chapter has been to outline the theoretical perspective of this work. It has focused on issues and debates in social psychology and in the sociology of education. The unifying theme between the two areas is the concept of 'crisis'. The critique of positivism in sociology in the late sixties and early seventies provided the context for the emergence of the New Sociology of Education, which drew heavily upon phenomenology and ethnomethodology. Writers in this tradition are referred to in the contemporary 'crisis' literature in social psychology. The radical symbolic interactionist perspective is the major source of continuity between sociology of education and social psychology.

In both periods the concept of 'crisis' is understood in terms of the interrelated issues of method and, what Harre refers to as, the 'metaphysical basis' of the discipline. Central to both is the 'model of the subject'. In the sociological crisis, the major distinction was constructed between a passive, determined subject of positivism and the active subject of interpretive sociology. Whereas the former was 'the subject', appropriate to or required by the experimental method, the latter presupposes an alternative form of explanation grounded in meaning and subjectivity. The distinction between these two models of the subject reflects the differences between positivist and interpretive methodologies and metaphysics.

The contemporary literature marks a further fundamental development by distinguishing between the unitary and decentred models of the subject. This distinction reflects the influence of post-structuralism upon current social psychology. The implications and possibilities of a decentred subject and the associated model of agency, in terms of 'discourse', will provide the theoretical understanding of 'the social' in social psychology for this work.

The purpose of this Chapter has been to define the basis for what Howitt *et al* term a 'sociological social psychology' which draws upon both earlier positions in the sociology of education and more recent post-structuralist concerns. These issues will be applied, more specifically, to the educational process in Chapter Two.

CHAPTER TWO

THEORETICAL DEBATES IN EDUCATION

I now want to consider the implications of the discussion in Chapter One for both the teacher involved with AIDS education and the researcher investigating such education in the classroom. The concern, here, is with the pedagogic aspects of dealing with a symbolically overdetermined area and the problems of researching teaching within an area of this type. There are interesting parallels between the positions of teachers and researchers in this respect in that both are concerned (though in different ways) with processes of meaning construction in the classroom context. The teacher is concerned, essentially, with pupils' reception of educational knowledge, or 'messages', and the researcher with analysis of the processes and conditions of transmission and reception. My own role, in the past, as Advisory Teacher and researcher has focussed these as a concern within the present study which both reports on that role and research undertaken within it (Section Two) and involves a critical reflection upon it from the basis of a current theoretical framework which differs significantly from that at the earlier time (these issues will be developed in more depth in Section Two).

In this chapter, I will begin by reviewing the ways in which educational research in sociology and psychology has approached the issue of meaning construction. I will begin by considering the 'New Sociology of Education' of the early nineteen seventies and then turn to more recent work adopting a 'cultural studies approach' which can be seen as drawing upon a broadly similar set of theoretical concerns as those outlined in Chapter One. The 'new sociology of education' provides an interesting comparison with the current 'crisis' in social psychology, both in its criticisms of positivism and its use of symbolic interactionist and phenomenological ideas, and also raises issues about the relationship between sociology and psychology in educational research[2].

The New Sociology of Education

The New Sociology of Education (Young, 1971) advocated a radical change in the way in which sociologists approached the study of the school. This position was often referred to at the time as representing a 'paradigm change' in sociology of education (Sharp and Green,

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[2] Pollard (1990) has presented a strong argument for a fusion between sociology and psychology in the area of educational theory and research based on the complementarity of symbolic interactionism and social constructivism.

1975). Similar claims are being made today about the 'new' social psychology. This change was located within the more general crisis in sociology discussed above. Karabel and Halsey refer to positivistic social science as the 'arch-enemy' of ethnomethodology and in their review of sociology of education write

> ...unlike the functionalist and conflict theories of education, both of which are essentially concerned with the macrosociological question of the structure of the relationships between schools and other social institutions, the interpretive approach focusses directly on the internal operations of the schools themselves. The preoccupations of the 'new' sociology of education - above all, classroom interaction and the sociology of the curriculum - correspond quite strikingly to the professional interests of students in institutions primarily devoted to training school teachers.
> (Karabel and Halsey, 1977 p50)

The introduction of the New Sociology of Education is, therefore identified by Karabel and Halsey as involving a major shift in focus away from macro concerns to one upon classroom interactions. This interactionist approach was formulated within the phenomenological framework.

New Sociology of Education writers within the early seventies emphasised the following points:

[1] sociologists of education must 'make' rather than merely 'take' problems. That is, unlike the orthodox approach, sociologists should not simply take over official 'definitions of the situation', for instance, as in defining what counts as 'a problem'. In his introduction to Knowledge and Control, (the collection which initiated the 'new direction'), Michael Young says that

> On the whole, sociologists have 'taken' educators' problems, and by not making their assumptions explicit, have necessarily taken them for granted. These implicit assumptions, of most sociologists of education and of educators, might be adequately characterised by what Dawe has called an 'order' doctrine, which as he suggests, leads to explanations in terms of a system perspective. This starting from a loosely defined consensus on goals or values (in this case values about 'what a good education is'), conceives of change (or innovation), in terms of structural

differentiation towards such goals, and defines 'order' problems as failures of socialization (a concept which as Bernstein says, is trivialized in the process).
(Young, 1971 pp1-2)

Not only does the 'taking' of problems in this sense incline sociologists towards a macro perspective which is absolutist and functionalist, it also carries with it politically conservative implications, based on the imposition of taken-for-granted definitions by those with power.

[2] social reality must be seen as socially constructed and as multi-faceted in character, reflecting the various viewpoints and interests of those involved in any social situation. Applied to the classroom, this meant that the New Sociology of Education wanted to focus upon meaning construction within the classroom and in such a way that pupils' meanings were accorded as much sociological status as those of teachers.

[3] an important aspect of the sociologist's task is to problematise taken-for-granted assumptions about the nature of social situations and the meanings whereby different groups account for them.

For the sociologist who undertakes this task, however, the 'problems' identified by educators (*eg* the 'below average child') are themselves phenomena to be explained. With 'what counts as educational knowledge' highly problematic, the structural issues that dominated the normative paradigm recede into the background, and the micro-level problems of the curricular, pedagogic and assessment categories held by the school curriculum become the dominant categories of educational research.
(Karabel and Halsey, *op cit* p46)

In keeping with the ethnomethodological approach, New Sociology of Education writers took as a major focus the common sense understandings and accounting procedures of everyday knowledge in the school.

[4] an explicit objective should be to explore how competing definitions of a situation interact and the role of power relations in privileging particular accounts. In this respect, the New Sociology of Education was particularly close to similar views in the area of deviance theory which was seen as relativising social and moral values, especially in

terms of problematical areas relevant to this study such as drugs and sexual behaviour. As I shall go on to indicate at a later point, these relativistic tendencies of radical sociology were seized upon by politically conservative critics of educational progressivism. Such critical views have become, if anything, more relevant and influential today with the rise of the neo-conservative New Right and the opening of schools to market pressures and so-called consumer demand (see Chapter Three).

[5] Although there was a major concern with intersubjectivity and the social construction of reality, the New Sociology of Education writers were also concerned with the historically situated character of these processes and in this respect, there was a tension between the approach and phenomenological sociology (Moore, 1988). The New Sociology of Education was influenced by a 'sociology of knowledge perspective' which was interested in the broader social conditions of knowledge production. This interest carried with it an implicit commitment to the kinds of macro-sociological concepts which pure phenomenologists had rejected, for instance, Michael Young says

> Thus the direction of research for a sociology of educational knowledge becomes to explore how and why certain dominant categories persist and the nature of their possible links to sets of interests or activities such as occupational groupings.
>
> (Young, *op cit* p6)

Implicit within this statement can be seen a leaning towards a form of Marxist structural analysis which became increasingly pronounced in the mid-1970s.

As the seventies progressed, New Sociology of Education writers increasingly turned towards more structural and deterministic forms of theory and analysis, especially under the influence of the work of Althusser and Bowles and Gintis (Moore, 1988). The New Sociology of Education theorists went beyond the American ethnomethodologists in developing an explicit interest in power and by acknowledging that the social construction of meaning is historically situated and subject to sets of wider social constraints which in various ways delimit freedom of action of the individual (Sarup, 1978; Moore, 1988).

In this way they began to reintroduce into radical sociology higher level theoretical concepts such as class, power, social structure, which the phenomenologists had rejected. In doing this they began to identify phenomenology as a form of extreme voluntarist subjectivism which seemed to imply that the key to changing the world was simply changing consciousness. By identifying phenomenology as a form of idealism and by taking

account of social structural constraints, they reconstituted the classic dilemmas of sociology - the problems of objectivism versus subjectivism and of determinism versus voluntarism. This issue of the relationship between the individual and the social is a key feature in the literature associated with the crisis in social psychology and this will be returned to later.

In describing the above developments in the New Sociology of Education (NSE), Moore says that

> Whitty (1977) described the difference between phenomenologists and the NSE in terms of a distinction between 'analytic' and 'possibilitarian' approaches respectively. Whereas the former were merely concerned with 'exposing the constitutive features of lived reality', the latter were concerned to 'actually challenge the mundane experience of that everyday world'. In using the same distinction, Sarup says of the 'analytic' approach that, 'The New Sociology of Education has no sympathy with this type of apolitical theorising. It is felt that more is needed than merely 'showing' the form of life...it should be challenged'...
> (Moore, 1988 p53)

The New Sociology of Education writers tend to have a political interest which led them to reject the relativism of phenomenology and to seek to link their radical sociology with broader demands for educational and political change.

It can be pointed out that the New Sociology of Education, though drawing heavily upon the interactionist tradition and what Howitt *et al* (1989) call 'sociological social psychology', made little explicit reference to psychology as a discipline. The call for a new model of social psychology as being presented by contemporary writers refers back to Armistead's *Reconstructing Social Psychology* (1974). (Parker and Shotter's *Deconstructing Social Psychology*, 1990, deliberately recalls the earlier title). A major contribution which suggests a more explicit collaboration between sociology and psychology is Henriques *et al*'s *Changing the Subject* (1984), a text frequently treated as a major reference in recent writings.

As far as educational theory is concerned, this situation is related to the breakdown of the long-established Piagetian paradigm in educational psychology and the development of a social constructivist approach drawing upon the work of Vygotsky . This has increased educational psychologists' awareness of the need to address interaction, 'meaning' and the subject's negotiated definition of the situation. The ontological status of 'self' and

'identity' is called into question and emphasis is, instead, placed on the origin of psychological development in social processes and interactions.

> ...any function in the child's cultural development appears twice or on two planes. First it appears on the social plane, and then on the psychological plane....First it appears between people as an interpsychological category and then within the child as an intra-psychological category
> (Vygotsky, 1934 p163)

The spontaneous behaviour of the child is given meaning in interaction with others. The behaviour becomes increasingly regulated and incorporates the signs and signification systems of the culture. This is mediated predominantly through language. While disagreement remains within the Vygotskian camp as to whether the child transforms or merely copies what it learns through interaction, the move from the universalism and individualism of Piaget's developing child provides for a more dynamic and complex model.

Current work within the sociology of education shows a return to an interest in the educational process involving a similar set of concerns and approaches to the social psychology being referred to here. The current climate, in contrast to that of the early seventies, would appear to be supportive of a positive collaboration between sociology and psychology. It is also the case that the tension between subjectivism and structural analysis recalls the current problems of relativism in discourse theory in social psychology.

Criticisms of the 'enlightenment' model

The issues raised by the previous section can be related to existing work in other areas which share with AIDS discourse this feature of 'extended meaning' and symbolic complexity. The area of 'race' in the school curriculum, in particular, offers insights which can be of value to the AIDS field and I will draw upon the work of Philip Cohen and the 'cultural studies' approach to 'race'(Cohen and Baines, 1988; Cohen, 1991). The purpose of what follows is to develop the interpretive sociological concern with meaning in the educational process beyond the impasse left by the new sociology of education in its movement back towards more deterministic and structural approaches. The work discussed below can be seen as relating to two major concerns: the first, that of defining an approach which draws upon both sociology and psychology ('sociological social psychology'), and,

secondly, the need to move away from the individualistic subjectivism of phenomenology and to draw upon discourse theoretical approaches to meaning.

The 'enlightenment' model

As far as the educational dimension is concerned, the key issue raised, here, is that of the appropriateness of what Cohen characterises as the 'enlightenment' model of education. The 'enlightenment' model is basically liberal and rationalistic in character. Its guiding principle is the view that the main role of education is to counteract the 'ignorance' which is the result of a lack of knowledge and a developed capability for rational thought and behaviour. The approach combines a faith in the inherently rational nature of people with one in the power of 'knowledge' to produce 'reasonable' attitudes, values and behaviour. Prejudice is seen as the result of 'ignorance' which, in turn, is understood as a lack of knowledge and of uninformed values. The task of the teacher is to provide pupils with knowledge and the skills of rational thought with which knowledge can be used to 'empower' them as 'rationally autonomous' or 'self-directing' decision-makers. It follows from these principles that such a person would be 'enlightened' not only about their own behaviour but in respect to other peoples' also. Hence education in this manner produces, liberal, reasonable and tolerant individuals. The key feature of the approach is that it is a 'deficit' model of the pupil which sees them as simply lacking the crucial ingredients that education can provide.

This understanding of the pupil can be seen as common to both 'traditional' and 'progressive' approaches, despite their dissimilarities in other ways. Traditionalism tends to treat the pupil as an 'empty vessel' waiting to be filled with 'worthwhile' knowledge. The influential liberal philosopher R.S.Peters described the child as a 'barbarian' outside the gates of civilisation awaiting to be 'initiated' by the teacher (quoted in Moore, 1990). School discipline has the purpose of restraining children's unruly 'natural' (animal-like) behaviour sufficiently for them to be 'disciplined' in the knowledge and values which eventually lead to a civilised form of life. The ideal of this model is that of the 'rationally autonomous' individual - an independent, free decision-maker applying the capacity to reason to the possession of knowledge. The 'child-centred' progressive approach begins from a positive image of the child as containing within him or herself a natural potential for 'inner growth' (*ibid*) which the teacher has to nurture by responding to individual needs, interests and states of 'readiness'.

Whereas prejudice for the traditionalists was associated with a lack of knowledge, for the progressives it is associated with a distortion or corruption of the child's true (pure) inner

nature (innocence). The ideal for the progressives is a 'self-realised' individual free from inner conflicts and repressions (reflecting the influence of humanist therapeutic models such as those of Maslow and Rogers). Both approaches see the purpose of education as leading the child to an 'enlightened' state which realises their inner capacity for reason.

Traditionalism has tended to be supported by liberal rationalist philosophers and linked to epistemology (*eg* P.Hirst). Progressivism became strongly associated with child psychology and especially the application of Piagetian research. Developmental child psychology was seen as lending scientific support to the Romantic view of 'the child' in the child-centred approach (*ibid*). However, in recent years the Piagetian paradigm in educational psychology has gradually given way to one drawing upon more strongly sociological models of 'meaning construction'.

The 'cultural studies' approach

In a critique of the 'enlightenment' model in the area of multicultural education, Cohen has argued that it fails to recognise the complex symbolic character of 'race' within a broader cultural field concerned with myths of 'origins', community and identity (Cohen, 1991). Racist belief and behaviour is not simply the result of ignorance - a lack of knowledge and reason. They are located within a powerful discourse which shapes the selection and interpretation of 'facts', beliefs and experience. In order to counter racism, Cohen argues, it is necessary to understand and engage with these cultural 'codes' and their symbolism rather than simply attempt to make up the assumed deficiencies in children's knowledge.

A feature of Cohen's critique and his alternative 'cultural studies' approach to this and other issues is that it draws upon theoretical work concerned with culture, meaning construction and representation similar to that discussed above in relation to AIDS discourses. A sophisticated theoretical approach of this type is needed in order to accommodate its complexities as a symbolic discourse. This is required theoretically but also for research and educational purposes.

I will now briefly illustrate the way in which a 'cultural studies' model can be applied to educational discourses by considering two examples.

(1) Work and masculinity - "Learning to Labour"

Paul Willis' *Learning to Labour* (1978) has acquired the status of a classic ethnographic study in the sociology of education. In part this reflects the originality of the

interpretation of the material. Willis begins by asking the question, 'why do working class kids end up with working class jobs?' and is concerned with the role of the school in (apparently) reproducing social inequality. He studied a group of anti-school working class "Lads" in order to identify the factors and influences affecting their occupational aspirations and attitudes to school. At the time of writing, sociology of education was dominated by two contrasting approaches to issues of this type.

The originality of Willis' analysis lies in the manner in which he depicts the the Lads as actively choosing to adopt a particular attitude towards the school based upon their attitudes to work and sexuality (Giddens, 1984). The Lads, in Willis' account, are not the victims of ideological manipulation or conditioning by the school (he stresses the extent to which the teachers genuinely work hard for the success of their pupils), rather they deliberately reject educational success on the grounds that intellectual labour (school work or non-manual occupations) is *feminine*. For the Lads, manual labour is a celebration of *masculinity*. Manual labour involves *active* engagement with the world and its transformation through physical means. This represents the 'male principle' in contrast to the passivity of the feminine. Boys who conform to the school's demands are contemptuously dismissed by the Lads as "ear'oles" which Willis sees as denoting the contrast between the passive (and rather absurd) character of the ear and the active (phallic) principle of their own identity.

The importance of Willis' work for the present study is the manner in which he derives an understanding of the Lads' attitude to school from an analysis of its position within a wider discourse which symbolically links work and sexuality and physical labour and masculinity.

The study provides an interesting illustration of the contrast between an 'enlightenment' approach to teaching and the 'cultural studies' perspective later developed by Cohen[3]. Willis contrasts the careers teacher's approach to the transition from school to work with that of the Lads. The teacher sees jobs in terms of choices and information. People are expected to choose a job on the basis of an informed consideration of the range of opportunities available to them. The teacher also has a particular model of how jobs are acquired in terms of filling in application forms, writing a curriculum vitae, attending interviews and 'presenting' in an appropriate manner. The purpose of the teacher is to provide pupils with information and to encourage and help them to make appropriate job

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[3] it can be noted that Willis and Cohen have similar intellectual roots and interests and were collaborators in *Schooling For the Dole* (Bates *et al*, 1984)

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choices. Pupils are seen as needing information and help in rationally weighing-up the possibilities - making an informed and rational 'choice'. We see, here, the familiar 'deficit' model of the pupil associated with the 'enlightenment' approach.

The Lads express in their interviews with Willis their profound scepticism of careers teaching. They view all work as undifferentiated 'graft' - jobs are not things you choose between. One job is much the same as any other. Their commitment is to labour as *such* not to a particular job or employer. They also tended to have substantial experience of work prior to leaving school and see themselves as much more knowledgeable about it than the teacher; especially in terms of the functioning of the informal 'social network' which is the major agency for recruitment rather than the formal approaches presented by the teacher.

In terms of the deficit model of the pupil constructed by the 'enlightenment' approach, the Lads are relatively ignorant and lacking in competence. From their own point of view, however, they are much more informed and experienced than the teacher and more competent in the skills that really count in their particular labour market. This knowledge, experience and competence is not only unacknowledged by the school, but deliberately shielded by the Lads themselves from official scrutiny (especially because much of their informal work experience was illegal) (see also Bates *et al* above). These themes are also present in the range of findings and analysis in this study (especially in relation to drugs) and I will explore the relationship between school knowledge and pupil knowledge in more depth in Section Two.

The most significant aspect of Willis' study, as far as this work is concerned, is the manner in which a discourse of sexuality and its construction of masculinity provides the key to understanding the Lads' attitude to school and work. This has clear implications for both teachers and researchers. An implication of the analysis is that if educators wanted to *effectively* engage with the Lads attitude to work, they would in fact have to focus on *sexuality* and not directly upon work - a very different approach to careers education from that enshrined in the official model. In this respect, Willis' study of labour is similar to Cohen's of race. Both reveal the *symbolic* complexities of the fields of discourse within which attitudes and behaviour are located and how these 'extended meanings' are associated with 'displacements' whereby the initial object (work or 'race') has to be approached through an apparent 'detour' into another metaphoric space. In this respect, of course, they parallel the points made above in relation to Sontag, Weeks and Watney.

(2) Women, risk and condom use - the WRAP project

I will now turn to a recent study which relates more directly to the concerns of this work. The *Women, Risk and AIDS Project* (WRAP) (Holland *et al*, 1990a, 1990b, 1991a, 1991b, 1993) is concerned with the reception of AIDS education messages by young women and, in particular, with those concerned with the use of condoms. The study is relevant in three ways: first, in terms of its subject matter, secondly through the way in which it locates knowledge and behaviour within discourse and power relations, and thirdly through it discussion of methodological issues.

The writers identify a fundamental contradiction within the social framework in which AIDS education operates in relation to young women. Condom use is promoted as a means of protecting against HIV transmission; but the different meanings of condom use for men and women are overlooked. Reservations related to reduction in sensitivity and spontaneity are glossed over; the implications for women of carrying condoms (Lees, 1986) are ignored and the different meanings condom use has for young men at different stages in the development of their sexual identity are not addressed. Education incorporating an awareness of the cultural dynamics of sexual interaction is required.

The WRAP research acknowledges the complex way in which knowledge is embedded within wider discourses which can neutralise information gained within an 'enlightenment' form of pedagogy. For young women to carry condoms or to insist on their use could be seen as signifying that they are knowledgeable, independent, assertive and taking control of their own lives or, on the other hand, simply that they are slags. At the same time, precisely those qualities listed before could be judged not as virtues but as 'unfeminine' and seen as making a young women undesirable.

Possession of knowledge in itself does not guarantee any predictable effect at the level of either attitudes or behaviour. The wish to be 'desirable' may outweigh the wish to avoid risk in sexual relationships. Little direct relationship may be seen to exist between demonstrating to teachers that you know the right answer and demonstrating to peers or boyfriends that you are a 'normal' young woman. Knowledge, in practice is always contextualised, both within discourses and subject to the relations (especially those of power) of the contexts within which it is applied.

Conclusion

The following points can be derived from studies within the approach under discussion:

[1] knowledge does not have an effect simply by virtue of being accurate, well supported, worthwhile, *etc*. It acquires value through its location within a discourse and its symbolic signification within that discourse. For instance, within the discourse of romantic love, to insist that a partner uses a condom negates the values of spontaneity, passion and sexual subservience associated with the woman's role. It denotes that the woman does not really love the man and if she is willing to have sex with a man she does not love then she is a slag.

[2] knowledge changes meaning between discourses, *eg* between the 'enlightenment' discourse of the teacher and those of the same sex peer group or that operative within a relationship with an opposite sex partner. Appropriate realisations of behaviour will vary according to the dominant discourse of a particular context. Pupils will know the right things to say about sex (or race, or drugs, or work) in the school (or interview) situation and also how to behave differently elsewhere. Cohen, for instance, demonstrates how pupils know both how to say 'the right things' about race to teachers and also how to say the wrong things in order to wind them up. In some cases, where schools place great emphasis on multicultural values, being racist becomes a way of being anti-school. The pupils' apparent racism is not really to do with race at all - it is to do with school.

[3] context is a major factor in regulating discourse. In just the way that knowledge is embedded within discourses, so discourses are contextualised by social relations. A number of discourses may be 'present' within any particular context, such as a classroom, but which becomes dominant depends upon the structuring of power within the situation and what that structure allows as 'normal' - how far is it 'normal' for girls to carry condoms or to discuss sex in terms of its pleasure for women rather than exclusively for men. Power works selectively to legitimate, articulate or disable and eclipse discourses.

[4] knowledge is embedded within discourse and discourses are active within contexts. Contexts, in their turn, are structured by power relations which regulate the relationships between discourses and define what is to count as normal, appropriate and legitimate.

CHAPTER THREE

EDUCATIONAL REFORM AND TEACHING ABOUT HIV/AIDS

The purpose of this chapter is to review the institutional context of teaching about HIV/AIDS (and drugs, as it relates to these) and to locate the empirical study within the broader field of the educational reforms of the nineteen-eighties. The nineteen-eighties witnessed a major change in the way in which the PSHE curriculum can be implemented in schools. In part, this is related to the major pattern of educational reform carried out by the New Right Conservative governments of the period, (culminating in the 1988 Education Reform Act, ERA), but there are also aspects of these reforms which are of special significance to PSHE and to the issues of drugs and HIV/AIDS. Particular attention will be given to:

a] the *ideological* climate within which those changes occurred and, in particular, the impact and influence of *neo-conservative* thought upon the school curriculum. Specifically, I will argue that these two things, in combination, have placed PSHE within a new moral context where the professional views of educational and other 'experts' are subject to 'accountability' to various lay groups and 'moral constituencies'.

b] *institutional* changes in the control of education, *eg* open enrolment, opting out, the increased powers of school governing bodies and the attenuation of LEA and teacher control over the curriculum.

The relationship between the ideological and institutional dimensions of change is especially significant. Changes in institutional arrangements are essentially to do with *control*. Control is exercised with a purpose. In the case of the education system, the purpose is linked to the realisation of a wider political vision of social order and moral regeneration. The fact that the education system is made to carry this load reflects the view, widely shared in modern societies, that it is uniquely powerful in its capacity to shape future generations of citizens. As Ranson says:

> The significance of education is very deep-seated historically. Church and state have struggled to control its form and purpose.
> Understandably, because the process of learning can shape not only the purposes of individuals but through them the ordering of society and polity. The shaping of individuals is at the same time the shaping of a generation. Choices about the purpose of education take on a wider

> significance as an expression of social and political purpose. The vehicle for the elaboration of educational aims as social purpose is found in the structuring of government which constitutes distinctive values in policies and in its supporting organisational forms. For some the government of education possesses the distinctive role in articulating and embodying the vision of society's future.
> (Ranson, 1990 pp1-2)

From this point of view, the way in which education is *controlled* reflects beliefs about its social purposes and the way in which the *form* education adopts 'shapes' individuals and their generation (Moore, 1991). Consequently, there is a relationship between views about the learning process itself and views about the nature of society. This is clearly seen in the history of public debates about 'traditionalism' versus 'progressivism', and, in the eighties in particular, around multicultural and anti-sexist education.

The positions and debates reviewed in this chapter can be seen as revolving around conflicting views about the nature of the relationship between the individual and society and the role of education in mediating that relationship. The rise of the New Right has introduced a new model of that relationship which stands in contrast to that of the social democratic era. Its combined ideological and institutional impact has been to significantly change the relationship between professional and lay discourses. The PSHE area is now much more widely open to the direct influence of 'common-sense' opinion, especially as that might be articulated through the ideological rhetoric of neo-conservative views. Significantly, the corresponding marginalisation of professional opinion affects the status of social scientific knowledge to the extent that sociologists and psychologist were influential in constructing the expert discourse of teachers.

Placing education about HIV/AIDS in this context clearly reveals that it is not simply a matter of finding the most effective teaching method for providing young people with relevant knowledge. Beyond issues of pedagogy and the psychology of learning are broader and deeper ideological issues. As Weeks says, "What is remarkable about AIDS... is not simply its virulence, but the *weight of symbolic meaning* that it carries." (Weeks, 1989a p18 *emphasis added*). He argues

> ... that the only way to understand the political and ethical implications of AIDS is to see it in a wider social context: of rapid social change and the anxieties attendant upon this, especially those changes which have affected social behaviour and values, race and

> social non-conformity; of political and moral struggles in which old certainties have collapsed and new ones emerged; of new personal identities, many of them now fashioned in the furnace of personal suffering.
> (*ibid* p18)

This chapter will focus upon the manner in which the structuring of government of education has changed during the 1980s. The major feature of this change, both ideologically and institutionally) is the rise of the New Right. The fundamental contrast is between the 'social democratic' period from the end of the war until the mid-seventies (exemplified in education by the 1944 Education Act) and the New Right (Thatcherite) governments of the eighties (whose educational reform programme resulted in the Education Reform Act of 1988). Not only do these changes have major implications for the context within which Health Education operates today, but the issues of AIDS and drugs played a significant symbolic role in the broader ideological context within which change occurred. This chapter will, therefore, be concerned with the implications for teaching *about* HIV/AIDS within the political climate of the 1980s.

The ideological climate of educational reform

I will now look in more detail at changes within the education system since the end of the war, with a view to outlining the changing political and ideological climate.

The Education Reform Act of 1988 set out to equal the 1944 Act in terms of the scope and the scale of the changes it wrought upon the educational system. The ERA can be seen as constituting a radical break with the period following the 1944 Education Act.

> The Education Reform Act (29 July 1988) proposes the most radical redirection of the service since 1944. Yet the 1988 Act will seek to emulate as well as replace its revered predecessor. For the intention of both pieces of legislation was and is not only to recreate the form of education government but to do so as the significant part of a broader reconstituting of the social and political order. Within this Act, as elsewhere, there is the vision of a consumer democracy that is intended to replace the purported weary assumptions of the liberal democratic state that have lasted for a generation or more.
> (Ranson, 1990 p1)

In general terms, this is seen as a movement away from the social democratic principles of the post war era to a "New Right" social philosophy of the late seventies/eighties (Maclure, 1989; Dale, 1989; Flude and Hammer, 1990). It has effects far beyond the world of education - the purpose of the radical right has been a transformation of society as a whole. This movement has special implications for education, however - and Health Education in particular.

A major justification for educational expansion was that it would promote greater economic efficiency. This expansion was also associated with an extension of the scope of educational concerns within the school and of the professional role of the teacher. Comprehensivisation saw the rise of the pastoral system in state schools with an increasing concern with the social and personal aspects of pupils' development. Partly, this reflected the need to secure order and maintain discipline in the new, large purpose-built comprehensives of the sixties and seventies, but it also marked a commitment to a broader definition of the teacher's role and of professional concern. As Ryder and Campbell say

> Pastoral care structures in their modern form arose in response to pressures generated by the creation of comprehensive schooling in the late 1960s and the raising of the school leaving age in 1972. Their justification was in terms of supporting increasingly diverse and urgent student needs and of facilitating communication, both within schools and with parents and with other professionals outside. In practice, however, pastoral work was often a matter of systematising procedures for discipline and control and of coping with student (and even staff) crises, than of promoting the goals of positive mental health.
> (Ryder and Campbell, 1988 p71)

The rise of 'social education' in the post-ROSLA (Raising Of School Leaving Age) period was underpinned by Schools' Council initiatives (Schools Council Social Education Project, 1974; Lee, 1980) and by the 'Newsom' philosophy which informed the raising of the school leaving age to sixteen. Health Education developed as part of the broader pastoral/social education movement.

This movement in the sixties and seventies, developed within the teaching profession a group of teachers who became experts in the pastoral side of schooling and in Personal and Social Education. They were supported by other groups, in teacher training and elsewhere who provided the ideas and resources with which such teachers worked (Ryder and

Campbell, *op cit*). Advisory teachers in Drugs Education were a later example of such 'support' agencies.

'Permissiveness' and education

Although the main focus of this chapter is the 1980s when the New Right was established firmly in power, it is the 1960s which provide the key pivotal moment in the movement from a broadly social democratic society to the post-Keynesian, monetarist policies which became increasingly influential in the 1970s. Certainly, as far as the *rhetoric* of the New Right is concerned, the 'permissive sixties' are a touchstone for the rationale and legitimation of their programme. Weeks has provided the following account of the significant trends of this period,

> ... however flimsily based, the British economy itself saw a growth unprecedented in its modern history, leading to the dawn of what was optimistically labelled the 'age of affluence'. Its impact was to reshape many areas of social life, from class relations to moral attitudes and family life, leading to the emergence of new social opportunities, new sub-classes, changed political alliances, significant modifications in the relations between the sexes, an explosion of youth cultures, the fragmentation of moral consensus - and in the end, acute social tensions.
> (Weeks, 1989b pp249-50)

The situation as described by Weeks, especially in relation to the 'fragmentation of moral consensus', is precisely that taken by the New Right as necessitating a national programme of radical *moral* as well as *economic* regeneration. Education was seen as central to this both as a cause of national degeneration (associated with permissiveness and progressivism) and as a solution. The fragmentation of consensus automatically implies its opposite - a proliferation of choice and of 'options'. It is this latter possibility, especially when applied to central dimensions of identity such as gender, 'race' and sexuality which has alarmed the New Right. The issue of AIDS (alongside that of anti-racist and anti-sexist education) has focused concern amongst moral conservatives that *sexual orientation* itself was being treated by progressive educators not as a natural and God-given constant, but as an 'option' to be explored amongst a range of possibilities of self-hood.

The New Right

The New Right explicitly aimed to create a radical break with the social democratic period. Its arguments were both economic and social or moral. Its supporters believed that their programme would make society not only more economically efficient, but also more morally cohesive and 'healthy'. In particular, it challenged the idea of the welfare state and the role of professionals or experts in state agencies as providing for the social, educational, health and welfare needs of individuals and the community. These professionals are associated with encouraging, on the one hand, 'dependency' and, on the other, 'permissiveness'.

The social democratic welfare state is seen as providing the basis of a 'bureaucratised intelligentsia' (Evans, 1989/90). Quoting the New Right commentator, Digby Anderson, Evans says that

> ...for the New Right the economic travails of the 1960s were inextricably linked to the moral decline signified by 'permissiveness' wrought primarily by the bureaucratised intelligentsia, composed we are told of: 'lecturers, teachers, NHS bureaucrats, directors of leisure, health education officers, adventure playground leaders, advisers, abortion counsellors, environmental health officers and gay bereavement counsellors'.
> (*ibid* p86)

Groups such as teachers and local authority workers, can exercise an influence which is seen as damaging to the traditional authority of the family and society. As I shall go on to argue, in detail, HIV/AIDS and drug use, as issues, especially within education have become a major focus of these concerns.

The radical Right rejected the basic principles of social democracy and of the welfare state, arguing that:

1] the welfare state created a 'dependency culture' which prevented individuals from developing their own initiative and taking responsibility for their own lives and actions. This was reflected in both economic life, through the stifling of 'enterprise' and in social life by undermining individual moral responsibility.

2] the welfare state not only drained economic resources from the productive sectors of society but provided a privileged and protected environment to groups of 'producers' (professionals, experts, *etc*) in the public sector who were exempt from the 'discipline of the market' and who assumed that they knew best what the 'consumers' needed.

3] the liberal values and reforms of the sixties and seventies are seen as 'permissiveness' which has undermined traditional values and authority. A number of severe social problems are seen as having followed from this - the breakdown of the family, the rise of 'illegitimacy' and abortion, crime, drug use, AIDS, *etc*. This perception has been associated with calls for a return to traditional morality and the family and respect for traditional authority.

4] pluralism, rather than being positively affirmed, is seen as a product and a cause of social disintegration. Such views are reflected in calls for schools to transmit a traditional moral code and to promote 'responsibility' and in opposition to multicultural and anti-sexist education. Compromise and consensus are seen as lack of 'commitment' rather than a positive aim.

The major thrust of radical right reform has been to 'roll back the state' and to prioritise the position of consumers over producers. This has involved shifting emphasis away from the political process (especially at the local level) towards the market and redefining the individual as a 'consumer' rather than a 'citizen' (Ranson, *op cit*). The rolling back of the state in this sense dismantles the material base of the 'bureaucratic intelligentsia'. Its aim is to remove the permissive philosophy which the New Right associates with the welfare state. The withdrawal of state agencies breaks down the cultural dependency and is seen as re-establishing 'the family' in its natural and rightful place as the source of both moral authority and support.

The composition of the New Right

The New Right is a complex phenomenon with a number of tendencies which are often in contradiction to each other. At both the ideological and institutional levels, it has major implications for PSHE. The New Right is usually seen as comprising three major groupings - Neo-Liberals, Neo-conservatives and Modernisers (Jones, 1989; Whitty, 1990; Quicke, 1989; Hickox and Moore, 1990). It is the first two which are most relevant to the present concerns.

1] *The Neo-Liberals*

Essentially Neo-Liberalism is an economic doctrine concerning the desirability of unfettered market forces. However, this doctrine also has a number of moral principles and implications. It is profoundly anti-collectivist and anti-statist, prioritising the position and 'liberty' of the individual. It is often characterised as 'possessive individualism' (Gleeson, 1986; Moore, 1987). It argues that individuals should be free to pursue their own self-interests without interference from the state. The market is the mechanism through which this takes place in the form of the buying and selling of 'services' at market pries.

This model assumes that the 'general good' emerges out of the aggregation of individual transactions. The ideal of a 'general' good over and above that of the individual is denied as is the idea of 'the social' as a supra-individual phenomenon. Within the philosophy of the social sciences, this position is called 'methodological individualism' (ref) and has been associated with behaviourism in social scientific explanation. A popular expression of the view can be seen in Mrs Thatcher's well-known remark that there is no such thing as society, only individuals and families (Evans, *op cit* p83).

The most significant feature of the neo-liberal position is its stress on the individual and upon 'responsibility'. The combination of individualism and responsibility is ideologically important. The neo-liberal position as such is compatible with a form of extreme libertarianism which reproduces within a market-economic model the permissiveness of the radical Left. However, the laissez-faire principle of neo-liberal economic doctrine has not been extended into social behaviour. Individualism and the pursuit of self-interest are constrained by an authoritarian moral philosophy, which has been characterised as 'conformist individualism' (Dale, 1989).

2] *The Neo-conservatives*

Especially within education, the neo-conservatives have probably provided the major force within New Right reform. Neo-conservatism stresses the role of traditional values and authority. As Weeks says, "At the centre of New Right discourse has been a symbolic crusade against what was seen as the moral excesses of the 1960s and seventies, what in Britain has been called 'permissiveness', and an effort to reaffirm traditional family and sexual values" (Weeks, 1989a p11). Neo-conservatism is committed to a model of 'the British Way of Life' which it sees as having been undermined by the 'permissiveness' of the sixties and by social democracy more generally. Major public debates around National

Curriculum areas, such as History and English, reflect neo-conservative pre-occupations with 'the British Way of Life' or 'Heritage'.

3] The Modernisers

The modernisers (Jones, 1991; Dale, 1989; Moore, 1987) can be seen as in some ways set apart from the previous two tendencies and in a certain sense as the most radical of the three groupings in the New Right. They are associated with a call to modernise the British economy and to promote vocationalism and training in education. Historically, they are linked to the emergence of the Manpower Services Commission (MSC) as a major influence in the 1980s with the development of the Youth Training Scheme (YTS). Hence they had a major power base in a state agency. The one-time MSC Chairperson David (Lord) Young was also extremely influential with Margaret Thatcher.

The Modernisers' position is distinctive in that it mounted a major attack upon educational traditionalism (Dale *et al*, 1990) which it held accountable for Britain's industrial decline. In this sense, it parted company from the neo-conservatives. It also advocated strong state support for a vocationalist model of education which offended the free-market principles of the neo-liberals. However, it also developed market-type procedures for the distribution and allocation of funding in the Further education and Secondary School spheres through the introduction of contract bidding for YTS and Technical, Vocational and Educational Initiative (TVEI) money.

Although its preoccupations with the 'needs of industry' and modern technology put it somewhere to the side of the central concerns of this work, it has been influential in the promotion of the so-called 'competency approach' in education and training. It was prominent in developing a skills-based version of Social and Life Skills Training through YTS which has had a considerable influence on schools, *eg* through the growth of profiling, Records of Achievement and other behaviouristic types of skills/competencies based pedagogy and assessment (Ryder and Campbell, *op cit*).

Social and Life Skills training itself has its origins in a behaviouristic approach to personal therapy and counselling which was perceived to be very much in conflict with the principles and approaches of Social Education as it had developed in the post-ROSLA period in the schools (Davies, 1979; Moore, 1984; Cohen, 1984; Lee, 1980).

There are major differences between the three tendencies that make up the New Right. Most notably these have to do with relations to the state. Whereas, the neo-liberals

starting from a free-market position, are hostile to the state, the neo-conservatives have supported a strong minimal state model as a means of sustaining moral authority. This is particularly evident in the National Curriculum which specifies curriculum content and has been attacked by neo-liberals as inhibiting consumer choice in educational matters. However, each group in its own fashion, has been concerned to restrict the professional autonomy and the power of 'experts' or 'producers' over that of 'consumers' and in their opposition to the role of Local Education Authorities (LEAs) in organising the delivery of the local educational service. The last of these has implications for PSHE in relation to the role of the Advisory teachers and others in promoting curriculum development and supporting particular models of good practice. The decisive change brought about by the influence of the New Right groups has been in the relationship between professional and 'lay' control over schooling.

Popularism and the moral entrepreneurs

The neo-conservative tendency within the New Right has expressed itself in the form of an authoritarian popularism associated with the activities of a group characterised by Dale as 'moral entrepreneurs'. The ideas of a supposed 'silent', 'moral majority' have been counterposed against the articulate and highly audible views of 'the chattering classes' - the 'trendy experts' of the bureaucratic intelligentsia and pundits of the permissive society. In the US, the silent majority was associated with Christian fundamentalism and in this country, with Thatcherite new conservatives such as Government Minister Norman Tebbit, who identified Tory 'wets' such as former Conservative Prime Minister, Edward Heath with the economically and morally bankrupt principles and policies of the social democratic era.

According to Dale, "Populism in the broad sense of appeal to the 'national instincts' of the people and to unifying factors like class, race and gender has been identified by a number of writers...as a key strand of Thatcherism." (Dale, *op cit* p84).

The right wing popular press gave strong support to this position and on numerous occasions in the eighties attempted to mobilise opinion against both the Labour party and non-Thatcherite Tories. Left-wing Labour local authorities were a special target for such treatment. This had strong implications for education both because local education authorities were a frequent target (*eg* London Borough of Brent) and because particular educational issues were taken up as vehicles for this treatment[4]. Sex education was (and

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[4] For examples of this, see Durham (1991).

remains) a crucial 'touchstone' (Weeks, 1989b) for gauging the effectiveness of the 'moral' lobby, especially in terms of the effectiveness of their *lobbying* (Durham, 1991). The 'Gillick Affair', is a good illustration of this.

Victoria Gillick came to prominence when she initiated a campaign to prevent General Practitioners prescribing contraceptive pills to girls under the age of sixteen without parental consent. Gillick had wide support not only from many Conservative MPs, but also from the Catholic Church, though they were not consistent in their support. Cardinal Hume, for example, did not feel able to lend his authority to the Gillick campaign. The Catholic Teachers' Federation supported her, as did some evangelical Protestant organisations, like the Salvation Army. The Afro-Asian-Caribbean Standing Committee, The Union of Muslim Organizations (UK) and the West Indian Standing Conference officially backed Gillick, as did the 'moral lobby', notably, Family and Youth Concern and the Order of Christian Unity. The Society for the Protection of the Unborn Child (SPUC) also, somewhat surprisingly in view of rising teenage abortions, gave her their support. The lobby was powerful, varied and vocal and the points they raised can be summarised as follows:

a] the importance of defending the family against State interference and usurping of the parental role

b] financial interests and rising consumerism used sex for the commercial exploitation of the teenage market

c] early sexual activity carries risks to mental and physical health

d] permissiveness is the root of moral decay in society

e] contraceptive provision allows girls to be further exploited sexually

During my time as Advisory Teacher, the emotional temperature was running high and introducing programmes of education touching on sexual activity, particularly in Cambridgeshire, to which Gillick was local, was anything but straightforward.

Running parallel to the Gillick campaign was the debate about sex education policy. Moral campaigners such as the Conservative Family Campaign, the Parents Rights Group, Family and Youth Concern and CARE argued that sex education encouraged promiscuity and homosexuality. The 1980 Education Bill provided a focus for these concerns and an

amendment was proposed giving parents the right to approve sex education programmes and to withdraw their children from sex education. It also ruled against the promoting of homosexuality as 'natural and normal' (Durham, *op cit*). The amendment failed because of a lack of time and, in spite of maintaining attacks on sex education policy and materials, the critics of sex education did not achieve much formal success prior to the third reading of the 1986 Education Bill in the House of Lords. This allowed that sex education programmes in schools should be subject to parental approval and that parents could withdraw their children from sex education lessons. The Education Act (No. 2) 1986 gave school governors the power to decide whether or not sex education should be taught in school. It requires that sex education should be given in such a manner as to encourage pupils to have due regard to moral considerations and the value of family life. DES (1987) Sex Education at School (Circular 11/87) gives governors the power to accept or reject requests from parents to withdraw children from sex education lessons.

In the nineteen-eighties attacks on sex education as encouraging homosexuality became more prominent. London Boroughs, in particular, were under constant criticism for their tolerant policies, including the well-publicised example of Haringey (Jones and Mahoney (eds), 1989) and also the issue of the inclusion of the book 'Jenny lives with Eric and Martin' in school libraries. The issues at stake were:

a] the claim that financial interests and lobbies who were anti-family were subverting young people, undermining the family and traditional values and putting children at risk

b] that liberal attitudes to sexuality would lead to more sexual activity amongst the young, more child prostitution, more sexually transmitted diseases and more unwanted pregnancies

c] that amorality posing as 'reason' was undermining genuine moral codes, religion and true values

d] that homosexuality is a threat to the family, abnormal and a perversion; that it encourages promiscuity, the spread of diseases and paedophilia.

The emergence of HIV revived nineteenth century associations of sex with disease and death and the assertion that sexually transmitted diseases are the just deserts of the impure. Chief Police Constable James Anderton spoke of people "swirling around in a human cesspit of their own making" and Baroness Cox, in the House of Lords, stated "I cannot imagine how on earth in this age of AIDS we can be contemplating gay issues in the curriculum". Typically, as the above instances illustrate, the moral lobby mobilised around

specific cases as a means of gaining publicity for the range of issues they were concerned to promote. The tabloid press was especially effective in amplifying these concerns and linking them with the broader Thatcherite political agenda.

Dale points out that the position of the moral entrepreneurs is not without contradiction. It expresses most clearly the conflict within the New Right between economic and social laissez-faire, between the market and the state.

> Those I am calling the moral entrepreneurs see education at the heart of the fight for a particular morality and against (im)moralities which would undermine it... This kind of moral entrepreneurship is curiously poised between authoritarianism and privatism. On the one hand, it argues that things like sex education are essentially private matters and are the concern of the family rather than the State or school. On the other hand, the whole point of the moral entrepreneurs is that social behaviour should be controlled by a set of rules and moral imperatives, and that it its an area in which *laissez-faire* had no place.
> (Dale, 1989 pp85-86)

This position is more accurately seen as 'anti-social democratic' rather than 'anti-state' (*ibid* p84). The popularism with which it is associated is highly *exclusive* in character.

> ...'the people' appealed to and allegedly represented in this popularist strand, by no means includes 'everyone'. Effectively, it means the deserving, those able and willing to make the most of opportunities offered to them and most stifled by Welfare State nannying. It does not include the improvident or those unwilling to help themselves... The objection to the social democratic State is that it tries to bring about 'unnatural' things like social justice. This involves upsetting the natural hierarchy - or even meritocracy - which it is the legitimate task of the State to maintain, along with the family and other 'natural' social units.
> (*ibid* p84)

The distinction that Dale makes between the 'deserving' and the 'undeserving' is reflected in that between people with AIDS who are 'guilty' or 'innocent'. These categories and their associations are traced within the symbolic discourse of AIDS. The 'virtues' of the

deserving, "thrift, hard work, self-restraint, responsibility and respectability" (*ibid* p89) are precisely those disdained by 'permissiveness' by the 'grandees' of the Old Tories (Dale, 1989).

Institutional reform and changes in control

As mentioned above, the New Right reforms of the eighties produced the paradoxical result of strengthening both the central state and the Market. The first is expressed in the considerably expanded powers of the Secretary of State and in the National Curriculum, and the second in a range of measures which increase parent ('consumer') power and choice. Troyna and Carrington have summarised the situation as follows:

> On the one hand, it provides for a massive shift towards strong direction and control from the centre, through the introduction of a National Curriculum with targets of attainment and assessment at ages 7,11, 14 and 16. In all it delegates over 400 new powers to the Secretary of State for Education. On the other hand, it allows for greater devolution of power to parents and governors over the way in which schools (and colleges) are organised, funded and governed. With the creation of City Technology Colleges (CTCs), the introduction of open enrolment and, in cases where a majority of parents, governors and the Secretary of State are in agreement, the opportunity for schools to 'opt out' of local authority control, assume grant maintained status (GMS) and obtain funding directly from Whitehall, the ERA formalizes a system where market forces seem to prevail.
> (Troyna and Carrington, 1990 p83)

A major effect of the ERA of 1988 has been to reduce the influence of LEAs and expand the power of the DES.

During the eighties and in the formative debates around the education reforms of the Thatcher period, the curriculum was a major battleground. The agenda of the reform was effectively constructed by neo-Conservatives in and around the Conservative leadership and by influential elements of the national press. Taking up the Black Paper (Wright, 1977) criticisms of the seventies, it was increasingly effectively argued that professional control of education had led to a decline in educational standards. This had two aspects. First, a decline in standards in the 'basic' subjects under the impact of progressive teaching

methods and the overburdening of the curriculum by 'trendy, fringe subjects' (such as Social Education and Peace Studies), and secondly, a decline in standards of behaviour as a result of lax, permissive attitudes by teachers influenced by the sixties cultural radicalism. During the eighties, these complaints were further fuelled by media attacks on anti-racist and anti-sexist education, especially in so far as they were associated with the Left-wing LEAs (Troyna and Carrington,*op cit*).

A major priority of the eighties reforms was to take curriculum control away from the profession (or 'the liberal education establishment' as it came to be termed by the New Right critics) and from politically-motivated (Left Wing) local authorities (Dale, *op cit*; Ranson, *op cit*; and Troyna and Carrington, *op cit*).

The changing perception of the position of the teacher (and welfare state professionals more generally) between the social democratic and New Right periods is well captured between the following two descriptions. In the first, Ranson describes their role under social democracy, and in the second, Dale summarises the views of the influential neo-conservative MP, Rhodes Boyson,

> Only the professional judgement of the teachers in the classroom could identify the learning need of each pupil and release their talents and capacities. Other partners needed to support their fragile relationship. Young citizens had to be nurtured in a caring environment by professionals dedicated to public service.
> (Ranson, *op cit* p6)

Basically, Boyson is set upon promoting commonsense theory, and the people (together with 'natural' social units, like the family) above the experts. His attacks are aimed at the betrayal of the people by experts, social engineers who claim to know what's good for people, but whose half-baked theories have led only to drastic decline in standards and discipline, and to a collapse in confidence in education.
> (Dale, 1989 p84)

This professional expertise is typically contrasted by the New Right with the 'natural wisdom' and authority lodged in an idealised heterosexual family unit. Troyna and Carrington report how Kenneth Baker, at the Conservative Party Conference of 1987, characterised local authorities as 'anti-family, anti-police and anti-competitive values in

schools' and as "apostles of mediocrity and bigots of indoctrination" (Troyna and Carrington, *op cit* pp91-92).

The shift in power to the centre was a major part of this but the objective was also pursued through the development of neo-liberal-inspired market mechanisms directed towards the school. Although all of these reforms are continuing to be subject to subsequent modification, the main features are as follows:

1] 'open enrolment' which enables parents to have a greater choice as to which school their child attends

2] 'opting out' which allows schools subject to parental vote, to leave the LEA and receive funds directly from the DES. Together with CTCs this increases the range of schools between fully maintained and independent.

3] LMS (Local Management of Schools) which devolves a number of LEA powers and responsibilities on to the school itself including the financial management of the school budget.

4] increased powers of governing bodies including the administration of the school budget, the hiring and firing of staff and the right to determine whether or not the school includes sex education in the curriculum. Governing bodies are also required to ensure that the National Curriculum is taught

5] the publication of results

In combination these changes place maintained schools in a 'quasi-market' environment in which the views and choices of 'consumers' (*ie* parents not children) can powerfully affect school policy. In effect, schools will be competing with each other for children and, hence, funding. However, because all maintained schools must deliver the National Curriculum, the 'choice' isn't about what type of education but about which schools are best at teaching National Curriculum subjects as measured by the associated assessments and examination results.

These market influences are seen as being most likely to drive schools towards a narrow focus on central National Curriculum areas delivered in a safe, conservative pedagogy and aimed at maximising 'results'. Their effect could be at the expense of groups such as pupils with learning difficulties and those with language problems and be detrimental to creative

and innovative initiatives by teachers and other educational professionals. They will reduce or marginalise the influence in the curriculum of groups such as Advisory Teachers who the New Right critics have seen as especially subversive of traditional standards and methods (Flude and Hammer, 1990).

In total, these developments deliberately aim at undermining the institutional base of educational professionals (especially those outside the schools) and to marginalise their influence. As Troyna and Carrington describe, this reflects the view of New Right thinkers such as Roger Scruton, that these groups have been set on a deliberate policy of political subversion.

> According to this view, political indoctrination had been achieved through the introduction of subjects such as Peace Studies, 'whose main purpose is to project a particular set of attitudes', and in the politicization (or subversion) of existing subjects (Scruton *et al*, 1985:7). For these polemicists, schools under the proliferating influence of left-wing radicals 'are exceeding the limited authority conferred on them by the 1944 Education Act'. Set alongside the inexorable growth of a 'para-educational establishment' (*ie* LEA advisers and administrators), Scruton and his associates identified what they saw as an insidious trend which needed to be curtailed, by means of stronger direction from the centre, to ensure 'the maintenance of standards in education' (Scruton *et al*, 1985:49)
>
> (Troyna and Carrington, *op cit* pp81-82)

In the same spirit, teaching about homosexuality has been characterised as "perversion on the rates" (Weeks 1988 p17). These moves to marginalise professional influence in education must also be seen in relation to the continuing degradation of teacher education and the declining influence of 'the disciplines' in relation to more 'practical' elements of teaching practice.

The combined result of these changes is to significantly reduce the 'insulation' between professional and lay views of the purposes and preferred forms of education. Teachers are constrained in an unprecedented way to take direct account of the requirements and views of 'consumers'. Professional or expert opinion has been demoted relative to that of lay demands. The effect of changing arrangements of control, both through the state and through the market, is to change the ideological balance between the constituencies involved in education.

Conclusion

The context for teaching about AIDS/HIV and drugs in schools is constructed by the complex relationship between what Ranson terms, 'the elaboration of educational aims as social purpose' and 'the government of education'. This chapter has explored the changes in these relationships in terms of the ideological and institutional dimensions of educational change and control. These have been located within the broader historical movement between 1944 and 1988 Education Acts form a social democratic welfare state to the ascendency of the New Right. We can understand these changes, as they impinge upon the school and teachers' work, as changes in the boundary relations (Bernstein, 1977) between different types of discourse regulated by changing institutional arrangements of control. The changing position of teachers and educational professionals is part of the more general attack upon the influence of the 'bureaucratised intelligentsia' of welfare state professionals or 'experts'.

Troyna and Carrington have described the situation as it affects anti-racist education in the following way:

> The terrain has changed; the struggle for the promotion and infusion of anti-racism into education provision and practices must now take place at the meetings of every school governing body. In the absence of the regulatory functions of the LEA, each governing body will need to be convinced of the value and efficacy of anti-racist education (and other egalitarian reforms) and be persuaded to use part of its restricted budget to support existing (or develop new initiatives along anti-racist lines). As we have made clear, neither the economic nor political climate seems conducive to such a development.
> (*op cit* p94)

What they say about anti-racist education is equally (if not more) true of HIV/AIDS and drugs education. The crucial factor which they pinpoint is the changing relationship between professional and lay discourses which accompanies the changing distribution of control between educational professionals and school governing bodies. There is, however, a tension within government policy between the moral restorationist platform with its popularist appeal and the need to actually do something concrete and effective about AIDS and other health issues. It is at the level of the school curriculum that this tension becomes particularly apparent. Appeals to 'traditional morality' do not provide the basis for an

effective health education programme. However reluctantly, it had to be admitted that sex education which raised and discussed sexual issues frankly and explicitly with young people had to remain on the policy agenda.

CHAPTER FOUR

THE CURRICULUM AND THE SCHOOL

The purpose of this chapter is to examine 'the curriculum' as the setting for HIV/AIDS and drugs education in the school. I will first consider the curriculum in general and then the more specific case of PSHE as the most likely context for HIV/AIDS and drugs education. The general discussion will draw together the themes of the previous chapters and to provide a focus on the particular issues and concerns of HIV/AIDS and drugs education.

The curriculum: approaches and issues

As Golby (1989) points out, there is no one, general accepted theory of 'the curriculum'. It is not my intention, here, to provide an exhaustive review of approaches to the area, but to outline some general features which are relevant to the concerns of this work. Concerns with the curriculum can be seen as focusing on three main areas:

[1] its *content* and *organisation*: content concerns what should be 'in' the school curriculum, *ie* what should count as 'school knowledge'. This involves questions of legitimacy and classification. Organisation has to do with how the knowledge is presented, *eg* is it in the form of well-defined subjects (a 'knowledge-based' curriculum) or is it presented in an 'integrated' form as in topic or project work? As far as HIV/AIDS and drugs education is concerned, the crucial issue is whether such topics should be found in the school curriculum at all. As was indicated in the last chapter this (and sex education) has been fiercely contested by neo-conservatives who see its inclusion in the curriculum as undermining the moral authority of the family. If it is included, there is then the further issue of *where*, *eg* as part of PSHE, of religious education or in, say, a biology course?

[2] *how pupils learn*: the curriculum is there to be 'acquired' by pupils through the learning process and, therefore, the question of 'how children learn' is intrinsic to curriculum theory. The differences encountered in curriculum organisation are often explicitly justified by reference to rival learning theories. This is particularly the case in relation to 'integrated' approaches which have often been associated with the view that academic subject divisions are artificial and prevent the 'natural' acquisition of knowledge by the child. Supporters of the knowledge-based curriculum, however, might argue that the intrinsic rationality of the 'forms of knowledge' (Hirst, 1972) develop the child's capacity for Reason. It is the case that all models of the curriculum must contain or be associated with (explicitly or implicitly) a *learning theory*. Learning theories, in turn, involve *models of*

the subject and *theories of agency*. As I argued in Chapter One, PSHE concerns with learning, attitude change and behaviour can be appropriately located within a social psychological approach and within the broader concerns of that chapter, I examined the theoretical context within which that view could be located.

[3] *social context and control*: Chapter Two considered in detail the changing institutional context within which HIV/AIDS and drugs education is located. The Education Reform Act of 1988 and the introduction of the National Curriculum have made these issues especially prominent in recent work in the area (*eg* Flude and Hammer, 1990). The concerns with this aspect of the curriculum, however, was a central aspect of the New Sociology of Education of the early seventies where such writers as Young (*eg* 1976) were concerned to establish a recognition of the fact that school knowledge is socially constructed and historically located. This view was initially advanced within a 'sociology of knowledge' perspective (Young , (ed), 1971), but became increasingly dominated by a Marxist analysis of educational knowledge as ideology and its links with class interest (Bowles and Gintis, 1976; Moore, 1988). This type of approach was further developed by feminist analyses of schooling and gender and by studies of 'race' and education.

These three broad areas of concern are interrelated, especially within the area of public debate and policy-making. Arguments about how schooling should be controlled are often couched in terms of claims and assumptions about *how* and *what* children should learn. The continuing debate about 'traditional' versus 'progressive' education is a notable example of this. The 1980s, in particular, saw heated and heavily politicised instances of this type, especially in relation to gender, 'race' and sexuality. As I argued in Chapter Two, HIV/AIDS and drugs education can be seen as providing a particularly potent case where issues of curriculum and control provoke powerful responses from different groups in society.

Curriculum traditions

The term 'curriculum traditions' (Golby, *op cit*) refers to the three major approaches to the curriculum typically described by writers in this area (see also, for instance, Pring, 1989). Golby refers to these traditions as 'liberal-humanist', 'progressive' and 'technocratic'. In this respect, he is drawing upon distinctions generally in use, though terminology and emphases can differ. Pring, for instance, employs a similar set of terms in his review of the 'educational traditions' (Pring, *op cit* p98). Both writers utilise the familiar 'traditional'/'progressive' distinction, but differ somewhat in their third terms. Where Golby writes of a 'technocratic' tradition, Pring writes about the 'useful curriculum' which is concerned with producing knowledge and skills for 'the world of work' (p100). I now want

to develop these descriptions of curriculum or educational 'traditions' in terms relevant to HIV/AIDS and drugs education.

For any aspect of knowledge, the first question to be asked as far as the curriculum is concerned is 'should it be a part of school knowledge or not?' If the answer is 'yes', then the next question is: 'how should it be treated?' The traditional/progressive distinction raises issues of where and how knowledge is located. This has to do with its relationship to the rest of 'school knowledge'.

In a traditional, subject-based curriculum, the issue will be which 'subject' should HIV/AIDS and drugs education be associated with, or conversely, should it not be associated with a 'subject' at all but consigned to a non-academic area such as 'the pastoral system' (Ryder and Campbell, 1988). This in turn, reflects broader issues of school organisation, *eg* between 'academic' and 'non-academic' or pastoral areas of school life and how they are constructed and institutionalised. Concerns of this type have been an enduring feature of PSHE in general. Decisions concerning these issues reflect perceptions of the relative status of different types of 'knowledge' and of the ultimate purposes of schooling.

An integrated curriculum presents a different range of possibilities for an area such as PSHE and specific concerns such as HIV/AIDS and drugs. It tends to be the case that the 'progressive' tradition in general has presented itself as concerned with 'the whole child' and with personal development and well-being, than is the case with the traditional, 'academic' model. This is reflected in the progressive slogan - "we teach children, not subjects". From this point of view, a sharply defined 'academic/pastoral' divide will be less in evidence. The acquisition of knowledge is seen as continuous with or even secondary to, 'personal development'.

The traditional/progressive axis has important implications for how HIV/AIDS and drugs education is located in the curriculum and the form it will adopt. Both of these, however, can be contrasted with Golby and Pring's third 'tradition', the 'technocratic' or 'useful' curriculum. Golby and Pring provide different treatments of this approach, but their respective emphases can be seen, in practice, as illuminating aspects of the same perspective.

Pring's 'useful curriculum' is related to the needs of industry. This is not, however, simply 'vocationalism' in the broad sense. The significant feature of 'the useful curriculum' is that it is concerned with 'skills'. It is at this point that Pring's description can be seen as parallel to Golby's 'technocratic' model. Golby describes this as being concerned with "the

specification of clear objectives and the choice of technically apt methods for the achievement of those objectives". (Golby *op cit* p31)

> Clear objectives entail the specification of outcomes in terms of the learners' abilities at the end of the course or item of instruction. Preferably these outcomes should be stated behaviourally; that is, they should be statements open to no or little interpretation, being value-neutral statements containing verbs of learner behaviour which can be observed to be present. Success in curriculum is to be measured in terms of the learners' status in relation to these behavioural measures. (*ibid* p31).

Golby is describing, here, what is often referred to as the 'competence' approach to learning (Moore, 1987) and can be associated with the 'moderniser' tendency in the New Right discussed in Chapter Two. In the PSHE area, it is associated with Social and Life Skills Training. Golby relates the approach to a 'means-end model of human action' (*loc cit*). It can be seen as an example of 'positivism' as discussed in Chapter One.

The distinction between the 'technocratic' or 'competence' approach and traditional and progressive liberal education is particularly significant because it introduces a further dimension into the analyses of the curriculum which has particular implications for HIV/AIDS and drugs education, and PSHE, more generally. That is, it focuses attention upon the manner in which the *ends* (outcomes or purposes) of education are being defined.

Golby's account of the 'technocratic' tradition raises a number of relevant issues. First, at the more general level it exemplifies the 'positivist' paradigm examined in Chapter One and, in the form of the Competency Movement, can be seen as a contemporary example of the approach, which is growing in influence. Secondly, it highlights a 'normative adjustment' model of education which is clearly contentious for an area such as PSHE where value issues are a central concern. In its emphasis upon 'adjustment' and the foreclosing of debate around aims and objectives, it resonates with neo-conservative moral authoritarianism. Fourthly, it enables the construction of a second dimension (in addition to the traditional (knowledge-based)/progressive (integrated) one) which can be seen as representing the degree of 'openness' in terms of which educational outcomes are evaluated.

Having outlined in broad terms the major curriculum traditions, I will now look at approaches to health behaviour. As with curriculum models, such approaches are

concerned with the relationship between knowledge, belief and behaviour and with promoting change.

Health behaviour models

Teaching programmes within health education reflect lay and professional assumptions about what affects health-related behaviour. Suggested determinants of health behaviour have been incorporated into more formally conceptualised health behaviour models which reflect and, in turn, feed into lay and professional perceptions.

Acknowledging that, although people may be aware of the efficacy of particular health behaviours and the risk of others, they may still persist in the more damaging behaviours and avoid those that would afford better health prospects (Berg, 1976), factors other than information have been considered in relation to health behaviour. Several studies have suggested that providing information about particular illnesses and health-related behaviours is not enough to produce behaviour change *eg* Valdisseri *et al* (1987) in relation to condom use, McKusick *et al* (1985a) in relation to condom use and reducing numbers of sexual partners, Ross and Herbert (1987) and Siegel *et al* (1987) in safer sex and Fineberg (1988) in terms of needle-sharing and sexual behaviour.

Rationality models, based on the assumption that information will lead to behaviour change possibly via attitude change are now widely held to inaccurately reflect the processes involved in changing attitudes, beliefs, intentions and behaviours. The interrelationship between knowledge, feelings and actions is complex and Health Education theories have developed to take on board the need for appropriate (targeted) content (information and attitude clarification), the development of skills (such as communication skills, decision-making skills, critical awareness and political awareness) as well as the need for an appropriate methodology, which encourages active participation, a sense of self-worth and an awareness of the needs and influence of others. Individual responsibility is emphasised, as is the belief that individual control over life-events and social behaviours is possible.

Within schools, there is much debate about voluntarism. To what extent do we really want young people to make up their own minds? Is any form of behaviour acceptable, so long as it is thought through? Are young people really free to choose, or are they constrained by environmental and social factors? It is the ideological aspects of health promotion messages and the interactional influences on actual behaviour that are most often ignored within health education programmes. For practical reasons, and because of the emphasis

on the rationality or enlightenment model of education, school-based health promotion has tended to emphasis information and attitudes. Situational factors and skills are addressed out of the actual context of the behaviours and in the heavily constraining context of the teacher-pupil relationship and the classroom.

Health behaviour models of increasing complexity and sophistication have been developed to accommodate additional influencing variables. Particularly influential amongst these are the Health Belief Model (Rosenstock, 1966; Maiman and Becker, 1974; Janz and Becker, 1984); Blooms taxonomy of educational objectives (Bloom *et al*, 1964); self-regulating systems theories (*eg* Leventhal and Cameron, 1987); the Theory of Reasoned Action (Ajzen and Fishbein, 1980) and the Theory of Planned Behaviour (Ajzen, 1985); and PRECEDE (Green *et al*, 1980).

Health Belief Model

This model is developed out of the theorising of Rosenstock and Becker (Rosenstock, 1966 and Becker and Maiman, 1975). It attempts to predict preventive health behaviour (and sick-role behaviour), with an emphasis on attitudes and beliefs as the possible basis for action. It considers the following variables - perceived susceptibility, perceived severity, perceived benefits and perceived barriers - all of which relate to the preventive health behaviour, or what it is protecting against. Janz and Becker (1984), through critically reviewing forty-six Health Belief Model investigations since 1976, found that perceived barriers had the highest significance-ratio (89%) indicating this dimension to have most impact on behaviour (followed by perceived susceptibility (81%), benefits (78%), and severity (65%)).

It has proved to be effective in predicting attendance for screening for cancer and for vaccinations. Cleary (1987) suggests, however, that for different health behaviours, different variables from amongst those suggested may be more salient. The Health Belief Model's explanatory power is limited, in that it can only explain as much variance in an individual's behaviour as can be accounted for by that individual's (health) beliefs. It does not account for non-health factors such as habitual, economic, social and situational aspects of behaviour.

Bloom et al's (1964) taxonomy of educational objectives

This is a general educational model, rather than a specifically health-related theory and suggests that education is composed of three domains - the affective domain (including

attitudes and emotions towards a subject); the cognitive domain (consisting of information) and the psychomotor domain, which relates to a person's ability to perform related behaviours. Bloom *et al*, argue that these domains are sequential, that is unless attitudes are addressed, information will not be effectively received and, in turn, relevant behaviours will not be produced. In education related to the affective domain, it is necessary first to ensure that the message is received (in terms of Health Education this may entail accurate targeting of a population and using an appropriate method and intermediary); secondly, the message must be accepted; thirdly, it must be valued and fourthly, it must be accommodated into a more general, behaviour-related framework.

Whilst marking an improvement on purely informational models, the taxonomy pays insufficient attention to social and interactional issues. As Joseph *et al* (1989) have indicated in their study of safer sexual behaviour, situational factors (such as the type of relationship) influence the salience of particular beliefs (*eg* the amount of risk entailed).

Self-regulating systems theories (eg Leventhal, 1970, 1983; Bandura, 1977; Rosen et al, 1982; Leventhal and Cameron, 1987)

In response to criticism of simple causal links drawn between information, attitude, intentions and behaviours, Leventhal, Bandura and Rosen *et al* have considered the contribution of motivational and decision-making factors which lead people to develop skills for risk reduction. People are more likely to make changes to their behaviour when they are given specific instructions on how, when and where to act, opportunities for rehearsal of responses and ways of handling particular behavioural cues and a sense of self-efficacy. Failure to adopt or maintain new behaviours is, they suggest, largely caused by unchanged environmental factors that prompt established habits.

This body of theory regards the individual as actually engaged in reaching a goal and developing strategies for its achievement. It includes cognitions about the health threat, behaviours and consequences, strategies for coping or advancing towards the goal state and evaluation of progress, which feeds into a modification of strategies. Emotional responses and cultural and social factors are indicated as potential confounding variables at each stage. The concepts are difficult to operationalise and relatively little empirical research has been generated to test the model.

The Theory of Reasoned Action (Fishbein and Ajzen, 1975; Ajzen and Fishbein, 1980); The Theory of Planned Behaviour (Ajzen, 1985)

The Theory of Reasoned Action suggests that attitudes and perceptions of social norms produce intentions to perform particular behaviours and that intentions are the best predictors and most immediate determinants of behaviour. Since intentions do not always lead to the performance of behaviours and other factors than attitudes and perceptions of social norms influence behaviour, such as habits (Bentler and Speckart, 1979, 1981), impulses (Emmons *et al*, 1986; Lawrence and Singaratnam, 1987); McKusick *et al*, 1985a) and peer support (Joseph *et al*, 1987), the original theory was adapted by Ajzen (1985) to include perception of control or potential control. This version of the theory is known as the Theory of Planned Behaviour. Various factors to do with particular situations, times or circumstances may intervene in the translation of an intention to an actual behaviour *eg* intoxication may reduce the likelihood of carrying out planned action.

PRECEDE - (predisposing, reinforcing, and enabling constructs in educational diagnosis and evaluation), Green et al, 1980

The PRECEDE model considers the antecedents of health-related behaviours

- predisposing factors - the attitudes, beliefs, values and perceptions that influence motivation, either positively or negatively.

- enabling (or disenabling) factors - such as social pressures, absence or existence of resources, legal barriers. In the case of HIV-related risk behaviour, McKusick *et al* (1985a) show that lower use of drugs or alcohol leads to less risky behaviour. Stall *et al* (1986) have demonstrated that more drug use leads to more risk of HIV transmission because of the disinhibiting effects of drug use, altered personality and the aphrodisiacal qualities of some drugs. Alcohol and drug consumption also provides a social context for sexual behaviour.

- reinforcing factors - the positive or negative feedback from others that influences behaviour.

This model emphasises external factors, though it does not present a developed theory of interactional processes.

Models of health-related behaviour in general

Cummings *et al* (1980) have analysed fourteen models of health-related behaviour and suggest that the variables considered to influence behaviour constitute six broad factors

1. accessibility to health care
2. evaluation of health care - in terms of its importance, relevance and effectiveness
3. perceptions of the threat to health and symptoms of the disease
4. social network characteristics
5. relevant knowledge
6. demographic characteristics - age, sex, ethnicity, homelessness, employment, cultural, social and political background.

Prentice-Dunn and Roger (1986); Mullen, Hersey and Iverson (1987) and de Vries, Dijkstra and Kuhlman (1988) add to this, self-efficacy.

Criticisms of the models

Concept operationalisation and measurement

There has been very little validation of the various models and, as they tend to test different variables, operationalised in different ways it is difficult to evaluate their relative effectiveness as predictors of health-related behaviour. The models tend to assume simple causal links where more complex ones exist (Liska, 1984) and, in the collection of hard data, oversimplify via the reduction of complex behaviours to attitude scale completion. By aggregating different subjects' responses on scales, the oversimplification is compounded, since unsubstantiated assumptions of comparability are made in relation to interpretation of items and response ranges.

Variables have to be considered in terms of their interrelation and changes over time and across situations and their relevance to the individuals tested and the particular behaviours in question (Conner, 1992). The Theory of Reasoned Action and self-regulating systems theories address a more dynamic and information-processing or problem-solving aspect of health behaviour, but again have an insufficiently developed theory of interactional and transactional processes.

At a more fundamental level, theorists, particularly within the discourse analytic tradition have questioned the existence of cognitions, such as attitude, beliefs and

intentions, within the individual (Austin, 1962; Gergen and Davis, 1985; Gilbert and Mulkay, 1984; Potter and Wetherell, 1987, 1988). These are inferred from responses to questionnaire items. In contrast to this cognitive social psychology, discourse theorists suggest that what we say is a management of a particular social situation rather than the expression of a stable cognition or trait. In this case, questionnaires only measure how individuals manage their responses in that particular context.

Abraham and Sheeran (1992), whilst acknowledging the tendency to oversimplify in surveys and to use surrogate measures for actual behaviour, suggest, firstly, that criticisms of social cognition models may be overstated and secondly, that adaptations to research design may make studies more reliable and valid. They cite King's research using the health belief model and attribution theory to predict 83% of attendance behaviour at a screening clinic (King, 1982) as evidence of the predictive validity of such studies and suggest that textual variability may be an effect of topic or context, rather than an inevitability - *ie* people may be more likely to produce justifications and variability in discussing racism than health beliefs and in response to a face-to-face interview rather than a questionnaire. Arising from these responses to 'the constructivist challenge', they propose that longitudinal studies, measuring actual rather than reported behaviour and a triangulation of sources, will produce more accurately predictive findings.

In addition, they emphasise the need to consider variables between intention and behaviour, going beyond 'contemplation' to 'action management'. These variables, including the physical and social context, the expectations of others and a person's accounting strategies (to justify their behaviour), will vary from behaviour to behaviour and between aspects of those behaviours. For example, in considering needle-sharing behaviour, the outcome will be influenced by the availability of injecting equipment, the relationship between those potentially sharing, peer pressure, cultural norms, *etc.* In breaking the behaviour down into its sub-units, different skills will be necessary to handle different stages, getting the injecting equipment, negotiating an offer of sharing, *etc.* Effectiveness in handling the different aspects of interaction will relate to perceived self-efficacy (Ajzen and Madden, 1986; Rosenstock *et al*, 1988; Rene and Van der Pligt, 1991; Bandura, 1989).

Action management involves a series of separate acts which need to be considered, alongside the expertise and experience of the subject in specific situations (Vallacher and Wegner, 1987).

The importance of social factors

The emphasis on the individual's behaviour as responsible for health, takes attention away from social and economic influences and is one factor in the victim-blaming nature of much Health Education.

There is an implicit assumption within most of the models that health behaviour and life-style choices are freely made. This ignores the social context of health related behaviour in terms of social influence and interactional processes (Green, 1970; Green and Johnson, 1983), power relations and ideologies (Hollway, 1989; Holland *et al*, 1991a, 1991b) and, in the case of drug use and sexual behaviour, the comfort and anxiety reduction that these may entail. The Theory of Reasoned Action goes some way to considering social factors in the 'subjective norm' variable, but in practice this is generally measured in terms of perceived responses of two or three significant others. Complex interactional factors are ignored.

Assumptions of rationality

Health behaviour models assume that individuals are rational decision-makers and ignore both the deviations from rationality that occur in behaviour and the value judgement implicit in assumptions of what is 'rational'. There are clear parallels, here, with the 'enlightenment' model of education.

Comment

Although affording methods of researching health-related behaviour, the models discussed, despite their increasing complexity and sophistication tend to oversimplify behaviours and provide inadequate operationalisation of concepts. In particular they tend to ignore changes over time, across situations and the interactional aspects of behaviour. More rigorous design, along the lines of Abraham and Sheeran's recommendations, affords a more promising and potentially predictive approach to social cognition and health behaviour, complemented by qualitative research that addresses the more symbolic and social aspects of behaviour.

In terms of pedagogy, the theories incorporate the cultural dynamics of behaviour, but this is rarely translated into effective classroom practice, not least because of the restrictions of the classroom order and pupils and teachers' expectations.

Health Education Approaches

There are numerous typologies of Health Education, reflecting, in part, preferred teaching style and also assumptions about desired outcomes and the degree of voluntarism anticipated. Howe and Wright (1987) present one such typology in relation to drugs education which is indicative of the dominant and less dominant trends in both HIV/AIDS and drugs education.

1. The didactic approach

This approach divides into two - the shock-horror approach and the scientific information-giving approach

a] shock-horror

Shock horror is popular with pupils and is based on the 'deterrence-by-horrible-example' theory and features, for example, dead addicts on mortuary slabs (as in Gale is Dead, BBC 2, 1986) and in the Department of Health's 1990 anti-drugs campaign . Interestingly, despite a lot of evidence indicating that this is neither a 'safe' nor an effective approach, it was the method to which many LEAs resorted in the initial panic around AIDS in 1985, preceding and following the 'Don't Die of Ignorance' Campaign, presumably seen as fact, not shock horror in the overall approach. The outcomes in terms of beliefs and behaviour are clearly specified and this approach assumes that eliciting a particular affective response (fear and aversion) is the optimum strategy for behaviour change.

It uses fear-based propaganda and has been demonstrated to be ineffective or counter-productive (Bagnall *et al*, 1987; Chaturvedi, 1987; Fangler, 1987; Woolley and Kinghorn, 1987). Fear-based approaches prompt denial, stress and viewing oneself as an exception. They may have the reverse of the desired effect in prompting experimentation or be completely rejected, if the message contradicts experienced reality.

b] scientific information-giving

Information-giving has for a long time been the major strategy of prevention within the legal/moral and public health models of drug use (van de Wijngaart, 1990). Giving information about proscribed drugs has been used to gain support for controlling their availability and for controlling those who use them. It is also intended to affect behaviour. This approach is based on the belief that, behaviour is rational; that an

increase in knowledge can lead to changed behaviour and that rationality will produce a change in the desired direction. Howe and Wright suggest that although giving information increases knowledge, it has virtually no impact on drug use or intentions to use drugs.

For those already inclined to be 'anti-drug', such information reinforces their intentions not to use (Research Bureau Ltd, 1986; Andrew Irving Associates, 1984, 1986). Those attracted by risk and breaking conventions are likely to reject or ignore the messages or even be prompted into experimentation (Professor G Pearson, cited in The Guardian, September 17, 1986).

Relevant and accurate information is important, as inaccurate and exaggerated information reduces the credibility of the source and the likelihood of acceptance of the message. Information is clearly essential, but it does not, in isolation, influence behaviour. It must be actively received and related to previous and current experience.

2. *Affective approach*

Here, the assumption is that clarification of feelings and attitudes will result in healthier behaviour and that increased knowledge coupled with attitude change, will lead to behaviour change. Howe and Wright report that evaluations of such programmes appear to be successful in clarifying and/or modifying attitudes, but there is marginal effect on knowledge or behaviour.

3. *Behavioural approach*

Although, at the extreme, this approach could scarcely be called education, since it is often criticised as being manipulative, there is evidence (Howe and Wright, 1987), in the case of some substances, (notably tobacco), that it has been effective in promoting 'more sensible' drug use. The assumption is that drug use is learned, functional behaviour and that increased self-esteem and social skills will lead to reduced drug use.

4. *Situational approach*

This assumes that the situation in which a person is offered a drug is important and that the exercise of specific, informed skills is necessary to make healthy choices. The approach focuses on giving information and increased decision-making skills. Howe and Wright state, again, that there is no evidence to suggest that this reduces experimentation

or drug use, but that it does lead to increased knowledge, improved decision-making skills and possibly safer drug use.

5. Cultural approach

This is a new and underused approach which focuses on the social situation of the drug user. As yet, it has not been evaluated as a strategy. It is based on the assumption that culture, race, class and income influence behavioural norms and that socio-economic factors and behavioural norms influence drug use. Exploration of these factors, as they relate to the individual is seen, within this model to be beneficial.

6. Casualty reduction approach

Rather than being a different educational model, as presented by Howe and Wright, this represents a particular educational goal - that is, the reduction or minimising of drug-related harm. It does not aim to prevent drug use or to reduce experimentation, but to explore the risks involved in different methods and circumstances of drug use.

Having considered the models and the resources seen by Howe and Wright to exemplify these approaches, the teachers responsible for developing and implementing the PSHE programmes, adopted an eclectic and pragmatic approach. They opted for a combination of didactic, affective and situational approaches, using a range of resources available at the schools or Health Promotion Services. These they supplemented with ideas and materials of their own.

The curriculum, society and the individual

Whatever the differences between various 'curriculum traditions', all share one, basic objective: to change the learner. Learning, by definition, entails change. An individual who is no different at the end of a learning process than from at the beginning could not be said to have learnt anything. Curriculum traditions can be seen as differing in terms of their theories (or assumptions) about effective learning and about what it is worthwhile or desirable to learn. Pring describes the process of education in this way:

> Education, therefore, is concerned with helping people to think and understand. It is about empowering them - giving them the mental tools to reflect, reason, to argue and to solve problems. It is about developing those human endowments, those human qualities, whereby they can

understand themselves, other people and the world around them, and therefore assume some measure of control over their own life and destiny. It is not just a matter of acquiring knowledge; it is a matter of acquiring understanding and insight. It is not just a matter of being insightful in any old thing; it is a matter of having insights into matters of importance. And it is not just a matter of insight as such; it is a matter of being able to translate those insights into meaningful courses of action.

(Pring, *op cit* p98)

Pring's extended definition of education could also be read as a description of a type of person - the person who has become 'educated' in this particular sense. Empowerment comes from understanding, insight and control in significant areas. This description could be further transformed into a description of a type of society - one of which such people are citizens and which values and respects these characteristics. Curriculum traditions can be understood, in this way, as concerned with models of the person and society. This was the point made by New Sociology of Education writers in the seventies and is clearly also the concern of popular debates in the eighties and nineties.

The model presented by Pring (a well-known liberal educator who has contributed to the development of Social Education) stands very much in contrast to Golby's depiction of the 'technocratic' tradition and to neo-conservative moral authoritarianism. This contrast indicates that educational ideologies differ significantly in relation to their basic concerns with knowledge, the individual and society.

In her review of approaches to Social education, Rosemary Lee (1980) produces a typology of aims of social education curricula which involves two basic dimensions: the first is whether the focus is on the individual or society and the second is whether or not the approach is concerned with initiating change.

Table 1 : Four possible overall aims of social education programmes

	Focusing on society	Focusing on individuals
Concern to initiate change	*Social change* To help students see the need for political and social change and to develop relevant action skills	*Individual change* To maximise the life-chances of the individual within society
Not concerned to initiate change	*Social control* To initiate students into societal norms related to work, family and citizenship	*Non-directive pro-autonomy* To encourage informed autonomous choice of social life-style

(Lee, 1980 p52, figure 5)

Both the 'social control' and the 'individual change' positions can be seen as normative in the sense that they do not challenge existing *societal* arrangements or values. In the case of the former, the intention is to 'adjust' individuals to social expectations in specific areas of social life (*eg* 'the world of work'). An example of such an approach is the type of Social and Life Skills supported by the MSC for the YTS. The 'individual change' approach often begins from a deficit model of the 'trainee' and aims to enhance his or her capacity to conform to social expectations. It would typically be applied to groups such as the unemployed or 'socially disadvantaged' categories such as ethnic minorities and women for whom it functions as a type of compensatory education.

The 'social change' perspective is concerned with developing, in individuals, capacities required to bring about social change through collective action. The Schools Council Social Education Project can be seen in this light (Schools Council, 1974) and was a dominant perspective in schools in the post-ROSLA period. It was often allied with social studies and can be seen as reflecting the influence of radical sociology upon this area of the curriculum. The non-directive 'pro-autonomy' position can be seen as close to the ideal described by Pring, in that it focuses upon the individual as an 'autonomous decision-maker'. This can be related to both the 'rational autonomy' of liberal philosophers such as R S Peters and Paul Hirst and to progressive notions of self-realisation. Like the social change perspective, it is potentially radical. However its emphasis is individualistic

rather than collectivist and its concern with 'autonomy' would not preclude an individual 'autonomously choosing' retreatism or conservatism rather than social change.

Within the individual/social, change/non-change grid that Lee developed, a further, underlying dimension can be defined which, in terms of the earlier discussion, relates to the degree of openness or closure within which objectives and outcomes are being defined and evaluated. Hence, the 'normative' positions are socially prescriptive and assume existing societal values (or a version of them). Critical discussion of these is precluded from curriculum objectives (the MSC made this a formal requirement of YTS funding). The social change position is critical, but prescriptive, in the sense that it explicitly advocates social change through collective action. Non-prescriptive pro-autonomy actively seeks to avoid prescribing ends in favour of individuals 'choosing for themselves'. It can, however, be seen as a critical position in that the view that individuals *should* be able to choose challenges the values and assumptions of groups such as cultural conservatives or religious fundamentalists which emphasise conformity to traditional authority.

Lee's typology provides a useful means of conceptualising and focusing upon significant features of the curriculum in general. As Chapter Two demonstrated, the public and political debates which dominated education in the eighties and which provided the context and justification for the educational reforms of the New Right were predominantly concerned with how far an earlier generation of curriculum development and educational reform had moved in a critical and non-prescriptive direction. The liberal ideals of 'choice' and individual 'autonomy' were seen by neo-conservatives in particular, as having degenerated into 'permissiveness'. Crucially, this involved exercising choice where it should not apply - in the areas of gender identity and sexuality, for instance. Essentially, the New Right backlash against 'permissiveness' registered the fear that a naturally ordained (and divinely sanctified) order was being not simply questioned but deliberately undermined. As commentators such as Weeks and Watney have argued, AIDS provided an apocalyptic focus for these concerns.

There are clear, though not exact, parallels between Lee's typology and that developed by Campbell and Ryder (*op cit*). This is a useful and detailed summary of approaches in the PSHE area. Their categories 'radical/political' and 'medical/traditional' can be seen as corresponding to Lee's 'social change' and 'social control' types. The 'pastoral/individual' and 'educational/rational' would seem to reflect differences in teaching style in the 'progressive/traditional' form based on differing emphases upon 'self-development' or 'reason'. Given that it tends to be the case that, conventionally, in our schools more 'progressive' approaches are applied to less 'academic' pupils and associated with 'deficit

models' and more subject-based approaches to the 'academic'; it is reasonable to suggest that Campbell and Ryder's 'pastoral/individual' would tend to correspond to Lee's 'individual change' and 'educational/rational' to 'non-directive pro-autonomy'. The former, in this sense, would tend to be compensatory whereas the latter assumes a basic competence in the pupil.

Typologies of this type tend to abound in this area of the curriculum and perform useful functions in conceptualising approaches, in clarifying aims and objectives and suggesting concrete strategies in teaching methods. However, in practice, teachers tend to utilise approaches in a more eclectic and pragmatic way and rarely apply a particular approach exclusively or in a 'pure' form. Hence, these typologies should be seen more as 'ideal types' than as descriptions of real practices to be directly encountered in schools.

For the purposes of this work, the significant dimension is that which has to do with how prescriptive an approach is in terms of the messages the curriculum is required to convey. Major debates in the HIV/AIDS and drugs area of the curriculum have tended to focus upon issues of this type, especially under the influence of the moral authoritarianism of the neo-conservative New Right discussed in Chapter Two.

In general terms, it can be argued that liberal educational philosophies in both traditional and progressive forms tend to be low in prescriptiveness, valuing versions of 'autonomy' (*eg* 'rational autonomy' based on Reason and knowledge or 'empowerment' developed through 'self-realisation', *etc*). Both the 'competency' approach and the neo-conservative influence on the curriculum in the eighties attempt, in different ways, to prescribe much more precisely *what* should be learnt. The National Curriculum and Standard Assessment Tasks (SAT) represent institutionalised controls over content *and* learning. In the PSHE area, this distinction between the degree of 'openness' or 'closure' in relation to prescriptiveness has to do with normative adjustment - how far the curriculum is concerned with developing the capacities for change (individually or socially) or how far it is inculcating a given model of 'appropriate' social behaviour.

It is important to note that this model does not simply reproduce the familiar 'traditional/progressive' distinction. For example, both liberal rationalist and neo-conservative curricula have a 'traditional' subject-based form, but the aim of the former is to develop rational autonomy, whereas that of the latter is to inculcate 'traditional values'. Whereas 'rational autonomy' seeks to empower the individual as a decision-maker, the neo-conservative ideal is the 'conformist individualist' (see Chapter Two). In a

similar fashion, the 'competency' approach prescribes sets of 'skills' to be acquired in precise detail but operates with a 'progressive', experiential pedagogy.

PSHE, the curriculum and control

The above discussion has developed a distinction between curricula in terms of how far they aim towards 'choice' or 'conformity' in the individual as the results of learning. This can be seen in terms of how far they seek to encourage *innovation* in the learner or how far they *prescribe* outcomes in the form of values, attitudes and behaviour. Although this distinction can be applied to the curriculum in general and reflects the basic tension within education between innovation and conformity, it has particular implications for the area of Health Education where health behaviour can be related to life-style and to moral codes and judgements (*eg* in relation to drug use or sexual behaviour).

Whitehead (1989), in a wide-ranging review of 'education for health', has identified a set of major conflicts within Health Education policy. She summarises these in the table reproduced below.

Table 2: Policy Conflicts In The School System

1a. Policies encouraging broadly based health education programmes encompassing *positive* concepts of mental and social health.	1b. 1985 onwards, direct government pressure for 'crisis' education in schools on separate health problems - preventive medicine model.
2a. DES and other policies encouraging development of health education and personal and social education as *essential* parts of the curriculum.	2b. No place for these in the National Curriculum.
3a. Broadening of concept of sex education and growing practice of incorporating it into wider health and personal education programme. Recognised as 'crucial'.	3b. Individual school governors given responsibility to decide if *any* sex education to be included in the curriculum and, if so, what and how.
4a. HMI encourages more exploration of sensitive issues about homosexuality, contraception and abortion. Contraception in examination syllabi.	4b. Teachers advised not to give contraceptive advice to girls under 16. Contraception removed from exam syllabi in 1988. Restrictions on discussion of homosexuality, moral codes, family life.
5a. Inservice training for health education encouraged.	5b. Teachers overloaded with training for other innovations.
6a. School increase health education input in formal curriculum.	6b. Messages conveyed by school environment and ethos contradict health messages received through curriculum.

source: Whitehead (*op cit*) p18, Table 2

These conflicts reflect tensions identified earlier between the social democratic legacy of teaching as an activity carried out by relatively autonomous professionals exercising independent judgements (a 'bureaucratised intelligentsia') and the New Right concern to subject such groups to control by 'consumers' and market forces. It was argued in Chapter Two that neo-liberal laissez-faire co-existed in the New Right with the social authoritarianism of the neo-conservatives. This tension is particularly apparent in the third, fourth and sixth of Whitehead's 'conflicts'. Essentially, the underlying conflict is between the need to provide effective health education in general and in relation to specific concerns such as HIV/AIDS and drugs and the desire to structure education around the neo-conservative moral agenda, especially in terms of its model of the 'traditional family' and its associated heterosexist myths.

These conflicts reflect both a general tension between liberal education and the New Right and the problems the government had in responding effectively to the specific problems of drug use and HIV/AIDS. The educational development of Health Education was clearly in conflict, in the eighties, with the political requirement that the curriculum be a bearer of specific ideological messages. As Weeks has pointed out,

> Sex education has been a touchstone for the moral Right throughout the West. Publicly provided sex education has been seen as a means for the undermining of parental authority, and as a channel for the promotion of 'perversion on the rates'.
> (Weeks, 1988 p17)

Whitehead reports that a teachers' pack on AIDS prepared by the HEA was rejected by the DES "because some of the group work it suggested was too open-ended and because the moral messages in it were not strong enough" (*op cit* p18).

However, it is not the case that the *only* issue, here, is the endemic conflict between liberal education and the New Right. As far as drugs and AIDS education is concerned there was a more difficult problem for government policy. Both drugs and AIDS (and the latter in particular) were social issues that required a substantial and effective *response*. Given the absence of an effective medical cure, *education* became a key plank in the government's response to the AIDS 'crisis' and this meant that it could not rely on upon the crude simplifications of neo-conservative moral ideology. To be *effective*, HIV/AIDS education had to draw upon precisely those progressive/liberal educational approaches and practices which the New Right was determined to eliminate from the school system.

Conclusion

Locating HIV/AIDS within the school curriculum raises several areas of controversy. There is considerable debate over whether HIV/AIDS and, in particular, related issues such as sexuality and safer sex, should be taught at all and, if so, *what* should be covered and *how*. The mode of delivery concerns, not only the organization of the curriculum (*eg* whether topics related to PSHE should be included in tutorial time, specific PSHE lessons or subject specialisms) but also the method of teaching.

Underlying pedagogic practices are models of education and its purpose. These are discussed by commentators under a variety of headings, but concern, centrally, the

traditionalist versus progressive understandings of children and the educational process, and more recently, the skills-based approach to learning which stands in opposition to both traditional and progressive models.

Drawing in part on models of health behaviour and also on preferred teaching styles, Health Educators, specifically, have debated the most appropriate content, skills and pedagogic practice for HIV/AIDS and drugs education. Problems raised within this area of concern are compounded by controversy over whether Health Education should be aimed at promoting choice or conformity, change or reproduction of social values and practices.

CONCLUSION TO SECTION ONE

Section One provides the theoretical background to the empirical study summarised in Sections Two and Three. It has addressed discourse and HIV/AIDS, current debates in the social sciences about knowledge and agency, political and institutional developments as the context for HIV/AIDS education and the curriculum. Reflections on each of these areas point to the necessity to adopt a sophisticated model of pedagogy, reflecting the complex interactions of different levels of influence upon behaviour, understanding and the classroom. Similarly, the researcher needs to engage with these dynamics, drawing upon a broad range of theoretical and methodological resources.

SECTION TWO

INTRODUCTION TO SECTION TWO

Section Two reports on a study in 1985/6 of school children's responses to a questionnaire on drug use and HIV administered before and after a programme of education. Responses from the Study group are compared with those from a Control Group who did not receive any formal education on these issues during the period of the study. Results are also related to comparable studies around that time and findings from the questionnaires are discussed and developed with reference to qualitative data derived from interviews and classroom observation.

The study took place as part of my role as Advisory Teacher (Drugs and Health) in Cambridgeshire. It provided a form of evaluation of teacher in-service training and school-based education, as a basis for developing further work in these areas. The quantitative data are presented first of all descriptively and then subjected to more complex factor analysis, to provide a more sophisticated level of statistical treatment. Interpretations of the factors provide a link with the qualitative material in Section Three.

The qualitative data raise issues of the importance of context for the way young people talk about drug use and HIV/AIDS. Three main contexts are discussed: the formal PSHE lesson, informal groups within PSHE sessions and group interviews. The questionnaire material provides a fourth source of contextualised 'talk'. This raises issues for

a] our understanding of the objectivity of questionnaire responses, which is discussed in terms of conventional critiques of positivist methodology

b] the privileging of 'talk' and discourse analysis.

These are discussed in more detail in the conclusion to this Section.

CHAPTER FIVE

BACKGROUND TO THE STUDY

As part of the government's anti-drugs initiative, one Drug Education Advisory Teacher was appointed per county in 1985. The appointments were the result of Education Support Grants made available by the Department of Education and Science for the employment or secondment of a teacher or youth worker in each Local Education Authority. The aim was to co-ordinate drugs education and to support teachers and youth workers in dealing with drug-related incidents. To some extent this was the legacy of the public health education campaigns on drug use (notably, the Heroin Screws You Up campaign, DHSS, 1985), which had considerable impact on the climate as discussed in Chapter Three) within which the educational initiatives developed.

The Report of the Advisory Council on the Misuse of Drugs (HMSO, 1984), citing Triesman, *et al* (1973) and the Institute for the Study of Drug Dependence (ISDD) (1983), noted that drug use had spread from fairly localised centres (particularly London) throughout the United Kingdom and that it now constituted a 'national problem'. The total number of those who were known to have experimented with drugs had increased and was estimated in the region of several millions. Whilst it was acknowledged that only a proportion of these experimental users went on to use regularly or episodically, and a further sub-group developed problems, this was seen as being a significant and growing concern. It was further concluded that existing measures across the range of responses to drug use (prevention of availability, use and harm) were not adequate.

Amidst the general concern about drug use and its effects, was the specific issue of education (at community level and of particular groups). The Report highlights the current debate about reduction of use or reduction of harm, positions that became further polarised by the risk of HIV transmission.

It was felt that early intervention was crucial to prevent harm and the development of more serious drug-using problems and this reflects the increasing emphasis on school-age children as targets for Health and Personal and Social Education programmes. Schools were seen as an appropriate channel for the dissemination of information and more general social skills training. At this time, a few schools were able to provide a PSHE programme that covered health issues and the difficulties of reconciling personal conviction with school policy and curriculum are implied within the report. Decision-making skills, self-esteem, pastoral care and interpersonal skills are all emphasised as important elements

within a school Health Education programme and as considerations for teachers beyond theoretical understanding of the causes and effects of drug use and an exploration of attitudes. Implications for initial teacher-training and in-service training are outlined and the limitations of existing models commented on. In the light of these concerns the government provided funding for Educational Support Grants to provide each Local Education Authority with a key-worker (within schools or the Youth Service) to provide the necessary training for key teachers in each school and key youth workers in each area. The model adopted (the cascade model of in-service training) assumes that there will be a dissemination of skills and information downwards from, in this case, regional workers to specific staff and from them to all appropriate staff.

Cascade training is, theoretically, very cost-effective and with the advent of 'Baker Days' - compulsory days of training for school staff outside term time, which were introduced by Kenneth Baker - staff in school management positions were invariably keen to have training (from outside agencies or their own staff as part of the cascade) in order to fill these compulsory slots without additional cost to the school. In contrast, many teaching staff, in the initial introductory phase of Baker Days when attendance was seen as yet another increase in demands on their time, resented the compulsory training.

Local Education Authorities were allowed to determine the location of the Education Support Grant funding. Acknowledging that non-attendance at school effectively removes young people from education programmes and that youth work (centre-based and detached) was also essential, Education Authorities were allowed to appoint a youth worker rather than an Advisory Teacher, if this was felt to be more effective.

Support, in the form of materials, training, information and advice was already available from ISDD, SCODA (the Standing Conference on Drug Abuse) and TACADE (The Advisory Council on Alcohol and Drug Education), all of whom were represented at the induction conference in Southampton for the Education Support Grant workers. The National Youth Bureau, the National Association of Youth Clubs and the National Intermediate Treatment Federation also already provided similar support.

The Southampton Conference, in September 1985, the first of several, provided input from HMI, key academics in the Health Education field, such as Keith Tones, and TACADE, ISDD and SCODA. In a series of lectures, they promoted a broad systems approach with emphasis on small group and individual work. A major aim of the conference was to promote 'networking', though essentially, the Education Support Grant workers were left to devise their own programmes of in-service training within their Authorities. This reflects

both a flexibility necessary for accommodating different institutional arrangements and also a lack of clear guidance. An outcome of this was that the methods developed by the Drugs Education Co-ordinators were frequently at odds with the more general trend of the government towards more didactic, traditional and moralistic approaches.

Within Cambridgeshire, I developed a programme of initial drug awareness training for representatives of all schools (Primary and Secondary) within the Authority and for all youth centres. This was followed up by Working Parties on policy and curriculum, which involved observation within schools to establish good practice and to support teachers in their work. Sixty teachers and youth workers also opted for a twelve week course on counselling skills in education. As part of the observation and feedback aspect of my work, I conducted the research project which is summarised in this section. Adapting a questionnaire devised by a local drugs agency, for use in Further Education, I arranged for it to be administered in four schools with PSHE programmes. This was done before and after the relevant education programmes, and also in a fifth school which did not have a formal PSHE programme or a developed Tutorial system, as a Control Group.

The increasing publicity on AIDS, at the time, resulted in a broadening of the brief of many Drugs Education Co-ordinators, in the absence of anyone else in the Authority able to tackle the issue. At this stage there was no general PSHE Adviser or Advisory Teacher in the county. The additional responsibility, seen as a related issue, carried no promotion or additional resources, but was regarded by the County Inspectors as a matter of urgency and one which should be given a high priority.

The incorporation of AIDS and HIV issues into the brief of some Drugs Education Co-ordinators compounded the associated tensions and sensitivities. As well as drug-related issues, AIDS and HIV education raised questions of what could and should be taught in sex education, about sexuality and, in particular, homosexuality.

Since the DHSS memorandum in May 1974 (Section G), which stated, in response to rising teenage pregnancies and abortion, that it should not be considered an offence for a doctor to prescribe contraception for a teenager if s/he acted 'in good faith' and that confidentiality should be assured, there had been a massive mobilisation of 'pro-family' and moral lobbies in opposition to increased liberalism as regards teenage sexuality. This included sex education as much as contraceptive provision. Prior to the General Election in 1979, the Conservative Party had promised a review of sex education guidelines. After its election, the Government decided to maintain the possibility for doctors to prescribe contraceptives in exceptional cases. This enraged and disappointed the campaigners.

In Cambridgeshire, Victoria Gilllick attempted to extract a guarantee from her Area Health Authority that they would not provide contraception for any of her daughters under-sixteen and that she would be informed if they sought contraception. She was unsuccessful and turned instead to court action, which made her one of the leading moral campaigners since Mary Whitehouse's campaign to clean up television. Her claim that the Memorandum promoted law-breaking as regards the age of consent for sex was not supported in court in July 1983, but the Appeal Court, in late December 1984, decided in her favour. Kenneth Clarke took the matter to the House of Lords, where the decision of the Appeal Court was reversed. Although, Gillick lost the legal battle, her campaign, which was well-publicised in the national press continued and had a profound effect on the climate within which sex education occurred, particularly within Cambridgeshire and especially during the period of the court cases. It was in the wake of the Gillick campaign that issues of HIV education and related issues of sex education became part of my brief as Advisory Teacher.

The heated debate meant that it was necessary for Advisory Teachers to be involved increasingly in consultation, and often argument, with School Governors and parents. Whilst widening the brief of some Drugs Education Co-ordinators, the inclusion of HIV education, brought them and their work much more under parental scrutiny. Despite increased responsibilities, autonomy became significantly reduced.

In spite of an initial brief to cover drug-related issues, it became impossible not to also cover issues of sexuality in taking over responsibility for training in HIV education. Within Cambridgeshire, the Health and Education Authorities combined in early 1986 to provide basic AIDS awareness sessions for teachers, parents and governors in the hope that this would promote a tolerant and reasonable response to the problems posed for educators by AIDS. On a par with the attacks on sex educators as supplanting moral values with amorality, posing as rationality, we met similar opposition, notably from Emily Blatch (now a Life Peer and Minister of State for Education; then Leader of Cambridgeshire County Council and a school governor), who denounced the awareness sessions as "promoting the teaching of bestiality and sodomy to eleven year olds".

Despite the substantial difficulties of having policies on drugs, AIDS or sex education approved by parents and governors in several schools and the even greater difficulties of managing public meetings, it was generally the case that teaching staff were supportive of broad-based drugs and HIV education.

Although targeting school-children for AIDS education might be seen as odd in that they are not a major 'risk group', they do constitute a very easily accessible 'captive audience' for Health Education generally, and are a group about whom there is much concern - because of their current drug use and because adult drug use (particularly of tobacco) is thought to be influenced by earlier patterns (The Guardian, 8 May 1989, reporting the British Medical Association's comments on the launch of National No Smoking Day). Swadi (1988), from his survey of more than 3,000 pupils in six London comprehensives, suggests that more than 20% of school-children aged between 11 and 16 have used drugs or sniffed glue or other solvents; 1 in 12 claimed repeated use of drugs or solvents and the average age at which drugs or solvents were first used was found to be below 13.

The Census Office's study (OPCS, 1986) showed that 10% of 11 to 15 year olds in England and Wales smoked regularly. Among fifth form pupils, 30% of girls and 19% of boys were regular smokers. Both studies show a trend towards equalisation between sexes in smoking and drinking behaviour, where previously boys had higher rates in use of both substances.

It is argued that education on drug use and HIV at an early stage is a form of 'inoculation' against drug or HIV-related harm in the future. Additionally, they provided a focus for activity in a period when some sort of action was demanded. Despite the concern over the increasing rate of HIV infection amongst drug users, very little information about HIV and injecting drug use was available at that time, though injecting drug users were being considered the second largest 'risk group'. Two leaflets were in circulation - one produced by the Standing Conference on Drug Abuse and the other by the Scottish AIDS Monitor - and the Terrence Higgins Trust had one full-time worker funded to work in HTLV-III (as HIV was then known) Health Education in the intravenous drug use field (Nelles, 1986). Since then, a wide range of initiatives have developed (Jones, 1990), but at the time, there appeared to be little in progress or in the pipeline.

The commitment on the part of mainstream education to deal with these issues in a more personalised approach than the current mass media campaigns was important given the findings of the (then) Health Education Council in its review of 250 evaluation studies. Personal educational approaches have more effect than generalised strategies (Gatherer *et al*, 1980; Whitehead, 1989).

As well as being an ideal place to target school-attenders, schools are important because of the enlightenment model of education, as discussed in Chapter Two. Nevertheless, in reality, this approach created a range of problems. These included conflict with upholders

of traditional morality and between what were seen as good practices in the area and the more traditional approach being promoted in the National Curriculum and the educational reforms. Additionally, it entailed an over-simplification of classroom culture and the teaching-learning process.

The Cambridgeshire study

As a response to the situation in Cambridgeshire and by way of an evaluation of what was being achieved in this area, through the action of those involved in the drug education programme, I began a study of what young people in five Cambridgeshire schools thought and knew about drug use, HIV and AIDS. The study looks at attitudinal change in adolescents towards drug use and AIDS, as related and separate issues. It considers the appropriateness of particular interventions, their impact and the interplay of knowledge, attitudes and fear. The survey was constructed in terms of methodological and pedagogic thinking at that time, but within the context of this thesis, it is going to be related to another set of methodological and pedagogical issues (as previously outlined).

The study developed primarily as a form of evaluation and feedback of the drug and HIV education programmes developed after initial drug and HIV awareness training for school teachers. The initial survey questionnaire, adapted from two existing questionnaires (ISDD, 1976 and The Bridge Project (unpublished)), represents, in retrospect a very blunt instrument for measuring information, attitudes and responses to such complex issues as HIV and drug use. It is in reflecting on my role as Advisory Teacher, observations within the classroom, both formal and informal, and the responses to the questionnaires, that my ideas about methodology have developed.

Upon appointment, I developed a programme of in-service training utilising Howe and Wright's (1987) framework of theoretical approaches to drugs education, which was at that time being trialed prior to publication. Briefly summarised, their framework covers six models of drugs education (discussed in Chapter Four).

1. didactic approach
2. affective approach
3. behavioural approach
4. situational approach
5. cultural approach
6. casualty reduction approach

Initial In-service training and study design

Training and exploratory phase

This built on structures that were already in place within schools. Health Education and general Personal and Social Education had a growing profile within the county and were delivered in one format or a combination of formats. These comprised PSHE via

1] the Tutorial system - This method involves form tutors having regular contact with their tutorial groups with a view to providing some sort of social education. For some schools - a small minority - this involved a timetabled slot of up to one hour in the week. For others, PSHE competed with registration, uniform checks and class administration and discipline in the fifteen minutes between the first bell of the school day and the first taught period. In each case, the tutorial system was co-ordinated by a Deputy Head with responsibility for pastoral care or a Head of Year. In one school, within the county, Tutorial groups were vertically rather than horizontally allocated, *ie* they comprised school-children from eleven to sixteen years of age, rather than all of one year grouping. This school was not included in the Study sample. The tutorial curriculum, where it could be said to exist, largely revolved around the set of books 'Active Tutorial Work' (Baldwin and Wells, 1979) which cover the First Year of Secondary School to the Fifth Year. In addition, some schools were using the work of Lesley Button (Button, 1974) on developmental group work with adolescents. Since the Project, these have largely been replaced by the 'Skills for Adolescence' programme (Quest International, 1986) produced by TACADE and funded by The Lions Club in the UK.

2] Timetabled Personal, Social and Health Education lessons - At the time of this study, these were a rarity within secondary schools in Cambridgeshire, but it is from the schools that provided this form of PSHE that the Study sample was drawn. In these schools, PSHE was given a relatively high profile and a time allocation of between thirty and sixty minutes. In general, the subject was poorly resourced with subject teachers drawing on funds for other subject areas such as Biology and Religious Studies (the latter also generally with little finance). In most schools where this form of delivery existed, the programme was overseen by the pastoral Deputy, very few schools had PSHE co-ordinators and even fewer had co-ordinators paid to take the additional responsibility. As such, its success tended to depend very much on the enthusiasm, good-will and resourcefulness of key teachers (the teams involved in PSHE). In these schools materials tended to be much more selectively drawn from a range of resources, notably, in terms of drugs education, those published by TACADE and ISDD. AIDS education at this time was virtually without

published materials and teachers tended to use videos of television programmes, notably *First AIDS* Granada (22.2.87), and materials they had devised themselves.

3] Health Education within Biology - The focus here tended to be, understandably, scientific. Effects of certain drugs and viral transmission constituted the informational content and, in two schools only, this was supplemented by resources addressing broader social and personal issues (one using, *Free to Choose*, TACADE,1983 and the other *Chasing the Bandwagon*, Eye Films,1985).

4] Personal, Social and Health Education within Religious Studies. Focusing more on moral issues, voluntary support for drug users and debate as a teaching method and generally disregarding the multi-faith or multi-cultural issues around drug use and HIV or sex education, these schools were very much in the minority.

5] Personal, Social and Health Education as an integrated subject area. Here the rhetoric is that school-children learn what they need to know about personal and social development via their interaction with others within the school community. Emphasis is placed on the hidden curriculum and the co-ordination of the teaching of cross-curricular issues. In general, this means that only lip-service is paid to provision of Personal, Social and Health Education, though it cannot be doubted that pupils do pick up the implicit messages of school organisation and the pedagogic process.

The training and exploratory phase included:

a] *offering training* All the secondary schools in the county were offered training for one or two Personal, Social and Health Education teachers per school, usually including the PSHE co-ordinator, if there was one. Training of staff was conducted on the basis of voluntary in-service development. All of the study schools sent at least one representative to the LEA training sessions and two of the schools requested additional training - one on drugs, for the PSHE team, and the other on HIV, for the whole staff, including non-teaching staff. Those schools who had only one or two representatives on the training programme, organised their own 'cascade' in-service training. One of the schools, used for observation only, sent no members of staff to a training session.

The training sessions were a day long, in each case. They focused on attitude clarification, basic drugs or HIV awareness and consideration of the range of teaching materials and models available, some prior to formal publication (*eg* Howe and Wright, 1987). The

sessions were generally activity - based, though some information was also given in lecture format. Some attention was given to the prevalence of drug use within the area.

b] *observing current practice* A great deal of emphasis within the Local Education Authority was placed on 'good practice' and, early in my appointment, I was contacted by Heads of Schools who felt that I should observe Personal, Social and Health Education lessons within their classrooms as a guide to what constituted good practice. In general, what I observed was good control and the first hints of 'misrecognition', 'recontextualisation' and 'shielding' which I will discuss later in relation to my qualitative study. Basically, these concepts relate to the systematic misrecognition of pupils' existing skills by teachers who are out of touch with what their pupils know or by the operation of the 'pedagogic device' (Bernstein, 1990) which regulates the relationship between different discourses. In relation to sexual activity and drug use, it is often the case, that the pupils in the classroom have significantly more experience and knowledge than the teachers. Their skills are ignored or 'recontextualised' and considered to be evidence of their vulnerability, ignorance or 'at risk' status. In order to avoid a clash with authority and the moral judgements that their revelations might prompt, many pupils choose to shield their knowledge within the classroom context.

Whilst observing sound educational approaches and shadowing teachers with a view to sharing skills and giving constructive feedback, which fed into training and on-going developmental programmes with teams of teachers, I also observed some of the discontinuities between formal classroom and informal classroom culture. Some of these findings are developed in relation to drug-talk and classroom contexts.

c] *review of Health Education teaching materials and literature* Prior to providing in-service training, it was necessary to review the materials and models of Health Education that already existed. Much of this is summarised in Section One. Ultimately, however, within the teams of teachers with whom I worked and the New Resources working party which developed, the emphasis was on re-working existing materials to meet the needs of specific schools and adopting a flexible and more pupil-centred approach, with negotiated curricula rather than rigid adherence to a set programme. The current dominance of *Skills for Adolescents* within secondary PSHE has, to a significant extent, removed this possibility. It constitutes an extensive programme of lessons and the specific instruction not to deviate from the set format, which is seen as necessary and developmental.

d] *visits to local drugs agencies* Within the drugs awareness training sessions, some time was spent on prevalence of particular forms of drug use in the local area. Drug workers were

involved in the training, to give information from their own experience of working with drug users, particularly those of school age, and to provide a point of contact for referrals.

The education programme

After the initial training, teachers developed their own programmes for their pupils. Despite the openness and range of possibilities, most followed a fairly standard pattern which is summarised below.

Drug education

Teachers gave basic information about drugs using the *Facts and Feelings about Drugs, but Decisions about Situations* pack produced by the ISDD, which was also the basis for some of the situational exercises used. One or both of the videos, *Chasing the Bandwagon* (*op cit*) and *Scene: Cold Turkey* (BBC 1, 1983) were shown. In both of the videos, there is a narrative of decline and degeneration associated with drug use and of 'the evil pusher'.

Alcohol and tobacco were included in the substances discussed. The dangers of tobacco were emphasised in comparison with other substances to stress that, in terms of mortalities resulting directly from use, it is one of the more dangerous drugs. Alcohol did not receive the same comparative or negative treatment. Amphetamines were covered in considerably less detail than cannabis, heroin, alcohol and tobacco. The emphasis was on the risk of HIV transmission through injecting. In the Huntingdon and Cambridge areas known HIV infection in the drug-users was concentrated amongst amphetamine injectors.

One class adopted a behavioural approach to drug education in a 'warm-up' exercise, involving one pupil having to try to persuade another to take an imaginary substance. The second pupil had to refuse in as many different ways as possible. Attitude questionnaires were used as a stimulus for discussion and the situations themselves, from or similar to those in *Facts and Feelings about Drugs but Decisions about Situations* (ISDD, 1985a) raised ethical and moral issues which contributed to the 'attitude clarification' aim of the affective drug education. Within the behavioural exercise and in discussing the attitude questionnaire, 'myths' related to drug use were discussed, such as 'drug takers have more friends', 'parties are more fun with drugs' and "drugs help you to do things better'.

Far more time was spent on attitude clarification, situational exercises and discussion of the videos than in information-giving, with a resultant emphasis on the personal aspects of drug use rather than the effects of particular substances and the methods of use.

AIDS education

A considerable amount of time was spent on giving information about routes of HIV transmission. This was reinforced in exercises such as quizzes or the continuum exercise where pupils place cards summarising risk behaviours on a line from no risk to high risk. The videos *First AIDS* and *AIDS* (Leicestershire Health Authority, 1985) were used as supporting materials. The dominant recurrent message was that condoms should be used during sex and the focus was on heterosexual sexual intercourse. Drug use was mentioned, but was not so central to the lessons as the possibilities of sexual transmission.

Attitude questionnaires were used to prompt discussion and scenarios were constructed with questions to consider mainly in relation to situations involving prejudice and discrimination. Pupils were sensitised to the problems of over-generalising assumptions of HIV infection within 'risk groups'.

Pupils were told about the local agencies which can provide support, advice and testing. Reference was made to the time taken for antibodies to be produced and the possibilities of early false-negative results, but issues related to testing such as ethical issues and the practicalities of mass screening were not covered. Teachers mentioned the reduced risk from blood products and the infection of haemophiliacs before awareness of HIV prompted screening and treatment of blood, but little time was spent on this.

There was some stilted role-play of how potential sexual partners could negotiate condom-use in one class and the issue of safer sex arose in relation to some of the scenarios under discussion.

Design phase

a] *design of the questionnaire* The main method of data collection was a questionnaire of 99 items, including a gender classification and demographic information, which produced variables related to attitudes to drugs, drug users, AIDS, people with AIDS and people with HIV; information on certain drugs and their effects and on AIDS and HIV; attitudes to sources of information and to advice on preventing the spread of HIV, as well as present smoking and drinking patterns (smoking in relation to self and friends and drinking in relation to friends only).

The questionnaire was based on one used by a local drugs agency in local sixth form and Further Education colleges. This in turn was developed from an Institute for the Study of Drug Dependence questionnaire (ISDD, 1976). The rationale being that this would afford a comparison. However, the links with the sixth form and Further Education College did not continue and there was, as a result, no data from this source to compare. However, the John Balding 'Health Related Behaviour Questionnaire - Cambridgshire Results, 1990' Survey provided an alternative comparison.

Some alterations were made to the original questionnaires in terms of layout of the demographic section which was drawn from the Heartbeat Wales children's questionnaire (1985) and the questions on knowledge of drugs. Students were asked about heroin, cannabis and amphetamines, as these were the most popular illegal substances in the region, according to drug agency information.

Additional attitudinal items, particularly in relation to HIV and AIDS were designed specifically for the study. These were based on current myths, anxieties and opinions expressed by students at the school from which the pilot sample was drawn. The final questionnaire is included as Appendix One.

As causal links between specific educational processes and learning was not my primary aim, issues of validity associated with causality are not relevant here. However, questions of validity are relevant in relation to sampling, method of data collection and the internal and external validity of the analysis. Although the schools represented do not constitute a random sample, there appears to be no reason to consider them untypical of Cambridgeshire schools. Comparisons can be made of the socio-demographic data with statistics from other studies to provide a rough indication of representativeness. Some interchange of students within each school occurred due to absence and so the populations for the first and second questionnaires were not absolutely identical.

The design of the questionnaire and its administration also raise issues of validity and reliability. A major issue is content validity, *ie* the extent to which the items chosen are indicators of the domain measured. There are two related issues here - are the items representative of the field of drug and HIV attitude and knowledge, and, secondly, do the ratings achieved from the questionnaire reflect the knowledge and attitudes they represent? As the questionnaire mostly replicates previous studies apart from the items related to attitudes to HIV and AIDS, which are based on the format of the drugs questions and content derived from discussions with students in the pilot school, the content validity

appears relatively sound. However, no claims are made as to the predictive validity of the measures in terms of future attitudes, knowledge or behaviour.

The derivation of the basic questionnaire from previous studies, the detailed instructions given to teachers in the initial interview in relation to administration and the pilot study were intended to ensure reliability.

b] *choice of sample schools* Study schools were chosen from those schools which provided a sound PSHE programme, *ie* had regular timetabled slots, a formally organised programme of content and a team approach to methodology. In addition, they were schools where at least one teacher had attended the awareness courses and where at least one teacher was involved in the Policy and New Resources Working Parties. This was necessary since the research exercise was linked to the need to evaluate the training and education programmes. The Control school, in contrast, was one which had no formal PSHE programme at all and where no teachers had been involved in any of the in-service training. One Study School also provided its own internal Control Group, as not all of the pupils received drugs and AIDS education at the same time. The population of the survey is school children in Cambridgeshire and the sample consists of single year groups, between the ages of 13 and 15. Initially, six schools were included in the study, however, one school withdrew as they felt the issues to be too sensitive. In three of the remaining schools, students were taught both drugs and AIDS education; in one school a minority of students did not receive drugs and AIDS education during the survey period (the small control group, referred to above) and in the fifth school, students were given no formal education on drugs and HIV. This last school, therefore, provides the major control sample.

In each case, representation was made to the Head and parents were informed that the survey was to take place. All parents were requested by letter with a 'tear-off slip' to indicate their willingness, or otherwise for their children to take part. Those students without written consent were to be excluded from the study and the students themselves were given the option of participating or not. In the event, all the students in the year groups concerned who were in school on the day of the survey actually took part. Absentees from school on the day of administering both questionnaires were not felt by PSHE co-ordinators to be unrepresentative of the school population more generally - *ie* it was not thought that the study population was invalidated by exclusion of those who were not in school on the day.

The students selected within each school were those who would normally receive PSHE. In general, this was Fourth Year students, though in one school the year group was the Third Year. In the control school, the sample group was the Fourth Year.

Interviews prior to Questionnaire design

I conducted interviews of forty minutes duration with two groups of six pupils from a rural Cambridgeshire school at which I had taught prior to my secondment as Advisory Teacher. All of the pupils were familiar to me, having been in classes I had taught. The purpose of the interviews was to seek advice on the sorts of issues that should be covered in relation to HIV transmission and the sort of information that could be sought from pupils.

HIV transmission

The main concern of the pupils in the interview groups was the possibility of being infected with HIV and the measures that could be taken to prevent this.

eg

P: I think it is something we'd want to talk about - well write about or answer questions on, because it *is* spreading and we need to know how to avoid it.

and

P: You need to know what to do and what to not do.

They made various suggestions as to how HIV transmission could be limited, some of them far more extreme than responses to the actual questionnaire revealed in the survey.

I: Do you think there is anything that can be done to stop more and more people getting AIDS?

P1: Yes.

P2: Yes, I do. I think it's up to the government to do something.

I: What could the government do?

P2: For a start find out who has got AIDS.

P1: Test everybody.

I: Everybody?

P1: Yes, I think everyone should be tested and then those that have AIDS or the virus should have to carry cards to say so.

P3: Or everyone should have to have a card to say if you have it or not.

I: How would that help?

P4: You could keep everyone seperate who has AIDS.

P2: No. You'd know if you were going to go to bed with someone that they had the AIDS virus.

and

I: How do you think you might protect yourselves from ever getting AIDS?

P8: Keep away from anyone who might have AIDS.

P9: Not have sex with anyone who has AIDS or anyone you don't know.

P8: Anyone you don't know? (laughs)

P9: I mean anyone you don't know really well and you know that.

The effects of having 'the AIDS virus'

I talked to pupils about what it might be like to have the virus. They raised issues of stigma and the inevitability of death, after very unpleasant illness. Pupils were not particularly explicit about the form of the illness, but they felt that it was 'awful'. There was some suggestion that some of the people who had AIDS deserved it and a sense that those who acquired HIV now were more to blame than those who contracted it before 'everyone knew about AIDS'.

eg

P5: I think it's awful, really awful. You get sores and I think blind. Everything about the illness is really bad; worse than cancer.

and

P7: Most people die. I think they all die. Some die pretty quickly. Really there's nothing can be done for you.

There was an awareness that the people who had AIDS at the time in the UK were mainly gay men and that there was a lot of prejudice against them.

P2: It's mainly gays (laughs), homosexuals. Nobody likes them. Less now that they have AIDS, too.

and

P7: I feel sorry for them, even those who brought it on themselves.

I: Who do you think brought it on themselves?

P7: (very quietly) Well, I think the gays, really.

P8: I think all those people who got it when they knew it was around. Once everyone knew about AIDS, really those who still got it are to blame themselves.

Pupils were ambivalent about whether or not you could tell if someone has HIV. Familiarity with a person, they suggested would give you a greater possibility of knowledge and there seems to be a clear indication that it is 'other' people who might be a risk in terms of transmission.

P2: Maybe. I think you'd know. I think there would be something about them. If you knew them, you would know and if you didn't then you'd know there was a chance.

and

P6: No. That's what they say. You never can tell.

P5: Sure, they say you can't tell, but I think you might know.

Items were included in the HIV attitude scale to reflect the areas of concern and the sorts of remarks that pupils made in these preliminary interviews.

Questions relating to own drug use

Those pupils interviewed felt that it was acceptable to ask questions about smoking and that responses would be genuine. However, they considered that respondents might not be honest in answering questions about alcohol use.

P: They [school teachers and the Head] clamp down on us hard about drinking. If you're in The White Swan and one comes in they give you a hard time about it. On the sponsored walk there was a lot of trouble about drinking. I think maybe a few people would lie. Others would say they drank more than they do to be big.

Teachers involved in the survey also expressed reluctance to have questions about alcohol included.

T: It's asking them about an illegal activity and parents might complain.

Although not strictly true as regards the law, it was felt diplomatice to exclude any questions about pupils own drinking habits, particularly if they were unlikely to yield honest responses. Heads would not give permission for questions about actual use of illegal substances to be included.

T: He [The Head] says parents would object. I think it's more likely that he's scared there'll be a lot of drug use or kids will say they use drugs when they don't and that word will get out - *then* parents would complain!

Pupils were similarly negative about questions about illegal drug use

> P: Oh no. You couldn't ask that. They say they wouldn't check who it was, but could you imagine if you said you injected heroin... They'd know; they'd find out. Well you wouldn't risk it.
>
> and
>
> P: I wouldn't say if I used anything, though I don't.
>
> and
>
> P: Those who do wouldn't say. Those who don't might say they did.

The Pilot Study

In December 1985, the questionnaire was piloted on the same group of twelve Fourth Year pupils. Pupils' comments on the format of the questionnaire and related issues were recorded and the questionnaire was modified as a result. The only change that was necessary from the original questionnaire was the section on the dangers of amphetamines, cannabis and heroin. Initially, pupils were asked to rate how dangerous amphetamines, cannabis and heroin were and to say how they were taken, then to comment on the ways in which each substance in turn is dangerous. Pupils said that this was confusing and suggested that all the questions related to each substance should go together. In the final questionnaire this revised format was adopted.

Main Study

a] *interviews with PSE co-ordinators in schools re administering of questionnaires,observation and interviews* Each school had slightly dqifferent requirements for the administering of the questionnaires, depending on other organisational factors. In one school, all the questionnaires were administered to the year group in the main Hall, in the other schools, the pupils completed the questionnaires as class groups in their own tutorial rooms. Detailed instructions on administering the questionnaire were given, in order to assure reliability.

b] *administration of first questionnaire prior to education programme* This questionnaire was administered just before the start of the education programme - not more than one week previously.

c] *observation of education programme* (limited by time under the constraints of the post) Qualitative data was also collected from observation and interviews (via tape recordings and field notes) within these schools and two others within the county for which I was Advisory Teacher. The sampling for this was opportunistic rather than systematic, because of the practical difficulties of combining the research project with other requirements of my work.

d] *administration of second questionnaire* The questionnaire was administered approximately eight weeks after an educational programme. It was also given to two smaller control groups, with the same time lag.

e] *analysis of results* The data collected was analysed using the programme 'Statistical Packages for the Social Sciences' (SPSS). Tables of results are fully presented in Appendix Two (Tables 2.5.1 - 2.10.221) and discussed in subsequent chapters of Section Two. The following analyses were carried out:

i) simple frequency distributions and crosstabulations were calculated

ii) Control and Study group responses both on the first and second questionnaires were compared using chi-square analysis (Tables 2.5.1 and 2.5.2)

iii) responses within the groups, before and after the educational programme, were analysed using the Wilcoxon non-parametric test for matched pairs (Tables 2.5.3 and 2.5.4)

iv) collections of linked items were factor analysed and Cronbach's alpha was calculated for each series to determine whether they constituted a reliable scale

v) t-tests for differences in scores between significant groups were calculated to determine if control and study populations, before and after samples, different gender and different class groups responded differently to particular sections of the questionnaire

vi) t-tests were used to analyse differences in responses to attitudinal items to assess amongst those who tended to trust formal rather than informal sources of information

vii) t-tests were also used to analyse differences in responses given by those who reported smoking regularly or belonging to peer groups who smoked or consumed alcohol regularly

Responses to the questionnaire items were compared with and contextualised by interview and observation data, analysed qualitatively. After preliminary analysis of the quantitative data, small group interviews were arranged to supplement the findings and also to follow up particular issues raised by the questionnaire analysis - in particular, the increase in knowledge of amphetamine use in the Control Group in the school which had both a Study and Control Group.

The survey was initially intended to follow the traditional line of a 'before and after' study, evaluating the effects of an educational programme. A major aim of this thesis is to explore the limitations of this conceptualisation. The effects of education cannot be separated from the many other factors that were involved in the period between the administration of the two questionnaires. Additionally, the approach entails more general methodological and theoretical problems, discussed above and explored below in relation to the results of the survey.

Summary

This study investigated young people's attitudes to drugs, drug users, AIDS, people with AIDS and people with HIV; information on certain drugs and their effects, and on AIDS and HIV; attitudes to sources of information and to advice on preventing the spread of HIV, as well as current smoking and drinking patterns. Data were collected both before and after a programme of education, or, in the case of the Control group, at an equivalent time interval. Demographic information was also included. The method of data collection was primarily by questionnaire, although some more qualitative material was also acquired by opportunistic sampling. The quantitative data was analysed statistically and efforts were made to establish reliability and validity. Consideration was then given to the appropriateness and impact of the programmes, particularly as regards what students knew or thought before they received any teaching and the relationship between their existing knowledge and their new learning. Although not a representative sample, it is not thought that either study or control groups were in any way untypical of the population.

CHAPTER SIX

BACKGROUND INFORMATION ABOUT PUPILS

In this chapter, socio-demographic data are presented, pupils self-reported smoking behaviour, responses to the questions on peer smoking and alcohol drinking behaviour and sources of information on drugs and HIV/AIDS. Pupils giving different categories of response in this chapter are later compared in terms of their 'factor scores' (their scores on particular factors emerging from factor analysis of the attitude frames).

Socio-demographic information

Five schools were included in the survey, all on the outskirts of Cambridge and all Village Colleges, *ie* schools which serve small semi-rural communities and offer adult education as well as secondary schooling. Three of the schools provided drugs and HIV/AIDS education to all of the relevant year group and so were Study Schools only; one had a smaller Control group within the school which did not receive education on drug use and HIV/AIDS at the same time as the Study Group in that school and the fifth school was a Control School only, for purposes of comparison. The number of pupils in each school included in the survey and the gender division is summarised below.

Table 3 : Number and gender of pupils in survey by school, time and group

SCHOOL	TIME	CONTROL OR STUDY	NUMBER OF PUPILS	GIRLS	BOYS
A	1	Study	70	46	24
	1	Control	68	40	28
	2	Study	47	15	32
	2	Control	67	40	27
B	1	Study	64	30	34
	2	Study	59	25	34
C	1	Study	129	66	63
	2	Study	130	67	63
D	1	Study	238	99	139
	2	Study	226	101	125
E	1	Control	47	20	27
	2	Control	56	28	28
	1 (Total)		**616**	**337**	**279**
	2 (Total)		**585**	**276**	**309**

Socio-demographic data collected from the sample allows a rough assessment of its representativeness by comparison with known statistics for the population more broadly. The table below compares the sample to the OPCS Fertility Study (Davies *et al*, 1982), the Longitudinal Study conducted by the National Children's Bureau (NCB) (Fogelman, 1976) and the Parenthood Education Project (Prendergast and Prout, 1986) which drew its sample from those about to take parenthood classes (therefore students at the end of Year Three and beginning of Year Four, aged around fourteen years) in three Cambridgeshire schools and one London school.

Table 4 : Paternal social class comparison of sample and with other studies

REGISTRAR-GENERAL SOCIO-ECONOMIC CLASSES	THIS STUDY'S SAMPLE	OPCS FERTILITY STUDY - FATHERS OF BABIES BORN IN 1970	NCB - PATERNAL SOCIAL CLASS OF 1958 COHORT	PARENTHOOD EDUCATION STUDY (1983)
I and II	35%	21%	24%	24%
III non-manual	15%	10%	10%	20%
III skilled manual	26%	43%	43%	27%
IV and V	24%	21%	19%	27%

There are few statistics available on equivalent populations (pupils in Years Three and Four about to have drugs and HIV education in state secondary schools in 1986/7). The assessment of the representativeness of the sample can, therefore, only be a rough guide. On the basis of the statistics available, social classes I and II are over-represented, those with III non-manual fathers are over-represented in relation to the two more general surveys and under-represented in relation to the smaller, but more equivalent study (Parenthood Education Study, 1983). Skilled manual workers are under-represented, as in the Parenthood Education Study. There was no significant difference between the control and study groups.

Gender

Three hundred and thirty seven boys and two hundred and seventy-nine girls responded to the first questionnaire and three hundred and nine boys and two hundred and seventy six girls responded to the second one. There was no significant difference between the proportion of boys and girls in the control group and the study group, nor for the two administrations of the questionnaire.

Age

At the time of completion of the questionnaires, the ages of the respondents were as follows:

Table 5 : Age of respondents at time of first and second questionnaire

	13	14	15	Total
First	88 (14.3%)	378 (61.4%)	150 (24.4%)	616 (100%)
Second	27 (4.6%)	316 (54%)	242 (41.4%)	585 (100%)

Responses to the question asking **'What kind of place do you live in?'** which provided boxes to be ticked relating to the five categories below, suggest that the largest proportion of pupils lived in villages and that Cambridge is variously categorised as a city or a town. There was no significant difference between the proportions in each category in the control and study groups.

Table 6 : Responses to question 'What kind of place do you live in?'

	City or large town	Town	Village	Country-side	Don't know	Total
First	3 (0.5%)	37 (1.1%)	543 (88.1%)	18 (2.9%)	15 (2.4%)	616 (100%)
Second	2 (0.3%)	39 (6.7%)	525 (89.7%)	18 (3.1%)	1 (0.2%)	585 (100%)

Smoking behaviour

Research on young people's cigarette smoking and alcohol use around the time of this study (Bewley *et al*, 1980; OPCS, 1985; OPCS, 1986) suggests that between 20% and 25% of secondary school children smoked cigarettes, that most had consumed alcohol by the age of thirteen (rising to 90% by the age of seventeen) and that gender differences in smoking and drinking alcohol were diminishing.

Swadi (1988) in a study of drug and substance use amongst 3,333 London comprehensive school pupils suggested that 60% of 13 year olds, 69% of 14 year olds and 76% of 15 year olds had consumed alcohol and 11.6% of their total sample had drunk alcohol once or more a week. Amongst 13 year olds, 16% were currently smoking cigarettes, compared to 26% of 14 year olds and 27% of 15 year olds. The overall percentage of smokers (18%) was similar to the 22% in a similar age range revealed by the OPCS, 1985 survey. Swadi also demonstrated that significantly more girls than boys were daily and occasional smokers. As overall smoking rates have not changed, it appears that though the number of girls smoking had increased, the percentages of boys smoking had decreased. No significant sex differences were observed in patterns of alcohol consumption.

Students were asked about their own smoking behaviour and asked to categorise their smoking in one of six categories from 'never tried' to smoking more than twenty a week (full results are given in Tables 2.6.1 and 2.6.2). Head teachers and PSHE co-ordinators ruled out the possibility of asking pupils about illegal drug use, but allowed the inclusion of items relating to tobacco and alcohol use in peer groups . Given the trend towards an equalisation of smoking behaviour between boys and girls (linked to an increase in girls smoking and a decrease in boys smoking) as discussed above, it seemed relevant to the focus of this study to establish whether similar patterns existed within the survey population. The data was analysed to see whether there would be differences between socio-economic groups in self-reported cigarette smoking behaviour .

There were no significant differences between the study and control groups at the time of either questionnaire. Between 38 and 43% had never tried smoking, 35-38% had tried once or twice, 11-13% smoked occasionally, 2-4% smoked less than ten a week, 3% more than ten and 4-8% more than twenty. Chi-square analysis revealed that those in social groups I, II and III (non-manual) according to the Registrar General's classification were more likely to be non-smokers or occasional smokers than those in social groups III manual, IV and V, who were more likely to be regular smokers (First Questionnaire chi-square = 12.68; DF 1; $p < 0.001$; Second Questionnaire chi-square = 5.85; DF 1; $p < 0.05$). No gender differences emerged in terms of self-reported smoking and friends' smoking.

The data gathered in this section of the questionnaire can be compared with that from John Balding's 'The Health Related Behaviour Questionnaire - Cambridge Results 1990" (Balding, 1991) which is the only large scale survey of behaviour and attitudes in that geographical area, during a similar period. Balding's results show that in Year Three 56.4% of girls and 59.4% of boys had never started smoking and in Year Four, 43.4% of girls and 45% of boys had never smoked. This suggests that rather fewer of my survey

population had not smoked cigarettes than Balding's study (investigating responses of 576 Third Year boys, 557 Third Year girls, 1475 Fourth Year boys and 1286 Fourth Year girls). Those who said that they had smoked 'once or twice' constituted a larger proportion on the Balding Questionnaire than within this Study (Year Three: 25% of the girls; 23.5% of the boys; Year Four: 25.8% of the girls and 21.9% of the boys). The overall percentage of those who had never smoked or who smoked very rarely is, therefore, similar in both samples.

Table 2.6.3 shows percentages reporting different levels of smoking in the last week, as indicated in Balding's results. A comparison with my own data, suggests that fewer of this study's sample fell into the 1-10 bracket (between 2 and 4%); around 3% smoked 11-20 cigarettes in the week (a similar proportion to the combined 11-15 and 16-25 categories on the Balding questionnaire) and a similar percentage (4-8% on my questionnaire) smoked more than twenty cigarettes. This suggests a not dissimilar set of results.

Friends' cigarette smoking and drinking of alcohol

Students were also asked about the smoking habits of their friends (see Tables 2.6.4 and 2.6.5), because of the popular assumptions about peer group influence and to establish whether boys and girls have diferent reference groups in this respect. The data was again analysed to establish any differences between socio-economic groupings.

There were no significant differences between groups on the two occasions. Chi-square analysis revealed that those in social groups I, II and III (non-manual) according to the Registrar General's classification were more likely to have non-smoking friends than those in social groups III manual, IV and V (First Questionnaire chi-square =13.4; DF 1; $p < 0.001$; Second Questionnaire chi-square = 8.69; DF 1; $p < 0.05$). No gender differences emerged in response to this question.

After discussion with the pilot group and the Head Teachers, it was decided that a question about own alcohol consumption should not be included in the questionnaire. Heads were concerned that pupils should not be asked about illegal activities and students felt that responses, within the school context, might not be honest. I therefore asked *'How many of your friends drink alcohol?'* (Frequencies of responses and percentages are given in Tables 2.6.6 and 2.6.7).

No significant difference emerged between groups. Between 10 and 18% reported that all their friends drank alcohol, 23-30% said most and 18-26% more than half; 25-34% said not many and 3-13% none at all. Both the Study and Control Groups exhibited a general

increase in friends' reported drinking over the time between the two questionnaires. No statistically significant differences were evident between socio-economic groups in response to this question. At the time of the first questionnaire more boys than girls reported that half or more of their friends drank alcohol (chi-square = 4.7; 1 D.F. $p < 0.05$). There was no significant difference in girls' and boys' responses on the second questionnaire.

Balding's results allow a more detailed analysis of drinking behaviour, four years later, and the relevant results are summarised in Tables 2.6.8 and 2.6.9. These figures suggest that around half of the respondents had drunk some alcohol in the last seven days and between 7.7 and 14% of the Third Year and between 14 and 22.5% of the Fourth Year reported drinking more than one unit of alcohol a day on average.

If occasional smokers were included with regular smokers, between 21 and 24% of this study's sample smoked - a very similar figure to that of the Swadi study. Balding's questionnaire suggests lower levels of smoking than this study. At fourteen, 7.9% of boys and 10.4% of girls were smoking between one and ten cigarettes a week, 1.1% of boys and girls smoked eleven to fifteen cigarettes a week and 1.7% of boys and girls smoked between twenty-six and thirty-five. These figures compare with 13-16% at the lowest level, 3% (11-20 cigarettes a week) and between 4 and 7% smoking more than twenty cigarettes a week. Concurring with Swadi' figures on young people drinking, the present study suggests that between 32 and 45% of the sample population had friendship groups in which all or most of the members drink. This increased to between 57 and 64% if pupils were included who report that half of their friends drank alcohol.

In Balding's survey 53% of the third year and 39.6% of the fourth year reported having drunk alcohol in the week prior to completing the questionnaire. Although this reverses the trend for increased alcohol consumption with age, it further substantiates the prevalence of alcohol consumption amongst the young.

Sources of information

Pupils were asked to indicate on a list of ten sources who they would trust for information about drugs and HIV/AIDS, and could indicate any number of these sources. These are summarised in terms of frequencies and percentages for Study and Control groups, as indicated on both sets of questionnaires in Tables 2.6.10 - 2.6.15 and Tables 2.6.18 - 2.6.23. It was felt important to establish who pupils trusted because of the implications of this for health education and to test out the extent of peer group influence and the importance of formal and informal information networks. They were, therefore, also asked to suggest

other people they would trust as sources of information on drugs and HIV. Responses to these questions are summarised in Tables 2.6.16, 2.6.17, 2.6.24, and 22.6.25.

a] ABOUT DRUGS

Whose word would you trust about drugs?

Within both the Study and Control groups, on both questionnaires, Doctors constituted the group which most pupils indicated as a source to be trusted with regard to information about drugs. They were also the group trusted most by all groups, but the Study group at the time of the first questionnaire, who ranked them second to parents. Parents rated second highest in frequency of response as a source to be trusted on all questionnaires and second highest in the ordering of those most trusted, apart from as just indicated. Teachers, police and ex-addicts were also very frequently mentioned as a source to be trusted, with ex-addicts and siblings being rated as more trustworthy when the groups were ranked. This suggests that where siblings are trusted (or where there were siblings) the trust is high.

Current drug users were regarded as the least trustworthy source of information about drugs, with friends second and older boys and girls third least trustworthy (except in the Control Group at the time of the second questionnaire, when these two positions were reversed). It is interesting to note that, although peer influence is often stressed as a reason for young people undertaking many risky activities, including drug use, they constituted a group for whom, at least here, there is low trust. This raises questions about peer-group influence. Are peers very influential despite low trust? If so, what are the implications for the relationship between values, attitudes, beliefs and behaviour? Is the low rating of peers on this question an artefact of the context? In Section Three I will highlight the importance of peers as expressed in a less formal context.

When asked *'Who else would you trust?'*, the government, nurses, other relatives, scientists and drug workers were mentioned. Of these, other relatives were most often listed.

Balding (*op cit*), in his survey , asked about sources of information on drugs. The figures presented in Table 2.6.26 are based on combined Year Three and Year Four responses as these are the most directly comparable to my own survey population. Increases in percentages occurred between Year Three and Year Four, including in the 'No information from any source' category. Whilst it might be expected that school-children would acquire more information about drug use as they got older, it is difficult to explain why the number claiming to have received no information should also have increased, particularly as the

year 1988-1989 was not unusual in terms of health campaigns - several anti-drug campaigns pre-dated this.

From Balding's study, parents and teachers appear to be the most common source of information, followed by the media and then friends. Given the low percentage of use of substances, it is, however, still possible that those who used substances within the peer group were receiving information from that group. Information on hallucinogens, which had a less obvious public profile than, for example, heroin and cannabis, came as much from friends and the media as from parents, though teachers still provided information to a substantial proportion. Pupils clearly felt that they received a significant amount of information from the media, perhaps suggesting that formal campaigns are not without benefit; though, more pupils were acquiring information from direct contact with informed others. The figures here do not give any indication of accuracy of information. It also seems to be the case that pupils received more information about drugs such as cocaine and heroin than the hallucinogens, despite offers and use of hallucinogens, particularly synthetic, being higher. Health Education not only targeting specific populations, but also relating to appropriate substances is required.

b] ABOUT HIV

Whose word would you trust about HIV?

Pupils were given a similar list of sources of information to that provided in relation to drugs. The categories 'People who take drugs and ex-addicts were removed and replaced by 'People with AIDS/HIV'.

Tables 2.6.18 - 2.6.21 indicate that, as with information on drugs, the most trusted source was Doctors and this was also the group most often indicated as a trustworthy source. Parents were second on each of those scales. Teachers and people with AIDS also ranked highly, with teachers cited more frequently as a source, but people with AIDS considered more trustworthy. Again, older boys and girls rated lowest on the list of sources both in terms of times cited and amount of trust.

When asked *'Who would you trust least?'*, in general, friends were the group said to be least trusted for AIDS information, with older boys and girls second. People with AIDS were listed next, suggesting (in comparison with the data on those trusted most) a split between those who invest a lot of trust in people with AIDS or HIV and those who lack trust in them.

Pupils were asked *'Who else would you trust?'*. Similar groups emerged as additional sources of information to those mentioned as sources of drug information, though nurses do not recur, drug workers are replaced by social workers and the category 'Someone who knows someone with the virus' is added.

Balding (*op cit*) suggests that the main source of information about sex for third and fourth year pupils was friends (apart from third year girls who gained more information from parents). Parents were the second greatest source of information, apart from for third year girls, where friends came second. Teachers and books or television programmes ranked next (see Table 2.6.27 for a summary of the relevant information from Balding's study). It is interesting to note that although in Balding's survey friends were most often cited as the main source of information about sex, they were one of the groups considered least to be trusted according to this study.

When asked what the main source of information about sex should be, Balding's respondents mostly suggested parents (51 - 74%). Teachers were regarded as the second main source (9.6 to 26.3%) and friends came third (6.4 to 8.3%). Girls rated parents more highly than boys did as a source of information and boys rated teachers much more highly than did the girls. It appears that young people feel that their information should come from adult and formal sources rather than their friends, siblings and the media.

Within the Health Related Behaviour Questionnaire, pupils were also asked whether they had discussed AIDS with their parents, teachers, friends, siblings, close relations or doctor and whether they had learned any facts about AIDS from TV adverts, TV programmes, newspapers, posters, leaflets, school videos or school lessons. More than half of the sample (Year Three and Four) had not discussed AIDS with their parents or had only once or twice. The same was the case for discussing AIDS with teachers and around half responded in these two categories in relation to friends. Respondents were even less likely to discuss AIDS with siblings than teachers and parents and still more so with other relatives. More than 90% had never discussed AIDS with their doctor. When asked whether they had learned facts about AIDS from TV adverts, more than 90% said they had, more than 80% had learned facts from TV programmes and 50-60% from newspapers. Posters were a source of information for more than 70% of the pupils and leaflets for more than 80%. In Year Three, about 40% had learned about AIDS from school videos and lessons and in Year Four this increased to 60-65%. More Year Four students felt they had learned about AIDS from school lessons than said they had discussed AIDS with a teacher.

It appeared that TV adverts were the major source of information for the majority of the respondents, with TV programmes and leaflets second. More pupils suggested that they gained information from posters than lessons.

Summary

Socio-demographic information

No significant difference emerged in socio-economic groupings between the Study and Control Groups, though, by reference to comparable studies, it could be argued that skilled manual workers were under-represented in the survey population generally.

The proportion of boys and girls was relatively equal in both the Study and Control groups on both questionnaires.

The Study and Control samples lived in broadly similar areas; the majority in villages around Cambridge.

Smoking behaviour

Smoking - self-report : the Study Group and Control Group demonstrated no significant difference in smoking behaviour. There was a lower incidence of smoking in higher socio-economic groupings (I, II, III,non-manual) than in the lower groupings (III, Manual, IV, V) and no significant difference between boys and girls in response to this question.

Friends' cigarette smoking and drinking of alcohol

Friends smoking : the Study and Control Groups responded similarly to this question. No gender difference emerges and those in higher socio-economic groupings were more likely to report having non-smoking friends than those in lower socio-economic groupings.

Friends drinking alcohol : no significant differences emerged between the Study and Control groups, though both groups demonstrated a significant increase in friends' drinking alcohol on the second questionnaire. No differences were apparent in responses from different socio-economic groups. On the first questionnaire (but not on the second) boys were significantly more likely than girls to report having friends amongst whom half or more drank alcohol.

The data supported the general trend for about 25% of young people in this age group to be smoking cigarettes and more than 50% to belong to peer groups that consume alcohol. Gender differences in smoking appeared to be decreasing and there was little evidence that drinking behaviour was significantly different either . By the age of 17, 90% of teenagers had consumed alcohol (OPCS, 1986).

Sources of information about drugs

There was most trust for formal sources of information, notably doctors, parents, police and teachers.

Peers were rated low on trust and this has implications for our understanding of peer group influence and the relationship between beliefs, pressures, values and behaviour.

Current drug users rated lowest of all as a source of information about drugs, whereas ex-addicts were regarded as trustworthy. This distinction suggests the existence of a 'narrative' of drug use, (which is also apparent in responses to the attitude statements). The implicit line of development is that, along with a reformation in terms of drug use, goes a reformation of moral character - once s/he has ceased to use drugs, the ex-addict becomes a reliable individual. The slippery slope to drug addiction has a corresponding social as well as physical dimension, but, once the addiction has been dealt with negative social consequences are also removed.

Sources of information about HIV

As with information on drug use, more formal sources were given highest trust, particularly, doctors, teachers and parents.

People with AIDS, though less frequently cited as a source of information, perhaps because of limited contact pupils were aware of having with this group, were still regarded as trustworthy. This perhaps reflected the influence of Health Education campaigns and documentaries featuring HIV-positive individuals telling their stories and warning of the dangers of transmission.

Friends and older boys and girls were again rated lowest in terms of trust on this issue. This restates the problems mentioned earlier, in relation to drug use, of making straightforward assumptions about peer group influence. At least within this context, peers were not rated highly in terms of trusting them as sources of information.

CHAPTER SEVEN

KNOWLEDGE OF ILLEGAL DRUGS AND HIV TRANSMISSION

Local drugs agencies suggested that the illegal substances most often used at the time of the survey by young people around the age of the respondents, were amphetamines and cannabis. Questions relating to these substances along the lines of the Bridge Project Questionnaire, were included in the study and questions relating to Heroin were also asked, as this was the substance receiving most media attention at the time. Questions covered the methods of use and the potential harm attached to using these three drugs. The section began, as follows:

You are now going to be asked about three kinds of drugs. If you do not know the answer, just say so - please don't just guess.

Results are given in full in Tables 2.7.1 - 2.7.13.

Amphetamines

Initially, the responses from the two groups to the question of how dangerous amphetamines are did not differ significantly. Between 60 and 67% did not know. The remaining responses were spread across the other categories, with those in the Study Group mainly opting for 'very dangerous' and those in the Control Group for 'quite dangerous'. However, by the time of the second questionnaire the Control Group and Study Group responses were significantly different (chi-square = 14.57; DF = 4; $P < 0.01$). Although initially more than half of each group indicated that they did not know how harmful amphetamines were, by the time of the second questionnaire, this had been substantially reduced in each group, but more particularly in the Control Group. In general, this represented a shift to responses in the 'quite dangerous' category in the Control Group and to the 'quite dangerous' and 'very dangerous' categories in the Study Group. In terms of 'before and after' responses, both groups demonstrated a significant change (Study Group: Z = -9.1199; p = .000; Control Group: Z = -2.4212; $p < .05$).

Within the Study Group, the change could be accounted for by an explicit focus in the educational programme on the risks attached to amphetamine use, particularly injected amphetamine and the attendant risk (particularly in the fenland area) of HIV transmission. Interviews with the Control Group suggested that in one school the increased knowledge of amphetamine use was linked to an informal network, involving older siblings

(see Section Three). Within this group, knowledge concentrated around oral use of amphetamines and awareness of dangers connected with this, rather than injecting practices, perhaps accounting for the shift to the 'quite dangerous' rather than 'very dangerous' category amongst Control respondents.

Cannabis

Although both groups tended to class cannabis use as 'quite dangerous' or 'very dangerous' (70% and upwards in each case), they are significantly different in their responses at each point of testing. Initially, the Control Group rated the danger higher than the Study Group, but this position was reversed on the second questionnaire. The Control Group responses did not change significantly over time, whereas the Study Group's did ($Z = 3.5321$; $p < .001$). This change in the Study Group is explained by the reduction in 'don't knows' and a substantial increase in the 'very dangerous' category and lesser increase in the 'very harmless' category. Education may have increased the pupils' confidence to make an assessment of risk, though not a particularly accurate assessment.

Far more time in the lessons was spent on personal aspects of drug use than the effects of substances or their forms of use. It may be that the pupils who received the education programme formulated stronger views on generalised risk from drug use, without necessarily making distinction between substances to an extent that would allow them to acknowledge the limited risks attached to cannabis use. It may also be the case that teachers were reluctant to appear to condone any form of illegal drug use and therefore did not stress the limited risks to health of cannabis use.

Heroin

Heroin was rated as 'very dangerous' by around 70% of subjects in each group at each point in time. No significant differences emerge in either group in their responses on each questionnaire, nor between the groups at either point in time.

Around 13% in each case saw heroin as 'very harmless' or 'quite harmless'. Respondents indicating these views appear to have approached the questionnaire in a straightforward and honest manner generally, *ie* they had not opted for extreme or unlikely responses on a systematic basis; nor had they given responses that could be classed as 'incorrect' on a regular basis, where such an evaluation of responses was possible. It seems fair to assume therefore that they had rejected the popular stereotype of heroin use as inevitably dangerous. This is not attributable to education, as the Control Group does not differ

significantly from the Study Group, although it was the case that the education programmes focused on people and forms of use, rather than substances themselves, which might have led to a lower rating of the dangers attached to substances themselves.

Methods of use

Pupils were asked how people take each of the three substances. This was an open question and responses were, therefore, not constrained by the questionnaire itself. More than one response was possible and so percentages add to more than one hundred. Given the openness of the question, it was decided not to perform statistical tests. Analysis is on the basis of visible differences in responses.

Initially, the Control Group indicated more often that amphetamines could be inhaled, swallowed or smoked; whereas the Study Group had more 'inject' responses. By the time of the second questionnaire the main differences are that a higher percentage of the Control Group knew that amphetamines could be swallowed and a much lower percentage of the Control Group indicated that they did not know how amphetamines are used. Interview data suggests that this is attributable to a very effective informal network in one school. Pupils talked freely at interviews of their knowledge gained from talking to one of their peers whose brother regularly uses amphetamines at a pool club, locally. It is possible that the questionnaire prompted discussion and sharing of information on amphetamines, and the information was probably gained via this route, since there is no reason to assume that the Control Schools would be any more likely than the Study Schools to watch particular television programmes, hear specific radio broadcasts, or read distinctive literature.

Responses to the question 'how do people use cannabis?' showed a considerable increase in knowledge in both groups and a decrease in 'don't know' responses. 'Smoke' was the most frequent response given (75-94%) and, by the time of the second questionnaire, virtually all pupils made this response. If pupils knew anything about cannabis use, they knew that it could be smoked. In the Study Group, the number saying that cannabis can be eaten increase markedly (from 0.4 - 26%), possibly as a result of teaching. Both groups show a similar increase in responses in the 'inject' category (from 5 - 10% in the Study Group and from 3 - 9% in the Control Group), presumably the result of confusion between substances.

Both Study and Control Groups were similar in the frequency of responses in each category to the question, 'how do people take heroin?'. Most were aware that heroin can be injected (64 - 82%) or smoked (50 - 67%) and a few mentioned the term 'Chasing the Dragon'. The Control Group shows an interesting decrease in awareness that heroin can be smoked (from

67% to 50%), possibly due to the openness of the question and less detailed responses on the second occasion, or absentees.

The dangers of drug use

Pupils were asked, in open questions to be specific about the dangers of using particular substances.

If you said amphetamines were dangerous, in what ways are they?

Few people mentioned the possibility of addiction to amphetamines. More than 10% mentioned the phrase 'screws you up' and this number increased with time. This is a form of wording used in the anti-heroin campaign and one that became a powerful anti-drugs slogan generally. By far the largest category of response here is the 'don't know' category, though the percentage giving this response decreased for both groups over time (from 85% to 66% in the Study Group and from 77% to 60% in the Control Group). In general, only a very few pupils indicated each of the risks listed.

If you said cannabis is dangerous, in what ways is it?

Initially, about 50% in each group were not sure what the dangers of cannabis might be, though this number reduced considerably in the Control Group on the second questionnaire (15.4%). The most popular category of response, apart from 'don't know' was 'screws you up' (21 - 32%), though a substantively significant number suggest that 'addiction' is a risk (12 - 29%) and that cannabis 'can kill' (10 - 15%). As with amphetamines, it seems that only a few pupils were able to give specific reasons why the substance is dangerous and this led to small frequencies in each category, generally. A small number of pupils were able to list several dangers and account for most of the variety of response.

If you said heroin is dangerous, in what ways is it?

Pupils were clearer about the dangers of heroin use. A relatively substantial number (4 - 12%) mention 'overdose' (though the frequency of this response decreases in the Control Group on the second questionnaire); 'AIDS' is mentioned by about 5% (apart from on the second Control Group questionnaire where 12% give this response); 'brain damage' is mentioned by around 5%. 'General threat to life' and 'addiction' are listed by around a quarter of the respondents (this percentage increases to about a third in the Control Group on the second questionnaire. Between 23.5% and 35% said they did not know what the risks

of heroin use were and, again, the highest frequency, after the 'don't know' category, was 'screws you up' or 'destroys your life' (31 - 35%).

Reasons for taking drugs

Pupils were much more able to generate reasons for taking drugs, with excitement, curiosity, depression, showing off and the influence of others, as the most popular responses. Only between 3.5% and 13.2% said that they did not know why people took drugs. Fewer pupils in the Control schools felt unable to give a reason and so responses to this question seem not to be determined by education.

KNOWLEDGE OF HIV TRANSMISSION

Pupils were asked to respond 'true' , 'false' or 'don't know' to statements about routes of transmission of HIV. The education programme focused predominantly on how the virus can be contracted, not only giving information, but also dispelling myths. Some of these myths had to do with regarding all people within one group (*eg* heroin users, drug users, gay men) as sources of infection. At the time, there was considerable emphasis in the popular press and more academic literature on risk groups. There was, however, beginning to be concern about the stigma that was then attached to people within those groups, regardless of their antibody status and also that those outside these so-called risk groups could become unrealistically complacent (Dixon and Gordon, 1987). More recently, (Chrystie *et al*, 1992) there has been a return in some quarters to emphasising and targeting risk groups, the argument being that not everyone is equally at risk and resources are being diverted from those most in need. This, in turn, has led to counter-criticisms (Boag *et al*, 1992; Willocks *et al*, 1992)

It was anticipated that responses could be judged as being 'correct' or 'incorrect', particularly after education, when pupils would have been sensitised to the over-generalisations implicit in:

You can get AIDS from having sex with any homosexual man.

You can get AIDS from having sex with anyone who injects heroin.

There has been criticism of expressions like 'getting AIDS' (for contracting HIV) and 'the AIDS virus' (for HIV) (Aggleton *et al*, 1989). The language used within the questionnaire mirrors that used at the time, in popular and academic journals. As such, it was not

misleading to the respondents who fully understood what the terms referred to. The 'AIDS Strategic Monitor: Report on the Survey Period November 1987 - December 1988' (Health Education Authority, 1991) makes a similar point

> ' It is important to note that the language used in the 1988 questionnaire (and therefore in this report) was appropriate to the state of public knowledge at the time. The research is designed to assess public knowledge, *not* of itself to educate or promote the use of certain terms; for example, the term "HIV" was little known among the general public in 1988, but "the AIDS virus" was a concept which was understood. We cannot *impose* terminology which introduces serious difficulties of communication with the general public; in that sense, the language used in research has to follow rather than lead.'
> (p5)

Respondents were given the following instruction:

'Please tick TRUE, FALSE, or DON'T KNOW for the following statements. Try not to guess'.

The statements and responses are given in full in Tables 2.7.14 - 2.7.37.

Statements to which pupils generally responded 'true'

You can get AIDS if blood from an infected person enters your blood. The vast majority of pupils registered their awareness of the risk of blood-to-blood transmission of HIV. Very few pupils indicated that they thought this statement was false and the Study and Control Groups exhibited no statistically significant differences from each other on either questionnaire. Apparently, most pupils already knew what the Study Group were about to be taught in this respect.

The number giving correct responses here was very high initially (Study Group 97%; Control Group 92%). Follow-up interviews related to this particular issue suggest that, after discussion of the risk of blood transfusions, some of the pupils whose responses changed from 'true' to 'false' were answering as if to a question on blood transfusions. Although this still constitutes an incorrect response, the logic is that, as blood transfusions in this country are now deemed to be safe, any infection in the blood banks is treated in some way to make it safe.

You can get AIDS from having sex with an infected person. Few pupils disagreed with this statement and upwards of 93% correctly identified it as a risk behaviour. Study and Control Group responses were not significantly different from each other.

You can get AIDS if you share a needle for injecting a drug with someone who has the virus. Pupils were evidently already aware of the risk of sharing injecting equipment and a 'ceiling effect' is observed (93% responding 'true' in the Study Group and 96% in the Control Group), with little change possible in the direction of correct responses.

Statements to which pupils generally responded 'false'

You can get AIDS from sharing cups or glasses with infected people. In general, pupils understood that sharing cups or glasses with people who have HIV carries no risk of transmission of the virus (72-94% responded 'false').

You can get AIDS from toilet seats. The majority of pupils (77-91%) were aware that HIV cannot be transmitted in this way.

You can get AIDS from being near someone with the virus. Although most pupils (88-93%) were aware that social contact carries no risk of transmission of the virus, a small proportion (6-11%) were unsure.

You can get AIDS from touching someone with the virus. In general, pupils were aware that this carries no risk (90-96%) and most knew already what the Study Group was about to be taught. A small proportion (4-10%) responded that they did not know the risk involved.

You can get AIDS if you share a towel with someone who has the virus. Most pupils (63-82%) knew that sharing towels is not a risk for HIV transmission, although a sizeable proportion (15-33%) were unsure.

Statements to which pupils generally responded less consistently

You can get AIDS from having sex with any homosexual man. Between 32 and 47% of pupils believed that sex with *any* gay man would transmit the virus and between 17 and 29% were unsure. This represents a sizeable over-estimation of HIV prevalence amongst gay men. Although the proportion recognising that not all gay men are HIV-positive increased, the

number responding 'don't know' or 'true' remained high. The Control Group manifested the greatest swing towards 'false', something not explicable by the impact of formal education.

You can get AIDS from having sex with anyone who injects heroin. Again, a large proportion of both populations on both occasions (20-29%) considered anyone who injects heroin to be a risk in terms of HIV transmission, though this was smaller than for gay men, with 31-52% responding 'false' and 27-43% saying that they did not know.

You can get AIDS from insects that bite. This item produced a more varied response, in that a substantial proportion of pupils did not know whether insects could transmit the virus (20-42%) and a substantial minority gave incorrect responses (7-15%). Between 49 and 65% said that this was false.

You can get AIDS from kissing someone who has the virus. Although the majority of pupils responded 'false' (68% in the Study Group and 57% in the Control Group on the first questionnaire; and 79% and 85% respectively on the second), there appears to have been some initial uncertainty about the risk involved in kissing (23% of the Study Group and 30% of the Control Group said that they did not know). This reduced over time to 16% in the Study Group and 11% in the Control Group. The element of doubt may reflect the discussions, reported briefly in Section Three, of the conditions under which kissing might be a vector for transmission.

Differences between Study and Control Group responses

Chi-square analysis revealed the differences between the Groups' responses on the following items:

You can get AIDS from sharing cups or glasses with infected people. Although pupils generally responded that this was false, the Study and Control groups demonstrated significantly different responses on both questionnaires. On the first questionnaire, the Control Group produced more 'false' responses and fewer 'don't knows' than the Study Group (chi-square = 8.25; DF = 2; $p < 0.05$). On the second questionnaire, they produced more 'don't knows' (chi-square = 9.56; DF = 2; $p < 0.01$), perhaps suggesting that the issues were not clarified in the Control Group.

You can get AIDS from insects that bite. Although no significant differences were evident between Study and Control Group on the first questionnaire the Control Group had significantly less 'don't knows' than the Study Group on the second questionnaire. This

appeared to be the result of an increase in both correct and incorrect responses (chi-square = 8.47; DF = 2; $p < 0.05$).

You can get AIDS if you share a towel with someone who has the virus. The Study and Control Groups were significantly different on Questionnaire One (chi-square = 7.44; DF = 2; $p < 0.05$) with more in the Control Group responding 'don't know'. This difference was not evident on Questionnaire Two, when the number of correct responses in both groups increased.

Differences between same-subject responses over time

A Wilcoxon signed ranks test demonstrated the following significant changes

You can get AIDS from sharing cups or glasses with infected people. The Wilcoxon matched-pairs signed-ranks test indicated that both the Study and the Control Group changed significantly in their responses to this item (Study Group: $Z = -4.2171$; $p = .0000$; Control Group: $Z = -3.4452$; $p < .001$). In each case the move was towards a straightforward increase in correct responses and a corresponding decrease in incorrect and 'don't know' responses.

You can get AIDS from having sex with an infected person. The Wilcoxon matched-pairs signed-ranks test indicated that the Control Group changed significantly in their responses to this item (Control Group: $Z = -1.9917$; $p < .05$). An already high proportion of correct responses (Study Group: 97.5%; Control group: 98.2%) was reduced (Study Group: 94.5%; Control Group: 93.8%) with increases in both 'false' and 'don't know' categories. Some pupils appeared to be taking the safer sex messages on board in a way that made them negate or question the risk of sexual transmission. That is, in follow up interviews, some pupils suggested that condom use ruled out sexual transmission of HIV.

You can get AIDS from having sex with any homosexual man. The Wilcoxon matched-pairs signed-ranks test indicates that both the Study and the Control Group changed significantly in their responses to this item (Study Group: $Z = -3.9349$; $p = .0001$; Control Group: $Z = -2.2306$; $p < .05$). As in the total sample, a reduction in 'true' and 'don't know' responses reflected a clarification that not *all* gay men are HIV-positive.

You can get AIDS from having sex with anyone who injects heroin. The Wilcoxon matched-pairs signed-ranks test indicated that only the Study Group changed significantly in their responses to this item (Study Group: $Z = -2.5137$; $p < .05$). The move was from 'true' and

'don't know' to 'false', indicating an increased awareness that not all intravenous drug users are HIV-positive; a change which was in line with the emphasis in the education programme sensitising pupils to over-generalisation.

You can get AIDS from toilet seats. In both the Study and Control Groups, the number giving incorrect or 'don't know' responses reduced over time. The Study Group changed significantly over the study period ($Z = -2.3481$; $p < .05$). The move was towards a correct evaluation of the risk - that this is not a route of transmission. This may well be a direct effect of the education programme.

You can get AIDS from being near someone with the virus. The Study Group changed significantly in their responses on the two questionnaires ($Z = 2.3369$; $p < .05$). The change was from incorrect or 'don't know' responses to the correct response. In the Control Group the move in this direction was not large enough to constitute a significant change and again this effect might be predicted as a result of the education programme.

You can get AIDS if you share a towel with someone who has the virus. The Wilcoxon matched-pairs signed-ranks test indicated that both the Study and the Control Group changed significantly in their responses to this item (Study Group: $Z = -2.6420$; $p < .01$; Control Group: $Z = -2.00819$; $p < .05$), both moving away from incorrect and 'don't know' categories to the correct response (false).

You can get AIDS from kissing someone who has the virus. The Wilcoxon matched-pairs signed-ranks test indicated that both the Study and the Control Group changed significantly in their responses to this item (Study Group: $Z = -4.5574$; $p = .0000$; Control Group: $Z = -2.0157$; $p < .05$), increasing the number of correct responses and decreasing the others correspondingly.

No significant responses between Study and Control Groups and same-subject responses over time

No significant differences were shown from chi-square analysis nor from a Wilcoxon signed ranks test on:

You can get AIDS if blood from an infected person enters your blood.

You can get AIDS if you share a needle for injecting a drug with someone who has the virus (Tables 2.6.21 and 2.6.22 in the Appendix).

Both of these were consistently correctly assessed as routes of transmission of HIV.

Summary

Knowledge of amphetamines, cannabis and heroin

Pupils reported that they did not know about the dangers of amphetamines more often than for cannabis and heroin. Consequently, cannabis was more often rated as 'very dangerous' than amphetamines and heroin more often still. Both the Control and Study Group show a decreased 'don't know' response with time and, for one of the Control schools, it is clear from interview data that informal information networks involving older siblings were very effective.

There was an overall increase in awareness of different ways of taking the three substances, although the level of knowledge of heroin use was already high and, therefore, changed less. This is probably attributable to the anti-heroin campaigns and media coverage of heroin use. The Control Group demonstrates a greater increase than the Study Group in knowledge of methods of amphetamine use (perhaps linked to the informal network previously mentioned). Both groups show an increase in the number of people thinking cannabis is injected.

The dangers of drug use are often seen in terms of 'screwing you up' and a surprisingly high proportion of pupils said that they did not know what the dangers were. More than 60% in all groups responded 'don't know' in relation to amphetamine use; about 50% in the Study Group said they did not know the dangers of cannabis use and the Control Group showed a reduction from 50% to 15% in 'don't know' responses. In relation to heroin, 23% to 35% were not sure of the dangers.

The danger most often cited in relation to each drug is that it 'screws you up' or 'destroys your life'. This is a generalised sense of drug-related damage which owes much to the 'Heroin Screws You Up' campaign. Between 10 and 22% thought amphetamines 'screwed you up', more than 20% thought cannabis did and 31-35% thought heroin did. Other commonly cited dangers are 'addiction' and 'threat to life'.

In general, little seemed to be known about the specific dangers of particular forms of drug use. Some inaccuracies are evident, *eg* the risk of AIDS, damage to skin and veins and heart

attacks from cannabis use. Although thought to be harmful, few could say in any detail, why the three substances were.

Pupils were much more able to given reasons for taking drugs: excitement, curiosity, depression, lack of self-confidence, showing off and the influence of others being the most often cited. The Control Group apparently was as informed, if not better informed than the Study Group, and exhibited some of the more substantial changes, particularly in relation to amphetamine use.

The education programme focused more on the social and personal effects of drug use than the properties of the substances and this may be reflected in the responses amongst the Study Group in this section. There is a general sense that all of the drugs were harmful, though the pupils often could not say in which ways. As the Control Group gave similar sets of responses to the Study Group, it is again not possible to attribute any changes to formal education alone.

Knowledge of HIV transmission

On the following items the majority of both Study and Control Group appeared to have known the correct response at the time of the first questionnaire:

You can get AIDS from sharing cups or glasses with infected people

You can get AIDS if blood from an infected person enters your blood

You can get AIDS from having sex with an infected person

You can get AIDS from toilet seats

You can get AIDS from being near someone with the virus

You can get AIDS from touching someone with the virus

You can get AIDS if you share a towel with someone who has the virus

You can get AIDS if you share a needle for injecting a drug with someone who has the virus

You can get AIDS from kissing someone with the virus

The majority of correct responses was smaller in relation to 'sharing a towel' and 'kissing', and only on the items relating to blood to blood transmission, having sex with someone with HIV and sharing a needle with an HIV-positive drug user was there a 'ceiling effect' in terms of correct responses (*ie* no significant improvement in accuracy is possible). It is, therefore, the case that several items demonstrated a significant increase in correct answers.

Both the Study and Control Groups showed significantly more correct responses on the second questionnaire in evaluating the risk of 'sharing cups', 'having sex with any gay man', 'sharing a towel' and 'kissing'. Only the Study Group showed significantly increased accuracy in evaluating the risk from toilet seats, being near someone with HIV and having sex with any heroin user. These changes may have been the result of education.

Responses to the item 'You can get AIDS from insects that bite' (Tables 2.6.17 and 2.6.18 in the Appendix) remained spread across the range and the Control Group showed a significant reduction in accuracy in response to the item about sex with someone with HIV. Interviews suggested that this may have been partly due to the assumption that condom use negates this risk. Pupils also raised the issue, at interview, of blood transfusions and it appears that some confusion may have arisen in assessing the risk of infected blood entering your blood, in the light of the monitoring and screening of bloodbanks. As a consequence of discussing blood-banks, the item on infected blood was contextualised within that piece of discourse, resulting in responses changing from 'true' (you can get HIV from infected blood) to 'false'. This issue of contextualisation or 'reading in' of additional information is also evident amongst the Study Group in the sensitisation to over-generalisation within 'risk groups' and in the 'reading in' by some pupils of condom use in sexual activity.

CHAPTER EIGHT

HIV TRANSMISSION: PERCEPTIONS OF RISK

Perception of groups at risk of contracting HIV

In 1986/7, at the time of the study, a great deal of attention was paid to 'risk groups'. Epidemiology demonstrated the prevalence of the virus in particular sectors of the population - gay men, intravenous drug users and haemophiliacs. It was felt increasingly appropriate to target these groups in providing health education, though, as mentioned in the previous section, this approach was not without its critics, because of the stigmatising of those within groups and the complacency it encouraged in those outside the immediate 'risk' populations.

To assess pupils' knowledge of the risks attached to belonging to particular groups, they were asked to respond to a grid, listing various groups of people and providing boxes for them to indicate whether they regarded them as being at 'very great risk', 'some risk', 'very little risk', 'no risk at all' or whether they were 'not sure'. The instruction was:

'Please put a tick in the column which best shows how much at risk these people are from AIDS'.

Responses are presented in Tables 2.8.1 - 2.8.34. In retrospect, a frame related to risk behaviours, rather than risk groups would have been preferable, but, as with the use of language, the research tends to follow rather than lead in its presentation of HIV and AIDS.

Chi-square analysis of difference between the Study Group and the Control Group shows that the responses of the two groups to this set of statements were less similar *before* the educational programme than after. The groups initially differed significantly in their assessment of the risk of seven of the seventeen groups (homosexuals, people who have blood transfusions, anyone who has sex with another person, people in hospitals, people who work with haemophiliacs, nurses and doctors). On the second questionnaire, significant differences only existed in responses to assessment of risk of people who have blood transfusions and people who work with drug users. The results of the Wilcoxon signed-ranks test are only given where they indicate a significant difference in pupils' responses on the two questionnaires.

Groups for whom the dominant response was 'at very great risk'

homosexuals. Between 74 and 84% of pupils considered homosexuals to be 'at very great risk' of HIV transmission.

people who have sex with lots of partners. Those having sex with lots of partners were considered to be 'at risk' of contracting HIV and, by the majority, the risk level was seen to be very great (65-73%).

prostitutes. There was a general consensus within and between the groups (74-94%) that prostitutes are 'at very great risk' of contracting HIV, very much on a par with homosexual men.

people who inject heroin. Between 47 and 53% thought this was a very high risk group and 82-87% responded in the 'at some risk' and 'very great risk' categories combined.

people who inject any drug. Pupils gave similar responses to the last item (41-48% 'at very great risk' and 64-85% responded in the 'at some risk' and 'at very great risk' categories combined).

people who share needles to inject drugs. A very marked increase in the 'at very great risk' category in all groups (up to 80-83%) compared with the last item, also indicates pupils' knowledge of the hierarchy of risk involved in drug-taking behaviours. This was a substantial part of the informational input of educational programme on HIV and drug use. It is, therefore, interesting to note that most pupils seemed to have that knowledge already.

Groups for whom the dominant response was 'at some risk' or 'at very great risk'

anyone who uses any illegal drug. Although responses are divided, they mainly fall within the 'at very great risk', 'at some risk' and 'not sure' categories. Between 67 and 73% suggested some or very great risk and 18 to 27% were 'not sure'.

Groups for whom the dominant response was 'at some risk'

people who have blood transfusions. The majority of responses fell in the 'at some risk' category. Between 58 and 74% of pupils indicated that they thought them to be 'at some risk' or 'at very great risk'.

people who use heroin any way A very similar pattern of response emerged with regard to heroin use as for use of 'any illegal drug'. Some discrimination between forms of use is apparent, in that there are more responses in the 'at very great risk' and 'at some risk' categories for people injecting heroin or 'any drug', but there appears to be an association between illegal drug use generally and HIV transmission (even though the incidence of injection is lower than that of other methods of drug use). Partly, interpretation of these sorts of items reflects the need to see attitudes within their rhetorical context (Billig, 1989).

Groups for whom the dominant response was 'at very little risk'

people who work with homosexuals. The majority of pupils considered working with homosexuals to be little or no risk for transmission of HIV. There was no significant difference between the Study and Control Groups' distribution of responses on either questionnaire. Considering that the vast majority of pupils knew that social contact such as sharing a cup (more than 72%) or towel (more than 63%), being near someone with HIV (more than 88%) or touching them (more than 90%) could not cause transmission of the virus, it is surprising that a reasonably high proportion thought there was a risk even if very little (46.3% to 55.6% thought there was the possibility of risk, even if small and 14.9% to 23.6% were not sure).

people who work with haemophiliacs. The response distribution is similar to that in relation to people working with homosexuals, though pupils were slightly more likely to be 'not sure' and slightly less likely to say 'at very little risk'. This continues to illustrate the disparity between cognitive and affective responses. Although pupils were aware that there is no risk of social transmission when asked specifically about routes of transmission, they did not appear to apply this knowledge straightforwardly in their assessment of levels of risk to particular groups. Additionally, more pupils than would be predicted from levels of knowledge, indicated that they would avoid people with HIV or AIDS.

the general public. Responses consistently suggested that the general public was seen as 'at very little' or 'at no risk at all'. A reasonably large proportion, acknowledged some risk. It is interesting to note that the general public was seen as being at less risk than anyone who has sex with another person, suggesting perhaps that the general public was not thought of in terms of its sexual activity.

Groups whose risk status was rated less consistently

anyone who has sex with another person. Very few responses were made at the two extremes, 30-45% responded in the 'at some risk' and 'at very little risk' categories and 14-24% were 'not sure'.

people in hospitals. Very few pupils gave responses at the two extremes and hardly any thought this group were at great risk. Otherwise responses covered the range with 30-45% suggesting that they were 'at very little risk' or 'at some risk' and 14-24% 'not sure'.

nurses. Over half of the respondents considered there to be an element of risk of transmission of HIV for nurses, though hardly any thought they were 'at very great risk'.

doctors. Responses to this item were similar to those in relation to nurses.

people who work with drug users. Hardly any responses fell in the 'at very great risk' category, 20-44% were 'not sure' and the rest were spread across the remaining three categories.

Significant differences between Control and Study Group responses

The following were rated significantly different according to chi-square analysis by the Control and Study Groups on one or more occasion:

homosexuals. The Control Group assessed the risk significantly more strongly than the Study Group at first (combining 'not sure', 'very little risk' and 'no risk', chi-square = 6.09; DF = 2; $p < 0.05$). However, their slight reduction on the second questionnaire in the 'at very great risk' category and the increase on this response in the Study Group, removes the significance of the difference.

people who have blood transfusions In assessing the risk of receiving blood, the Study Group were more likely, on the first questionnaire, to regard them as a substantial risk than the Control Group who saw them as relatively low risk (combining 'at very little risk' and 'at no risk at all' categories, chi-square = 9.38; DF = 3; $p < 0.05$). Although both groups reduced their assessment of risk over time, this remains more marked in the Control Group and produces a difference of still greater significance (chi-square = 35.85; DF = 4; $p < 0.0001$).

anyone who has sex with another person. This category produced varied responses, with the majority of pupils in the Study Group regarding anyone having sex as at 'some risk' and in the Control Group as 'at very little risk'. At the time of the first questionnaire, this difference was significant (chi-square = 10.35; DF = 4, $p < 0.05$), but changes, predominantly in the Control Group (increasing response in the 'some risk' category and reducing the 'not sures' removed the significance.

people in hospitals. The Control Group were more likely to consider people in hospitals as 'at some risk' from HIV on the first questionnaire and the Study Group more likely to regard them as 'at no risk at all'. This produced a significant difference between the groups (chi-square = 11.65; DF = 4; $p < 0.05$) which did not remain on the second questionnaire, when many more in the Control Group responded that people in hospitals were 'at no risk at all', than they did previously. The 'at some risk' and 'not sure' categories showed similarly marked changes. The result was that the Study and Control Groups' responses were not significantly different from each other on the second questionnaire.

people who work with haemophiliacs. Initially, there was a significant difference between the Study Group and the Control Group (chi-square = 11.37; DF = 4; $p < 0.05$) with most of the Study Group indicating that they were 'not sure' about the risk to people working with haemophiliacs and more of the Control Group seeing them as 'at some risk'. An increase in the Study Group in the 'at very little risk' category, a slight increase in the 'at some risk' category and a corresponding decrease in 'not sure' reduced the difference between the groups to a level that was no longer significant on the second questionnaire.

nurses. Initially the Control Group rated this more highly than the Study Group: 35.7% were regarded as 'at some risk' by the Control Group, compared with 19% in the Study Group (chi-square = 15.41; DF = 4; $p < 0.005$). However, on the second questionnaire the two groups were not significantly different in their responses.

doctors. A difference, initially, with the Control Group rating Doctors risk higher than the Study Group (chi-squared= 9.61; 4 DF, $p < 0.05$) was not evident between groups at the time of the second questionnaire. Again, it was a shift in the Control Group, mainly via a reduction in 'at some risk' and an increase in 'very little risk' or 'at no risk' that brought the groups closer together.

people who work with drug users. Major changes within each group in different directions, produced a significant difference by the time of the second questionnaire (chi-square = 10.80; DF = 4; $p < 0.05$). In both the Study and Control Groups there was a reduction in 'not

sures' with time. In the Study Group, there was a corresponding increase in 'at some risk', with a much smaller increase in 'at very little risk', and in the Control Group the main increase was in the 'at no risk at all' category. It is difficult to speculate on the reasons for the two conflicting but systematic modifications of response. Certainly, the education programme did not suggest that those working with drug users were at risk and could not therefore account for that change.

Significant differences between same-subject responses on the two questionnaires

The following groups were rated significantly differently by same-subjects on the two questionnaires according to a Wilcoxon signed-ranks test:

homosexuals. The Study Group demonstrated a significant increase in 'at very great risk' responses, with a reduction in 'at some risk' and 'not sure' responses ($Z = -2.4496$; $p < .05$). This may be attributable to the education programme, though whether it was desirable to focus on the group as at risk, rather than to specify behaviours (no special emphasis was placed on anal sex within the education programme) is debatable.

people who have blood transfusions Responses in the Study Group on the second questionnaire were significantly different to those given on the first ($Z = -3.3674$; $p < .001$). Whereas from the chi-square analysis it would seem that this difference was not attributable to formal education because the change is more marked amongst those not receiving the AIDS education programme, the opposite was indicated by the Wilcoxon analysis and it may well have been as a result of education that people who have blood transfusions came to be regarded as less at risk by those in the Study Group. From interviews with the Control Group, it was evident that having answered a questionnaire prompted discussion amongst peers and effective dissemination of information.

people in hospitals. The Wilcoxon analysis showed that when each pupil's responses are compared on the two questionnaires both groups had significantly different responses (Study Group: $Z = -2.2436$; $P < .05$; Control Group: $Z = -2.9158$; $p < .01$). Again, as the changes occurred in both the Study and Control Groups and in a more pronounced form in the Control Group, they were not attributable to the formal education programme.

people who work with homosexuals. The Study Group significantly changed in its response pattern on the second questionnaire ($Z = -2.8867$; $p < .01$). This was mainly accounted for by a reduction in the assessed level of risk, from that indicated on the first questionnaire.

nurses. Some clarification seems to have occurred in the Control Group, possibly because of peer discussion and respondents more often indicated that nurses were 'at very little risk' or 'no risk', than they did previously. This was a significant change as indicated by the Wilcoxon test (Z = -3.5004; p = .0005).

doctors. There was a reduction in 'at some risk' and an increase in ' at very little risk' and 'at no risk' categories (Z = -3.1626; p < .005).

prostitutes. The increase in 'at very great risk' responses in the Study Group is significant (Z = -2.0630; p < .05).

people who inject heroin. The increase in the Study Group of responses in the 'at very great risk' category was significant (Z = -2.3397; P < .05). As the education programme did not focus on safer injecting practices and as heroin was the main substance focused on as injectable, it is not surprising that the lesson content may have led to an assessment of risk that is higher than that prior to the education.

people who inject any drug. Education may have increased the strength of this assessment in the Study Group, which demonstrated a significant increase in assessment of risk on the second questionnaire (Z = -2.6697; p <.01). Inclusion of information on safer injecting might have produced a different effect, as responses in Chapter Seven show that, after education (or less formal learning) about safer sex, some pupils rated sexual activity as less risky, because of the assumption of the efficacy of condom use (see also qualitative data in Section Three).

people who share needles to inject drugs. The increase in 'not sure' responses in the Control Group and the decrease in the 'at very great risk' and 'at some risk' categories constituted a difference which is just significant statistically (Z = -1.9242; p = .05).

people who work with drug users. The change in the Study Group (a reduction in 'not sures', an increase in 'at some risk' and a smaller increase in 'at very little risk') was significant (Z = -4.0200; p = .0001).

No significant differences between responses of Control and Study Groups or for same-subjects on the two questionnaires

No significant differences were found between Study Group and Control Group responses or same-subject responses on the two questionnaires in relation to the following groups:

people who have sex with lots of partners. These were generally considered to be 'at some risk' or 'at very great risk'.

anyone who uses any illegal drug. HIV and illegal drug use were generally associated in the responses of the pupils and no significant differences emerged between the groups or within them, over time.

people who use heroin in any way. Pupils consistently indicated that they considered this group to be 'at some risk' or 'at very great risk'.

the general public. There was no significant change in responses that generally categorised them as 'at very little risk' or 'at no risk at all'.

AIDS-related behaviour

Health Education in the area of AIDS and HIV has focused on behaviours that are seen as risky, because of the possibility of transmission of HIV. The schools involved in this survey, in common with many other schools, felt it inappropriate to talk about safer drug-using practices such as sterilising injecting equipment, because of the possibility of being perceived as condoning drug-use, or encouraging experimentation.

Where safer sexual behaviour has been discussed with school-children in Cambridgeshire, the focus has been on heterosexual activity and on the protection afforded by reducing the number of sexual partners (possibly to one and, in some schools with the emphasis on this being within marriage), by using a condom and by being aware of a potential partners sexual history.

Balding's study affords some comparisons. Of his sample of 3894 Year Three and Year Four pupils (2051 boys and 1843 girls) 80.8% said that they would take precautions to prevent themselves from 'getting AIDS' (77.1% of boys and 84.9% of girls). A further 16.7% said that they were not sure (18.7% of boys and 14.5% of girls) and 3.1% said that they would

not take precautions (4.1% of boys and 2% of girls). Figures below from this study are compared with relevant results from Balding's work.

Pupils were asked:

'How much notice would you take of the following pieces of advice on protecting yourself from AIDS in a sexual relationship. (Please note, these are some people's points of view, NOT accepted truths)'.

The 'advice' and a summary of pupils' responses are given below. Differences between Study and Control Groups and boys' and girls' responses were analysed using chi-square. Same-subjects responses on the two questionnaires were analysed using the Wilcoxon test. Full details of responses are presented in Tables 2.8.35 - 2.8.55.

Advice of which pupils generally said they would take notice

Only ever have sex with one partner. Most pupils felt that they would take notice of this advice in relation to HIV and AIDS (60-82%).

Always use a condom when having sex with someone whose sexual background is not known. An even larger percentage of students on each questionnaire in each group said that they would take notice of this advice (88.7-96.7%). A very small proportion said that they would ignore the advice. In the Study Group, this constituted the same eight students on each occasion. Follow-up interviews with two of the eight revealed that they were practising Roman Catholics and, therefore, unable to use condoms because of their religious beliefs.

Don't have sex with a man who has been involved in a homosexual relationship. Percentages remained fairly constant in response to this piece of advice, both between groups and over time. The majority of respondents (72-76%) felt that they would take notice, with very few saying that they would ignore the advice (4-6%). However, a substantial number (17-23%) were not sure.

Keep the number of sexual partners low. There was substantial agreement between groups and over time in response to this advice, too. Between 86 and 89.4% said that they would take notice, with very few unsure or asserting that they would ignore the advice.

There were no pieces of advice that pupils generally said they would ignore, although responses were divided on one item (see below).

Advice to which pupils made less consistent responses

Don't have sex outside marriage. Responses to this question were very much divided. Between 35 and 56% said they would take notice, 22-41% said they would ignore it and 19-30% were not sure.

Significant differences between Control and Study Group responses

Only ever have sex with one partner. Significantly less respondents in the Control Group answered that they would take notice, at the time of the first questionnaire, than in the Study Group (chi-square = 8.31; DF = 2; $p < 0.05$). In the analysis of the responses to the second questionnaire, this difference was not significant. Both Control and Study Groups demonstrated an increased 'good advice' response and the change in the Control Group was large enough to remove the statistical significance of the difference. Monogamy was not part of any educational programmes that were undertaken in the survey schools, nor was it promoted in the video material that was used (First AIDS, Granada, 1987). The views of the pupils may have been influenced by the evidence and prevalence projections presented on sexual transmission in both teachers' accounts and the video information on the spread of HIV. However, as the Control Group manifests the same trend as the Study Group, and to a more marked degree, this cannot be attributed to the school-based educational programmes. Indeed, the direction of the effect is in contradiction to the messages given on condom use, which reflected a liberal and permissive ethos, tending to assume that monogamy was unusual, rather than the norm. Of Balding's sample, 14.4% said that they would only ever have sex with one partner (14% of boys and 14.9% of girls). This is a figure far lower than my own study suggests. As the questions on the Health Related Behaviour Questionnaire were open-ended it is possible that the discrepancy may be explained by this option not occurring as readily to pupils as some others.

Pupil responses may have been influenced by the pedagogic context, giving the responses that they felt were appropriate in the school setting. Edwards and Mercer (1987) and Billig (1988) believe that teachers operating with a supposedly open and progressive form of pedagogy lead their pupils to produce particular responses. They refer to this process as 'cued elicitation' and suggest that it is an insidious form of control, no less, and possibly more, powerful than conventional didactic forms of pedagogy. This is discussed further in Section Three. Interview and observation data reflected a more permissive sexual attitude

amongst students and a tendency to predict and produce the answer that they think the teacher wants.

Always use a condom when having sex with someone whose sexual background is not known. In the Control Group at the time of the first questionnaire, a larger percentage of pupils said that they would ignore this advice and a smaller percentage that they would take notice, than in the Study Group (chi-square = 8.43; DF = 2; $p < 0.05$). Over the period of time between the two questionnaire administrations, this changed and the significant difference no longer existed. In fact, the Control Group then had the highest percentage of respondents indicating that they would take notice (96.7%) and no pupils saying that they would ignore the advice.

Don't have sex outside marriage. Between the Control and Study Groups, a significant difference existed at the time of the first questionnaire (chi-square = 8.44; DF = 2; $p < 0.05$) and this had increased by the time of the second questionnaire (chi-square = 24.75; DF = 2; $p < 0.0001$). This marks a polarisation between the groups in terms of the 'good advice' and 'not good advice' responses, with a trend to increase the already significantly higher number of 'good advice' responses in the Study Group and, to a much lesser extent, the 'not good advice' responses in the Control Group. This trend in the Study Group may be attributable to the indirect effects of the educational programme with awareness of the risk of sexual transmission leading to more pupils feeling that extra-marital sex is a major risk factor. However, none of the educational programmes had a moral component based around marriage. Responses to this question indicate less agreement with the advice compared to the question related to only having sex with one partner.

Significant differences between same-subject responses on the two questionnaires

Only ever have sex with one partner. A Wilcoxon test showed that the increase in the Control Group in 'good advice' responses was significant ($Z = -3.1399$; $p < 0.001$).

Always use a condom when having sex with someone whose sexual background is not known. A Wilcoxon test showed the change in Control Group responses between the two questionnaires to be significant ($Z = -2.4820$; $p < .05$). Again, it is not possible to attribute the change to school-based education. In fact, quite the opposite appears to be the case. Some source of information or influence outside the formal educational context appears to be operating. This might be the media, the peer group or parents.

Significant differences between boys' and girls' responses

Always use a condom when having sex with someone whose sexual background is not known. Although no significant difference emerged between boys' and girls' response to this advice on the first questionnaire, there was a significant difference on the second questionnaire (chi-square = 8.48; DF = 1; $p < .005$). Combining 'don't know' and 'not good advice' categories and comparing these with 'good advice' responses, girls were more likely than boys to take notice of advice to always use a condom than boys (97% of girls; 90.9% of boys) and boys were more likely to be unsure or to ignore the advice (2.9% of girls; 9.1% of boys). Despite this awareness of risk and desire for protection, many young women are, however, unable to negotiate safer sex in actual sexual relationships (Holland *et al*, 1991a). This reflects two important issues. Firstly, it is important to consider the context in which the responses are given (this is discussed further in Section Three) and secondly, that intention and information are not enough to ensure safer behaviour, when social power imbalances and pressures operate against these (see Section One, Chapter Two).

Responses to Balding's questionnaire, indicated that 78.9% mentioned condoms as one of the best methods of protection from getting AIDS (85.2% of boys and 71.8% of girls) and a further 21.2% (20.6% of boys and 21.8% of girls) referred to contraception generally. In the total sample, 5.1% mentioned safe sex generally (5.2% of boys and 5% of girls). This suggests a similar level of awareness, to that displayed in this study, of the efficacy of condom use in preventing transmission of HIV and perhaps also knowledge of other forms of safer sex.

Don't have sex with a man who has been involved in a homosexual relationship. There were no significant differences between groups or on same-subjects' responses to this item. However, the implications of this advice are clearly different for girls and for boys. For girls, the issue is whether or not they will avoid having sex with someone who has been or is bisexual. For boys, the issue relates to their own involvement in homosexual activity .

Chi-square analysis suggests that girls were more likely to respond 'don't know' to this piece of advice than boys and boys were more likely than girls to say that it was 'good advice' (Questionnaire One: chi-square = 9.88; DF = 2; $p < .01$; Questionnaire Two: chi-square = 20.69267; DF = 2; $p < .0001$). Of the girls, 27.2% said they did not know on the first questionnaire and 25.2% on the second as compared to 16.7% of boys on the first and 11% on the second. The difference between girls and boys responding that they would take notice became more marked on the second questionnaire, with a shift from 77.9% to 83.1% for boys and 68.4% to 68.6% for girls. The major change here was in boys' responses.

Keep the number of sexual partners low. Again, there were no significant differences between groups or on same-subjects' responses to this advice. Chi-square analysis comparing boys' and girls' responses revealed a significant difference on both questionnaires (Questionnaire One: chi-square = 10.44; 2 DF; p = .005; Questionnaire Two: chi-squared = 20.69; DF = 2; p < 0001). Girls were more likely to say that they would take notice of advice to keep the number of sexual partners low than boys. In response to Questionnaire One 90.8% of girls said they would take notice compared to 86.1% of boys and 7.8% of boys said they would ignore the advice as compared to 1.8% of girls. The difference was even more marked on the second questionnaire with 93.4% of girls and 82.8% of boys saying that this was 'good advice'. Although not a statistically significant change over time, the responses show a polarisation rather than a trend in one direction, with boys seemingly less likely to restrict numbers of sexual partners and girls more likely. On the second questionnaire, 10.1% of boys said that this was 'not good advice', as compared with 1.5% of girls.

Comparison with Balding's (1991) study revealed much lower figures stating this as an option in response to an open-ended question (27.7% overall, 22.6% of boys and 33.4% of girls). Again, the discrepancy may be the result of the openness of the question on the Health Related Behaviour Questionnaire, in contrast with the directness and forced choice nature of the question in this study. Of Balding's sample, 4.1% suggested celibacy (4.4% of boys and 3.7% of girls) and 8.2% (6.7% of boys and 9.8% of girls) said that knowing the sexual history of a partner was one of the best forms of precaution.

Although there is evidence to suggest that females are more at risk from heterosexual transmission than males (Bury *et al*, 1992), thus providing support from epidemiology for the difference in patterns of response, this evidence was not current at the time of the study. It seems more likely that the difference reflects a double-standard with regard to sexual activity, with boys experiencing more social pressure to be sexually active and with different partners and girls experiencing the opposite pressure (Holland, *passim*).

Summary

Perception of groups at risk of contracting HIV

Assessments of risk by the Study and Control Group tended to converge over the course of the study period, with only significant differences in the evaluation of the risk of haemophiliacs and people who work with drug users remaining. As changes occurred in

both Study and Control Groups, it was difficult to ascribe any change to the education programme alone.

Gay men, people who have sex with lots of partners, prostitutes and people who inject heroin or any drug, particularly those who share injecting equipment, were seen as being at very great risk of contracting HIV. A significant increase in the Study Group in the perceived risk for gay men, prostitutes, and people who inject heroin or any drug may have been affected by the education programme. No emphasis was placed in the educational programme on safer sex other than safer vaginal penetration and no input was given on safer injecting practices. Unlike the case in the section on transmission, pupils did not import information to qualify the risk of these particular behaviours, arguably, because they had not been given that information. What they were given was statistical evidence that stressed the risk of these groups, it is therefore not surprising that their assessment of risk changed in the direction it did.

People who use heroin or any illegal drug in any way were regarded as being at some risk, with many responses falling in the 'very great risk' or 'not sure' categories.

Haemophiliacs, people who have sex with anyone, nurses, doctors and people who work with drug users were regarded as being at some risk, though generally little. The Study Group's reduction in level of risk perceived for haemophiliacs may have been the result of education, but their increase in risk ascribed to those who work with drug users is difficult to explain, as the issue did not arise in the education programme. The Control group demonstrated a significant reduction in the risk attached to being a doctor or a nurse, which is also a change that would not have been expected.

People in hospitals were seen as being at little risk, though a lot of responses fell into the 'not sure' category. The Study and Control Groups both showed a significant increase in the 'very little risk' and 'no risk' categories and the move to 'no risk' is particularly evident in the Control Group, which makes it difficult to account for the change in the Study Group in terms of education alone.

The general public, people who work with homosexuals and people who work with haemophiliacs were seen as being at little risk of contracting HIV. In the Study Group, there was a significant reduction in the amount of risk attached to those who work with homosexuals and to those who work with haemophiliacs (which may be attributable to education), though many respondents were unsure of the risk of working with haemophiliacs.

There was clearly change and dissemination of information amongst the Control Group as well as the Study Group. Although it is possible to speculate that some changes may be the results of the education programme, it is not possible to establish this conclusively.

AIDS-related behaviour

The majority of respondents said that they considered it 'good advice' to only ever have sex with one partner (60% to 82%), to use a condom when someone's sexual history is not known (88% to 96%), to avoid sex with a man who had been involved in a homosexual relationship (72% to 96%) and to keep the number of sexual partners low (86% to 89%). Responses were more divided on the advice concerning not having sex outside marriage, though 35% to 43% still said that they considered it 'good advice'. This is substantially fewer than the number saying that it was 'good advice' to only have one partner.

Girls were more likely than boys to think that insisting on condom use with a partner with an unknown sexual history was a good idea and to keep the number of sexual partners low. Boys were more likely to say they would avoid having sex with a man who had been involved in a homosexual relationship. However, as stated earlier, the implications of this advice are different for boys and for girls in terms of their own sexuality.

Although most pupils suggest from their responses that they would take heed of advice about safer sex, the results of the WRAP Survey (Holland *et al*, 1991a; 1991b) suggest that, women in particular, find it difficult to insist on safer sexual practices with men or to assert their wishes not to have sex. This indicates that knowledge and beliefs are not sufficient to predict or affect behaviour. Social situations and interpersonal dynamics, in particular, power relations, are also crucially important.

CHAPTER NINE

ATTITUDES

As the questionnaire was designed in part as an element within an evaluation of Health Education programmes, it was necessary to construct it in such a way as to reflect the factors that influence health behaviour. In relation to HIV, Fineberg (1988) has suggested that education programmes based on information-giving have been much more successful in raising awareness of HIV and knowledge than altering behaviour. To some extent this may be related to the need to incorporate work on attitudes, beliefs and values (Ross and Rosser, 1989; Tones, Tilford and Robinson, 1990), though it may also relate to imbalances in power relations which prevent people adopting safer behavioural practices (Holland *et al*, 1991a, 1991b). In terms of the construction of the questionnaire, the emphasis was on the part played by attitudes and values in determining health behaviour and also in affecting people's responses to others (*eg* drug users, people with HIV). The items on the drug use attitude scale were drawn from the ISDD (1974) questionnaire and its modifications by the Bridge Project in Cambridge for use with sixth form students. The rationale for including attitude items, more generally, draws on an evaluation of Health Behaviour Models, specifically, Bloom's Taxonomy of Educational Objectives (Bloom *et al*, 1964), the Theory of Reasoned Action (Ajzen and Fishbein, 1980), the PRECEDE model (Green *et al*, 1980) and The Health Behaviour Model (Rosenstock, 1966; Maiman and Becker, 1974; Janz and Becker, 1984). These are summarised and discussed in Section One, Chapter Four.

All of the models suggest that Health Education needs to incorporate more than information and to understand people's predisposition towards particular behaviours we need also to consider attitudes, values and beliefs. Without addressing this affective domain, according to the models, it is unlikely that there can be any real effect on knowledge and behaviour. It was, therefore, felt necessary as part of a Health Education programme to include affective education and, as part of an evaluation, to provide some measures of attitudes and beliefs. These included attitudes to: drugs and HIV; to people who take drugs or who have taken drugs; to those who supply drugs; to those who are HIV-positive and who have AIDS; and to those who work with these people, as well as attitudes related to the effects (social, physical and mental) of taking drugs and the possible outcomes of certain behaviours (*eg* sexual behaviours or use of particular drugs in particular ways).

The Theory of Reasoned Action and the PRECEDE model additionally emphasise the importance of perceived norms and social pressures and support. It was, therefore, felt to be

important to appreciate the weight given to particular influences (as considered earlier in the section on sources of information) and to peer group pressure and support.

Finally, the models acknowledge situational determinants of behaviour and health education programmes have been developed and were used within the study to address behaviour in particular situations. Whether working through such issues in the classroom bears any direct relation to behaviours in real situations is very much open to debate. It was not possible in the construction of a questionnaire to build in items that provide a measure of situational determinants. However, the later discussion on the importance of context for talk about drugs and HIV highlights related issues.

In considering the limits of a knowledge-based approach to either education or evaluation, it was also necessary to acknowledge that inaccurate knowledge can often be a greater inhibitor of particular behaviours than accurate information, *eg* the belief that cannabis can kill (see Chapter Seven) and beliefs about the relative dangers of cannabis and alcohol, (see below).

Attitudes to drug use

Attitudes to drug use were assessed using a frame of 25 items in which respondents had to indicate their agreement on a five-point Likert-type scale - 'agree strongly'; 'agree'; 'not sure'; 'disagree' and 'disagree strongly' . The instruction was:

'Here are some views on people taking drugs which have not been prescribed for them by a doctor. With some you may agree and with others not. Please read each one and tick the column which shows how YOU feel about these statements'.

Results are summarised below. The frequencies of particular responses in the Study Group, before and after the educational programme, and in the Control Group on the first and second administration of the questionnaire are given in Tables 2.9.1 - 2.9.50 in the Appendix.

Statements with which respondents tended to 'agree' or 'agree strongly'

The majority of pupils indicated agreement with the following views:

Taking drugs makes you into a different kind of person.

People who take one drug will want to take others. In this case, there were a lot of 'not sure' responses and a substantial number of 'disagrees'. However, very few pupils disagreed strongly and the general trend was to agree with this statement.

Drug taking leads to illness.

Drugs often lead to frightening experiences. The highest proportion of responses fell in the 'agree' category and a large number of pupils were unsure about this statement. Very few disagreed or disagreed strongly.

Even experimenting with drugs is dangerous.

People usually start on drugs out of curiosity. The largest category of response was 'agree'. The 'agree strongly' category was not often used and there were a large number of 'not sures'

A person who pushes drugs is not much better than a murderer.

If I had a friend who used cannabis, I would be very worried. Here, a clear majority of responses fell into the 'agree strongly' category.

Statements with which respondents tended to 'disagree' or 'agree strongly'

The majority of pupils indicated disagreement with the following views:

Drugs are only harmful if taken regularly. There was, generally, more disagreement than agreement with this statement, although a large proportion of respondents indicated that they were not sure.

Drugs help you to do things better. There was very little agreement at all with this statement.

Drugs are not a danger to health. Again, there was little agreement with this item. The level of agreement was considerably less than the level of disagreement with the item 'Drug-taking leads to illness'. This may be related to the inevitablilty implied by the latter statement.

Drug takers make lots of friends.

Certain drugs are worth trying. Generally, students disagreed with this statement, which goes against the trend in reality for young people to experiment with illegal substances (Swadi, 1988) and, in Cambridgeshire, at the time, to experiment particularly with solvents.

The dangers of drugs are very much exaggerated in the press and on TV. The tendency to disagree or disagree strongly with this statement remained throughout. Despite this, the media were not rated generally as the most trusted source of information in the section on sources and, in interview, some pupils commented on press over-exaggeration of drug use and presentation of HIV as a gay disease.

Most people start taking drugs because they are bored. There were, however, a substantial number of 'not sure' responses to this item.

Smoking cannabis is better than drinking alcohol. Most pupils disagreed or disagreed strongly, possibly because of legal/moral considerations or because they were not aware of the relative dangers of cannabis and alcohol. In this instance, having accurate information about the physical effects of cannabis and alcohol might lead to a relatively more tolerant attitude towards use of cannabis. This was not covered in the education programmes explicitly; that is, no direct comparisons were drawn.

Statements for which pupils tended to respond 'not sure'

The majority of pupils indicated that they were not sure of their level of agreement with the following items:

Drugs make you feel good. Although the highest category of response was 'not sure', there was also more disagreement than agreement with this item.

Drugs lead to mental illness. More pupils indicated agreement rather than disagreement.

People start to take drugs because they lack self-confidence. A substantial number of respondents marked the 'agree' box and, for the Control Group on the second questionnaire, this was more than those responding 'not sure' (50.4% as compared with 30.9%). There were few responses outside of these two categories, which accounted for between 77% and 84% of pupils' responses.

Statements to which pupils tended to give less unanimous responses

Pupils gave less consistent responses to the following items:

Some drugs are harmless.

People who start taking drugs can't stop. The varied responses to this statement contrasted with the tendency to agree with *People who take one drug will want to take others.* There appeared to be more emphasis on succumbing to the temptation to experiment and the 'slippery slope' into greater drug use (whether more in quantity or in types of substance used) than on psychological or physical addiction.

People who take drugs become failures. A spread of response across the range persisted in both groups, with fewer opting for the more extreme responses. This possibly reflected a rejection of crude stereotyping of drug users.

Drugs help you relax. Few respondents agreed strongly with this statement and rather more opted for the middle of the response range. This may reflect an ambivalence about the effects of drug use or an awareness of the different effects of different substances. However, as few pupils agreed that drugs help you do things better, it seems unlikely that they were making such discriminations.

Significant differences between Control and Study Group responses

Chi-square analysis demonstrated significant differences between the two groups on the following items:

Taking drugs makes you into a different kind of person Although in all conditions more respondents were likely to 'agree strongly' and 'agree' with this statement than 'disagree' or 'disagree strongly', there were significant differences between the Study and Control Group responses at the time of both completions of the questionnaire and also significant differences within both Study and Control Groups between the two questionnaires. Between the Study and Control Groups at the time of the first questionnaire there was a difference (chi-square = 18.5; DF = 4; $p < 0.001$) in that significantly more of those in the Study Group indicated that they were 'not sure' than in the Control Group. By the time of the second questionnaire, more in the Study group were agreeing or strongly agreeing with the statement and less responding 'not sure' than previously. In the Control group, the shift

was towards strong agreement, with a decrease in every other category of response. The difference between them was still significant (chi-square = 14.59; DF = 4; $p < 0.01$).

Drug-taking leads to illness Although generally there was agreement with this statement, there was a difference between the Control and Study Groups (chi-square = 10.37; DF = 4; $P < 0.05$) at the time of the first questionnaire, with relatively more in the Study Group responding 'not sure', 'disagree' or disagree strongly' than in the Control Group, where all but 7.8% demonstrated some agreement with the statement. This difference had disappeared by the second stage, with more responses in the disagreement categories and also under 'not sure'.

Drugs often lead to frightening experiences There were differences between the Control and Study Groups throughout the survey period, with more agreeing and agreeing strongly and less 'not sure' in the Control Group (combining the 'disagree' and 'disagree strongly' categories - Questionnaire 1: chi-square = 12.25; DF = 3; $p < 0.01$; Questionnaire 2: chi-square = 12.18; DF = 3; $p < 0.01$).

Some drugs are harmless A shift towards more general agreement with this statement, less strong disagreement and less uncertainty in the Study Group produced a difference between the Control and Study Groups (chi-square = 17.4; DF = 4; $p < 0.01$). This was one of only two occasions when this difference was created between the Control and Study Groups when they had not already, at the initial questionnaire, been seen to diverge. From a chi-square analysis this would, therefore, seem to be one of the only occasions when the change might be attributable to the education programme, though the Wilcoxon test shows no significant differences in either group between responses on the two questionnaires.

Drugs are only harmful if taken regularly An initial difference between the Control and Study Groups (chi-square = 9.67; DF = 4; $p < 0.05$), accounted for by there being more strong disagreement with the statement in the Control Group, and slightly less not sure and in agreement and strong agreement, is no longer evident by the time of the second questionnaire.

Drugs help you to do things better There appeared to be little agreement that drugs help you do things better, although there was a significant difference at the time of the second Questionnaire between the Control and Study Group's responses (chi-square = 10.75; DF = 4; $p < 0.05$). More respondents disagreed strongly and less were not sure in the Control Group than the Study Group on the second questionnaire.

Drugs help you relax At the time of the second questionnaire, less pupils 'disagreed strongly' within the Study Group (8.2%) than in the Control Group (17.1%) (chi-square = 10.13; DF = 4; $p < 0.05$).

Certain drugs are worth trying There was a difference in response between groups after the second questionnaire (chi-square = 16.38; DF = 4; $p < 0.01$). This was mainly accounted for by their being relatively fewer 'not sures' in the Control Group and relatively more strongly disagreeing.

People usually start on drugs out of curiosity There was a reduction in the responses within the two categories of disagreement and the 'not sure' category in the Study Group after the education programme and a corresponding increase in agreement. This was not reflected in the Control Group and produced a significant difference (chi-square = 17.98; DF = 4; $p < 0.05$) at the time of the second questionnaire. This was the second occasion when a difference emerges between the Control and Study Group that was not previously evident and with the significant difference in the Study Group on the Wilcoxon test too (see below), it is likely that this was an effect of the education programme. Pupils saw two videos within the lessons - *Chasing the Bandwagon* (Eye Films, 1985) and *Scene: Cold Turkey* (BBC1, 1983). In each of these, one humorous and one drama, individuals are presented as experimenting with drugs. For some, the motivation was curiosity and it may be that pupils were drawing on these psuedo-case studies in revising their views on curiosity as a reason for drug use.

Significant differences between responses on the two Questionnaires

A Wilcoxon signed-ranks test for same subjects demonstrated significant differences between the two administrations of the questionnaire on the following items:

Taking drugs makes you into a different kind of person In the Study Group there was a significant shift ($Z = -2.8441$; $p < .005$) towards agreement and strong agreement.

Drug-taking leads to illness The Wilcoxon test showed a significant reduction in agreement in the Control Group ($Z = -3.0290$; $p < .005$).

Drugs often lead to frightening experiences In the Study Group, there was a significant increase from the first to the second questionnaire in numbers strongly agreeing. This corresponded with a decrease in the 'not sure' category ($Z = -3.8140$; $p = .0001$).

Drugs are only harmful if taken regularly Significant changes occured in the Control Group with a reduction in 'not sure' responses, a slight increase in disagreement and increases in 'agree' and 'agree strongly' categories ($Z = -2.4308$; $p < .05$). This may be attributable to informal peer information networks.

Even experimenting with drugs is dangerous This statement met with more agreement than disagreement in each condition. Considering same subjects' responses on each questionnaire, the Study Group showed a significant change ($Z = -2.8927$; $p < .005$) with an increase in 'agree strongly' and 'agree' responses and a corresponding reduction in the 'not sure' and 'disagree' categories. A slight increase was evident in the 'disagree strongly' category.

Most people only start taking drugs because they are bored The Wilcoxon test showed a significant change in the Study Group with more agreeing and less disagreeing after the education programme ($Z= 1.9765$; $p < .05$). This may have been related to the content of the television drama shown as part of the pupils' education.

People usually start on drugs out of curiosity A significant difference was evident in the Study Group ($Z = -3.0868$; $p < .005$) which supports the change, perhaps related to the education programme, indicated by the chi-square analysis.

If I had a friend who used cannabis, I would be very worried Mostly, respondents strongly agreed with this item and more than 80% of the pupils were included in the two agree categories in both Study and Control Groups on both questionnaires. This was in line with the responses to the item *Smoking cannabis is better than smoking alcohol.* There was a difference over time in the Study Group when same subjects scores were compared using the Wilcoxon test ($Z = -2.1609$ $P < .05$), with a slight increase in disagree categories and decrease in strength of agreement. This may have reflected information given during the education programme reducing the negative attitude towards cannabis.

No significant differences between responses of Control and Study Groups or on the two questionnaires

Chi-square analysis and a Wilcoxon signed-ranks test for same subjects demonstrated no significant differences between Control and Study Groups and on the two administrations of the questionnaire on the following items:

People who take one drug will want to take others The majority of respondents indicated agreement or strong agreement, a substantial number were 'not sure' or responded 'disagree'. Few students disagreed strongly.

Drugs make you feel good Within each group, there was a tendency to be more in disagreement than agreement with this statement, but more pupils responded that they were unsure. This pattern remained in both groups. This may reflect a lack of direct experience of illegal drugs or pupils' ambivalence, being aware of both the attractions and the negative consequences of drug use.

All drug takers get hooked Responses illustrated divided opinion on this statement amongst pupils. Similar proportions responded 'agree', 'not sure' and 'disagree'. Much fewer pupils gave responses in the more extreme categories.

Drugs lead to mental illness The tendency to 'agree' rather than 'disagree' with this statement was common to both groups and remained, although the largest group of responses is in the 'not sure' category.

People who start taking drugs can't stop Responses spread across the full range on this item.

Drugs are not a danger to health There was very little agreement with this statement in either group and this remained the case at the end of the survey period.

Drugs lose their effect if taken regularly There was a spread of responses across all categories with relatively fewer demonstrating strong agreement and rather more 'not sure'. There seemed to be little awareness of the physical tolerance that can develop towards drugs.

Drug-takers make lots of friends There was clear disagreement with this statement generally.

People start to take drugs because they lack self-confidence Most respondents indicated either agreement or that they were not sure, with few giving responses in other categories.

Smoking cannabis is better than drinking alcohol

A person who 'pushes' drugs is not much better than a murderer The tendency to agree with this statement remained in both groups. This is discussed in Section Three in relation to the much more tolerant attitude expressed towards drugs being readily available at parties pupils attended.

Attitudes to HIV/AIDS

Attitudes to HIV / AIDS were assessed in much the same way as those towards drug use, by means of a frame of 13 items in which respondents had to indicate their agreement on a five-point Likert-type scale - 'agree strongly'; 'agree'; 'not sure'; 'disagree'; and 'disagree strongly'. As no questionnaire was available at the time for investigating young people's attitudes to HIV/AIDS, the items were developed to include statements seen as significant from the initial interviews and to cover issues I considered important from my work in the field. The pupils interviewed expressed concern about the prevention of transmission. They talked in terms of people who were to blame, about whether or not everyone who contracted the virus would die and about preventive measures such as isolation, carrying identification cards, compulsory testing and avoiding people with HIV. From my own concerns, I devised items related to whether or not young people of this age were concerned about HIV/AIDS, whether they felt the panic about AIDS was justified, whether they felt that they were at risk at all of contracting HIV and if they saw teaching about AIDS and HIV as important.

The instruction was:

Here are some views on AIDS and HIV (Human Immunodeficiency Virus - the virus which can lead to AIDS). Please read each one and tick the column that best fits how YOU feel about the statement.

Responses are given in Tables 2.9.51 - 2.9.76 in the Appendix for each of the items, for both Study and Control Groups, for both questionnaires.

Statements with which respondents tended to 'agree' or 'agree strongly'

The majority of pupils indicated agreement with the following views:

AIDS worries me. Responses to this question were a clear indication that HIV was a worry to many young people of school age, although between 12% and 21% reported that they

were not worried about it. The Study Group and Control Group responses did not differ significantly from each other.

Balding (1991) offers a set of comparison data, though his question relates directly to 'getting AIDS'. Combining Year Three and Year Four data, 16.2% said they were not at all worried about getting AIDS. This is roughly comparable to the two disagree categories combined in this study, where the percentages range from twelve to twenty-one. Of Balding's sample, 12.1% worried a lot about getting AIDS, compared with between 12 and 17% of my sample who 'agreed strongly' that 'AIDS worries me'. Almost a quarter (24.7%) of those completing Balding's questionnaire said that they did not think about getting AIDS at all. This may be comparable to the 14.1% to 23.5% who responded 'not sure' in this study. From Balding's study, it appears that 31.3% worry about getting AIDS a little and 15.8% quite a lot. In both studies, more than 60% expressed some worry about AIDS or getting AIDS.

Everyone is at risk from AIDS .

Everyone should be tested for HIV. The responses indicated a general agreement, but not particularly strong agreement, with this statement, which persisted in both groups over the course of the survey period. This issue was not debated in any of the classes involved in the research. It should have been implicit in the information given on antibody testing that, in addition to ethical considerations involved in broad screening, results are not always an accurate indication of HIV status. An infected person may receive a negative result during the period of time (around three months) that it takes for antibodies to HIV to be produced.

Everyone should be taught about AIDS. Pupils made very similar responses in each category over time, most tending to fall into the agree categories (more than 90% in each case), mainly 'strongly agree' (more than 64% in each case).

Statements with which respondents tended to 'disagree' or 'disagree strongly'

The majority of pupils indicated disagreement with the following views:

People are panicking too much about AIDS. Although more people tended to disagree with this statement (44.5- 63%) than agree (27-36%), the responses covered the range.

If I knew someone with AIDS, I would avoid him/her. Respondents tended to indicate rather more disagreement than strong disagreement on this item.

Most people who get AIDS deserve it. A tendency to disagree with this statement, with more disagreeing than strongly disagreeing, is evident in both groups on both questionnaires.

If I knew someone with HIV, I would avoid him/her. On the whole, respondents tended to disagree with this statement. Compared with the number who would avoid someone with AIDS, rather more would avoid someone with HIV. This perhaps suggests that, whereas people with AIDS were seen, more sympathetically, in terms of their illness, HIV-positive people, who were not ill, may have been regarded more in terms of the possibility of HIV transmission.

It is obvious when someone is carrying the virus. Very few respondents indicated any level of agreement with this statement, although a substantial number remained unsure.

People with the virus should carry identification cards. The main trend was towards disagreement . However, the responses covered the range from 'agree' to 'strongly disagree', with 24%-29% showing some level of agreement.

People with the virus should be kept away from everyone else.

Statements for which pupils tended to respond 'not sure'

The majority of pupils indicated that they were 'not sure' of their level of agreement with only the following item:

HIV always kills. The majority of pupils appeared to be unsure about this statement and their uncertainty tended to persist. However, there was a reduction in the 'not sure' category and an increase in disagreement in the Study Group, on the second questionnaire.

Statements to which pupils tended to give less unanimous responses

Pupils gave less consistent responses to the following item only:

Homosexuals have only themselves to blame if they get AIDS. Responses to this question were very split on both questionnaires. In the Study Group, 45.5 - 50% fell within the

agreement categories and 30 - 34% in the disagreement categories. In the Control Group, 37.4 - 53% indicated some level of agreement and 27.8 - 37.4% disagreement. In contrast, there was general disagreement with the statement *Most people who get AIDS deserve it.* Given that, at the time, AIDS was seen as a predominantly gay concern, this is an interesting contrast. The reference to 'homosexuals' within the statement perhaps raises the profile of the issue of sexuality, rather than of sympathy.

Significant differences between Control and Study Group responses

Chi-square analysis demonstrated significant differences between the two groups on the following items:

If I knew someone with AIDS, I would avoid him/her. A more marked increase in disagreement in the Control Group produced a significant difference between the groups at the time of the second questionnaire (chi-square = 9.73; 4 DF; $p < 0.05$). If change is attributed to education, it is surprising that the Control Group manifested the relatively larger change, in this direction.

Most people with AIDS deserve it. There was a significant difference between the Study and Control Groups at the time of the first questionnaire (chi-square = 17.29; DF = 4; $p < 0.01$) with a larger percentage of the Control Group disagreeing. A reduction in disagreement in the Control Group at the time of the second questionnaire removed the significant difference and, again, the change was in a direction that would not have been predicted by the hypothesis that education affects attitudes.

Everyone is at risk from AIDS. An increase in disagreement and in strong disagreement in the Study Group, with a reduction in 'not sure' responses produced a difference between the Study and Control Groups at the time of the second questionnaire (chi-square = 10.31; DF = 4; $p < 0.05$). This suggests that, with education, pupils were able to distinguish between higher and lower risk behaviours and that some groups are, therefore, less likely to acquire HIV.

People with the virus should carry identification cards. An increase in strong disagreement within the Control Group produced a significant difference between Control and Study Group responses on the second questionnaire (chi-square = 14.76; DF = 4; $p < 0.01$).

People with the virus should be kept away from everyone else. An increase in the two disagree categories in the Control Group at the time of the second questionnaire produced a

significant difference between the Control and Study Groups (chi-square = 18.19; DF = 4; p <0.01).

HIV always kills. A reduction in the 'not sure' category and an increase in disagreement in the Study Group, on the second questionnaire, produced a significant difference between Study and Control Groups (chi-square = 14.26; DF p < 0.01). This is possibly attributable to education.

Significant differences between same-subject responses on the two questionnaires

A Wilcoxon signed-ranks test for same subjects demonstrated significant differences between responses to the following items on the two administrations of the questionnaire:

People are panicking too much about AIDS. Within the Study Group, a Wilcoxon test indicated a significant change between the two questionnaires (Z = -2.8325; p < .005). This was the result of an increase in 'disagree' and 'disagree strongly' responses and a corresponding decrease in the others.

If I knew someone with AIDS, I would avoid him/her. Although the majority of pupils indicated that they would not avoid someone with AIDS, a Wilcoxon signed-ranks test showed that, in both the Study Group (Z = -4.6442; p = .0000) and the Control Group (Z= -3.4562; p = .0005) there was a significant increase in disagreement in both groups.

Everyone is at risk from AIDS. The Wilcoxon analysis showed a significant change in the Control Group, with a decrease in 'not sure' and agree responses and an increase in 'disagree' and 'disagree strongly' responses (Z = -2.4330; p < .05).

If I knew someone with HIV, I would avoid him/her. The Wilcoxon test showed that both groups demonstrated a significant change over the two questionnaires with a reduction in 'not sure' responses and an increase in 'disagree' and 'disagree strongly' (Study Group: Z = -4.4293; p= .0000; Control Group: Z = -3.5728; p < .001).

It is obvious when someone is carrying the virus. Amongst those pupils who completed both questionnaires in the Study Group, there was a significant increase in 'disagree' and 'disagree strongly' responses and a decrease in the other categories (Z = -3.8938; p = .0001).

People with the virus should be kept away from everybody else. A significant increase in disagreement was evident on a Wilcoxon test of Control Group responses (Z = -3.0189;

$p < .0025$) and the Study Group also manifested a significant change in terms of an increase in 'disagree strongly' and a decrease in 'disagree' ($Z = -3.0189$; $p < .005$). In this latter case, the change represented strength of response rather than a change of opinion.

HIV always kills. For the Study Group, a Wilcoxon test showed that a reduction in the 'not sure' category and an increase in disagreement in the Study Group, on the second questionnaire, was significant on a same subjects' response analysis ($Z = -3.0897$; $p < .005$). This may have been linked to the education programme.

No significant differences between responses of Control and Study Groups or on the two questionnaires

Chi-square analysis and A Wilcoxon signed-ranks test for same subjects demonstrated no significant differences between Control and Study Group and on the two administrations of the questionnaire for the items below. There was consistent, general agreement with:

AIDS worries me.

Everyone should be tested for HIV .

Everyone should be taught about AIDS.

and a spread across responses to the statement:

Homosexuals have only themselves to blame if they get AIDS . Responses did not change significantly over time, nor were significant differences observed between groups.

Summary

Attitudes to drug use

In general the pupils demonstrated an 'anti-drugs' attitude throughout the survey period and few major changes occurred in responses to this set of items. This was evident both before and after the education programme in the Study population and was also strong in the Control Group. Pupils indicated belief that drug use leads to a change in the type of person you are, illness (physical and mental) and frightening experiences and that dangers are still present even on occasional use or experimentation. They disagreed that drugs could help you to do things better and that the media exaggerated the dangers of drug use. They

generally saw pushers as not much better than murderers and would be very worried if a friend started to use cannabis.

Some ambivalence existed around whether or not drugs make you feel good and help you relax. In addition, pupils were unsure about whether drug users would become dependent on their use and whether drugs tend to lose their effect if taken regularly. This reflects the emphasis in the drug education programmes on social and personal factors related to drug use and broad properties of substances rather than physical effects on the body.

Wilcoxon tests on same subjects on two different occasions suggested a slight softening of the anti-drug attitude in the Control Group, with a reduction in agreement that drug use leads to illness and and increase in agreement that it is only when taken regularly that drug use is harmful.

More changes were evident in the Study Group from the Wilcoxon tests, which is as might be expected from the implementation of an education programme. Pupils showed an increase in agreement that drug use can lead to frightening experiences, that even experimenting with drugs is dangerous and that drug use makes you a different kind of person. As well as indicating an increasingly anti-drug attitude, these changes may reflect the use of video material which presented characters involved in drug use in ways that correlate with the items on which change occurs. Similarly, an increase in ascribing drug use to motivations like boredom and curiosity, may have been a result of characterisation in the videos. The Study Group also showed a significant reduction in concern over the hypothetical situation of friends using cannabis. This may reflect the information given on the effects of cannabis and indicates the dilemma for the educationalist who wishes to deter illegal drug use in presenting accurate, rather than stereotypical information.

Chi-square analysis showed that only on two occasions were the Control and Study Groups similar at the point of the first questionnaire and responding differently on the second. These differences occur in response to the items relating to some drugs being harmless and curiosity as a motivation. It was, therefore, the case that only on one item (*People usually start on drugs out of curiosity*) do the two tests coincide in demonstrating change. In this case, the educational outcome was of little value and certainly was not a conscious aim of the teachers.

Very little can be directly attributed to education here and changes that are conceivably attributable are not always in line with educational aims. Influences other than the

formal educational programme cannot be ruled out, particularly the peer-group network (as discussed in the Section Three) and media influence.

There does seem to have been an increase in the group which undertook the educational programme in understanding possible motivations for drug use which may be due to the situational exercises and the video presentations.

Attitudes to cannabis remained broadly negative and the concern over friends using cannabis was counter to assumptions that might be made on the basis of the notion of negative peer influence. Drug use was not seen as conducive to making lots of friends, which, again, runs contrary to the peer pressure argument. Within this context, peer influence towards taking illegal substances appeared likely to be low. However, data drawn from other settings - *eg* on drug use and style and on 'users we know' revealed a different perspective on the peer issue.

Within this context, the media were seen as presenting a fairly accurate picture of drug use - not exaggerating its dangers. This attitude towards the media was not consistent across responses in different settings.

Attitudes to HIV/AIDS

It is clear from responses to the items in this section of the questionnaire that the pupils took HIV/AIDS very seriously. They expressed general disagreement with the statement that people are panicking too much about AIDS, agreement that AIDS worries them, that everyone is at risk from HIV and that everyone should be taught about it. The section on risk groups unpacked their notions of risk further, but AIDS is obviously a matter of major concern to the young people in the survey population.

Again, generally speaking, the responses indicated a tolerant attitude to people with HIV and AIDS and an awareness that HIV is not transmitted through social contact. Most would not avoid someone with AIDS or HIV and did not feel that people with HIV should be kept away from other people. These responses differed from those expressed by a different but comparable sample of pupils in small group interviews, prior to the main study Although disagreeing that most people who get AIDS deserve it, there was a much more divided response to *Homosexuals (gays) have only themselves to blame if they get AIDS*. In 1986, at the time of the survey, language such as 'the AIDS virus' and 'getting AIDS' was common. HIV and AIDS were used much more synonymously than they are now. Responses to the items *If I knew someone with HIV, I would avoid him/her and If I knew*

someone with AIDS, I would avoid him/her suggested that when their attention was drawn to the distinction, pupils treated the two terms (HIV and AIDS) differently.

In terms of prevention, most pupils thought that everyone should be tested for HIV, despite their knowledge of the possibility of testing negative and being positive and that a negative test at any one time does not guarantee a person staying negative. There was, however, disagreement over the suggestion that people should carry identification cards to inform others of their status.

There was an ambivalent response to the statement *HIV always kills*, reflecting the mixed messages in the media about progression from HIV to AIDS, and the likelihood of survival once diagnosed as having AIDS. This is also indicative of the ambiguous use of the term HIV within the media, which is sometimes synonymous with AIDS and, at other times, seen as distinct.

It remains difficult, as with the attitude statements on drug use, to attribute any changes directly to education. Wilcoxon tests revealed changes in both the Control and Study Groups, though rather more within the Study Group and, generally, on different items. Other factors than the teaching programme may have been responsible for the change. In the Study Group there was increased disagreement that people panic too much about AIDS and that everyone is at risk. Both the Study and the Control Group indicated an increased level of disagreement with the statements relating to avoiding people with HIV and AIDS. This would have been a predictable outcome of the education programme, but causal assumptions are confounded by the change that occurred in the Control Group, which cannot be attributed to formal education. Both groups also disagreed increasingly that people with HIV should be kept away from other people.

In line with the content of the educational programme, the Study Group demonstrated increased disagreement that it is obvious when a person has HIV and that HIV always kills. The Control Group shows a reduction in disagreement with the statement that people who get AIDS deserve it, though in general respondents did not support this statement.

CHAPTER TEN

FACTOR ANALYSIS OF ATTITUDE ITEMS

Factor analysis assumes that the observed correlations between measured variables are produced by underlying regularities in the data and that variance is caused by common determinants which affect all the variables. In this case, the assumption is that the set of questions samples patterns of belief and disbelief and vocabulary associated with particular discourses on drug use and HIV and AIDS. Responses to these scales were factor analysed to identify the concepts or discourses underlying them . The term discourse is being used here in the sense outlined in Section One, that is, discourse understood as an underlying organising principle or structure, rather than simply as conversation. In considering the qualitative data, I will demonstrate how the nature of these underlying discourses changes between contexts. Hence, the use of factor analysis can be seen as a midway point between the more empirical presentation of data in the previous chapter and the approach which is to be adopted in the qualitative analysis, following in Section Three.

Factor analysis works with the assumption that a causal system of underlying factors will always underpin one correlation system of measured variables and that the causal influence is uni-directional. This means that, in reading from variables to underlying factors, there is a degree of indeterminacy. This problem is compounded by the inevitability of sampling and measurement errors in this sort of data.

I factor analysed the scales using the SPSS-X statistical package. In the first instance, a minimum number of factors were extracted that could account for the correlations between observed variables. Where sampling and measurement error cannot be ruled out, some criterion has to be used to select an appropriate number of factors that are not most plausibly the result of methodological error. By rotating the data, keeping the number of factors and communalities (variance of each measured variable accounted for by common factors) fixed, factors that are more easily interpreted can be extracted. I selected an orthogonal rotation method - varimax. This maximises the amount of variance of each variable that can be accounted for by one particular factor. It minimises the cross-products of the factor loadings for each factor, by loading as much of the variance of a factor as possible on a few items, with as little variance as possible loading on other items. Orthogonal rotation avoids some of the pitfalls of non-orthogonal factor rotation, which allows factors which are not perpendicular to each other. This inflates loadings and makes the computation of communalities difficult to interpret.

Factors are listed in the matrix in descending order of importance (see Tables 2.10.1 - 2.10.24). The consequences of rotation, which imposes arbitrary limitations, are that variables may load high on more than one factor and factors can have items with both positive and negative loadings. Decisions then have to be made about which items to include on which factor. Those with clearly higher coefficients in the matrix on one factor rather than another are linked to that factor. Where items have substantial loadings on more than one factor, they are poor in terms of discriminating between factors and are best excluded.

In deciding how many factors to interpret, a number of criteria are possible, both statistical, such as significance tests like a large sample chi-square and eigenvalue criteria and substantive, such as the theoretical coherence of a factor. Kaiser (1974) favours a cut off point where the eigenvalue is greater than one for inclusion amongst factors for consideration. Cattell (1965) suggests a 'scree test' where factors are included up to the point at which the eigenvalues begin to level off. For the purposes of this study I used both the scree test and the substantive significance of the factors.

F-values were calculated to decide whether the percentage of variance explained by the factors could have occurred by chance, by dividing the mean square for the explained variation by the mean square for the residual variation.

It is important to consider both substantive significance and statistical significance. Given all the factors which could explain the variance, percentages as high as 35-44% are substantively significant and statistically significant.

Attitude to drugs factors

The drugs attitude scale of twenty-five items was factor analysed for the Control Group, the Study Group and both groups combined, for both questionnaires. The analysis revealed similar structures underlying each scale across the groups and these are discussed below. Typically, the dimensions that emerged most strongly were those which

a] disputed the positive aspects of drug use

b] emphasised addiction

c] emphasised physical, mental and moral decline

In addition to these, there were weaker factors which either related to a considered assessment of risk - on balance negative - or to a more general anti-illegal drug stance. Items which loaded highest on each factor and the amount of variance explained are given beneath the factor heading. Factor matrices are presented in Tables 2.10.1 - 2.10.12 in the Appendix.

Control and Study Group combined - Questionnaire 1

Four factors were selected using the criteria of theoretical coherence and the 'scree effect'. These factors explained 35% of the variance for the drugs attitude scale for all subjects on the first questionnaire. This was significant at the 0.05 level (F= 2.96; F crit = 2.82).

FACTOR ONE

Drugs make you feel good	(disagree)	.44359
Drugs help you to do things better	(disagree)	.64107
Drugs are not a danger to health	(disagree)	.58978
Drugs help you relax	(disagree)	.58315
Drug-takers make lots of friends	(disagree)	.54878
Certain drugs are worth trying	(disagree)	.56523

Variance explained = 15%

The 'disagree' in brackets after the item relates to the orientation to the statement that would yield a high score on that factor. A negative loading, therefore, would, in interpreting a factor, convert a 'disagree' to 'agree'.

Factor One could be interpreted as taking issue with positive statements about drug use. All of the included items involved responses disputing a discourse of persuasion around drug use. Within behavioural approaches to drugs education, where pupils act out specific roles (for example, one individual tempting another to take an imaginary substance and that individual refusing) statements such as these would be used. This type of persuasion is rather stereotypical, but it appears to be the discourse on which the pupils were drawing (and, perhaps, the one underlying the choice of these particular items on the original questionnaire).

FACTOR TWO

People who take one drug will want to take another	(agree)	.63805
All drug takers get hooked	(agree)	.73208
People who start taking drugs cannot stop	(agree)	.73255
People who take drugs become failures	(agree)	.44507

Variance explained = 7.7%

The items which load most strongly on this factor all related to addiction. The fourth item, however, concerned the general decline of the stereotypical drug user. Together, the addiction and decline elements comprised a 'slippery slope' factor, where the drug user was regarded as 'going downhill', fairly inevitably. This tallied well with the messages of the 'Heroin Screws You Up campaign', which was launched prior to the survey.

FACTOR THREE

Drug-taking leads to illness	(agree)	.47336
Drugs often lead to frightening experiences	(agree)	.62937
Drugs lead to mental illness	(agree)	.67923
People who take drugs become failures	(agree)	.38116
A person who pushes drugs is not much better than a murderer	(agree)	.36598

Variance explained = 7.1%

As 'People who take drugs become failures' was common to both Factor Two and Factor Three, it was removed from any later analyses involving factor scores. Although similar to the second factor in its emphasis on decline physical, mental and moral decline, there were differences. The first factor, particularly if the weakest item was excluded, related purely to addiction. This factor concerned physical, mental and moral deterioration.

FACTOR FOUR

Some drugs are harmless	(agree)	.36812
Drugs are only harmful if taken regularly	(disagree)	.65801
Even experimenting with drugs is dangerous	(disagree)	-.55103
The dangers of drugs are very much exaggerated in the press and on TV.	(disagree)	.61179

Variance explained = 5.2%

The negative loading on 'Even experimenting with drugs is dangerous' meant that it should be interpreted as something with which a high scorer on this factor would agree. Although acknowledging that not all drugs are harmful, the assessment of drug use was that it is dangerous and that media warnings are warranted.

Control and Study Group combined - Questionnaire 2

Four factors explained 38.4% of the variance. This, again, was significant at the 0.05 level (F= 3.43; F crit = 2.82).

FACTOR ONE

People who take one drug will want to take another	(agree)	.67225
All drug takers get hooked	(agree)	.74567
People who start taking drugs cannot stop	(agree)	.71267
People who take drugs become failures	(agree)	.46825

Variance explained = 17.5%

Factor One was identical in structure to Factor Two on Questionnaire One, except that on Questionnaire Two there was a marked increase in its strength as this factor explained 17.5% rather than 7.7% of the variance. This factor related to drug addiction and the negative result of failure. As with the first questionnaire, the items related to taking more drugs (not necessarily more of the same drug, but also different drugs) loaded most strongly on this factor.

FACTOR TWO

Even experimenting with drugs is dangerous	(agree)	.55610
Drugs are not a danger to health	(disagree)	-.31619
Certain drugs are worth trying	(disagree)	-.33529
The dangers of drugs are very much exaggerated in the press and on TV	(disagree)	-.37762
Smoking cannabis is better than drinking alcohol	(disagree)	-.54323
A person who pushes drugs is not much better than a murderer	(agree)	.46390
If I had a friend who used cannabis, I would be very worried	(agree)	.72291

Variance explained = 8.2%

This Factor represented a very anti-illegal drug stance and related to concern about the (non-specific) dangers of illegal drug use.

FACTOR THREE

Drug-taking leads to illness	(agree)	.53439
Drugs often lead to frightening experiences	(agree)	.71891
Drugs lead to mental illness	(agree)	.57487

Variance explained = 7.3%

This factor was similar to Factor Three on the previous questionnaire and explained virtually the same amount of variance. It related to ideas of physical and mental decline.

FACTOR FOUR

Drugs make you feel good	(disagree)	.80372
Drugs are only harmful if taken regularly	(disagree)	.35876
Drugs help you to do things better	(disagree)	.33839
Drugs help you relax	(disagree)	.71032

Variance explained = 5.4%

Factor Four was similar to factor One on the first questionnaire, but considerably weaker (explaining 5.4% of the variance, in comparison with 15% previously). Disagreement with these items suggested a discourse involving exploding myths about drug use, or disputing the positive value of drug-taking.

Study Group - Questionnaire 1

Similar factor structures emerged for the Study Group, analysed for both questionnaires, as for the combined groups. Four factors explained 33.8% of the variance for the Study Group on Questionnaire One ($F = 2.82$; $F\ crit = 2.82$; $p < 0.05$).

FACTOR ONE

Drugs make you feel good	(disagree)	.40659
Drugs help you to do things better	(disagree)	.64150
Drugs are not a danger to health	(disagree)	.59316
Drugs help you relax	(disagree)	.56119
Drug-takers make lots of friends	(disagree)	.58589
Certain drugs are worth trying	(disagree)	.59824

Variance explained = 14.3%

This first factor was similar in both structure and the amount of variance explained to the first factor emerging from the analysis of the combined groups' responses. The responses disputed the positive assertions about drug use.

FACTOR TWO

People who take one drug will want to take others	(agree)	.61922
Drugs make you feel good	(disagree)	.34816
All drug takers get hooked	(agree)	.73436
Some drugs are harmless	(disagree)	-.31983
People who start taking drugs can't stop	(agree)	.72703
People who take drugs become failures	(agree)	.38772
Drugs help you relax	(disagree)	-.37798

Variance explained = 8%

This factor corresponded to the analysis of the whole sample data, where the second factor accounted for 7.7% of the variance and could also be interpreted as an addiction or 'slippery slope' dimension.

FACTOR THREE

Drug-taking leads to illness	(agree)	.44593
Drugs often lead to frightening experiences	(agree)	.62808
Drugs lead to mental illness	(agree)	.61302
People who take drugs become failures	(agree)	.45133
Drugs lose their effect if taken regularly	(agree)	.35287

Variance explained = 7.3%

The amount of variance explained was close to that for the whole sample. The factor can be linked to understandings of physical and mental decline resulting from drug use, as with the combined groups' data.

FACTOR FOUR

Some drugs are harmless	(disagree)	.41440
Drugs are only harmful if taken regularly	(disagree)	.69911
People start to take drugs because they lack self-confidence	(disagree)	-.49861
The dangers of drugs are very much exaggerated in the press and on TV	(disagree)	.55799
If I had a friend who used cannabis, I would be very worried	(agree)	-.35174

Variance explained = 5.2%

This factor largely concerned assessment of risk. The item 'People start to take drugs because they lack self-confidence', although statistically linked to the other items appeared to have less theoretical coherence with them. The amount of variance explained was identical to that explained by Factor Four for both groups on the first questionnaire and the interpretation of both was similar.

Study Group - Questionnaire 2

Four factors explained 36.5% of the variance (F = 3.16; F crit = 2.82; $p < 0.05$). The factors were similar to those revealed by the factor analysis of the questionnaire preceding the education programme, though each factor was marginally stronger . This suggested that the education programme did not fundamentally alter the structures underlying the attitudes towards drugs as revealed here.

FACTOR ONE

Drugs help you to do things better	(disagree)	.46096
Drugs are not a danger to health	(disagree)	.58174
Drugs lose their effect if taken regularly	(agree)	.61466
Drug-takers make lots of friends	(disagree)	.59659
Certain drugs are worth trying	(disagree)	.52498
Smoking cannabis is better than drinking alcohol	(disagree)	.53598

Variance explained = 16.7%

As previously, this first factor consisted of disputing positive aspects of illegal drug use.

FACTOR TWO

People who take one drug will want to take others	(agree)	.62814
All drug takers get hooked	(agree)	.77205
People who start taking drugs can't stop	(agree)	.69479
People who take drugs become failures	(agree)	.42592

Variance explained = 9%

Again, the second factor related to addiction and the 'slippery slope' of drug use.

FACTOR THREE

Taking drugs makes you into a different kind of person	(agree)	.41979
Drug-taking leads to illness	(agree)	.59145
Drugs often lead to frightening experiences	(agree)	.67020
Drugs lead to mental illness	(agree)	.59127

Variance explained = 7.4%

This can be interpreted in terms of physical, mental and, possibly, moral decline.

FACTOR FOUR

Drugs make you feel good	(disagree)	.81095
Some drugs are harmless	(disagree)	.34410
Drugs are only harmful if taken regularly	(disagree)	.39275
Drugs help you to do things better	(disagree)	.37215
Drugs help you relax	(disagree)	.72423

Variance explained = 5.4%

As with Factor One the emphasis was on disputing positive aspects of drug use and safe use. There was a difference, however, in that this last group was more concerned with assessment of risks and effects than exploding myths about drug use.

Control Group - Questionnaire 1

Factor analysis of the Control Group data demonstrated similar structures underlying pupils' responses to that of the Study Group. The first three factors were very closely related, although a more complex view of drug use was demonstrated. The dangers of drug use were acknowledged, but there was also a rejection of some of the more stereotypical notions. The fourth factor was less clearly interpretable, but linked to a more general anti-drugs stance; again, without accepting some of the cruder judgements on drug use and drug users. Four factors explained 41.1% of the variance ($F = 3.88$; $F\ crit = 2.82$; $p < 0.05$).

FACTOR ONE

Drugs make you feel good	(disagree)	.49504
Drugs help you relax	(disagree)	.51066
Certain drugs are worth trying	(disagree)	.64295
Smoking cannabis is better than drinking alcohol	(disagree)	.78148
If I had a friend who used cannabis, I would be very worried	(disagree)	-.80877

Variance explained = 19.2%

Factor One refuted positive aspects of drug use. This was broadly similar to the Study Group Factor One, but was a stronger factor.

FACTOR TWO

Drug-taking leads to illness	(agree)	-.69371
Drugs often lead to frightening experiences	(agree)	-.51177
Drugs are only harmful if taken regularly	(disagree)	.52026
Drugs help you to do things better	(disagree)	.75297
Drugs are not a danger to health	(disagree)	.53474

Variance explained = 7.9%

This factor acknowledged the danger involved in drug use, but disputed the inevitability of illness and negative experiences. Though similar to the Study Group equivalent, the rejection of cruder stereotypes was an important difference.

FACTOR THREE

People who take one drug will want to take others	(agree)	.53559
All drug takers get hooked	(agree)	.45210
People who take drugs become failures	(agree)	.78787

Variance explained = 7.7%

The factor relating to addiction and the 'slippery slope' of drug use was virtually identical in strength and composition to that of the Study Group.

FACTOR FOUR

People who take one drug will want to take others	(agree)	.36196
Drugs are only harmful if taken regularly	(disagree)	-.44391
People start to take drugs because they lack self-confidence	(disagree)	.55570
Drugs lose their effect if taken regularly	(agree)	.32804
The dangers of drugs are very much exaggerated in the press and on TV	(disagree)	-.77859

Variance explained = 5.4%

This factor was composed of items that present drug use as a problem for those who are addicted or involved in the drug scene, but sees the dangers as exaggerated more generally. This factor linked more to the personal aspects of drug use that Factor One, where the focus was more on the effects of the substances themselves.

Control Group - Questionnaire 2

Four factors explained 43.2% of the variance (F = 4.29; F crit = 2.82; $p < 0.05$).

FACTOR ONE

Drugs are only harmful if taken regularly	(agree)	.35670
Drugs are not a danger to health	(disagree)	.37943
Drugs help you relax	(disagree)	.38322
Certain drugs are worth trying	(disagree)	.66583
Smoking cannabis is better than drinking alcohol	(disagree)	.73995
If I had a friend who used cannabis, I would be very worried	(agree)	-.78660

Variance explained = 21.9%

In general, this factor refuted arguments for taking drugs. Occasional use was regarded as less risky and, though alcohol was seen as 'better' than cannabis, the negative loading on

the final item indicated disagreement that they would be very worried if a friend was using cannabis. The focus was on the substance rather than the person within this factor and it presented a selectively anti-drug stance.

FACTOR TWO

People who take one drug will want to take others	(agree)	.65382
All drug takers get hooked	(agree)	.82891
People who start taking drugs can't stop	(agree)	.76247
People who take drugs become failures	(agree)	.41140

Variance explained = 7.6%

The addiction and 'slippery slope' factor always appeared within the results of the factor analysis and accounted for much the same amount of variance in each case.

FACTOR THREE

Drugs often lead to frightening experiences	(agree)	.74312
Drugs lead to mental illness	(agree)	.53936
Drugs are only harmful if taken regularly	(disagree)	-.65309
People who take drugs become failures	(agree)	.46919

Variance explained = 7.2%

This factor was also recurrent within the analysis of each data set and related to physical and mental decline. In this instance, the agreement that 'Drugs are only harmful if taken regularly' indicated by a negative loading on this factor, suggested that there was some tolerance for occasional use.

FACTOR FOUR

Drugs help you to do things better	(disagree)	.65722
People who take drugs become failures	(agree)	-.36500
Drugs help you relax	(disagree)	.50286
Drug-takers make lots of friends	(disagree)	.83205
People start to take drugs because they lack self-confidence	(disagree)	.32946

Variance explained = 6.4%

The fourth factor can be interpreted as a rejection of positive aspects of drug use, but it also rejected stereotypical notions of drug users as failures and as people who begin their drug use because of a lack of self-confidence. It represented a largely anti-illegal drug stance and was similar, in that respect, to Factor One, though the emphasis here was more on personal characteristics and effects than the substance itself.

Attitudes to HIV/AIDS Factors

As with the scale of items representing attitude statements about drug use, the thirteen items in the frame of attitudes towards and beliefs about HIV/AIDS were factor analysed. F-values were calculated to establish whether or not the amount of variance explained by the factors was significant. The factor matrices are presented in Tables 2.10.14 - 2.10.25 in the Appendix.

The analysis showed both similarities and differences between the Study and Control Groups. Two common structures were exhibited, underlying the attitude statements

a] tolerance and acceptance of people with HIV and AIDS

b] invulnerability - HIV might have been a matter of general concern, but not of personal concern to these respondents

Analysis of the study Group data revealed three coherent factors, the third being personal concern about HIV and AIDS. In the Control Group, there were two additional factors to those common to both groups. These factors related to the rejection of myths about HIV and AIDS, linked to social stigma attached to those who have the virus or myths about viral

transmission and the progression from HIV infection to inevitable death. Within health education messages at the time, an important emphasis was placed on dispelling the idea that everyone who contracted HIV had a limited time to live.

Control and Study Group combined - Questionnaire 1

Three factors were extracted and together explained 45.9% of the variance (F = 2.55; F crit = 3.86; P > 0.05). The amount of variance explained is, therefore, not significant, statistically.

FACTOR ONE

If I knew someone with AIDS I would avoid him/her	(disagree)	.81134
Most people who get AIDS deserve it	(disagree)	.48446
If I knew someone with HIV, I would avoid him/her	(disagree)	.79188
People with the virus should carry identification cards	(disagree)	.59257
People with the virus HIV should be kept away from everyone else	(disagree)	.73379
Homosexuals have only themselves to blame for AIDS	(disagree)	.61204

Variance explained = 23.2%

This suggested a factor concerned with tolerance and acceptance of people with HIV/AIDS. The items might have been linked by the principle of 'invulnerability', except for the final statement listed here. This contextualised the others and suggested that the factor related to a liberal attitude towards others rather than low fear of contracting HIV.

FACTOR TWO

Most people who get AIDS deserve it	(disagree)	-.42590
Everyone is at risk from AIDS	(disagree)	.46348
Everyone should be tested for HIV	(disagree)	.69199
Everyone should be taught about AIDS	(disagree)	.65975

Variance explained = 13.6%

The second factor related to notions of invulnerability. It is assumed that HIV was not a matter of concern for everyone. It was linked to particular groups who deserved to be

infected. There seems to have been an assumption that this was natural rather than learned behaviour, as education for all about HIV was not thought necessary. This suggested that they believed some people would and others would not become infected regardless of education.

FACTOR THREE

People are panicking too much about AIDS	(agree)	-.80862
AIDS worries me	(disagree)	.69387

Variance explained = 9.1%

This factor expressed concern about the spread of HIV.

Control and Study Group combined - Questionnaire 2

Three very similar factors emerged to those from the analysis of the first questionnaire data. The amount of variance explained by the first factor was greater than previously, but that explained by the other two is much the same. The amount of variance explained (49.4%) was not significant at the 0.05 level (F = 2.93; F crit = 3.86). The fourth factor indicated in the table below lacked theoretical coherence and was excluded.

FACTOR ONE

If I knew someone with AIDS I would avoid him/her	(disagree)	.86023
Most people who get AIDS deserve it	(disagree)	.53742
If I knew someone with HIV, I would avoid him/her	(disagree)	.87619
People with the virus should carry identification cards	(disagree)	.59450
People with the virus HIV should be kept away from everyone else	(disagree)	.78544
Homosexuals have only themselves to blame for AIDS	(disagree)	.49116

Variance explained = 26.6%

This factor was similar to (but explains more variance than) Factor One of the Control and Study Groups combined and includes items related to tolerance and acceptance of people with HIV and AIDS.

FACTOR TWO

Most people who get AIDS deserve it	(disagree)	-.40189
Everyone is at risk from AIDS	(disagree)	.43663
Everyone should be tested for HIV	(disagree)	.69691
Everyone should be taught about AIDS	(disagree)	.66239

Variance explained = 13.6%

The second factor, related to a sense of invulnerability and the confinement of HIV risk to particular sectors of the population.

FACTOR THREE

People are panicking too much about AIDS	(agree)	-.81181
AIDS worries me	(disagree)	.69132

Variance explained = 9.2%

This factor is linked to concern about AIDS.

Study Group - Questionnaire 1

Three factors were extracted from the initial factor analysis on the basis of the 'scree criterion' and theoretical coherence. The amount of variance (46.3%) explained was not statistically significant ($F = 2.59$; $F\ crit = 3.86$; $p > 0.05$).

FACTOR ONE

If I knew someone with AIDS I would avoid him/her	(disagree)	.81887
Most people who get AIDS deserve it	(disagree)	.51365
If I knew someone with HIV I would avoid him/her	(disagree)	.79471
People with HIV should carry an identification card	(disagree)	.60496
People with the virus should be kept away from everyone else	(disagree)	.72086
Homosexuals have only themselves to blame for AIDS	(disagree)	.65058

Variance explained = 21.1%

This factor can be interpreted as indicating tolerance and acceptance.

FACTOR TWO

Most people who get AIDS deserve it	(disagree)	-.40189
Everyone is at risk from AIDS	(disagree)	.43663
Everyone should be tested for AIDS	(disagree)	.69691
Everyone should be taught about AIDS	(disagree)	.66239

Variance explained = 13.2%

The items in this factor indicated an attitude of intolerance and also invulnerability to HIV. Those scoring high did not see HIV and AIDS as a threat to themselves.

FACTOR THREE

People are panicking too much about AIDS	(agree)	-.81181
AIDS worries me	(disagree)	.69132

Variance explained = 9.0%

The third factor expressesd concern about AIDS for the population generally but not for oneself.

Study Group - Questionnaire 2

The same three factors were evident in the analysis of the second questionnaire as for the first. The first factor explained more variance on the second questionnaire than the first, and has therefore strengthened. Together the factors explained 50.1% of the variance, which was not significant at the 0.05 level (F = 3.01; F crit = 3.86).

FACTOR ONE

This can be interpreted as the 'tolerance/acceptance' factor:

If I knew someone with AIDS I would avoid him/her	(disagree)	.76590
Most people who get AIDS deserve it	(disagree)	.66201
If I knew someone with HIV, I would avoid him/her	(disagree)	.80591
People with the virus should carry identification cards	(disagree)	.66164
People with the virus HIV should be kept away from everyone else	(disagree)	.78396
Homosexuals have only themselves to blame for AIDS	(disagree)	.65194

Variance explained = 27.4%

FACTOR TWO

People are panicking too much about AIDS	(agree)	-.66083
AIDS worries me	(disagree)	.74382
Everyone is at risk from AIDS	(disagree)	.56976
Everyone should be taught about AIDS	(disagree)	.47295

Variance explained = 13.2%

Panic about AIDS was not seen as generally inappropriate, but AIDS was not regarded as an issue for them. This is the 'personal invulnerability' factor.

FACTOR THREE

This was the 'concerned' factor:

Everyone should be tested for HIV	(disagree)	.69036
It is obvious when someone is carrying the virus, HIV	(disagree)	.63595
Everyone should be taught about AIDS	(disagree)	-.49694

Variance explained = 9.5%

Although broadly similar to the three factors emerging from analysis of the first questionnaire data, there were also some differences. On the second factor, the issue of invulnerability remained, but others' concern was seen as justified. On the third factor, there was a shift to include the item 'Everyone should be taught about AIDS'. If the changes could be attributed to education, it may be that the education programme highlighted the importance of HIV as a general issue, but failed to convince all pupils that it was something that could affect themselves.

Control Group - Questionnaire 1

There was a difference between the structure of the factors underlying the responses to the attitude statements in the Control Group and the Study Group. In the analysis of the Control Group data for both questionnaires, four factors emerged. They explain 57.7% of the variance, which was not statistically significant at the 0.05 level (F = 2.73; F crit = 3.84).

FACTOR ONE

If I knew someone with AIDS I would avoid him/her	(disagree)	.92988
If I knew someone with HIV, I would avoid him/her	(disagree)	.89817
People with the virus HIV should be kept away from everyone else	(disagree)	.64220

Variance explained = 20.5%

This was the 'tolerance/acceptace factor which mirrored the first factor in the Study Group analysis.

FACTOR TWO

This second factor was the 'invulnerability' factor:

People are panicking too much about AIDS	(agree)	-.57704
AIDS worries me	(disagree)	.65747
Everyone is at risk from AIDS	(disagree)	.53119
Everyone should be tested for HIV	(disagree)	.63162
Everyone should be taught about AIDS	(disagree)	.62275

Variance explained = 14.8%

Although broadly similar to the second factor in the Study Group analysis, this factor was much stronger in the Control Group data. There was the belief that everyone should be concerned about AIDS, in that the panic was justified , but it was not seen as something that threatened the pupils personally, nor everyone in the population. Education for everyone about AIDS was therefore considered unnecessary.

FACTOR THREE

Most people who get AIDS deserve it	(disagree)	.70060
People with the virus should carry identification cards	(disagree)	.81273

Variance explained = 11.4%

This factor was different to the third factor of the Study Group and combined groups' data. It indicated a rejection of two of the most extreme and stigmatising statements about people with HIV or AIDS.

FACTOR FOUR

It is obvious when someone is carrying the virus, HIV	(disagree)	.62873
HIV always kills	(disagree)	.78004
Homosexuals have only themselves to blame for AIDS	(disagree)	.53286

Variance explained = 11%

The final factor also indicated a rejection of myths. The two items loading highest on this factor concerned the virus and its effects. The third, which reduced the factor's coherence, more concerned stigmatising statements as in the third factor.

Control Group - Questionnaire 2

Four very similar factors to those just mentioned emerged from the analysis of the second questionnaire data. They accounted for 58.4% of the variance ($F = 2.81$; $F\ crit = 3.84$; $p > 0.05$). The first two factors had increased in strength, the second was much the same and the fourth factor explained less variance than previously.

FACTOR ONE

This was the 'tolerance' factor:

If I knew someone with AIDS I would avoid him/her	(disagree)	.88503
If I knew someone with HIV, I would avoid him/her	(disagree)	.87379
It is obvious when someone is carrying the virus, HIV	(disagree)	.33493
People with the virus HIV should be kept away from everyone else	(disagree)	.76047

Variance explained = 22.5%

FACTOR TWO

This was the 'personal invulnerability' factor:

People are panicking too much about AIDS	(agree)	-.70810
AIDS worries me	(disagree)	.73782
Everyone is at risk from AIDS	(disagree)	.46393
Everyone should be tested for HIV	(disagree)	.56978
Everyone should be taught about AIDS	(disagree)	.50829

Variance explained = 15.7%

FACTOR THREE

Most people who get AIDS deserve it	(disagree)	.76521
People with the virus should carry identification cards	(disagree)	.59110
Homosexuals have only themselves to blame for AIDS	(disagree)	.64553

Variance explained = 11.2%

This factor represented a rejection of myths which stigmatise people with HIV and AIDS.

FACTOR FOUR

Everyone is at risk from AIDS	(disagree)	-.52137
It is obvious when someone is carrying the virus, HIV	(disagree)	.72257
HIV always kills	(disagree)	.67253

Variance explained = 9%

The items which loaded best on this factor were slightly different to those which loaded highest on Factor Four on the first questionnaire. *Homosexuals have only themselves to blame for AIDS* is replaced by *Everyone is at risk from AIDS*. As this latter statement had a negative loading it indicated that those scoring high on this factor would agree with the item. This factor could then be interpreted as rejecting myths about HIV transmission, with 'Everyone is at risk from AIDS' being a counter-statement to the emphasis, at that time, on risk-groups.

Factor scores and t-tests

Factor scores were computed by adding scores on the individual items which best represented the factor. Items which loaded strongly on more than one factor were excluded as they did not discriminate well between factors. Independent t-tests were used to compare factor-scores for different groups (see Tables 2.10.25 - 2.10.221 for detailed results). The groups considered were

a] boys and girls
b] socio-economic groups
c] those who considered themselves to be smokers
d] those whose friendship group comprised more smokers than non- smokers
e] those whose friendship group comprised more people who drank alcohol than not
f] those who trusted formal sources of information about drugs as compared to those who trusted informal sources
g] those who trusted formal sources of information about HIV as compared to those who trusted informal sources

Scores were computed on the data for combined groups, given that so little was attributable to education, unequivocally. The results are summarised below giving levels of probability at which the results were significant.

Gender and factor scores

Boys scored higher than girls on the following factors:

Questionnaire One

Drug Factor One	refuting positive aspects of drug use	$p < .01$
Drug Factor Three	physical and mental decline arising from drug use	$p < .05$
AIDS Factor One	tolerance and acceptance	$p = .000$
AIDS Factor Three	personal concern	$p = .05$

Questionnaire Two

Drug Factor Two	general anti-illegal drugs stance	$p = .000$
Drug Factor Three	physical and mental decline arising from drug use	$p < .05$
Drug Factor Four	refuting positive aspects of drug use	$p = .000$
AIDS Factor One	tolerance and acceptance	$p < .05$
AIDS Factor Two	invulnerability	$p < .05$
AIDS Factor Three	concern	$p < .05$

Girls did not score higher than boys on any factor. Given the range that these attitude structures cover, it would appear that all that can really be deduced here is that boys made more extreme statements than girls.

Socio-economic groupings and factor scores

Using the Registrar General's Classification of socio-economic groupings, t-tests were run on two sets of groups. First of all, groups I (professional), II (intermediate), IIIa (skilled non-manual) and IIIb (skilled manual) were compared with IV (semi-skilled manual) and V (unskilled manual). Secondly, socio-economic groups I, II, IIIa were compared with groups IIIb, IV and V.

From the first analysis, with the cut-off between skilled and semi-skilled work, there was no significant difference between the groups on any factor. In the second analysis, dividing between non-manual and manual work, the following differences were observed:

Questionnaire One

Drug Factor Two	addiction and 'slippery slope' socio-economic groups IIIb, IV and V had a highermean score than groups I, II, IIIa	p = .000
AIDS Factor Three	personal concern socio-economic groups IIIb, IV and V had a higher mean score than groups I, II, IIIa	p< .005

There was no significant difference between the groups in terms of mean factor scores on the second questionnaire. This indicated that, although initially groups IIIb, IV and V were more likely to regard drug use as a downward path to addiction and failure and to regard HIV as a matter of personal concern, at the time of the second questionnaire the difference was no longer evident. As the strength of the 'slippery slope' factor increased over the survey period, quite markedly, it seems that the disappearance of that difference was due to an increase in socio-economic groups I, II, IIIa of this attitude structure, rather than a decrease in groups IIIb, IV and V. The strength of the 'concern about AIDS' factor remained the same, suggesting a two-way shift in terms of attitudes, rather than a uni-directional one.

Smoking and factor scores

Scores of those who smoked, as compared with those who did not, were compared for each factor. The division was between those who reported smoking occasionally or regularly and those who had only tried or never tried cigarette smoking.

No differences were significant on the first questionnaire. On the second questionnaire, only one difference emerged:

Drug Factor Four	assessment of the risk of drug use as dangerous smokers had a higher mean score on this factor	p<.005

Although counter-intuitive that those who smoke should express concern about the risks of illegal drug use more strongly, especially as tobacco was also included within the education programme, this fits the findings of health education research (Bagnall *et al*, 1987; Chaturvedi, 1987; Fangler, 1987; Woolley and Kinghorn, 1987) that people will distance themselves from 'fear' messages if they concern them personally. The education programme stressed the greater number of people dying as a result of tobacco smoking than from illegal drug use. In spite of this, those who smoked tobacco were more likely than those who did not to emphasis the dangers of illegal drug use.

Friends who smoke and factor scores

Scores of pupils with friendship groups in which half or more smoked cigarettes were compared with those with friendship groups consisting of less smokers. The factor scores on which significant differences were demonstrated are:

Questionnaire One

AIDS Factor One	tolerance and acceptance those with a higher proportion of smokers in their peer group had a higher mean score	p = .000

Questionnaire Two

Drug Factor Four	refuting positive aspects of drug use those with more smoking friends scored higher	$p<.05$

The results suggest that, prior to education, those with friends who smoke were more tolerant and accepting of people with HIV and AIDS. This difference was not significant at the time of the second questionnaire. As the strength of this factor increased over time, this was attributable to a general increase in tolerance and acceptance, but one that was greater amongst those with non-smoking friends, perhaps because they were more influenced by the education programme, or because more of those with smoking friends had attitudes already in line with the aims of the education programme.

That those with smoking friends were more likely to have a higher mean score on the factor refuting positive aspects of drug use was in line with the smokers' higher scores on this on the second questionnaire. Given the very negative emphasis within the programme on the effects of cigarette smoking, this could have been the result, again, of fear-based education. Such education programmes, it would seem, are counter-productive for those most affected.

Friends who drink alcohol and factor scores

Mean scores were compared for those within whose friendship groups half or more drink alcohol, with those whose friendship groups contain a lower proportion of people who drink alcohol. Alcohol was discussed within the education programmes and its negative effects were very much emphasised, though not as much as the dangers of tobacco smoking. Significant differences in factor scores were demonstrated as follows:

Questionnaire One

Drug Factor One	refuting positive aspects of drug use those with a higher proportion of alcohol-consumers in their peer group had a higher mean score	$p < .005$

Drug Factor Three	physical and mental decline arising from drug use those with a higher proportion of alcohol-consumers in their peer group had a lower mean score	$p < .05$

Although more likely to negate reasons for using illegal drugs, those with more drinking friends were less likely to emphasis the effects of, particularly regular, drug use. Perhaps, again, this was part of the denial of adverse effects that might concern them.

Questionnaire Two

Drug Factor One	addiction and slippery slope those with a higher proportion of alcohol-consumers in their peer group had a lower mean score	$p < .005$

This may again be attributable to denial of the worst effects of any drug use.

Trusted sources of information and factor scores

a] on drugs

Questionnaire One

Initially, there were no significant differences in mean scores on any factor between those who trusted formal and those who trusted informal sources most.

Questionnaire Two

Significant differences were evident on two factors:

Drug Factor One	addiction and slippery slope those trusting informal sources most had a higher mean score	$p < .05$

This finding may well represent media influence on individuals and their peer groups and siblings, or the more receptive response of those trusting formal sources to the debunking of myths within the education programmes.

AIDS Factor One	tolerance and acceptance those trusting informal sources of information on drug use more than formal had a higher mean score	p = .05

b] on AIDS

Significant differences were evident on:

Questionnaire One

Drug Factor Two	addiction and slippery slope those who trusted informal sources of information were more likely initially to have a higher mean score	p < .05

Questionnaire Two

AIDS Factor Three	personal concern those who trusted formal sources less than informal had a higher mean score	p < .05

By the time of the second questionnaire, those who trusted formal sources of information were as likely to score high on this factor. Therefore, education, time or some other variable seems to have increased the perception that drug users are on the road to ruin. Those trusting informal sources demonstrated a greater increase in concern over HIV and AIDS than those trusting formal sources. This could have been the result of popular or media-induced panic or informal sources being a more effective means of influencing attitudes and beliefs, depending whether increased concern is seen as positive or negative.

Summary

Attitudes to drug use factors

Factor analysis revealed several reliable dimensions underlying the drug attitude statements and responses. No major differences occurred between the two questionnaires in either group, though there was a general strengthening of the factors. The Control Group demonstrated a more complex and possibly sophisticated attitude to drug use than the Study Group, with a rejection of cruder stereotypes, some acceptance of cannabis use and less harm attributed to regular use. this may reflect the catchment area of the larger Control School. Local drugs agencies were agreed that there was more recreational cannabis and amphetamine use within that area and that a large proportion of school children of this age would have come into contact with illegal substances. At interview, pupils from this school, more than any other, commented that, at a party, you would expect to be offered cannabis or speed. Nevertheless, the 'anti-drug' orientation was evident in the Control Group as in the Study Group. This may be a reflection of the research context, *ie* the questionnaire format in the classroom, or it may be a genuine statement of disapproval.

The most notable structures underlying the grouping of items by factor analysis are:

a] rejection of positive statements about drugs. This may be seen as a rejection of the stereotypical discourse of persuasion to try drugs.

b] acceptance of the 'slippery slope' dimension. This resonates with the 'Heroin Screws You Up' campaign and presents drug use as the beginnings of addiction and failure.

c] acceptance of inevitable physical and mental decline associated with drug use. In the Control Group, this was limited to those who use drugs regularly.

d] a more general anti-drug orientation related to the personal effects of drug use and characteristics of drug users.

The factors constituted different discourses of narratives about drug use. Pupils' scores on the individual factors were calculated so that t-tests could be used to investigate differences between groups on the individual factors. The results are presented in Appendix 2.10.13.

Attitudes to HIV/AIDS factors

The F-values suggested that the amount of variance explained was not statistically significant for any of the factor analyses. This may well be the result of the small number of items in the scale. Certainly, variance explained as high as 46 - 58% was substantively significant; that is, given all the variables that could cause variation, a system of factors accounting for more than half, was of importance.

The groups exhibited some common factors (tolerance/acceptance and invulnerability) throughout and some differences. The Study Group had a 'concern' factor; the Control Group had two 'rejecting myth' factors. In both cases, the same basic factor structure was evident on both questionnaires, mostly stronger on the second questionnaire. Time and education cannot be said, therefore, to have effected a change in attitude structure, though perhaps an intensification.

That the strongest factors both distanced self from HIV infection and that the Control Group dids not have a dimension related to personal concern, is interesting in the light of public health messages at the time, which were trying to convince the public of heterosexual spread. This was much more in line with the more prevalent notion of risk groups, at the time.

Factor scores and t-tests

Briefly, the findings were as follows:

a] boys tended to produce more extreme responses than girls.

b] lower socio-economic groups were more concerned about HIV after education/time. They were more likely to produce responses that loaded high on the 'slippery slope' factor at first. Suggesting an initial tendency to operate with a narrative of drug use as inevitable and general decline. However, by the second questionnaire, there was no significant difference between the groups (due to an increase in the strength of this factor in the higher socio-economic groups).

c] those who take legal substances or with peers who do are more likely to express resistance to the positive statements about illegal drugs, but less likely to take on board long-term negative effects of drug use. This latter may be the result of fear-based education, which, it has been suggested, prompts denial in those most affected.

d] informal networks are possibly better at transmitting information or information is more readily received from informal networks - though they tend to hold on more to media notions/popular assumptions and myths.

CONCLUSION TO SECTION TWO

Results of the quantitative study have been presented as an historical 'snapshot', supported by data from comparable studies. When questionnaire responses are regarded as one form of contextualised 'talk', to be related to 'talk' in the three contexts in Section Three, three key themes emerge.

1. The reflexive researcher/teacher

Within this thesis, I am reflecting on the effect of various contexts on young people's responses to questions related to HIV/AIDS and drug use, my role as researcher and Advisory Teacher, and the interrelation between the two roles. The two roles are similar in terms of their interest in attitudes, consciousness and changes in these, and there are parallels between traditional pedagogy and positivistic research method and progressive pedagogy and more qualitative and reflexive research styles. Traditional pedagogy assumes a body of knowledge and skills that can be handed on from one person to the next. Positivistic research, in this regard, attempts to measure levels of knowledge and skill and to give an indication of what is known and what remains to be learned. In both cases, the educational process is seen as unproblematic and emphasis is placed on the acquisition of knowledge and skills. In contrast, progressive pedagogy focuses on the nurturing of inner potentials and the development of the natural abilities of the child. Although the presuppositions of the child's capacities and tendencies may be called into question, the focus on the individual's understanding and constructs and the emphasis on the reflexive teacher or researcher, evaluating their own skills in leading out what the child knows, is common to both progressive education and reflexive research.

2. Research method and the enlightenment model of pedagogy

There is a parallel between the enlightenment model of pedagogy and positivist research. Positivist research sets out to detect what the child knows and does not know in a conventional way. This provides the teacher with an understanding of what needs to be taught. The pedagogic process is seen purely as a 'relay for messages' (Bernstein, 1990) from elsewhere not as a context in its own right. This can be developed further in an understanding of the cascade model of in-service training. This was the dominant model within the education service at the time, particularly in the areas of special needs and PSHE and one that is borne out in the hierarchical structure of the Local Education Authority. Under the guidance of subject Inspectors or Advisers (managerial positions), the Advisory Teachers develop curriculum policy and practice. Up to the appointment of an

Advisory Teacher for Drugs and Health, with Education Support Grant money from Central Government, Advisory Teachers in Cambridgeshire tended, on the whole, to operate from Teaching Centres, developing teaching materials and with a reactive rather than proactive contact with schools. The cascade model of in-service training reflects the belief that there is a body of skills, knowledge or expertise that can be handed down from those educationalists working outside schools to those within and from those so initiated to others within the same schools. The model assumes that information can be simply passed on without any kind of alteration from one context to another. Hence, it ignores questions of recontextualisation (Bernstein, *op cit*) and interpretation and construction in different contexts. Some attention is given to the need for on-going support, the problems of communication and conflict and organisational change, but the assumption is that, if handled correctly, the desired change can be effected.

The cascade model is assuming that a message can be transmitted from producers of ideas (*eg* Inspectors or Advisers), through the training process, into the classroom in an unaltered form, where it then simply has its effect upon the pupils. What this does not take into account are the complex dynamics of the classroom itself. It is assumed that the teachers can straightforwardly transmit what they themselves have perceived to the pupils in an unproblematical way. This ignores the discursive features which were referred to in Section One, in relation to the work of Willis, Cohen and the WRAP Project. What it ignores, in particular, is the symbolically complex nature of teaching as a form of discursive practice and the manner in which the message being relayed will be recontextualised by pupils within their own particular discourses. As was argued in Section One, what is necessary for effective educational transmission is that teachers are aware of these symbolic systems and the manner in which they recontextualise and reconstruct messages.

3. The debate on method - discourse analytic criticisms of the research method and counter criticisms

The main study followed conventional survey methodology. Pupils were asked a series of closed questions, some Likert style and a few more open-ended. This data was augmented by more qualitative material from interview and observation. The questionnaire data, in particular, is subject to the standard criticisms of positivist methodology as expressed powerfully by those within the discourse analytic tradition (notably Potter and Wetherell, 1987; Billig, 1988, 1989; Parker, 1992).

These criticisms can be summarised as follows:

1. quantitative methods are inappropriate because subjectivity and meaning are, by definition, non-obvious and non-measurable

2. attitudes are not cognitive objects that are stable, enduring and measurable

3. social behaviour, responses and attitudes have to be understood situationally. Positivistic approaches decontextualise meaning and behaviour and, in so doing, reduce it to the implicit assumptions held by the researcher in the guise of objective observer

4. given these complexities, it is not possible for the social scientist to claim that they produce totally objective knowledge and non-controversial accounts of individual meanings and interaction

In contrast, discourse analysts claim

1. to provide a reflexive approach to social science
2. to allow alternative interpretations
3. to provide a more social social science

By taking naturally occurring speech as the basis of their analysis, discourse analysts claim to provide a richer and more reliable account of the management of interaction. Positivism and discourse theory are set up as if they are mutually exclusive. Positivist social science is made into a straw-man and is 'knocked down' on the grounds that it is totally unreflexive, fails to accommodate context and alternative explanations and claims to be objective and 'true'. In contrast, the position to be taken in this study is that this does not *have* to be the case. I am going to argue for a complementarity of methods which implies, firstly, that positivism does not have to have the restricting character that its opponents ascribe to it.

As Hammersley (1989) argues, all theories fail to accommodate the full complexity of human life and social inquiry, but this does not mean that we should not adopt a pragmatic and instrumental approach drawing on the strengths of different theoretical approaches and minimising the weaknesses of each. The opponents of the 'positivist' approach have been accused of simplifying the so-called 'scientific method'. Positivism is probably not as naive nor as unreflexive as some of the qualitative researchers who oppose it suggest. A major criticism of the attack upon positivism is that it tends to lead people into relativism

and there is a general failure to acknowledge the range of problems that accompany a relativist position (Callinicos, 1989; Norris, 1992; Gellner, 1992). This is particularly true of current post-modernist arguments. A major strength of positivism is that it does seek to establish firm grounds for knowledge and the attack upon it has often tended to trivialise or marginalise the importance of this. Acknowledging positivism's limitations does not mean we have to throw out the methodological baby with the positivist bath-water. Rigorous sampling and analysis, combined with a reflexive approach to interpretation is entirely possible. Factor Analysis can be seen as describing the underlying structures and discourses. This is a well-established procedure in Personal Construct Theory (Kelly, 1955; Fransella and Bannister, 1977), which combines an interpretive approach with more rigourous statistical techniques.

As has been indicated, a major issue in current debates around discourse analysis in social psychology (Parker and Shotter, 1990) is the manner in which it is presented in *opposition* to so-called 'positivism'. As discussed in detail in Section One, the methodological benefits of discourse analysis (and discourse theory more generally) may be negated through association with a dubious relativist position. The problems of relativism can be seen as even greater than those imputed to 'positivism'. On the basis of the earlier argument, as I move through different types of analysis of the data, I will be attempting to demonstrate their complementarity rather than assuming their opposition.

SECTION THREE

INTRODUCTION TO SECTION THREE

The preceding section presented data from the pupil survey, first in the form of a direct summary of responses to the questions, and, secondly, on the basis of factor analysis. The purpose of the factor analysis was to discover patterned relationships between responses which may be indicative of broader discourses about drugs and HIV/AIDS underlying the responses to individual items. In this section, my intention is to develop a more qualitative analysis of the material which will take into account the differences between the *contexts* in which information was collected or revealed. As argued above, (page nos), it is not the aim of this work to treat 'positivist' and 'qualitative' methods as mutually exclusive, but rather as complementary. Therefore, ideas derived from interpretive sociology and discourse theory will be applied within a framework constructed by more conventional, quantitative methods. A particular focus, in this section, will be upon the significance of *context* as a regulator of 'performance'.

As outlined in the theoretical discussion in Section One, my intention is to approach 'discourses' as structured fields or 'formations' which can be viewed as resources upon which individuals draw in particular situations. The factor analysis in the previous section suggested that there are certain underlying themes which draw together attitudes towards drugs and HIV/AIDS. These 'themes' provide ways of making sense of those topics. They provide, for instance, reasons *why* people take drugs and particular views of drug users or people with HIV/AIDS. However, the point about such 'discursive resources' is that they are prestructured in ways that operate selectively upon meaning, limiting the possibilities available to individuals.

The major source of material for this section will be pupils talking about the topics of drugs and HIV/AIDS in three different types of situation. The first is that of the formal classroom lesson; the second the 'off-stage' situation in which pupils are talking together in small groups within the classroom lesson; and the third is the informal setting of pupils talking amongst themselves (though in my presence) outside of the classroom context. An examination of these situations and the talk produced within them indicates that *context* regulates the views and attitudes expressed.

I will argue that an important aspect of this 'regulation' by context is the manner in which it controls the relationships between different fields of discourse and discursive resources. Hence, in the classroom situation, pupils' talk is dominated by a model of 'school work' and

'teacher expectations' which powerfully affects both how pupils talk and what they say. In the informal situation, different principles come into play and meanings suppressed in the classroom situation (especially those associated with pupils' own experiences) come to the fore with the results that a different range of attitudes and values is revealed.

The method used for collecting this data was more 'qualitative' or 'ethnographic' in character, utilising modes of participant observation. In the formal classroom situation, I functioned as a non-participant observer, observing lessons in progress. In the 'off-stage' situation I had the position of a supplementary teacher, and was involved in the small group learning situations. In the informal situations I occupied the position of an active participant observer. However, the pupils in each of these situations were the same and, consequently, I did not fit into any one of the 'classic' participant observer modes (see Burgess, 1984). The pupils were aware that I was not 'a teacher' in the normal sense, though it is difficult to speculate precisely how they did define my position or role.

The analysis of the material in this section is more interpretive and intuitive than in Section Two and is obviously open to the criticims of subjectivism in the same way that the earlier analysis could be criticised as 'positivist'. As I have made clear at earlier points, my view (following writers such as Silverman and Hammersley) is that qualitative and quantitative methods should be viewed as complementary rather than exclusive. I am drawing upon my research data in ways which attempt to explore this possibility. I am not claiming that this analysis rigorously demonstrates the principle of complementarity of methods, but, rather, explores its possiblities.

I will conclude this section by formulating a set of concepts which attempt to describe the discursive dynamics of pupil talk in the classroom.

CHAPTER ELEVEN

CONTEXT AND PERFORMANCE

The purpose of this chapter is to provide a background theoretical discussion for the examination of the role of *context* in regulating the ways in which pupils talk about drugs and HIV/AIDS.

The 'contextuality' of social action has been emphasised by a number of currents within social theory and research. Ethnomethodology, in particular, concerns itself with the way in which social actors gear their 'performances' to a specification of context, and apply rules of appropriateness or competence, on the basis of a 'definition of the situation' (Potter and Wetherell, 1987). An implication of this approach is that individuals and groups can vary in their ways of defining situations, and as to what counts as appropriate or competent performance within any situation. In education, this approach was employed by writers in the New Sociology of Education movement of the 1970s (Young, 1971) as a way of challenging taken-for-granted assumptions as to what counted as 'normal' behaviour (*eg* by pupils in classrooms); and criticising the 'deficit models' of working class pupils, which were associated with 'normative' approaches (Keddie, 1971; Sharp and Green, 1975).

Speech and 'the situation'

The significance of context was emphasised by Goffman (1971) who argued that 'situation' had been a neglected aspect of social theory and analysis. Goffman argued that speech can only properly be understood 'situationally'.

> Is the speaker talking to the same or opposite sex, subordinate of superordinate, one listener or many, someone right there or on the phone; is he reading a script or talking spontaneously; is the occasion formal or informal, routine or emergency? Note that it is not the attributes of social structure that are here considered, such as age and sex, but rather *the value placed on these attributes as they are acknowledged in the situation* current and at hand.
> (Goffman, 1971 pp74-75, *emphasis added*)

The meaning of speech is not, therefore, immediately recoverable from the words spoken in themselves. They have to be related to the situation at hand and to the values held by

participants within that context. Goffman further argues that "situations...constitute a reality *sui generis*...and therefore need and warrant analysis in their own right" (p75).

On this basis, Goffman presents the view that the study (or 'ethnography') of speech must always be aware of its situated or contextual character. In a similar fashion, C. Wright Mills, in another early, influential paper, argued that,

> The postulate underlying modern study of language is the simple one that we must approach linguistic behaviour, not by referring it to private states in individuals, but by observing its social function of co-ordinating diverse actions.
> (Mills, 1971 p113)

Wright Mills relates this observation to the study of 'motive'. He argues that motives should not be understood simply as 'fixed elements "in" an individual' but as 'the terms with which interpretation of conduct *by social actors* proceeds' (*loc cit*). Like Goffman, Mills is stressing the *practical* character of situated speech. People speak for practical purposes in actual situations. Motives are reasons for *doing* things. In this sense, they organise or co-ordinate social action. Mills argues that motives should be seen in terms of the 'anticipated consequences' of social action, on the basis of the actors' definition of the situation and what is intended within it.

> Motives are words. Generically, to what do they refer? They do not denote any elements 'in' individuals. They stand for anticipated situational consequences of questioned conduct. Intention or purpose (stated as a 'program') *is* awareness of anticipated consequences; motives are names for consequential situations, and surrogated for actions leading to them.
> (*ibid* p113)

Mills argues that the study of motivation should not consider a 'motive' as an index of an inner state, but as "*a basis for inference for a typal vocabulary of motives of a situated action*" (*ibid* p115, *emphasis in the original*). Mills' idea of 'vocabularies of motive' can be seen as referring to 'discursive resources' available to different categories of person in different situations. This can be illustrated by considering the earlier discussion of the 'enlightenment' model of education.

Discursive resources

Essentially, the 'enlightenment' model can be seen as providing pupils with 'good reasons' for doing things (*ie* 'motives'). For example, in the case of girls and condom use, researched by Holland *et al* (1990a, 1990b), teachers will be concerned to give girls an understanding of how condom use protects them from unwanted pregnancies and sexually transmitted diseases, including AIDS. This can be seen as a particular 'vocabulary of motive' - *why* they should use condoms. However, as Holland *et al* point out, in actual situations where condom use is a practical issue, young women will come up against competing 'vocabularies'. For instance, that they carry condoms could define them as 'slags', or insisting on their use could violate the 'romantic' vocabulary (or 'rhetoric') which holds that 'love' is the only legitimate motive for a woman to have sexual intercourse. As is pointed out, young women can get caught in a discursive logic to the effect: "if you want me to use a condom, you don't love me and if you are prepared to have sex with a man you don't love, you are a slag". So, 'motive' is subject to situational or contextual conditions which make different vocabularies or discourses selectively available to different groups in different ways. This selectivity is crucially affected by relations of power and ideology which come to privilege some 'vocabularies of motive' over others.

Mills argues that situations of this type should not be understood simply in terms of a conflict between 'true' and 'false' motives, with the former referring to some 'true' inner state of the 'self'. Individuals can only formulate 'motive' in terms of the vocabularies socially available to them and in so doing formulate constructions of self in terms of normatively acknowledged 'needs', 'desires', 'motivations', *etc*[5]. Mills says that, "The motivational structures of individuals and the patterns of their purposes are relative to societal frames." (*ibid* p116).

> Rather than interpreting actions and language as external manifestations of subjective and deeper lying elements in individuals, the research task is the locating of particular types of action within typal frames of normative actions and socially situated clusters of motive.
> (*ibid* p 117)

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[5] The regulative function ascribed to 'vocabularies of motive' in this way can be compared with the very similar account of 'discourse' in the quote from Ball in the Introduction (see page 36).

If the term 'motive' is understood in the straightforward sense of a 'reason for doing something', then, in Goffman and Wright Mills' terms, 'reasons' must be located within the contexts in which individuals are practically active. Individuals act for particular purposes within given situations. On the basis of Goffman's emphasis on the 'situation', the *definition* of the situation is a crucial factor; and, following Mills, a crucial aspect of the situation is how it provides for or delimits available 'vocabularies of motive'. So, in a school setting, girls might define the situation as educational and be motivated by a desire to 'give the right answer' or 'please the teacher' or 'keep out of trouble' and within that frame of reference, give a situationally appropriate response to questions concerning condom use. In a different context, however, such as a relationship with a potential sexual partner, or peers or parents, where the issue is being posed within different parameters (and under different power relations) different answers could be given reflecting different motives appropriate to the situation 'at hand'.

In this manner, social context comes to regulate linguistic performance (Bernstein, *passim*). A classic illustration of this is provided in Labov's (1972) paper, *The Logic of Non-standard English*. Labov begins by outlining the influential 'linguistic deprivation' model of black American speech, as proposed by certain psychologists. He argues that the view of black Americans as linguistically deprived reflects, first, value judgements as to the innate superiority and normative status of standard English, and secondly, the crucial influence of the *experimental* setting within which these researchers developed their model. He argues that the typically formal circumstances and methods used in research had the effect of alienating and scaring the young black children and this severely depressed their performance. By changing the setting to one of informality, with a friendly black researcher who sat on the floor with the children, provided them with sweets and soft drinks, and allowed them to bring their friends and toys, their linguistic performance improved significantly.

Context, competence and performance

The relationship between speech and context has been developed in considerable depth by Bernstein (1990)[6]. Bernstein investigated the rules whereby social context and speech interact. An important implication of this work is that individuals or groups do not differ

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[6] An unfortunate consequence of Labov's paper has been to associate Bernstein with the linguistic deprivation view. This is a fundamentally incorrect interpretation of Bernstein and especially of the concepts 'elaborating' and 'restricting' codes - see Atkinson, 1985 and Bernstein, 1990.

in linguistic *competence* (as argued by the deprivation theorists), but in terms of the 'recognition' and 'realisation' rules through which they define contexts and the forms of speech (and other behaviour) appropriate to them. Different types of speech characteristically produced by different groups in (apparently) similar settings (*eg* classrooms, interviews) reflect not difference in linguistic competence, but differences in the rules through which they define context and the expectations appropriate to it. For example, middle class children will tend to recognise the classroom as requiring a specialised form of speech, whereas working class children will not apply the same 'recognition rule'. Hence, context regulates *performance* and differences in performance should *not* be taken as indicating basic differences in *competence*. What differs between groups is not their linguistic competence, but the ways in which they define competence (*ie* in terms of how strongly classified specific contexts might be and how far they require specialised performances) and what counts as 'valid' realisation of competence within that situation.

Bernstein has attempted to demonstrate the principle of shared competence but different realisations by constructing situations in which individuals come to 'switch' codes, thus demonstrating similar competence through sequentially different performances ('realisations') (Bernstein, 1990 pp100-113).

An important aspect of this process is that of 'classification' - that is, how strongly a context is defined as distinctive and separate from other contexts. According to Bernstein, the more strongly classified a context is held to be, the more 'specialised' the performance within it; for example, the more specialised and contextually specific the type of speech and/or behaviour. For children who define the school context as highly distinctive and separate from that of the home or other situations (such as the peer group), their speech will be geared more towards what are taken to be the specialised requirements of the school - such children will tend to produce a 'specialised' 'elaborating code' (Bernstein, 1990 pp101-113). Models of appropriate answers, for instance, will be constructed around specialised and specific understandings of what is required 'in school' or 'by the teacher'. From this point of view, pupils speech (or any other type of formal communication, such as essays or other written work) will be regulated, not so much by what pupils actually know or think, but by their assessment of what is expected within the context. Although, typically, this can involve pupils attempting to reveal their 'knowledge' (in that 'knowing things' and 'getting it right' are what school is seen to be mainly about), in certain areas the opposite can be the case. The 'right' answer may well involve pupils *suppressing* what they actually know or believe.

For instance, in sex or drugs education classes, pupils might well be cautious of revealing what they *know* to be the case from their own (situationally specific) experiences, because to be too knowledgeable could lead them into trouble. In addition, from the pupils' point of view, generally, the object of the exercise within the classroom is not to be engaging in a genuine debate about the truth of certain knowledge or views, but simply to satisfy the expectations of the teacher. Research into pupils behaviour in 'progressive' classrooms, which officially value 'discovery' by pupils (for instance, Billig *et al*, 1988) has demonstrated that the main task of 'discovery' that pupils perform is that of decoding the 'cues' that teachers provide to lead them to the 'right' answer. As I will go on to demonstrate with my own data, pupils will reveal themselves to be more sceptical and knowledgeable about drugs in less formal contexts than they would in the formal classroom setting.

It is important to stress that what is at issue here is not, as is sometimes suggested by discourse theorists, a distinction between 'unnatural' formal situations and 'natural' speech. *All* speech is situationally located and regulated in this fashion and 'natural' speech is no more free from such contextual regulation than answers to questionnaires or interviews. The key issue is to discover the types of rules operative within situations and the discursive resources ('vocabularies of motive') associated with them. It would be a mistake to think that people say what they 'really' think in certain situations and that one particular research method has a privileged access to this 'real' material.

At the same time, it is important to avoid pursuing this line of argument to the point of 'situational determinism'. It is not the case (or rarely so) that social actors do *no more* than produce speech (express values, views or ideas) which are situationally expected. Rather, the particular context within which performance is situated should be seen as *mediating* (or in Bernstein's terms 'regulating') the performance. As the classic studies of Goffman and of the ethnomethodologists illustrate, social actors are 'knowledgeable' in situations and make assessments of what the situation requires relative to their own views and purposes. In this sense, social action is an accomplishment in which individuals reflexively monitor their performance within the framework of the context as indicated indexically by the ongoing interactions within it (see Potter and Wetherell, 1987 pp18-23). On this basis, social interaction can be viewed as 'negotiated' between participants on the basis of a mutual 'agreement' to sustain a particular 'definition of the situation'. However, it is important to take into account the effects of power and ideology in structuring situations and what is possible for different categories of person within them. These processes have been

studied by sociologists of education in terms of pupil 'strategies' and the 'negotiation' of classroom relations between pupils and teachers (see Woods, 1990)[7].

The relationship between discourse and context

In order to avoid the extreme subjectivism and voluntarism that was associated with earlier phenomenological and ethnomethodological work (Demaine, 1981), it is important to emphasise the following principles which can be abstracted from the earlier discussions and presented as a basic theoretical framework for approaching the relationship between discursive fields and contexts or situations. These principles provide the basis for the analysis which follows in this section.

1] The discursive resources upon which individuals draw (*eg* 'vocabularies of motive') are *prestructured* according to principles reflecting the *power relations* of society - they are socially produced under specific historical conditions. In this sense they are *ideological* in character and can be viewed as 'formations' or 'fields of discourse', independently of their appearance within the subjectivity of individuals. As Goffman says of context, discursive fields can be treated as realities *sui generis*. This view also opposes the 'intertextuality' and relativism of 'post-structuralism' (Gellner, 1992) - *ie* discurive fields have specific effects in terms of the regulation of the possibilities of what can be said/thought, by who, where and how and these can be positively identified and described in a scientific way.

2] Discursive fields do not constitute coherent wholes which automatically provide social actors with the 'right' or situationally appropriate answer. Fields are internally contradictory in a complex way (see Billig *et al*, 1988). According to Billig *et al*, these internal contradictions are experienced and expressed by individuals as 'dilemmas'. They describe these 'dilemmatic' qualities of fields in this way:

> In contemporary Western society we have available to us a number of different ways of talking about ourselves and other people. On the one hand, the very notion of 'human nature' presupposes an identity common to those objects labelled 'human' (based on a capacity for 'rationality' according to the classical liberal theorists). On the other hand, we are also able to refer to the existence of infinite variation. The assertions 'We are all human' and 'We are all individuals' are

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[7] Similar problems about determinism and agency have already been noted in relation to discourse theory (see page 37).

both equally and self-evidently 'true'. The potential for contradiction is further enhanced by the existence of a third type of explanation which refers to categories of persons. Not only is it true that we are all human beings and all individuals: it is also accepted as a fact of life that we are all either male or female... The notion of 'types' of person, of what ever kind, is opposed in some senses both to the adage that all human beings are essentially 'the same' and also to the assertion that all individuals are essentially 'different'. The collision of these various available notions of human nature may result in a dilemma between categorisation and particularisation, summed up by the question "How far can we generalise?'

(Billig *et al*, 1988 p124)

As I will go on to show, the 'dilemma' of 'categorisation' is particularly important in explicating apparent contradictions or anomalies in pupils' replies to drugs and HIV/AIDS-related questions in different contexts, *eg* their different attitudes to drug users in general - 'them' (stereotypical 'junkies' or 'druggies') - and drug users they know - 'us'.

3] A key question for analysis is how *in context* different principles will be employed discursively, *eg* in ascribing 'motive' - *why* do people take drugs? How does context operate to regulate the employment of discursive resources? In different contexts, varying principles will be applied. For instance, in the classroom context, the governing principle will be that of pupils' understandings of 'school knowledge' and 'school work' and what counts as an appropriate response to a question (the 'right' answer). In a less formal context, a different principle may be applied - what is appropriate or possible to say with peers, for instance? Where peer group principles are operative, individuals my well treat differently drug users amongst their group compared to those categorised abstractly as 'junkies' in general. This would involve ascribing and drawing upon different 'vocabularies of motive' and producing different 'narratives' of their possible fates. The factor analysis at the end of Section Two revealed underlying principles of this type which reappear, with different degrees of salience and in different contexts discussed in the following chapters.

Situations and relationships

As mentioned before, there is a parallel here with 'social distance' models of racist belief and behaviour, where white individuals may express hostility to blacks in general, but be sympathetic to those they actually know as friends, neighbours or work-mates. Social difference measures indicate different circles of intimacy - "I dislike blacks in general", "I

like my black neighbour", "I wouldn't want my daughter to marry one", but at the same time can be seen as marking different social situations or contexts and indicating different discourses, *eg* of national identity; of neighbourhood; leisure or work-place relations; of the family. Attitudes to blacks, or drug users, or homosexuals or condom use will vary according to the context in which an issue is raised and the criteria of relevance within that context which regulate the discursive resources which might be appropriately called upon or invoked.

These points can be illustrated by considering McKeganey and Barnard's (1992) examination of needle and syringe sharing. I would suggest that, in terms of the above discussion, a fundamental distinction can be made between posing the question "Why does an individual do X?" and "Under what circumstances might an individual do X?" The former way of posing the issue suggests that the answer should be sought 'in' the individual *eg* as a personality trait or an attitude or cognition, whereas the latter, in line with Goffman and Mills, suggests that the behaviour becomes intelligible in *context* rather than in terms of assumption about 'inner states' of the person[8].

McKeganey and Barnard are concerned with the question, "Why do drug users share needles and syringes even when they know the dangers?" They argue that over-concentration on the behaviour itself can lead researchers to ignore "... the social context in which behaviour occurs" (p25). They believe that

> ... drug injectors' risk behaviour needs to be understood not only in terms of the social relationships between drug injectors, but also in terms of the local culture shared between people generally living within and area.
> (*ibid* p26)

In the area of their own research they note a strong community ethic of sharing and reciprocity which, they believe, could provide a general ethos supportive of the sharing of needles *etc.* More specifically, they found that the sharing of equipment is itself 'a socially patterned activity' (compare with Becker and Goffman *op cit*) and incorporates an important distinction between lending and borrowing, in which using someone else's equipment is very different from allowing someone to use one's own. The authors demonstrate that this distinction allows for the possibilities: *neither lending nor*

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[8] This line of thinking is also to be found in another influential and classic piece of work: Becker's *Becoming a marihuana user, 1972* .

borrowing; lending but not borrowing; borrowing but not lending; both lending and borrowing. They found that these possibilities relate to "... the assessment of one's personal relationship with the person concerned..." (p31). They add that, "It is evident that for many of the drug injectors *social distance* had a direct bearing on decisions to share injecting equipment" (p32, *emphasis added*).

People tend to share more often with sexual partners or siblings and women do so more often than men. Often, this was not seen as 'sharing'. In a way similar to condom use and young women in the Women, Risk and AIDS Project (WRAP) (see, for example, Holland, 1991b), the sharing or otherwise of injecting equipment was seen as symbolically marking the nature of the relationship between the persons concerned. As such, it constructed particular definitions of the situation (or 'contexts'), making different types of discourse available for use (*eg* "If you love me you would not make me use a condom"; "If you were my friend you would share your needles with me"). It is important to stress the 'irrationality' of these attitudes in the sense that social distance in the relationship has no bearing on degree of risk of the activity, except to the extent that a person might be informed about a partner's history.

In order to account for this patterning of behaviour, McKeganey and Barnard draw upon the work of Schutz. Schutz' 'social phenomenology' was an influential classic current (together with the 'symbolic interactionism' of G H Mead) in the development of the 'interpretive sociology' of the late sixties and early seventies, of which the New Sociology of Education was a part (Demaine, 1981).

> According to Schutz an important distinction in terms of people's perception is between those aspects which exist in the background of one's awareness (horizon) and those elements which are at the forefront of one's awareness and which are directly perceived (theme). This distinction is of value in beginning to understand how drug injectors might continue to share injecting equipment despite their knowledge of the risks involved. Whilst drug injectors might be aware of the risks associated with needle and syringe sharing, nevertheless, within any particular situation knowledge of the risks involved will be more or less thematic. A good illustration of this can be seen on those occasions where individuals commented that although they shared injecting equipment with their sexual partner or their best friend they did not perceive this as risky behaviour.
> (McKeganey and Barnard,*op cit* pp46-47)

The determination of what is to be 'horizon' and what is to be 'theme' relates to the further concept of 'topical relevance' (an idea later utilised in ethnomethodology). What counts as 'topically relevant' will vary between contexts. In different situations, different things will acquire topicality and the associated criteria of relevance will regulate what it is that is 'thematic'. In terms of the discussion above, we can say that shifts in topicality mobilise different discursive resources and principles. In the case of condom use, for instance, in certain situations the 'personal relationship' theme will take priority over that of 'controlling risk' and a discourse of romantic love (associated in turn with a discourse about female sexuality) will come to the fore.

Conclusion

This chapter has been concerned with developing a theoretical perspective towards the concept of *context* as a way of approaching the qualitative data from the study. The discussion began with two 'classic' papers by Goffman and Mills which were influential within the interpretive sociology of late sixties and early seventies. There they were located within a symbolic interactionist paradigm which was increasingly influenced by ethnomethodology and phenomenology. These two papers were particularly influential in the New Sociology of Education[9]. I have developed this early discussion by relating situation to discourse and to the view that context regulates performance through organising the relationships between discursive fields and their selective availability to different categories of person within a given situation.

More abstractly, following Bernstein, it is the *classification* of contexts which is important - their boundaries and the *strength* of the boundary. To the extent that different contexts ('situations') will be associated with different sets of discursive resources and thematic principles, there will be a hierarchical ordering of these resources for categories of social actors, which varies between contexts, given the 'situation at hand'. Teachers' expectations will have priority in the classroom over what girls might know from their own experience about sexual relationships with boys and what is typically possible for them within them. In relation to the enlightenment model of education, what is implied

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[9] The source for these two papers is the influential Open University reader *School and Society (1972)* which can be treated as highly representative of the intellectual background to the New Sociology of Education. It is interesting to note the extent to which 'classic' papers of that period (especially in ethnomethodology) are currently referred to in the current debate in social psychology.

by this is that the crucial issue is not so much what pupils know or don't know, but their resources for handling and resisting, challenging or contesting the dominant hierarchical principles of particular situations. How, for instance, could young women come to insist on condom use through challenging the sexist discourse which constructs insistence as evidence that they are 'slags'? What is required is not simply more knowledge, but an understanding of key 'vocabularies of motive' and a capacity to engage with and contest their logics.

Against this background, I will examine the manner in which 'context' was associated with differences in pupil 'talk' (I am including written responses to the questionnaire under this heading - 'text' and 'talk' being used interchangeably).

CHAPTER TWELVE

ANALYSIS OF QUALITATIVE DATA : DRUG EDUCATION AND DRUG USE

The Teachers and Drug Education

This section will focus upon the teachers in the study. It is concerned with their attitudes towards *teaching* about drugs (rather than their own attitudes towards drugs) and the approaches they adopted. The teachers' approach plays an important role in structuring the classroom context. Not only does the model of drugs education (and PSHE more generally) adopted affect the teacher's pedagogic style, it also influences pupil expectations about what counts as valid 'school work'. The teacher's approach will construct the principle governing interaction and pupils talk in the formal classroom lesson situation.

However, it must be emphasised that the particular model applied will not be totally determining. To the extent that pupils will be able to subvert the teacher's frame of reference, they can also influence the situation by introducing, for instance, the strategy of embarrassing the teacher or undermining his or her authority. Teachers will also be concerned with the ongoing problem of maintaining order and productivity in the classroom. The effectiveness of the specific approach to drugs education in any classroom will reflect these other aspects of the situation and, especially, the degree to which the teacher is able to maintain authority in the classroom and sustain a particular 'definition of the situation'[10].

All the teachers involved in the drugs education and HIV/AIDS education programmes under study were interviewed; *ie* eleven teachers in all. Interviews were conducted in the Staff Room during 'free periods' and were part of my role as Advisory Teacher: monitoring and observing current practice.

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[10] It should be further acknowledged that teachers rarely apply *a* particular model or approach in a 'pure' form. Rather, they tend to draw pragmatically upon a range of pedagogic resources in order to sustain an effective strategy of classroom management. However, these complexities of classroom practice are not the primary focus of concern here.

Approaches

I will begin by examining the teachers' frame of reference in drugs education. The views of the teachers in the sample can be seen as drawing upon aspects of the range of curriculum models reviewed in Chapter Four. The consensus amongst the trained PSHE teachers, as evident in their pedagogic practice, was that a sound educational programme would incorporate the following elements:

a] information - given in a non-evaluative, non-sensational manner
b] attitude clarification - again, in a non-judgemental framework
c] a situational component - acknowledging the specificity of behaviours and the contextual factors that influence them.

These elements parallel both Health Education theory (Howe and Wright, 1987) and psychological theory (see Chapter Four), but with some notable differences. First of all, there is the adoption of three approaches of Howe and Wright's five element model (harm reduction is regarded here, not as a sixth element, but as an orientation distinct from the abstinence model of drugs education (Jones, 1990)) and the disregarding of two elements.

Behavioural approaches were disregarded, being seen as 'training' rather than education and, therefore as too directive. Cultural Health Education was not taken up for different reasons. Firstly, it was not fully understood as an approach. Secondly, where it was understood as an approach, it was felt that it did not readily translate into educational strategies and materials. Thirdly, few published materials were available within this approach (Institute for the Study of Drug Dependence, 1985b) and these were felt not to be attractively packaged. Hence, the teachers tended to reject what might be seen as the two extremes: the behavioural skills training approach and the version closest to the 'cultural studies' approach which draws upon the kind of theoretical background discussed in the Introduction in relation to Cohen, Willis and Holland[11].

It is, of course, the 'cultural approach' which comes closest to that which is suggested by the earlier theoretical discussion and by the work of researchers such as Cohen (*passim*) and Holland *et al* (*passim*).

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[11] It is worth noting similar concerns in relation to multicultural/anti-racist education, for instance, (anecdotally) Philip Cohen's work has been perceived as too theoretically advanced to be easily made available to students or teachers.

Examples of comments made by teachers on the form of the education programme are given below. These were collected in informal interview sessions in the course of my work as an Advisory Teacher, supporting teachers in their classroom practice. Interviews were conducted in classrooms during break-time.

The choice of approach

Information was felt to be essential within the educational programme, but teachers also acknowledged the need to address attitudes, beliefs and the situations within which health behaviour choices are made.

eg

T: They need information, that's obvious. I know it's not fashionable to emphasise information these days, but they really do need it. But we like to include something on attitudes and then case studies or role plays - which they can act out or just discuss.

I: Do you include any behavioural work - acting out particular responses?

T: Only in so far as the role plays go. I mean... we don't tell them what to do or say. It's not like a 'Just Say No' approach - that's naive - well not just naive, it's manipulative too. It's like you said on the training day - it's not really education and I can't imagine they take much notice, not when they are outside school of things you've made them rehearse in school.

I: Yes - there was another approach we discussed on the training day - the cultural approach.

T: Oh yes.

I: Do you use that at all, would you say?

T: It's a nice idea. I mean obviously you have to take account of social things - but, well it's more for sociology than teaching.

I: You don't think it is useful for the classroom.

T: No I don't really. I don't see how it works in the classroom.

and

I: I don't know if you can recall the models I referred to from Howe and Wright's work on drug education ...

T: Oh, yes I can - shock, information, behaviour, attitudes, situations and something else.

I: The cultural approach?

T: Perhaps. I think so.

and

I: Have you come across Health Careers?

T: Yes, I borrowed it from The Shed when you recommended it, but..I can see what you meant, but it's not really any use for my groups. It's boring, isn't it. I mean there are no illustrations, it's not even nice print and what do you do with the information when you've got it?

Although the teachers sometimes displayed an awareness of the 'cultural approach', it is clear that they view it as theoretically and pedagogically obscure and difficult. Although, to some degree, this might reflect the lack of developed resources in this area, it is probably also the case that the approach challenges basic principles of mainstream liberal and progressive educational traditions. Despite its apparent 'relevance', progressivism is based upon a form of individualistic essentialism (expressed in the notion of 'the child' as a 'unique' individual) which tends to be resistant to treating children as members of social categories. The 'social', identified with family background, is often seen as something which corrupts and stunts the child and against which the teacher is struggling in order to enable the child to realise his/her *inner* potential. Hence, although as stated above, a 'situational' element is acknowledged in the teachers' model it is not developed with any degree of sophistication from a sociological or social psychological point of view.

Aims of the drugs education programme

All of the teachers involved in the study felt that, realistically, teachers cannot adopt a completely anti-drug stance. Their reasons were that we live in a drug-using society; that teachers lose credibility if they appear not to be attuned to drug-taking behaviour and 'street-wise'; and that it is necessary to give some indication of the possibilities of safer drug use. This latter point raised problems for all of the teachers concerned, in that they did not think it appropriate to be giving direct information on how to use drugs in a less harmful manner.

I: Would you say you are trying to stop pupils from taking drugs or to reduce the likelihood of harm, if they ever do.

T: Yes that - the harm reduction approach. It's hypocritical to think we can stop children taking drugs.

I: Could you say in what way it's hypocritical?

T: Unrealistic. Well, we all take drugs of some sort, don't we - paracetamol, cough medicine, alcohol, tobacco - well, I don't - smoke, that is but others do, others who teach Health Education.

and

T: We live in a drug-using society. Children have models of people taking drugs all the time. I shouldn't think any in my classes have parents who don't drink alcohol and quite a few smoke, though I think less than used to. It isn't reasonable to expect them to accept a completely anti-drug message, if they're surrounded by drug use.

I: Would you talk to them about safer drug use?

T: I'd talk about safer drinking - or maybe doing things more safely when they have drunk alcohol; like don't drive if you have had a lot to drink and don't operate machinery. I think not mixing drinks. Of course, they think that's clever, that, so I'm not sure what message really gets across. Safer smoking. Smoke less, low tar,

smoke less of the cigarette. I mean smoke fewer cigarettes and also leave the last third. But it's expensive to waste the last third, so I doubt they would do that. It's probably pointless talking about safer drinking and cigarette smoking to children. I think we tend to say, "don't smoke" and "drink carefully", but I doubt they take any notice of drinking advice.

I: Would you talk about other forms of drug use in terms of harm-minimisation?

T: Oh, I don't know. Not really. I think maybe in AIDS education. I might say, don't inject - but they don't inject here anyway. Well, I think they don't. Or don't share. Maybe even something about cleaning needles, but I doubt it. It's not really appropriate to them at the moment; maybe never and I suppose it has to be mentioned but... I couldn't talk about safer glue-sniffing or other drug use. I don't know enough to be confident and I think parents would object. They'd say that it would encourage them or make them think it could be safe.

I: Would you agree with that?

T: (long pause) Yes, I think so. We give them The Bridge Project's number. I think it's better if they tell them about that sort of thing.

and

T: You have to talk like you know what you are talking about, like you're street-wise or they think they know more than you do. Some of them do of course. The drug workers come in from the local place and it's useful, but they're so trendy and right-on and sometimes they ask you to leave. I know it's useful for them to talk to people who are really in the know, but it undermines our work and our relationships with the kids. We're the ones they come to when they are worried or upset. Sometimes the ones they ring when school's over and they're in trouble, too. It's a delicate balance - you have to seem stable and sensible, but also like you live in the real world.

These comments from the teachers illustrate a number of tensions. They are clearly concerned about the ambiguities of their position in talking about drugs with pupils, especially given the fact that society sanctions the use of legal drugs such as alcohol and tobacco. They also show concerns relating to their authority in the classroom. How should they handle pupils' own knowledge (the 'street-wise' pupil), especially in relation to their own lack, perhaps, of personal experience in this area? At the same time, augmenting their own material by calling in outsiders with other types of professional expertise to talk to pupils could also undermine their position. These conflicts reflect the range of factors and concerns mentioned at the beginning of the chapter which are at work in constructing and managing the classroom situation.

Classroom practice and recontextualisation

Although it is clear that teachers were, to varying degrees, knowledgeable about the theory of pedagogy in this area, that knowledge tended to be rather incomplete and patchy. This reflects the 'logic in use' of theory in the classroom, whereby teachers (for understandable reasons) draw pragmatically upon approaches rather than isolate them (as do researchers or theorists) within their distinctive theoretical boundaries. In this sense, theory comes to be recontextualised within educational practice by the pragmatic pressures which teachers have to contend with in their day to day work. While having a pragmatic value, this process may also weaken teachers' ability to critically reflect in an informed way upon their own practice.

In terms of psychological theory, the three combined approaches which were adopted (*ie* information giving, attitude clarification and situational education), tallied well with traditional attitude theory - that attitudes comprise three components: affective, cognitive and behavioural - and that each are influenced by modifying factors, notably, social pressure, social norms, and perceived barriers (see Chapter Four).

As already mentioned, important omissions are evident. Firstly, a complex understanding of 'the social' as incorporated into some aspects of social constructivist theory and as claimed by (but not always evident in) recent discourse analytic work. Secondly, a more sophisticated understanding of health and risk behaviours. Teachers can, on this basis, be seen as lacking in both a more theoretically sophisticated understanding of the discursive character of their pedagogy and its context and of the more complex models of health and risk behaviour which were becoming available.

Pupils in context

I will now turn to an examination of pupils discussing drugs in various contexts. Pupils were observed in drug education lessons in both whole class and small group activities and a sub-set in groups of six to eight pupils in an informal setting. Comments were noted in a field diary. There were, therefore, three distinct contexts within which qualitative data was collected:

a] the formal whole class lesson context
b] small group or 'offstage' lesson context
c] informal group interviews outside the classroom and lesson time

The observation was unstructured and the data analysed for (a) content and (b) in terms of the characteristics of the talk that emerged.

The formal lesson context incorporated all interactions that were a structured part of the lesson for the whole class, such as question and answer sessions or feedback from groups on exercises. The 'off-stage' lesson context involved communication in smaller group settings which was not intended for the whole class. In general, this was collected from small groups as they discussed issues or questions raised by the teacher. In this context, my role changed also. Instead of being an uninvolved observer, I became a participant observer in that I functioned as a member of support staff, feeding in additional information, asking questions to prompt further discussion and responding to pupils' comments.

Groups of students were also interviewed outside lessons and these interviews were recorded and transcripts made. Interviews took place in empty classrooms during break-times. All those interviewed were willing to be there and being involved in one of the discussion groups became a popular activity. In one school, several pupils brought bottles of pop and crisps to share, creating a very informal atmosphere. After this initial move on their part, which clearly enabled the pupils to talk more freely, I provided the refreshments and, to some extent, it seemed that the pupils provided the entertainment, as the meetings took on a 'performance' aspect.

The three different types of qualitative data collection yielded very different findings. In what follows, examples of pupil speech have been selected for their representativeness.

Context One - formal lesson context

Students provided virtually no spontaneous input into the drugs education lessons Speech was task-oriented in this context. In general, their speech took the form of direct answers to closed questions, direct answers to open questions and feedback on particular tasks.

Examples of direct answers to closed questions

T: We've talked about different types of drugs and about three categories - depressants, stimulants and hallucinogens. Can you give me some examples of depressants? (After silence) Anthony?

A: Alcohol.

T: Yes, any others?

A: Cocaine?

T: No, cocaine isn't a depressant. What is cocaine? Anyone?

P: Stimulant.

and

T: What do you think are the most common drugs around here?

[no responses]

T: Do you think there is a lot of heroin use? (pause) Emma?

E: No.

T: What do you think drug users use round here?

[Emma now avoiding eye-contact. Fairly uncomfortable pause]

P: Cannabis.

T: Good! That's probably the most common, isn't it? Any other suggestions?

P: Speed.

T: Yes.

P: Alcohol.

T: Well, yes. If we include legal drugs, too, then alcohol and tobacco would be more common wouldn't they?

Examples of direct answers to open questions

T: What might it be like for a person trying to give up drugs once they are addicted?

P: Very difficult.

T: Yes, and why would that be?

P: Because they need the drug?

T: In what ways?

P: To live. Like, they would be ill if they didn't.

and

T: You saw on the video the sorts of effects that taking drugs can have on your life and you may know things your self beyond this. What sorts of problems can people have with drugs and how can they be helped?

P: Addiction.

T: Yes, and why is that a problem?

P: You want more.

T: Yes... [indicating for the pupil to expand]

P: You need more drugs or harder drugs.

T: And what problems does that create?

P: It makes you ill.

P: You can die.

T: Anything else?

P: You mix with unpleasant people.

T: Possibly, yes and what might that lead to?

P: Taking more drugs.

T: Or?

[no responses]

T: It might lead to crime. People might have to steal to get the money they need for drugs because they are expensive. They might be violent when they use drugs.

Examples of feedback on particular tasks

T: What did you say you would do, Susan, if you were in this situation? *(Offered a substance that is unknown at a party, but told that it will make you enjoy the party more)*

S: Ask what it is?

T: Yes, then what might you do?

P: Say you don't want it?

T: Yes, any other suggestions?

P2: Go home.

T: Yes.

P3: Say they're stupid.

Pupils' responses are clearly often cued by the teacher. Although the format of the question and answer session is often seemingly open, the teacher often has a particular end in view if not a particular form of response. Pupils appear to be attempting to guess what the teacher requires and the teacher indicates, generally non-verbally, via gestures or tone of voice, when a pupil should expand or has not yet reached the answer that s/he has in mind. This is an example of 'cued elicitation' (Edwards and Mercer, 1987) where children are prompted in a 'discovery-based' lesson to discover precisely what the teacher requires; and the 'ideological dilemma' (Billig, 1988) for teachers of adopting a progressive, open-ended child-centred approach, whilst also 'leading out' or informing in a tightly controlled way.

Drug users as the 'other'

Feedback and responses revealed very little about students' own knowledge of drug use and attitudinal statements were related to an anonymous and stereotypical 'they'. It is possible that this reliance on the stereotype was an effect of the classroom context and became a safe way of meeting the teachers' expectations about what pupils were meant to know or express about drug use. It also has the effect of displacing attention from pupils' own experience and knowledge of drug use and drug users. We can see, in these comments, pupils using a particular 'vocabulary of motives' relative to drug use - *why* people take drugs.

eg

P: They take drugs because they are bored.

P: I think maybe things are wrong in their lives, like they come from a bad family background.

P: They start with something like cannabis, but mostly they then take other things as well.

P: It gets out of control, then they can't stop.

Tolerance towards other people's drug use

In case studies, presented in lesson materials, pupils tended to respond in a liberal humanist vein - in terms of individual responsibility, but with a tolerant attitude,

eg - about a woman who is a single parent in a run-down area, under pressure to take drugs,

P: We said she ought to stop. She has a child to take care of and she hasn't got any money anyway... Yes, we felt sorry for her. She has a hard life, but that's no excuse for not looking after the child.

- about a man in a rehabilitation unit

P: In the end it's up to him... whether he wants to be a junkie or he wants to be normal.

The major characteristic of the type of talk produced in the formal setting was its abstracted content. There was virtually no mention of pupils' own experiences and drug users were presented as 'others' outside of their own realm of experience.

Context Two - 'offstage' comments

'Offstage' comments were very different. These revealed a quite sophisticated knowledge and varied experience of illicit drug use (first or second hand, and usually via an effective peer-group network) and were spoken using a much more extended form of speech.

eg

P: My brother and his friends they take speed... Yeh, I could get it if I want it. It's mostly in the pool clubs in Peterborough.

P: What's amyl nitrate? Does it do you any harm? Some of my friends take it... at clubs. I don't but you see a lot of it.

P: Yeh, I know someone who's into drugs, but you wouldn't know it - like he works and he doesn't look obvious.

P: I don't think you could ever go to a party round here and there not be cannabis. Not everyone is into it, but it would be easy. You could be if you wanted to.

Pupils were aware of these differences in what and how things were said in different contexts. When talking about the lessons themselves - a theme they frequently raised - they felt that the teacher had a particular aim in mind (usually preventing them from using drugs or getting them to say that they would not). Pupils suggested that they were expected to respond in particular ways and these assumptions about teachers' expectations and aims guided both what they said and how they said it.

P: She wants us to say we'll never take it.

P: We have to say that it's wrong.

P: What do you think would happen if we said we thought it was okay!

P: Do you think she'd tell on us if we said we knew people who took drugs? I think she'd tell on us.

In the less formal setting of small group discussion, pupils were keen to know more about drug use and related issues. Although it is the case that an alternative explanation for the different speech styles in the two contexts might be the difference between talking to the usual PSHE teacher and talking to me, as an outsider with a specific interest in drug use and drug education, it was evident that pupils were also talking to the classroom teacher in a more open and extended way, too.

P: What's a rehabilitation like?

P: What's amyl nitrate?

P: Do you think it does you damage to just use a bit, say once?

P: Have you been a drug user?

P: Do you know drug users?

P: What we need is real drug users to tell us what it's really like.

The school context is seen as being different from the 'real world' and its requirement of a 'specialised discourse' closed down the kind of argumentative and challenging talk that could occur elsewhere. In one classroom, a teacher (not one from the training course), perhaps in an attempt to gain credibility in the eyes of the class and also to put them off illicit drugs, described the following scenario in a formal, whole-class teaching context:

T: I have a friend who is a Police Sergeant. He has a lot of experience of working with drug users and he could tell you just how tricky they are. He's told me about drug pushers and it's like this...
There is one who knows who waits outside schools for children like yourselves. He'll say to you "Give me your hand" and he'll take a pin with a bit of heroin on the end of it. He'll say "Try this. You'll like it". Then, if you let him, he'll put the pin down behind your cuticle - that's the skin round your nail - and you'll be high and before you know it, you're an addict.

Although clearly dealing in gross stereotypes and also presenting inaccurate or poorly informed views, the teacher met no overt rejection of this input from the pupils. Nobody spoke. Few pupils were looking at the teacher as he was speaking, although it could not be said that they were not listening as they were quiet and also attentive as he moved on to the next exercise. There was not a flicker of response of any form and no indication of how the story was received.

Later, in 'off-stage' discussion I asked some of the pupils about this part of the lesson:

I: What did you think of the story your teacher told you about the drug pusher?

P: (Laughs) (Incredulously) Do you think that's what happens?

I: Do you?

P: (Outraged) No, I don't.

I: You didn't say anything.

P: No.

I: Why not?

P: Couldn't be bothered really. He doesn't know what he's talking about.

I: You know more than him about this?

P: We all do.

I: But you wouldn't put him straight.

P: No - you don't tell teachers if they're wrong. You can't.

I: Is it not strange then if you're being told things you don't think are true.

P: That's school isn't it.

P2: And you can't tell them about drugs, maybe if it was something else. Maybe. Probably not then.

The pupils' reception of the classroom knowledge and their response to it is guided more by models of appropriate 'classroom work' and perceptions of teachers' authority than it is by the ideals of inquiry and discovery which teachers typically associate with their aims and methods.

The introduction of pupils' own knowledge and experience in this area begins to reveal a split in their discourse between, on the one hand, a view of the drug user as 'other' (as observed above, abstract and stereotypical) and, on the other, drug users known personally and (as members of the community or family) as 'us'.

Context Three - group interview

This context will form the focus for the next where it will be extensively discussed. I will limit myself to some preliminary comments, here. In the break-time sessions, fewer questions were asked, by pupils, of me, as tutor/facilitator, than in the 'off-stage' setting. Talk in this context seemed to be regarded as 'conversational' rather than 'pedagogic' and, in Bernstein's terms (Bernstein, 1990) was regulated by a different code. As interviewer, however, I was rarely included in the discussion, unless I directly intervened. My impression was that there tended to be a performance aspect to the speech that occurred and that 'impression management' in front of peers (and to me) was often evident.

During a discussion of 'influences', for instance, there was an initial consensus that pupils acted on their own volition without being much affected by others' views, until a boy (P4), who was dominant in the group and the class more generally, made his contribution. The effect was to turn the discussion around to an acceptance of, particularly maternal, influence. This illustrates the pressure towards conformity with those regarded as significant within the peer group.

P1: No, no one really influences me - I do what I want to do.

P2: Yeh, me too. I don't really get swayed by other <u>people.</u>

P1: (interrupting) [undistinguishable word - perhaps "<u>I'm/We're</u>"]... not easily led.

P3: I'd say I think for myself and it's not difficult to stand up for myself.

P4: My Mum. I'd say, I'm very influenced by her.

P1: Well, yes. I'm influenced by my Mum too.

P3: You have to do what they want, living at home.

P4: Mainly my Mum...

P3: Sometimes my Dad.

The most obvious feature of the informal context is the absence of the organising principle of school work and the authority of the teacher. This allowed, not only a different range of knowledge and experience to be introduced into conversation, but also alternative themes and organising principles. In this sense, the change in context altered the classifications of discourses and the relationships of inclusion/exclusion between them. These changes will be explored in more depth in the next section of this chapter.

Reflections on interview and observation data

Here, I will draw out the major themes which emerged from the pupils' talk about drugs in the informal setting and contrast them with those in the other contexts. I must point out that the contexts and themes were not *completely* exclusive - it is not the case that something that was raised in one was never ever raised in another (although it was the case that pupils' own experience with drugs was kept out of both lesson and small group situations). As I stressed earlier, context *regulates* but does not *determine* content and performance. The purpose, in what follows, is to identify different principles of contextual 'topicality' and how they regulate the introduction of different drugs discourses in different situations.

The three main themes which emerged from observations in general (including the factor analysed questionnaire data) can be broadly categorised as:

a] *stereotyped* images of drug users - 'they' or 'them'

b] drug use and *style*

c] a laissez faire attitude to drug use amongst those they know

There are two major distinctions or dichotomies at work within this set of themes:

[1] 'them and us' - the contrast between the stereotypical drug-user ('junkie') and drug users (or the use of drugs by individuals) known personally and identified as 'one of us'.

and

[2] between the 'stereotype' drug discourse (invoking, for instance, a particular 'vocabulary of motive') and the 'style' discourse. Style is distinctively related to youth and peer group contexts and concerns and is associated with anti-school values and pupil sub-cultures. For this reason, it is unlikely to be directly expressed in the classroom or to be directly invoked

as a principle for organising talk about drugs, except for the purposes of subverting 'school-work'.

Drug use and style

Drawing on images from current media campaigns about drug use, pupils present an attractive picture of the drug user, incorporating aspects of adolescent style. The drug user is presented as moody, angst-ridden and interesting. Much of this is symbolised by the black clothing, the pale skin and the gaunt appearance (again, reminiscent of the 'romantic image').

Justine, referred to in the extract from interview transcripts below, enjoyed a certain amount of notoriety within the year group and the school more broadly. She was a high achiever academically and in virtually all the girls' school sports teams. She was also suspended from school at the time of the interviews because of her classroom behaviour, which took 'teacher-baiting' to a subversive extreme. On two occasions she had been hospitalised after a combination of butane inhalation and excessive alcohol use. Pupils regarded here with a certain awe. Some were unimpressed by her drug using, but her 'style' seemed to meet with more general approval.

I: Have you seen the government's anti-drugs campaign...?

P1: (interrupting) Heroin Screws You Up, yeh?

I: That's the one. I've got one of the posters here...

P2: (interrupting) Could I have that?

I: Sure...

P2: Thanks.

I: You like it?

P2: He's cool.

P1: Yeh, he's good looking.

I: He's supposed to look ill.

P1: He looks really good. I like how he dresses - like Justine dresses.

P2: But she's a girl.

I: Do you think he's cool using drugs?

P1: I think he's cool.

I: So what does it tell you about heroin?

P1: It screws you up.

I: Anything else.

P1: Not really. It's cool to use it? (Laughs)

and

I: This is one of the posters from the Heroin Screws You Up Campaign

P3: It's a good one.

I: Why is it good?

P3: I mean I like it. I don't think it would put you off drugs.

I: Why is that?

P3: He's good looking and a lot of people would be impressed.

I: He's not supposed to be impressive.

P3: But he is, so they got it wrong, I think.

I: What do you like about him?

P3: His style. He looks good.

I: Do you think drug users are likely to look like this?

P3: Yeh, I think lots of them do. Like a rebel.

and

P: I remember the bloke on the heroin poster. The moody one in black. He was good looking. I wonder why they picked him. It doesn't really put you off. The one with the spotty-faced kid, who looks really unhealthy - the one where he's looking straight on - the one they've got in the chemist - that was better - or worse depending how you look at it.

We see in these excerpts, the clear connection between 'style', positive image and 'us', with pupils mentioning particular, known individuals, but also showing an awareness of how the posters fail to have the desired effect. It also seems to be the case that (at least some) known drug users are seen in this 'style-positive' way - 'like rebels', *etc.* There is the obvious problem that the more materials attempt to appear 'relevant' to young people, the more they risk their intended message being translated into a positive code of 'style' at the expense of the Health Education message. At the same time, the more they detach themselves from identifiable youth sub-cultural images, the more dangerous drug use is associated with 'them' and, hence, not a problem for 'us'.

Own experience

Several pupils were able to call on their own experience of drug users in their local community and mostly the drug use was seen as unproblematic - an issue of curiosity, not condemnation:

P: (referring to the same poster) I know some boys who are into drugs and some of them look like this. They look different, I think, but it hasn't done them any harm, no.

P: There's lots of cannabis around here. And speed. Nobody' s an addict, I'd say. But it's around at parties.

P: My brother and his friends, they're into a few things. Mainly leb, nothing harmful.

P: Amyl, that's pretty common. If there's good music.

P: You can't go to a party without being offered something and lots of people will take what's going, mainly dope. It's not like drug using, not like we talk about it in class.

P: It sounds scarey if you think about it like on the Scene video or the adverts, but really most people aren't taking that stuff and it's not much of a problem. Even the estates where they say it's a problem, it's not like London or Liverpool.

In contrast, hypothetical drug users were often seen in stereotypical terms, well on their way down the slippery slope:

I: What do you think could be done about drug use?

P1: Drug users need help to sort out their lives.

I: What sort of help would that be?

P1: They need help to get off...

P2: And they need somewhere to live.

and

Drug-dealing

P: They get into pushing. That's the worst thing. Then they're dangerous.

P: There are some really unpleasant people around selling drugs. They mix them with all sorts of things to make more money and that's what does people damage.

P: I think it's like the mafia (the people who sell drugs).

P: They hang around in town, looking for trouble.

'Slippery slope'

P: That's it, isn't it, really. Once you get into it in a big way, you'd be lucky to get out without dying.

P: I think it's all downhill when they are into the hard stuff.

P: Heroin users, they're the ones with the big problem. Hard drugs. Then you get mixing with some really rough types and taking more and of course it does you more harm, anyway.

P: I don't think cannabis is too bad - from what they say - it's what it leads you into.

P: You've more chance of using heroin, if you've been using cannabis and speed.

P: They have to steal to get the money to pay for all their drugs.

P: They go out of their heads and they're dangerous.

P: I've never met one. I wouldn't want to.

Again, we see in these comments the association between 'them' and 'us' and different drugs discourses. Drug use and drug users associated with 'us' are exempt from the 'stereotype' features of the 'them' discourse. Within the sphere of the pupils' own experience, in the locality and in personal relationships, drug use is not associated with 'problems'. The use as such is not a problem "here" ("even on the estates"), but is a problem *elsewhere, eg* London and Liverpool. Local users are not 'addicts' and, although pupils can get offered things at parties and have sibling and friends using drugs, they do not seem to know any 'dealers'. Similarly, those known do not suffer any harm, but the 'others' (elsewhere and unknown) are on the 'slippery slope' and generally considered dangerous to know. The

symbolic process of displacement onto 'others elsewhere' again recall Sontag's analysis of illness.

Relationships, distance and discourse

The use of different drugs discourses is related to social distance and associated contexts. Those close to them and routinely encountered in 'normal' situations and familiar contexts are treated differently from those who are further removed and constructed only hypothetically and in a decontextalised way. The hypothetical, 'stereotype' drug user is *nothing but* a drug-user represented nowhere other than in stereotypical drug-specific circumstances (no-one's brother/friend/neighbour *etc* and engaging in no activities other than drug use). An effect of the 'routine contextuality' of known users is to separate them from stereotypical images of drug use - they are hardly seen as 'drug users' at all (let alone 'addicts'), but rather as people we know who take drugs (*eg* at parties, *etc*).

In part, this effect can be attributed to the 'overdetermined' character of routine situations. The topical relevance of a known individual's drug use within the complexities of the everyday can be relatively slight compared with a range of other themes such as 'being my brother' or 'so-and-so's girlfriend' or 'my mate down the road' or whatever. In the Schutzian terms employed by McKeganey and Barnard, the known individual's drug use will be on the 'horizon' of perception rather than a topically relevant 'theme' within the everyday context.

The issue explored above is the form that pupil talk takes and the way it is regulated by the classroom context, including the teacher's deliberate or *covert* structuring of the interaction (Billig *et al, op cit*). Within the formal classroom setting, the social skills and cultural practices of the pupils are disembedded from their everyday setting and 'incorporated' within pedagogic discourse in a way that constructs them quite differently. They are *re*constructed, not only in the way they are understood by official classroom authority, but also in the way they are expressed *or denied* by the pupils themselves. This will be developed further at the end of this section.

Conclusion

The teachers comments clearly conformed to the 'enlightenment' model, as was apparent in the frequent references to 'knowledge' and assumptions about its capacity to change attitudes and behaviour. Their remarks suggested a straightforward model of causality:

knowledge > attitude change > behaviour change

Where the social was acknowledged, it tended to be simply in terms of forces which militate against the success of their work - the influence of parents or the media or peers.

It should be noted that this approach would have been standard and widespread at that time (and probably still is today) not only amongst practising teachers, but also amongst many teacher trainers, sociologists and psychologists involved in education. To the extent that the analysis of their views identified omissions and a lack of sophistication in the understanding of 'the social' and 'situation', this was with the benefit of hindsight which drew upon the development of understanding in the field as a whole.

The teachers' frame of reference constructed the immediate pedagogic context of drugs and HIV/AIDS education - the 'situation' within which pupils operate and which regulates their own speech and behaviour. Teachers, within the enlightenment framework, are essentially seeking to provide pupils with a particular 'vocabulary of motive', *ie good reasons* for doing some things rather than others. This can be seen as fundamental to the enlightenment model generally, based in the assumed superior rationality of the knowledge and values contained within its curriculum. On the classic assumption that all people are 'intrinsically' rational, the essentialist assumption of liberal education is that, if only the distorting influences of 'the social' (family, peers, *etc*) can be by-passed, teachers can actualise the rational potential of pupils through the influence of 'enlightened' knowledge and values.

The study method reflected the educational focus in order to provide evaluation of the effect of the teaching - *ie* it incorporated attitudinal and information items, with some reference to behaviour, (though this was minimal because of the problems of sensitivity and permission in schools). In this respect, it was originally constructed within the paradigm discussed above. It is interesting to note the parallel between the educational 'enlightenment' model and the traditional approach to researching attitude change. It, also, attempted to investigate links between items via factor analysis and, to provide a

richer understanding of the data, classroom observations and interviews were also conducted. Interview data was subjected to thematic analysis.

The discussion of pupil talk in context suggests that the three contexts and pupil speech within them can be distinguished as follows. Within the formal classroom lesson setting, pupils said little that was spontaneous and revealed almost nothing of their own experience and ideas. Their behaviour appeared to conform to the model in which pupils' primary concern in lessons is to meet teacher expectations of appropriate responses and answers. Even where pupils were deviating from this ideal pupil behaviour, they were still operating within its essential grammar. Hence, pupils might ask 'difficult' questions in order to embarrass the teacher (see that concerned with oral sex below) or subversively express views which they knew to be contrary to school norms. Cohen, for instance (1991), writes of how white male pupils might express racist or sexist views, not because they personally hold them, but because it is perceived as a way of being anti-school.

As Bernstein has pointed out (1990), the formal school code defines not just conformity, but also non-conformity (Woods, 1990; Coultas, 1989). In terms of the preceding discussion, it can be said that the formal classroom context provides a particular principle of 'topicality' in terms of prescriptions of both conformity and non-conformity to teacher expectations. Topical relevance is constructed, not by the formal content of the curriculum, but by pupil understandings of the sub-text of 'school-work'.

In small group interaction (the 'off-stage' classroom setting), pupil talk became much more elaborated and revealing. Pupils were more likely to initiate topics, extend discussion and refer to their own experience and knowledge directly. Pupil-directed talk dominated and the emphasis shifted to impression-management and performance within the peer-group rather than being focused primarily on and by the teacher. This 'defocusing' of the teacher allowed topicality to shift into new areas of relevance.

An interesting feature of the situation was that pupils tended to ask *more* questions about drugs and related issues than in *either* the more formal lesson *or* in the less formal break-time group. Possibly the reason for this was that although impression management with peers was important, it did not have the over-riding importance it had in the break-time sessions. The small group classroom context was still perceived as formal enough (part of lesson-time) for pupils to ask genuine, information-seeking questions.

The 'off-stage', small group lesson situation would appear to reduce the pressures of conformity to *both* teacher *and* peer expectations. The 'on-stage' setting of the formal

lesson, especially where it involves (teacher) question and (pupil) answer sessions, exposes individual pupils to the full glare of both teacher and peer surveillance and perhaps maximises the extent to which pupils will 'play safe' in terms of both sets of criteria of relevance. Where pupils can choose their own groups, it might be that they also experience the extra security of a *friendship* group of like-minded peers as opposed to the larger peer community of the class.

Pupils' classroom talk about drug use tends to be organised around a *stereotype* drugs discourse because (a) pupils are seeking to provide teachers with 'the right answer' and (b) conventional stereotypes of drug users and drug use are seen as a good guide to what such answers should be. In the informal context, however, pupils tend to be more 'open' in their talk and draw more upon peer and sub-culture principles of topicality and relevance than upon the 'school-work' topic. This is not to imply that the 'style' discourse is more 'real', 'authentic' or 'autonomous' than that of 'stereotype', indeed, given the salience of peer approval and pressure for young people, it can be even more constraining than the stereotype discourse which commands less personal commitment. In the formal lesson context, the topic 'school-work' encourages the use of the 'stereotype' drugs discourse, whereas in the informal, small group context, peer group concerns raise 'style' as a topic.

Symbolically, 'style' can be seen as mediating between 'them' and 'us'. Where drug users are being treated as 'them', they are constructed *stereotypically* as 'other'. Where, however, they are being treated as 'us', they are constructed through the discourse of 'style' with its connection with youth sub-culture. Style has the effect of translating 'others' into 'us'. As I will illustrate below, where Health Education materials or publicity campaigns construct images which can be assimilated into a current 'style' discourse, their effects may be counter-productive and end up by 'glamourising' drug use rather than the opposite. As was noted, by reference to Sontag, in the introduction, this effect has also been associated with certain illnesses such as the Romantic, artistic associations of consumption in the nineteenth century.

This can be represented diagrammatically as follows:

Table 7 : Diagrammatic representation of contextualised talk about drug users

	DRUG USERS AS...	
social distance	'THEM'	'US'
drugs discourse	stereotype	style
situation	lesson	small group
theme/topical relevance	school-work	peer group/youth culture

CHAPTER THIRTEEN

ANALYSIS OF QUALITATIVE DATA - AIDS EDUCATION AND HIV/AIDS

As with the data collected in relation to drugs education, verbal interactions were recorded in AIDS education lessons in three different contexts - formal classroom, informal (offstage) classroom and group interview. Notable differences were observed between the three settings, paralleling those observed in the drugs education sessions.

The main differences between the AIDS education and the drugs education contexts are:

[a] In the case of AIDS (especially through its association with gay sexuality), the issues were more unambiguously associated with 'others' and, therefore, more open to stereotypical discourse. Although people with AIDS were not routinely encountered by pupils, where homosexuals were known to individuals this did tend to 'soften' the stereotypical view (see below). However, the absence of a routine context, in this area, eliminated the possibility of a dichotomous set of discourses equivalent to 'stereotype' and 'style' in the drugs area.

[b] The close proximity of the AIDS discourse to that of sexuality created problems for teachers in discussing the issues with pupils and also affected pupils' perceptions of and responses to the issues. The 'overdetermination' of AIDS discourse (discussed in the Introduction to the thesis) clearly creates considerable pedagogic problems.

The teachers' view

Teachers' comments on AIDS Education were also recorded. These indicate clarity as regards the key issues or information to be covered, but also a reluctance to get drawn into sensitive areas.

eg

T: Yes, I think AIDS education is absolutely essential. They (the pupils) need to know about how you can get the virus and they need to be told about condom use. If we can get that across, then we won't be doing badly.

T: Routes of transmission is what we cover mostly and safer sex - well, condoms, anyway. We don't really get into any other safer sex issues.

T: They know injecting is a risk and we reinforce that, but it's safer sex we concentrate on, I suppose. I think that's what is most likely to affect them directly.

T: I don't think it's our place to talk too much about issues of sexuality and sexual behaviour broadly. I suppose I skirt around the issues. We use the continuum exercise, high risk through to no risk and place cards along it. So they might mention oral sex or anal sex, but we don't really talk about them. I sort of assume they know what it's about or ask parents or friends, of course. I hope they don't ask me (laughs).

The fourth quote highlights the knowledge the pupils already had. From the questionnaire data, it seems that many pupils were already well-informed about HIV and AIDS. Their knowledge appears to have been underestimated by the level at which the information input was pitched, though, as the teacher said, reinforcement is also important.

Formal AIDS education

There were even fewer spontaneous comments and questions within the sessions on AIDS than those on drugs. Where questions were asked they were generally 'testing out' teachers as evident from the small group prompting before the question and the general class hilarity after.

eg

P: Do you use condoms, sir?

and

P: What's oral sex?

Woods (1990) discusses the ways in which pupils use humour as a strategy for 'surviving' school. Having a laugh at the teacher's expense is seen as part of 'mucking about' and

> 'Mucking about' is mainly an antidote to boredom and/or youthful high spirits impacting against deadening aspects of the school system. This at times, shades into another form of laughter of a more political nature, aimed at countering or neutralizing the power of the teacher (Woods,*op cit* p214)

Although in the instances referred to above, the pupils appeared to be having a good-natured jibe at the teacher, it is this potential for power-challenges and for loss of control that many teachers fear in opening up discussion of personal or sensitive issues.

The second question above occurred in the same session as one of the few examples of a pupil question genuinely requiring an answer within the formal pedagogic setting. Pupils had been asked by the teacher to order various activities written on cards in terms of their risk (high, medium, low and none). In the resulting feedback, pupils were asked to justify their ordering. One card required pupils to rate 'kissing', which had been regarded by some pupils as low risk and by others as none. Disagreement revolved around whether or not it was possible to contract HIV via small cuts in the mouth, if the other person had mouth lesions themselves:

> P1 : You could. Yes you could (*contract HIV*). If you had cuts in your mouth, or your gums bleed and they had the same...
>
> P2: Or mouth ulcers...
>
> P3: Yes, ulcers or cold sores, or cuts on your tongue.
>
> P4: But you don't use your tongue when you are kissing, do you?
>
> [silent pause, pupils waiting for teacher to respond]
>
> T: (evasively) Well, maybe, but of course it's very unlikely. There are very few cases of people getting AIDS... HIV through kissing. Well, none at all. So where shall we put this card? Shall we say it is low risk or nor risk?

This piece of interaction, coupled with the more teasing question in relation to oral sex, raises some interesting anomalies in relation to the question and answer format of some lessons. Although, in theory pupils are invited to ask questions and to gain the information they want or need, in actuality, teachers often avoid answering questions if they feel they are not sincere requests for information or if the teacher loses confidence in answering them. This inconsistency in turn may deter pupils from asking what they wish to know.

P: We put some questions in a box. Not in this stuff, but in sex education. She didn't answer mine. I didn't dare ask why. Maybe she thought it was a joke. I was serious. Maybe she didn't have time. Maybe she just made up the questions and put ours in the bin.

P: She gets embarrassed. Some people ask questions to embarrass her more, to see if she'll go red. Mostly, it's best to keep quiet and get it over with.

Teachers expressed sentiments like:

T: I feel strongly that children should get answers to their questions. I like to answer rather than leave them in the dark, even if it is embarrassing.

T: We encourage them to discuss things frankly. We give them information and we discuss what they want to know. It can get embarrassing at times.

However, there seemed to be a general tendency to take evasive action rather than to deal with the question directly. This may have been influenced by the presence of another adult, though I would have expected that having discussed sexual activity and sexuality at training sessions with minimal embarrassment and having stated their belief in frank responses, that teachers would have been more rather than less likely to answer pupils' questions in the presence of a researcher who was at the same time the Advisory Teacher in the area. Pupils comments also support the impression that their questions are not always answered.

The questions reveal different intentions amongst pupils within the same class. On the one hand, some pupils see the classroom interaction as a game and HIV education as an ideal opportunity to bait the teacher (whether in a light-hearted or more aggressive manner).

On the other hand, pupils may see it as a situation within which they can air their concerns and gain the information that they lack. That both exist simultaneously raises issues about how pupils interpret the informal rules of the classroom and how much safety really is available for those pupils who make themselves vulnerable in exposing either their knowledge or their ignorance.

The different levels of question and knowledge amongst pupils within the same class raises issues of pedagogy. These relate to how such differences are best handled and the ethical issues of teaching to either the highest level of awareness or the lowest. Teachers are well aware of this dilemma.

T: You've got Simon, winding you up, not nastily, but he does... talking about oral sex or asking about it, when he knows perfectly well. You only have to look at the graffiti in the boys toilets to see that some of them are not at all naive when it comes to sex. Then there's the other one - Andrew - the one who asked about kissing, using your tongue. He really didn't know, you know. And what do you say - to either of them? You want to keep things open, but is it fair if someone like Andrew is dragged in one lesson from not being aware of french kissing to knowing about oral sex. It's a problem. Obviously you want them to be protected - from HIV. But you also want them to be innocent too, when they're only children and some of them *are* only children. And I'm not even sure I really believe that! So it's hard thinking through what you think after the lesson. At the time you have to think and answer on your feet. It's impossible to know what to do.

Pupils gave direct answers to closed questions:

eg

T: So is sharing a cup risky?

P: No. No risk for that.

T: And mosquito bites?

P: I don't think so.

T: So that's no risk, too?

P: Yes, no risk.

Many of the answers to more open questions related to the discussion of situations and the delivery of prepared feedback by pupils. The prepared feedback revealed little of the issues of debate within the less formal, offstage groups. Within one such situation, pupils were asked if they would give mouth to mouth resuscitation to someone dragged from a canal, if marks on his arms revealed him to be an injecting drug user. The formal feedback was as follows:

T: So which shall we consider next? The drug user in the canal. So what did your group think?

P1: We thought you should help him. It's not really risky.

T: So you would have decided that there wasn't really any risk of getting HIV, so you would have done what you could?

P2: (same group) If you could do artificial respiration. If not, you'd have to get someone else.

P3: (different group) And we decided, maybe if there was blood around - in their mouth - that you wouldn't do it then either.

This contrasted with the offstage remarks about the situation, which dealt with the situation more personally. In one small group, all boys, the discussion went as follows:

P1: It would depend if it was a man or a woman.

P2: And if it was a good-looking woman.

I: Why is that?

P1: You wouldn't want to be seen kissing a man.

P3: There's no one else there. That's why you have to give them resuscitation, so no one could see you anyway.

P1: But I wouldn't want to kiss a man anyway.

P2: Ugh, no.

P3: It isn't real kissing.

P2: So you would do it, would you. That's pervy.

P3: Don't be stupid. So you'd let him die (to P1), or your dad or your brother?

P1: My brother, yes (laughs). I'd have pushed him in.

P3: Seriously, ...

P1: Yeh, I suppose. If it was someone I knew and no one was looking.

P3: That's still stupid. You'd let someone die, just so no one would think you were kissing them, even though it would be obvious that you were saving their life.

P1: So we'll say... yes, you'd help, no risk.

P2: Right.

P3: Yeh.

Though not directly an issue of sexuality in the context of this particular scenario, it still raised such issues and, though some of the remarks were clearly tongue in cheek, it was a matter of concern - and one that was shared by at least two of the boys immediately involved. This issue - though directly relevant to HIV education - was never raised in the formal classroom setting. Pupils opted to respond to the situations in a way that reinforced their 'otherness', not the connections they made with the material. Clearly, also, response in the classroom was *managed*. Pupils considered appropriate responses to the context, the

audience and the teacher's expectations or supposed expectations. Again, this relates to the notion of 'cued elicitation' (Edwards and Mercer, 1987).

It is interesting to note how problems of 'identity' are involved at a number of levels in this area. As described above, the idea of giving 'the kiss of life' to a man (regardless of the HIV transmission issue) was perceived as a problem by some boys. Teachers also had a particular difficulty in terms of the material and its demands for sexual explicitness and their construct of the 'innocence' of 'the child'. At least some teachers experienced a conflict between their desire to inform ('enlighten') pupils and to protect their innocence, which is an important ingredient of the 'child-centred' model of progressive education.

Group interviews

From field diary notes and transcripts, pupils asked more questions in the group interviews on HIV than those related to drug use. However, they did retain their performative aspect.

Questions

eg

P: Do you really not get AIDS from mosquito bites? Look at Africa.

and

P1: If you have a sexually transmitted disease, not just HIV, but some other, too and you, you know, do it with someone else, have you still got it after you've given it to them?

I: Oh yes, it doesn't just go away, if you give it to someone else.

P2: It's not like pass-the-parcel, you pass it on, but you've still got it too, isn't it?

I: Yeh, that's right.

Pupils were performing in that they were keen to establish their experience or knowledge.

eg

P: I know some gays. Yeh, they're alright really. They don't hassle you or nothing.

P: There's one in the village (gay man). I like him. I don't think he's got AIDS. I think I'd still like him then.

P: I've seen syringes on the rec. Drug users. I know who they are. I can't tell, though.

P: My mum knows someone who has a cousin, I think, who had it (AIDS). He died. He was gay, of course.

I asked groups of pupils questions related to questionnaire items, being particularly interested in anomalies such as why some pupils felt *Always use a condom when having sex with someone whose sexual background is not known* was "not good advice" and why others moved from responding "True" to *You can get AIDS if blood from an infected person enters your blood* to responding "False", after education. I was also interested in why some pupils did not rate the risk of sexual transmission highly. Although pupils were identifiable by questionnaire numbers, prior assurances of confidentiality necessitated indirect group questionning, rather than isolating and direct questionning of individuals.

Sexual transmission and condom use

P: I think it's blown up out of all proportion - the risk to everyone. Mainly its gays and drug users. It sounds in the papers like we're all at risk if we have sex, but that's just typical of The Sun

P: They make it sound like we're all likely to get it. But it's only really gays and druggies. A few others, but they might be gay and not saying.

P: I don't think I'd be at risk if I had sex with another person. I'd use a condom.

P: People use condoms now, so there's not a lot of spreading in this country.

P: I wouldn't take advice to use a condom, no. It's against the Church. I'm Catholic.

P: For Catholics, we're not supposed to sleep with someone before we're married and you certainly wouldn't sleep around. I think it makes us safer. We couldn't use durex, either

Blood to blood transmission

P: That's gone now, pretty much, hasn't it (blood to blood transmission)? They screen it and, I think, do they heat it, too? We had a lesson on it - part of it.

P: Yeh, that's it. That's why haemophiliacs are okay now.

I: What about passing infected blood by sharing injecting equipment - needles, syringes?

P: Oh, yeh. I thought it was about blood transfusions. I forgot about needles. I think I got it wrong. Can you change that?

Pupils also expressed concern about their generation and AIDS.

P: It's not fair really. We didn't bring it in, but we're the ones who'll suffer. We're the ones who will get it or not be able to do things that the older generation did.

P: It's hard for young people today. There's unemployment and there's AIDS. Older people didn't have to face these things and nuclear war, too. It's depressing if you think of what can go wrong.

P: There's a lot of people our age. And people in this school. Well, this class, too. They're not at all careful. I mean they sleep around and I shouldn't think they use condoms and particularly the girls

with the older boys, the ones who have left or men from the bases (American air bases) even.

Conclusion

As with the qualitative data collection on drugs education, the key finding here is the relationship between context and form of speech. Pupils expressed concern about HIV and appeared to be more concerned with eliciting information than they were in the case of drugs. The lack of routine contact with people with HIV and the tendency to associate it with 'others' (usually homosexuals) denies the topic a routine, 'normalising' context, which in the case of drugs, provides the basis for an alternative pupil discourse ('style'). However, rather than this simplifying the teacher's task, the overdetermined nature of AIDS discourse (and the crucial dimension of sexuality) considerably complicated the process. In particular, the enduring topicality of 'school-work' for pupils continually encouraged the exploiting of the material for its value as embarrassment to the teacher. Teachers were obviously aware of this danger and of the problems for them personally in handling such sexually sensitive material. Furthermore, the material also had deeper implications for educational discourses of the pupil as 'child'. It is also interesting to note how pupils tended to draw upon a broader discourse of the historical situation of *their generation* and how, within that, AIDS was yet one more problem they had to face which previous generations had been spared. It is interesting to speculate upon the degree to which young people do possess an 'apocalyptic' discourse of ecological and other disasters as defining the historical place of their generation.

CONCLUSION TO SECTION THREE

The analysis in this Section has related pupil talk about drugs and HIV/AIDS to the contexts in which it occurs. Context has been approached in terms of regulative principles which act selectively upon the discursive resources upon which pupils draw. These processes become increasingly problematical where the official concern and content of 'school knowledge' relates to that of 'everyday life' and where pupils will have direct experience of the topic in routine social contexts. Here, the management of the boundary between the 'formal' and the 'informal' can be especially crucial. With problematical and contentious areas such as drug use and sexual behaviour, there will be increased pressure upon pupils to maintain a separation between the classroom context and 'school knowledge' and their own 'everyday knowledge'. It can be suggested that in situations of this type, where the official curriculum aims to be 'relevant' to the everyday lives of young people and to reduce the boundary (or 'classification') between school knowledge and the everyday, pupils themselves may unofficially work at maintaining the boundary that teachers are attempting to dissolve. For instance, the 'stereotype' discourse of drug use provides a safe model for pupils to use.

In considering pupil speech in the formal classroom context, regulating principles relate to the ways in which pupils' everyday knowledge is redefined and reconstructed. Pupils are not credited with the knowledge that they have and, indeed, they are aware that having knowledge in relation to sexual activity or drug use may be regarded as negative within the moral discourse. The reconstruction of pupil skills and knowledge, however, is not just one-sided. It is not simply the case that teachers impose particular definitions of valid knowledge and expressed opinion upon pupils. Pupils, themselves, contribute to the denial of their competence and the disconnection between classroom talk and their own experience by shielding their knowledge and experience from the teacher's surveillance. In addition, given the topicality of 'school work' within the pupils' frame of reference, making committed and detailed contributions to the discussion of topics is not necessarily their major priority. The ways in which pupils contribute to classroom discussion are mediated by a range of factors in addition to those defined by the official curriculum. Following, Mehan, Silverman describes the basic logic of classroom conversational exchange as follows:

> teacher: question; pupil: answer; teacher: evaluation
> (Silverman, 1985 p131)

From the pupils' point of view, 'the point' of school work is to discover and meet the criteria of 'competence' in that situation - to supply the teacher with 'the right answer'. As Bernstein (1977) has pointed out, in an 'invisible pedagogy' (*ie* a 'progressive' teaching style) these criteria tend to be relatively *implicit* and the pupils' task of 'decoding' the message so much more difficult than in a 'traditional' classroom context. The process of decoding can be understood in terms of 'cued elicitation' (above and Billig *et al*, 1988) whereby pupils learn to decipher the subtle cues in teachers' behaviour which indicate the criteria for what counts as a 'right answer' or the realisation of 'competence' in the classroom context (see also Bernstein's discussion of 'recognition and realisation rules' (1990)).

Ironically, 'progressive' educational styles which attempt to 'open' the classroom and introduce 'relevance' and everyday knowledge may have the opposite effect and encourage pupils to systematically shield their own knowledge and experience from examination and evaluation by the official criteria of the educational discourse of the area. Skeggs (1990), for instance, has shown how young women on child-care courses tend to remain silent about their own experience of looking after young children and about the child-care practices of their mothers, in the face of the official pedagogy of 'child-care' encountered on their courses. As Skeggs shows, such students learn to meet the official criteria of the 'pedagogic discourse' (Bernstein, 1990) whilst maintaining a personal scepticism about it (similar points have been made in relation to vocational education and 'the world of work' in the school curriculum (Bates *et al*, 1984)).

I suggested above that the 'stereotype discourse' of drug use and drug users can provide pupils with the safest guide to what, in terms of content and acceptable values, could count as a 'right answer' in this context. The 'stereotype discourse' is called upon as a central discursive resource within the formal classroom context under the topical heading of 'doing classroom work'. Within the educational exchanges of the formal classroom situation, pupils are involved in managing the tension between official educational discourses of drugs and sexuality and those whose 'discursive base' (Bernstein, 1990) is located elsewhere (*eg* in the family, peer group and youth sub-culture, the media, *etc*). Essentially, what context does as a regulator of performance is to selectively privilege particular discourses and organise their hierarchical ordering, giving 'voice' to some and silencing others (Bernstein, *ibid*).

Reflection suggests that the complex dynamics of the situation, where the formal curriculum incorporates the 'everyday', can be defined in terms of four features:

1] Recontextualisation - this is the process by which aspects of the 'everyday' (in this case young people's knowledge of drug-use or sexual activity) are abstracted from their routine settings and repositioned within the institutional context of the official pedagogic discourse. In doing this, they are re-presented according to the interpretive and normative principles of the official discourse and its depiction of what the world is *really* like. This recontextualisation involves a selective reinterpretation of the everyday which transforms routine experiences, meanings and skills according to an official version of moral order (*eg* in the case of sex education - Holland *et al*, 1990b).

Being officially defined as 'requiring' education about drug use and HIV, pupils are constructed as naive or ignorant. Within the 'enlightenment' model of education, difficulties (especially those to do with power relations) that exist in 'real' interactions, *eg* the negotiation of condom use, tend to be ignored and failure to use forms of protection from HIV transmission are attributed to lack of knowledge or a disregarding of advice.

2] Misrecognition - as a result of recontextualisation, abilities and needs of pupils are reconstructed as personal deficits. Individuals are subjected to an assessment of their competence in terms of the criteria of performance established by the official discourse. Behaviour which is a routine accomplishment in the 'everyday' world is seen as 'incompetent' or marginal, or will be simply absent from the official context. Not only are aspects of social practice which are 'normal' features of every day life excluded or unacknowledged, but they may be systematically misrecognised as evidence of ignorance, incompetence or 'immaturity'. For instance, overtly 'progressive' approaches in the 'race' and gender areas have cast black and female pupils as 'underachievers' and the passive victims of monolithically oppressive racist and sexist ideologies (Jones and Moore, 1990), and have ignored both the ideological structuring of everyday situations and the competencies which such pupils deploy in handling them. The material reviewed in Section Three indicates that pupils are aware of these aspects of the formal educational discourse and react to them in complex ways.

3] Discounting - pupils may react to the discrepancies which they experience between their own values and practices and those promoted by the school, and between their sense of their own competence and the deficit models encountered within the official discourse, by systematically discounting what they receive from teachers - "it's just school"; "teachers don't understand". Pupils have their own cultural resources to draw upon and in terms of which they actively mediate the 'official' discourse.

What we are seeing here is the effect of a relationship between discontinuous fields of discourse. Pupils and teachers do not occupy opposite ends of a continuum 'ignorant - informed'; 'incompetent - competent'; 'morally inferior - morally superior'. They are operating at times within different fields of discourse with differing rules, principles and resources. Rarely do teachers and pupils engage with these anomalies - teachers *misrecognise* pupils' competencies and pupils *discount* teachers official accounts of the 'everyday'.

4] Shielding - in addition to the discounting of school knowledge, pupils may also actively seek to conceal their competence. There are a number of aspects to this. The sense of possessing superior knowledge or experience can give pupils a sense of power in an unequal situation. It can compensate for the demeaning effects of official deficit models in which the learner is automatically constructed as cognitively and often morally inferior to the teacher.

The pupils' model of the 'competent' person and their own relationship to it, may differ significantly from the teacher's. But in exposing this discrepancy pupils can run risks: first, they would have to confront the official discourse on its own ground - a context in which they are relatively powerless and, by definition, 'incompetent'. Secondly, the recontextualisation of their own knowledge and experience could come to define them as 'ignorant', 'deviant', 'at risk' or 'immoral'. In the classroom pupils learn to keep quiet about what they *really* know, in deference to what they understand they *should* know.

Typically, educational programmes, especially in areas such as PSHE tend to be uninformed about the social contexts within which young people actually operate. In their concern with issues such as 'accurate information', 'attitude clarification', 'behaviour modification' *etc*, they demonstrate an individualistic and rationalistic approach. This ignores the features of social membership, collective skill and peer discourse which construct social competence in the pupils' everyday world. Young people may not only attempt to shield such 'lay' knowledge and accomplishments from the scrutiny of official discourse, but their possession in return shields them from its demeaning effects. These processes can be seen in terms of Bernstein's concept of 'pedagogic discourse'.

Pedagogic discourse is a principle for appropriating other discourse and bringing them into a special relation with each other for the purposes of their selective transmission and acquisition. Pedagogic discourse, then, is a principle which removes (delocates) a discourse from its substantive practice and context, and relocates that discourse according

> to its own principle of selective reordering and focusing. In the process of the de- and relocation, the original discourse is subject to a transformation which transforms it from an actual to a virtual or imaginary practice. Pedagogic discourse creates imaginary subjects. (Bernstein, 1990 pp183-184)

As Bernstein says, pedagogic discourses construct *imaginary* subjects and practices. Especially where education is concerned with everyday life, the discontinuity between the lived experience and its formal representation within the official pedagogic discourse will be very clear to pupils.

The competencies that pupils acquire in the classroom are not those formally present in the syllabus, but the skills whereby they learn to measure up to the 'symbolic rulers' of performance imposed by the pedagogy (Bernstein, 1990). For example, in the process of 'cued elicitation' pupils learn to interpret the cues which progressive teachers supply whereby they can provide the 'right' answer to an officially open-ended process of 'learning by discovery'.

The approach outlined here stresses the *active* role of the pupils within these processes. This is in contrast to the simple socialisation model which underpins much educational theory. Pedagogic discourses have their effect *not* by transferring an official 'content' into the consciousness of pupils (*eg* by shaping their self-image through the internalisation of stereotypes contained within the official curriculum (Jones and Moore, 1992)), but by structuring the relationships *between* discourses. I am suggesting, with these concepts, a way of focusing on and engaging with the *processes* which might be involved in educational programmes which attempt to incorporate aspects of everyday life.

CONCLUSION TO THESIS

This thesis has its origins in a study undertaken as an evaluation of drugs and HIV education in Cambridgeshire. The research design and education programmes reflected the dominant paradigms at that time, assuming an enlightenment model of education and a positivist approach to research. This latter entailed the quantitative measurement of pupils responses to a questionnaire, supplemented by additional data derived from ethnographic studies in the classroom (opportunistic, rather than systematic and linked to my monitoring function as Advisory Teacher).

Rapid developments within social psychological theory, Health Education research and HIV/drugs education paralleled in my own professional development have led me to report my findings in a less straightforward manner than originally anticipated. I now question the assumptions of both the 'enlightenment' model of education and the positivist model of research. This is associated with a more sophisticated theoretical approach to the topic of AIDS itself.

First, theoretical debates about the nature of knowledge led me to question the 'truth' revealed by a quantitative analysis of questionnaire data. This reflects the qualitative sociological critique of positivism.

Secondly, however, methodological debates have caused me to reflect on the relationship between qualitative and quantitative research methods and, particularly, to reject the view that they are mutually incompatible. In this respect, I felt there were problems with the way in which the rejection of positivism tends to lead to a rejection of scientific rigour and to relativism. On this basis I was attracted to the views of writers such as Silverman and Hammersley, who argue that an eclectic approach to method is appropriate and that the attack on scientific method was both misguided and simplistic.

Thirdly, insights yielded by the fieldwork led me to develop a theory of the importance of context in understanding research data. I felt able to relate this understanding of context to a non-relativistic model of discourse theory which, unlike positivism, allowed the concept of discourse to be associated with a scientific model of enquiry and explanation. Specifically, context should be understood as involving the regulation of access to discursive resources.

Finally, developments within education - particularly the cultural studies approach to personal and social education - have resulted in my developing a view of the educational

process which is compatible with the above points in terms of theory and method. Not only does the theoretical approach allow insights into the complexities of the educational process, it also indicates that teachers need to be able to engage with the socially situated discursive practices of the classroom and everyday life.

On the basis of these understandings, I have subjected my original data and research experience to a very different type of analysis to that originally envisaged.

Although useful as a historical snapshot of particular pupils' responses to specific questions at that time and in that place, I have concluded that the quantitative analysis cannot be regarded as providing absolute knowledge (in the positivist sense) of children's awareness and attitudes. This is demonstrated theoretically in Section One and also by the argument related to context in Section Three. However, I do not support the view that the questionnaire and quantitative methods, in general, lack validity, as is often suggested by qualitative sociological criticisms of positivism.

The questionnaire itself can be seen as a type of context within which pupils respond in particular ways. It is governed by particular organising principles to do with what pupils feel is expected of them and the impression they choose to give, as well as by methodological limitations to do with how individuals construe the items and the rating scales. These sorts of arguments have been used within the qualitative/quantitative debate in social psychology and sociology to dispute the validity of quantitative analyses. However, my own findings related to context suggest that data gathered by less formal methods and by participant observation is similarly contextually regulated and so is no less constrained by organising principles. Indeed, the relative anonymity of the questionnaire approach and the impersonality of a pencil and paper response could be said to provide less pressure to perform in particular ways.

The attack on the questionnaire method, and scientific method more generally, as presented in, for example, Potter and Wetherell (1987) and Parker (1992), is flawed in its simplistic presentation of quantitative methodology and in its equation of all scientific enquiry with positivism. Advocates of the qualitative approach are led to a subjectivist or relativist position, by this latter assertion. This reduces the possibilities of deriving useful insights and applications in, for example, an educational or health setting, and, at worst, becomes a form of journalism. For Parker, in particular, who explicitly focuses on the ideological structuring of discourse and the political impact of relations between discourses, there is a discontinuity between method and theory. By adopting a relativist position and, especially, by drawing on post-structuralist ideas, he is prevented from acknowledging the

definitive (if also, socially constructed) existence of structured discursive fields (Eagleton, 1991). In turn, this bars the possibility of making definite statements; allowing only, in principle, an infinite number of competing interpretations with no epistemological or moral basis for choosing between them. Within applied settings, this is an untenable position. Some form of categorisation and prediction is necessary in making appropriate interventions and for ethically supporting some approaches over others. Radical critics of positivism too often seem to be unaware of how the relativistic implications of their arguments undermine their own positions, as well as those they want to attack.

Relativist discourse analysts make a virtue of their preoccupation with 'performance' (or 'surface structure') at the expense of rejecting the concept of an underlying generative 'deep structure'.

> In contrast to the Chomskian tradition, then, discourse analysis has embraced performance data in all its messy and ungrammatical complexity.
> (Potter and Wetherell, 1987 p14)

There is an assertion of superiority based on unexamined assumptions of naturalism. As mentioned above, and as suggested in Section Three of this thesis, the data collection environment of even the least interventionist form of observation is contextually regulated. Constraints on performance derive not only from the research method, but also from the everyday setting, itself. Survey and observation contexts are, therefore, not different in a radical epistemological way, as suggested by discourse analysts, within Potter and Wetherell's tradition. It is not the case that there is some kind of natural affinity between qualitative methods and everyday 'natural' settings which is lacking in scientific methods. All are equally, though in different ways, subject to different forms of contextual regulation that are open to description in terms of their specific rules and principles. I cannot claim to have demonstrated this fully, as the original research project was not designed for such a purpose and the qualitative sampling, in particular, lacks the rigour necessary for testing an hypothesis. However, the claim is more than assertion, in that there appears to be enough coherence in the analysis of different bodies of material, to plausibly support this thesis.

I have therefore disputed the dichotomising of quantitative and qualitative methods in current debates in social psychology, which simply rehearse similar arguments made in relation to positivism and relativism, twenty years previously within sociology. I have aimed to combine the two approaches and the data collected and to demonstrate the

complementarity of the methodologies. Again, the form of demonstration is not rigorous, but based on a retrospective analysis of data derived from a different research paradigm. However, as with my assertions of contextual regulation above, the overall coherence and plausibility of the interpretation and theory lend weight to the thesis.

Traditionally, combining methods has been justified on the grounds of triangulation. This suggests that a more 'truthful' account can be obtained by looking at an event from a range of viewpoints. In addition, it has been argued in combining quantitative and qualitative methods that qualitative data adds depth and texture to the research findings and quantitative data provides greater generalisability and rigour to the ethnographic material. This suggests that an eclectic approach is more beneficial because of the additive effect of combining two methods. However, such an approach still employs an empiricist model, assuming that there is a given 'object' about which absolute knowledge can be gained. In keeping with the theoretical view of AIDS discourse as an 'overdetermined' field, the 'object' is not a simple 'thing', but rather a complex set of possibilities, aspects of which are realised under the regulative principles of different contexts, as illustrated in the analyses of pupil talk in Section Three.

My argument goes beyond triangulation in suggesting that using the two approaches allows a deeper conceptual understanding, which would not be gained by simply adding the findings of a qualitative project to a quantitative one. The quantitative analysis lends rigour to what might otherwise be a subjectivist interpretation of qualitative data. In particular, the factor analysis revealed underlying structures within the responses to attitude scales in the questionnaire which paralleled the discourses drawn on in the interview and observation data. Continuities between discourses in each approach are not systematically demonstrated, as this was beyond the scope of the original data collection programme. However, the idea of underlying organised discursive fields within each setting, and of movement between situations resulting in movement between different regulative contexts and the expression of different ideas, is not implausible. Data collected from changed contexts illustrates the ways in which available discursive resources are rearticulated to achieve different purposes. This allows the analysis of discursive fields and, in particular, how context regulates the selection of different discourses and the access of different categories of person to those discourses. The gathering of data in different contexts with different organising principles allows for the development of a theory based on the concept of context as the factor regulating access to discursive resources, which is a dominant argument of this thesis. This would not be possible without a combined qualitative and quantitative method and, not simply adding, but reinterpreting the findings of one in the light of the other and theoretical understandings. Within this

approach, qualitative research is not just seen as a 'creative engine' for theory generation (Abraham, 1992), but as a more fundamental research setting for the explication of rules that govern behaviour in different settings and how the move between different sets of rules and practices is achieved. This goes beyond the combination of inductive and deductive reasoning (Abraham, *op cit*) leading to a more accurate knowledge, and hence to a different form of understanding based on contextual regulation of the relation between discourses, between subjects, between subjects and discourses and social expression.

An eclectic approach corresponds to the complexities of the phenomenon under investigation. It allows access to the range of discourses called on by individuals in particular situations, acknowledges the overdetermined nature of the field, explores the relationship between context and the use of particular discourses and suggests the organising principles that regulate the relationship between subjects and between discourses. This, therefore, replaces the given object of empiricism by a more complex and dynamic conceptualisation of social practices.

This approach to the combination of qualitative and quantitative methods is in line with that of Silverman (1985) and Hammersley (1990). Both reject a purely descriptive approach to qualitative data, arguing the importance of theory and also of testing and refining that theory, via systematic comparison with other cases and by significance tests. They oppose the complete rejection of positivist method (using quantitative methods to substantiate and refine theory), whilst acknowledging the need to be reflexive and also the overdetermined nature of social situations and behaviour. Whilst suggesting that aiming for absolute knowledge, in the positivist sense, is epistemologically misguided, they adopt, what Silverman terms, a 'realist' position. This involves the development of theories about the principles governing human behaviour, whilst also being aware of their provisional and socially constructed character.

Both Silverman and Hammersley argue for a more sophisticated conceptualisation of realism. Hammersley characterises realism as follows:

> I mean the idea that there is a reality independent of the researcher whose nature can be known, and that the aim of research is to produce accounts that correspond to that reality.
> (Hammersley, 1992 p43)

He acknowledges the widespread acceptance of this view and, also, the problems with accepting a realist position and accommodating theoretical notions of social constructivism

and interpretation by social actors, including researchers. Rather than resolving the conflict between (simple) realism and relativism by adopting either position, exclusively, Hammersley suggests a more complex and subtle understanding of realism. This would involve recognising that absolute knowledge is not possible and

> Assessment of claims must be based on judgements about plausibility and credibility: on the compatibility of the claim, or the evidence for it, with the assumptions about the world that we currently take to be beyond reasonable doubt; and/or on the likelihood of error, given the conditions in which the claim was made.
> (Hammersley, *op cit* p51)

Hammersley's model of enquiry also retains the realist tenet that the phenomena under investigation should be independent of our claims about them; *ie* are not changed by the enquiry and the theoretical formulation. In support of this, Hammersley suggests that social scientific research has little power to influence what it investigates. He further acknowledges that research *represents* reality and is thus one account amongst many possible accounts. This necessitates reflexivity within the research and reporting processes. Knowledge, therefore, does not require absolute certainty and, here, Hammersley departs from both relativist and naive realist positions. Knowledge requires substantiating and checking, but with the acceptance that total validation is not possible.

Additionally, Hammersley and Silverman suggest that quantitative data can only reveal correlations between variables, not causes of behaviour. It is necessary, therefore, to embed quantitative data within a theoretical understanding. As Silverman says:

> Only by the use of theory or logic, can the analyst go beyond his significance tests and impute a causal relationship between his variables.
> (Silverman, 1985 p114)

Further, since "statistical analysis can only demonstrate concomitant variation of two characteristics" (Silverman, *op cit*) quantitative methods do not allow for the complexity and overdetermination of social situations. Again, it is via theory and the inclusion of context as a factor for consideration, that more useful research can be achieved. I am not arguing that this research fulfils these criteria, but that a retrospective and reflexive analysis of the data collected substantively supports Silverman and Hammersley's model. This provides a research paradigm based on the complementarity of quantitative and qualitative methods, mediated perhaps through factor analysis. Small scale qualitative

research and literature review can provide the basis for designing questionnaire items. Interpretation and factor analysis of questionnaire responses can guide the researcher in the interpretation of a larger more systematic qualitative project.

Research that gives access to the organising principles and their effects is important for education. It explicates the 'pedagogic device' and suggests the optimum context for particular forms of education. In this instance, pupils seem more personally engaged and more autonomously active in the informal group-work setting in the classroom, where they are less constrained by 'school work' and impression management in front of peers. This suggests that 'incidental learning', guided by the principle of 'school work' (*ie* in the classroom and therefore topic-focussed) but also by the dominance of pupil relevance and yet out of the gaze of the teacher, as formal pedagogue, and peers, as normative censors, is the optimum method for the type of education intended within these schools.

This thesis presents a critical reflection upon a research project conceived and executed within a paradigm very different from that which is proposed by the thesis itself. In a sense, it might be viewed as an intellectual biography which relates my own professional development to theoretical developments in the area of study. The use made of the original research material attempts to establish the plausibility of the theoretical position developed, rather than to substantiate it, fully. In this way, the retrospective aspect of the work also points towards the future and the possibilities of an emerging position within current debates which seeks to extend the critique of positivism, while avoiding the pitfall of relativism, and retaining a belief in rigorous scientific enquiry as a basis for effective intervention in important social issues, such as 'the AIDS crisis'.

Bibliography

Abraham, C and Sheeran, P (1992) 'Inferring cognitions, predicting behaviour; two challenges for social cognition models', **Paper presented at the British Psychological Health Psychology Section Conference,** 18 September, 1992

Aggleton, P, Homans, H, Mojsa, J, Watson, S and Watney, S (1989) **AIDS: Scientific and Social Issues. A Resource for Health Educators,** London, Churchill Livingstone

Ajzen, I (1985) 'From intentions to actions: a theory of planned behaviour', in J, Kuhl and J Beckmann (eds) **Action-control: from cognition to behaviour,** Heidelberg, Springer

Ajzen, I and Fishbein, M (1980) **Understanding Attitudes and Predicting Behaviour,** Englewood Cliffs, New Jersey, Prentice-Hall

Ajzen, I and Madden, M (1986) 'Prediction of goal directed behaviour: attitudes, intentions and perceived behavioural control', **Journal of Experimental Social Psychology, 22,** 453-474

Andrew Irving Associates (1984) **Heroin Misuse Publicity Campaign: A qualitative study designed to guide the targeting and development of an effective mass media campaign,** London, Andrew Irving Associates

Andrew Irving Associates (1986) **Anti-heroin Misuse Campaign: Qualitative evaluation research report,** London, Andrew Irving Associates

Anslinger, H J (1937) cited in Hughes, T L (1991) **Reefer Madness,** Wallasey, Zephyr

Armistead, N (ed) (1974) **Reconstructing Social Psychology,** Harmondsworth, Penguin

Atkinson, P (1985) **Language, Structure and Reproduction: an introduction to the sociology of Basil Bernstein,** London, Methuen

Austin, J L (1962) **How to do things with words,** Massachussetts, Harvard University Press

Bagnall, G, Plant, M A and Plant, M A (1987) 'Effect of fear of AIDS on sharing of injection equipment among drug abusers', **British Medical Journal, 295,** 660-661

Balding, J (1991) **The Health Related Behaviour Questionnaire (Version 12) Cambridge Results, 1990,** University of Exeter, Schools Health Education Unit

Baldwin, J and Wells, H (1979) **Active Tutorial Work,** Oxford, Blackwell

Ball, S (ed) (1990) **Foucault and Education,** London, Routledge

Bandura, A (1977) 'Self-efficacy: toward a unifying theory of behaviour change', **Psychological Review,** 84, 191-215

Bandura, A (1989) 'Perceived self-efficacy in the exercise of personal agency', **The Psychologist,** 10, 411-424

Barnes, B (1985) 'Thomas Kuhn', in Skinner, Q (ed) **The Return of Grand Theory in the Human Sciences,** Cambridge, Cambridge University Press

Bates, I, Clarke, J, Cohen, P, Finn, D, Moore, R and Willis, P (1984) **Schooling For The Dole? The New Vocationalism,** Basingstoke, Macmillan

BBC 1, **Cold Turkey,**13 May 1983

BBC 2, **Man Alive: 'Gale is Dead',** 5 November 1986

Becker, H S (1971) 'Becoming a marihuana user', in Open University, **School and Society: A sociological reader,** London, Routledge and Kegan Paul

Bentler, P M and Speckart, G (1979) 'Models of attitude-behaviour relations', **Psychological Review,** 86, 452-64

Bentler, P M and Speckart, G (1981) 'Attitudes "cause" behaviours: a structural equation analysis', **Journal of Personality and Social Psychology,** 40, 226-38

Berg, R L (1976) 'The high cost of self-deception', **Preventive Medicine,** 5: 483-95

Berger, P L and Luckman, T (1967) **The Social Construction of Reality,** Harmondsworth, Penguin

Bernstein, B (1977) **Class, Codes and Control, Volume 3,** London, Routledge

Bernstein, B (1990) **The Structuring of Pedagogic Discourse**, London, Routledge

Bewley, T, Johnson, M, Bland, J and Murray, M (1980) 'Trends in Children's Smoking', **Community Medicine, 2**, 186-189

Billig, M, Condor, S, Edwards, D, Gane, M, Middleton, D and Radley, A (1988) **Ideological Dilemmas: a social psychology of everyday thinking**, London, Sage

Billig, (1989) **Arguing and Thinking: a rhetorical approach to social psychology**, Cambridge, Cambridge University Press

Bloom, B S, Krathwohl, D R and Masia, B B (1964) **Taxonomy of Educational Objectives**, London, Longmans

Boag, F, Nandwani, R and McCarthy, G (1992) 'HIV seroprevalence and antenatal clinics', **Lancet, 339, March 7**

Bowles and Gintis (1976) **Schooling in Capitalist America: educational reform and the contradictions of economic life**, London, Routledge and Kegan Paul

Burgess, R G (1984) **In The Field: An Introduction to Field Research**, London, George, Allen and Unwin

Bury, J, Morrison, V and McLachlan, S (eds) (1992) **Working with Women and AIDS: medical, social and counselling issues**, London, Routledge

Button, L (1974) **Developmental Group Work with Adolescents**, London, University of London Press

Callinicos, A (1989) **Against Postmodernism: a Marxist critique**, Cambridge, Polity

Cattell, R B (1965) 'Factor Analysis: an introduction to essentials (I) the purpose and underlying models, (II) the role of factor analysis in research', Biometrics, 21: 190-215, 405-435, cited in J Kim and C W Mueller (1978) **Introduction to Factor Analysis: what it is and how to do it**, London, Sage

Chaturvedi, S K (1987) 'Does AIDS fear dissuade intravenous drug abuse?' **British Journal of Addiction**, 82, 101

Chrystie, I L, Palmer, S J, Kenney, A and Banatvala, J E (1992) 'HIV seroprevalence among women attending antenatal clinics in London', **Lancet**, 339, Feb 8

Cleary, P D (1987) 'Why people take precautions against health risks', in N D Weinstein (ed) **Taking Care: understanding and encouraging self-protective behaviours**, Cambridge, Cambridge University Press

Cohen, P (1984) 'Against the New Vocationalism', in I Bates *et al, op cit*

Cohen, P and Baines, H S (1988) **Multi-Racist Britain**, Basingstoke, Macmillan

Cohen, P (1991) **Monstrous Images, Perverse Reasons: cultural studies in anti-racist education**, London, Centre for Multicultural Education

Cohen, S (1987) **Folk Devils and Moral Panics: the creation of Mods and Rockers**, Oxford, Basil Blackwell

Conner, M (1992) 'Pros and Cons of Social Cognition Models in Health Psychology', **Paper presented at British Psychological Society Health Psychology Conference**, University of St Andrews, 18-19 September, 1992

Cook , T D (1991) 'Postpositivist Criticisms, Reform Associations, and Uncertainties about Social Research', in D S Anderson and B J Biddle, (eds), **Knowledge for Policy: Improving education through research**, London, Falmer

Coultas, V (1989) 'Black girls and self-esteem', **Gender and Education**, 1, 3

Craib, I (1984) **Modern Social Theory: from Parsons to Habermas**, London, Harvester Wheatsheaf

Cummings, K M, Becker, M H and Maile, M C (1980) 'Bringing the models together: an empirical approach to combining variables used to explain health actions', **Journal of Behavioural Medicine**, 3, 2, 123-145

Dale, R (1985) **Implications for Progressivism of Recent Changes in the Control and Direction of Education Policy**, mimeo, Milton Keynes, Open University Press

Dale, R, Esland, G and MacDonald, M (1976) **Schooling and Capitalism: a reader**, London, Routledge

Dale, R (1989) **The State and Education Policy**, Milton Keynes, Open University Press

Dale, R, Bowe, R, Harris, D, Loveys, M, Moore, R, Shilling, C, Sikes, P, Trevitt, J and Valsecchi, V (1990) **The TVEI Story**, Milton Keynes, Open University Press

Davies, B (1979) **In whose Interest? From social education to social and life skills training**, Leicester, National Youth Bureau

Davies, J, Prendergast, S and Prout, A (1982) **The Health Knowledge of School-children, their Parents and Teachers**, London, Health Education Council

Demaine, J (1981) **Contemporary Theories and the Sociology of Education**, London, Macmillan

Denzin, N K (1971) Symbolic Interactionism and Ethnomethodology, in J D Douglas, **Understanding Everyday Life**, London, Routledge and Kegan Paul

Department of Education and Science (1977), **Green Paper: Education in Schools**, London, HMSO

Department of Health and Social Security (1974) **Memorandum**, May, Section G

Dixon, H and Gordon, P (1987) **Working with Uncertainty: a handbook for those involved in training on HIV and AIDS**, London, Family Planning Association

Douglas, J D (ed) (1971) **Understanding Everyday Life**, London, Routledge and Kegan Paul

Douglas, M (1970) **Natural Symbols**, London, Barrie and Rockcliff

Durham, M (1991) **Sex and Politics: The family and morality in the Thatcher years**, Basingstoke, Macmillan

Eagleton, T (1991) **Ideology: an introduction,** London, Verso

Edwards, D and Mercer, N (1987) **Common Knowledge: the development of understanding in the classroom,** London, Methuen

Eggleston, J (ed) (1974) **Contemporary Research in the Sociology of Education,** London, Methuen

Emmons, C A, Joseph, J G, Kessler, R C, Wortman, C B, Montgomery, S B and Ostrow, D G (1986) 'Psychosocial predictors of reported behaviour change in homosexual men at risk for AIDS', **Health Education Quarterly,** 13, 331-345

Evans, D (1989/90) 'Section 28: Law, Myth and Paradox', **Critical Social Policy,** 27, 9, 3, 73-95

Eye Films, (1985) **Chasing the Bandwagon,** London, Eye Films Ltd

Fangier, J (1987) 'AIDS awareness', **Nursing Times,** 83, 20

Fay, B (1975) **Social Theory and Political Practice,** London, George, Allen and Unwin,

Filmer, P., Phillipson, M, Silverman, D and Walsh, D (1972) **New Directions in Sociological Theory,** London, Collier-Macmillan

Fineberg, H V (1988) 'Education to prevent AIDS: prospects and obstacles', **Science,** 239, 592-596

Fishbein, M and Ajzen, I (1975) Belief, Attitude, Intention and Behaviour: an introduction to theory and research, Reading: Mass. Addison-Wesley

Flude, M and Hammer, M (eds) (1990) **The Education Reform Act, 1988,** Lewes, Falmer

Fogelman, K (1976) **Britain's Sixteen Year Olds,** London, National Children's Bureau

Fransella, F and Bannister, D (1977) **A Manual for Repertory Grid Technique,** London, Academic Press

Gatherer, A, Parfit, J, Porter, E and Vessey, M (1980) **Is Health Education Effective?** Health Education Council, London

Gellner, E (1992) **Postmodernism, Reason and Religion**, London, Routledge

Gergen, K and Davis, K E (1985) **The Social Construction of the Person**, New York, Springer-Verlag

Gibson, R (1986) **Critical Theory and Education**, London, Hodder and Stoughton

Giddens, A (ed) (1974) **Positivism and Sociology**, London, Heinemann

Giddens, A (1984) **The Constitution of Society**, Cambridge, Polity

Giddens, A (1990) **The Consequences of Modernity**, Cambridge, Cambridge University Press

Giddens, A (1991) **Modernity and Identity**, Cambridge, Polity

Gilbert, G N and Mulkay, M (1984) **Opening Pandora's Box: a sociological analysis of scientists' discourse**, Cambridge, Cambridge University Press

Gleeson, D (1986) 'Life-skills training and the politics of personal effectiveness', **Sociological Review**, 34, 380-395

Goffman, E (1971) 'The neglected situation', in Open University, ***op cit***

Golby, M (1989) 'Curriculum Traditions' in B Moon, P Murphy and J Rayner (eds) **Policies for the Curriculum**, Milton Keynes, Open University Press

Granada, **First AIDS**, 22 February 1987

Green, L W (1970) 'Status identity and preventive health behaviour', **Pacific Health Education, Report 1**, Berkeley, University of California

Green, L W and Johnson, K W (1983) 'Health education and health', in D Mechanic, (ed) **Handbook of health, health care and the health professions**, London, Collier Macmillan, 744-765

Green L W, Kreuter, M W, Deeds, S G and Partridge, K B (1980) **Health Education Planning: a diagnostic approach,** Palo Alto, CA, Mayfield

Gross, G (1974) Unnatural Selection, in N Armistead, N (ed) ***op cit***

Guba, E G and Lincoln Y S (1991) 'What is the Constructivist Paradigm?' in D S Anderson and B J Biddle (eds) ***op cit***

Hammersley, M (1989) **The Dilemma of Qualitative Method: Herbert Blumer and the Chicago Tradition,** London, Routledge

Hammersley, M (1992) **What's wrong with ethnography?** London, Routledge

Harre, R (1985) 'Foreword', in Claxton, G, Swann, W, Salmon, P, Walkerdine, V, Jacobsen, B and White, J, **Psychology and Schooling: What's the Matter?** London, Bedford Way Papers

Health Education Authority (1991) **The AIDS Strategic Monitor: Report on the Survey Period November 1987 - December 1988,** London, Health Education Authority

Heartbeat Wales (1985) **Children's Questionnaire,** Cardiff, Welsh Heart Programme

Henriques, J, Hollway, W, Urwin, C, Venn, C, and Walkerdine, V (1984) **Changing the Subject: Psychology, Social Regulation and Subjectivity,** London, Methuen

Hickox, M and Moore, R (1990) 'TVEI, Vocationalism and the Crisis of Liberal Education', in M Flude and M Hammer (eds) ***op cit***

Hirst, P H (1972) 'Liberal Education and the Nature of Knowledge', in R D Archambault (ed) **Philosophical Analysis and Education,** London, Routledge and Kegan Paul

HMSO (1984) **Prevention: Report of the Advisory Council on the Misuse of Drugs,** London, HMSO

Holland J, Ramazanoglu, C, Scott, S, Sharpe, S and Thomson, R (1990a) **"Don't die of ignorance": *I nearly died of embarrassment.* Condoms in context,** London, Tufnell Press

Holland J, Ramazanglu, C and Scott (1990b) **Sex risk and danger: AIDS education policy and young women's sexuality**, London, Tufnell Press

Holland J, Ramazanoglu, C, Scott, S, Sharpe, S and Thomson, R (1991a) **Pressure, resistance, empowerment: young women and the negotiation of safer sex**, London, Tufnell Press

Holland J, Ramazanoglu, C, Sharpe, S and Thomson, R (1991b) **Pressured pleasure: young women and the negotiation of sexual boundaries**, London, Tufnell Press

Holland J, Ramazanoglu, C and Sharpe, S (1993) **Wimp or Gladiator: contradictions in acquiring masculine sexuality**, London, Tufnell Press

Hollway, W (1989) **Subjectivity and Method in Psychology: gender, meaning and science**, London, Sage

Howe, B and Wright, L (1987) **Responding to the Challenge**, Health Education Authority, London

Howitt, D, Billig, M, Cramer, D, Edwards, D, Kniveton, B, Potter, J.and Radley, A (1989) **Social Psychology: Conflicts and Continuities**, Milton Keynes, Open University Press

ISDD (1974) **Drug Use Questionnaire**, London, Education Research Unit, Institute for the Study of Drug Dependence

ISDD (1985a) **Facts and Feelings About Drugs But Decisions About Situations**, London, Institute for the Study of Drug Dependence

ISDD (1985b) **Health Careers**, London, Institute for the Study of Drug Dependence

Janz, N K and Becker, M H (1984) 'The Health Belief Model: a decade later', **Health Education Quarterly**, 11, 1-47

Jones, C and Mahoney, P (eds) (1989) **Learning our lines: sexuality and social control in education**, London, The Women's Press

Jones, L D (1990) 'Working with drug users to prevent the spread of HIV: the application of an analytical framework to a range of programmes', **Health Education Research: Theory and Practice**, 5, 1, 5-16

Jones, L and Moore, R (1990) 'Equal Opportunities: the curriculum and the subject', Cambridge Journal of Education, 22, 2, 243-252

Jones, K (1989) **Right Turn**, London, Hutchinson

Joseph, J G, Montgomery, S B, Emmons, C A, Kessler, R C, Ostrow, D G, Wortman, C B, O'Brien, K , Eller, M and Eshelman, S (1987) 'Magnitude and determinants of behavioural risk reduction: longitudinal analysis of a cohort at risk for AIDS', **Psychology and Health**, 1, 73-86

Kaiser, H F (1974) 'Little Jiffy, Mark IV', Educational and Psychological Measurement, 34, 111-117 cited in J Kim and C W Mueller (1978) *op cit*

Karabel, J and Halsey, A H (eds) (1977) **Power and Ideology in Education**, Oxford, Oxford University Press

Keat, R and Urry, J (1975) **Social Theory as Science**, London, Routledge and Kegan Paul

Keddie, N (1971) Classroom Knowledge, in M F D Young (ed) **Knowledge and Control: New Directions for the Sociology of Education**, London, Collier-Macmillan

Kelly, G A (1955) **The Psychology of Personal Constructs, Vols 1 and 2**, New York, Norton

King, J B (1982) 'The impact of patients' perceptions of high blood pressure on attendance at screening: an attributional extension of the health belief model', **Social Science and Medicine**, 16, 1079-1092

Kolakowski, L (1972) **Positivist Philosophy**, Harmondsworth, Penguin

Kuhn, T S (1976) **The Structure of Scientific Revolutions**, Chicago, Chicago University Press

Labov, W (1972) The logic of nonstandard English, in A Cashsan (ed) **Language in Education: a sourcebook**, London, Routledge and Kegan Paul

Lawrence, A G and Singaratnam, A E (1987) 'Changes in sexual behaviour and incidence of gonorrhea', **Lancet**, i, 982-983

Lee, R (1980) **Beyond Coping: some approaches to social education,** London, Further Education Unit

Leicestershire Health Authority, (1985) **AIDS Video,** Leicester

Leventhal, H (1970) 'Findings and theory in the study of fear communications', in L Berkowitz, (ed) **Advances in Experimental Social Psychology,** New York, Academic Press, Vol 5, 120-186

Leventhal, H (1983) 'Behavioural Medicine: psychology in health care', in D Mechanic, (ed) **Handbook of health, health care and health professions,** London, Collier-Macmillan

Leventhal, H and Cameron, L (1987) 'Behavioural theories and the problem of compliance', **Patient Education and Counselling,** 10, 117-138

Liska, A E (1984) 'A critical examination of the causal structure of the Fishbein/Ajzen attitude-behaviour model', **Social Psychology Quarterly,** 47, 61-74

Maclure, S (1989) **Education Re-formed,** London, Hutchinson

McKeganey, N and Barnard, M (1992) **AIDS, Drugs and Sexual Risk: Lives in the balance,** Buckingham, Open University Press

McKusick, L, Horstman, W and Coates, T J (1985) 'AIDS and sexual behaviour reported by gay men in San Francisco', American Journal of Public Health, 75, 493-496 cited in M W Ross and B R S Rosser (1989) 'Education and AIDS risks: a review', **Health Education Research: Theory and Practice,** 4, 3, 273-284

Maiman, L A and Becker, M H (1974) 'The Health Belief Model: origins and correlates in psychological theory', **Health Education Monographs,** 2, 336-353

Mills, C W (1971) 'Situated actions and vocabularies of motive', in Open University, *op cit*

Moore, R (1987) 'Education and the ideology of production', **British Journal of Sociology of Education,** 8, 2, 227-242

Moore, R (1988) 'The correspondence principle and the Marxist sociology of education', in M Cole (ed) **Bowles and Gintis Revisited**, Lewes, Falmer

Moore, R (1990) 'The construction of skill', in D Gleeson (ed) **Training and its Alternatives**, Milton Keynes, Open University Press

Moore, R (1991) 'Understanding Curriculum', **Module 5, Course E333: Policy-making in Education**, Milton Keynes, Open University Press

Mullen, P D Hersey, C H and Iverson, D C (1987) 'Health Behaviour Models compared', **Social Science and Medicine, 24, 11, 973-81**

Nelles, B (1986) 'Politics of AIDS round-up (6): Bill Nelles on a 'deafening silence'', **New Statesman**, 30 May, p6

Norris, C (1982) **Deconstruction: Theory and Practice**, London, Routledge

Norris, C (1992) **Uncritical Theory: Postmodernism, Intellectuals and the Gulf War**, London, Lawrence and Wishart

OPCS, Office of Population Censuses and Surveys (1985) **Smoking among Secondary School Children**, London, HMSO

OPCS, Office of Population Censuses and Surveys (1986) **Adolescent Drinking**, London, HMSO

Open University (1971) **School and Society: A sociological reader**, London, Routledge and Kegan Paul

Parker, I (1989) **The Crisis in Modern Social Psychology - and how to end it**, London, Routledge

Parker, I and Shotter, J (1990) **Deconstructing Social Psychology**, London, Routledge

Parker, I (1992) **Discourse Dynamics: Critical Analysis for Social and Individual Psychology**, London, Routledge

Pawson, R (undated) Methodology in M Haralambos (ed) **Developments in Sociology: Volume 5**, Causeway

Pollack, M, Schiltz, M A and Lejeune, B (1987) 'Safer sex and acceptance of testing: results of the nationwide annual survey among French gay men', Paper presented at 3rd International Conference on AIDS, Washington D C, in M W Ross and B R S Rosser (1989) *op cit*

Pollard, A (1990) 'Towards a sociology of learning in Primary Schools', **British Journal of the Sociology of Education, 11, 3, 241-256**

Potter, J and Wetherell, M (1987) **Discourse and Social Psychology; beyond attitudes and behaviour**, London, Sage

Potter, J and Wetherell, M (1988) 'Accomplishing attitudes: fact and evaluation in racist discourse', **Text**, 8, 51-68

Prentice-Dunn, S and Rogers, R W (1986) 'Protection Motivation Theory and preventive health: Beyond the Health Belief Model', **Health Education Research**, 1, 3, 153-161

Pring, R (1989) **The New Curriculum**, London, Cassell

Prout, A and Prendergast, S (1986) **Knowing and Learning about Parenthood**, Cambridge, Education for Parenthood Project

Quest International, (1986) **Skills for Adolescence**, Manchester, TACADE

Quicke, J (1989) 'The "New Right' and Education', in B Moon, P Murphy and J Rayner (eds) *op cit*

Ranson, S (1990) 'From 1944 to 1988: Education, Citizenship and Democracy', in M Flude and M Hammer, *op cit*

Rene, R and Van der Pligt, J (1991) 'Factors affecting condom use amongst adolescents', **Journal of Community and Applied Psychology**, 1, 105-116

Research Bureau Ltd (1986) **Heroin Misuse Campaign Research Evaluation: Report of findings**, London, Research Bureau Ltd

Rosen, T J, Nathaniel, S T and Leventhal, H (1982) 'The role of esteem and coping in response to a threat communication', **Journal of Research in Personality**, 16, 90-107

Rosenstock, I M (1966) 'Why people use health services', **Millbank Memorial Fund Quarterly**, 44, 94-127

Rosenstock, I M, Strecher, V J and Becker, M H (1988) 'Social learning theory and the health belief model', **Health Education Quarterly**, 15, 175-183

Ross, M W and Herbert, P (1987) 'Responses of homosexual men to AIDS', Medical Journal of Australia, 146, 280 cited in M W Ross and B R S Rosser,*op cit*

Ross, M W and Rosser, B R S (1989) Education and AIDS risks: a review, **Health Education Research: Theory and Practice**, 4, 3, 273-284

Ryder, J and Campbell, L (1988) **Balancing Acts in Personal, Social and Health Education**, London, Routledge

Sarup, M (1978) **Marxism and Education**, London, Routledge and Kegan Paul

Sarup, M (1988) **An Introductory Guide to Post-structuralism and Postmodernism**, London, Harvester Wheatsheaf

Schools Council (1974) **Social Education: an experiment in four Nottinghamshire secondary schools**, Working Paper 51, London, Evans Brothers/Methuen

Sharp, R and Green, A (1975) **Education and Social Control**, London, Routledge and Kegan Paul

Siegel, K, Chen, J Y, Mesango, F and Christ, G (1987) 'Persistence and change in sexual behaviour and perceptions of risk for AIDS among homosexual men', Paper presented at 3rd International Conference on AIDS, Washington D C in M W Ross B R S and Rosser B *op cit*

Silverman, D (1985) **Qualitative Methodology and Sociology**, Aldershot, Gower

Skeggs, B (1990) 'Gender reproduction and further education: the case of domestic apprenticeships', in D Gleeson, D (ed) *op cit*

Sontag, S (1991) **Illness as Metaphor. AIDS and its Metaphors**, London, Penguin

Squire, C (1990) 'Crisis, what crisis? Discourses and narratives of the 'social' in social psychology', in Parker, I and Shotter, J (eds) **Deconstructing Social Psychology**, London, Routledge

Stall, R, McKusick, L, Wiley, J, Coates, T and Ostrow, D G (1986) 'Alcohol and drug use during sexual activity and compliance with safe sex guidelines', **Health Education Quarterly**, 13, 359-371

Swadi, H (1988) 'Drug and Substance Use Among 3,333 London Adolescents', **British Journal of Addiction**, 83, 8, 935-942

TACADE, (1983) **Free to Choose, Revised Edition**, Manchester, TACADE

The Bridge Project, (1985) **Drug Use Questionnaire**, Cambridge (unpublished)

The Guardian, 17 September 1986

The Guardian, 8 May 1989

Thomson, R and Scott, S (1992) **Learning about sex: young women and the social construction of sexual identity**, London, Tufnell Press

Tones, K, Tilford, S and Robinson, Y (1990) **Health Education: Effectiveness and efficiency**, London, Chapman and Hall

Troyna, B and Carrington, B (1990) **Education, Racism and Reform**, London, Routledge

Turner, B S (1984) **The Body and Society**, Oxford, Blackwell

Taylor, I, Walton, P and Young, J (1973) **The New Criminology**, London, Routledge and Kegan Paul

Valdisseri, R O, Lyter, D W, Callaghan C, Kingsley, L and Rinaldo, C R (1987) 'Condom use in a cohort of bisexual and gay men', Paper presented at 3rd International Conference on AIDS, Washington D C, in M W Ross and B R S Rosser *op cit*

Vallacher, R R and Wegner, D M (1987) 'What do people think they're doing? Action identification and human behaviour', **Psychological Review,** 94, 3-15

van de Wijngaart, G F (1990) **Competing perspectives on drug use: The Dutch experience,** (unpublished)

de Vries, H, Dijkstra, M and Kuhlman P, (1988) 'Self-efficacy: the third factor besides attitude and subjective norm as a predictor of behavioural intentions', **Health Education Research: Theory and Practice,** 3, 3, 273-282

Vygotsky, L (1934) **Thought and Language,** Cambridge: Mass, MIT Press

Watney, S (1987) **Policing Desire: pornography, AIDS and the media,** London, Methuen

Weeks, J (1988) 'Love in a Cold Climate', in P Aggleton and H Homans (eds) **Social Aspects of AIDS,** Lewes, Falmer

Weeks, J (1989a) 'AIDS: the intellectual agenda', in P Aggleton, G Hart and P Davies (eds) **AIDS: Social Representations, Social Practices,** Lewes, Falmer

Weeks, J (1989b) **Sex, Politics and Society: the regulation of sexuality since 1800,** Harlow, Longman

Whitehead, M (1989) **Swimming Upstream: Trends and prospects in education for health,** London, King's Fund Institute

Whitty, G (1976) 'Studying society: for social change or social control?' in G Whitty and M F D Young (eds) **Explorations in the Politics of School Knowledge,** Drifield, Nafferton Books

Whitty, G (1990) 'The New Right and the National Curriculum: State Control or Market Forces?' in M Flude and M Hammer, (eds), *op cit*

Willis, P (1978) **Learning to Labour: how working class kids get working class jobs,** Aldershot, Gower

Wilson, T P (1971) Normative and interpretive paradigms in sociology, in Douglas, J D (ed) *op cit*

Woods, P (1990) **The Happiest Days? How pupils cope with school,** London, Falmer

Woolley, P D and Kinghorn, G R (1987) 'AIDS publicity campaigns', **Lancet,** Aug 1, 284

Wright, N (1977) **Progress in Education,** London, Croom Helm

Young, J (1973a) 'The myth of drug-takers in the mass media', in S Cohen and J Young (eds) **The manufacture of news. Deviance, social problems and the mass media** (2nd edition), London, Constable

Young, J (1973b) 'The amplification of drug use', in S Cohen and J Young (eds) *op cit*

Young, M F D (ed) (1971) **Knowledge and Control,** London, Collier Macmillan

Young, M F D (1976) 'Curriculum Change: limits and possibilities', in R Dale *et al* (eds) *op cit*

APPENDICES

APPENDIX ONE

QUESTIONNAIRE

PLEASE READ THIS CAREFULLY

THIS IS A QUESTIONNAIRE ABOUT YOU AND WHAT YOU THINK ABOUT DRUGS AND HIV. YOUR ANSWERS ARE **PRIVATE** AND YOU SHOULD NOT WRITE YOUR NAME ON THE QUESTIONNAIRE. YOUR ANSWERS WILL NOT BE SEEN BY PARENTS, TEACHERS OR ANYONE ELSE WHO KNOWS YOU. THEY WILL BE COLLECTED AND GIVEN TO A RESEARCHER IN CAMBRIDGE

PLEASE SAY WHAT YOU THINK, NOT WHAT YOU THINK YOU SHOULD SAY. REMEMBER YOUR ANSWERS ARE PRIVATE.

WRITE THE NAME OF YOUR FORM HERE .....

NOW TURN OVER AND ANSWER THE QUESTIONS AS QUICKLY AS YOU CAN

1. Are you a boy or a girl? ( ) [Tick here if a boy] *Q84*

( ) [Tick here if a girl]

2. How old are you? ( ) [Write in] *Q85*

3. What kind of place do you live in? Please tick **one** box only. *Q86*

City or very large town ( )

Town ( )

Village ( )

Countryside ( )

Please say what your father's and mother's jobs are. Write down what they do, for example, car mechanic, nurse, secretary, lorry driver.

If you do not know, or if either your father or mother is not living with you, there is no need to write anything.

4. Father's job_____ *Q87*

Does he work for someone else?_____

Do other people work for him?_____

5. Mother's job_____ *Q88*

Does she work for someone else?_____

Do other people work for her?_____

Look at each question in turn and tick the answer that is right for you.

6. How many of your friends smoke cigarettes? ( ) all of them *Q89*

( ) most of them

( ) about half of them

( ) not many of them

( ) none of them

7. Do you smoke cigarettes, and, if so how often? ( ) I've never tried them

( ) I've tried them once or twice

( ) I smoke occasionally

( ) less than 10 a week

( ) more than 10 a week

( ) more than 20 a week *Q90*

8. How many of your friends drink alcohol? *Q91*

( ) all of them
( ) most of them
( ) about half of them
( ) not many of them
( ) none of them

9. Drugs are talked about a lot these days by lots of different people. Go down the list below and put a tick against ALL the people whose word you would trust about drugs. *Q92*

( ) your brothers and sisters
( ) your parents
( ) your teachers
( ) your friends
( ) older boys and girls
( ) people who take drugs
( ) people who used to be addicts
( ) doctors
( ) policemen
( ) people on radio and TV

10. Of all these who would you trust most?_____ *Q93*

_____

11. Who would you trust least of these?_____ *Q94*

_____

12. Is there anyone else not mentioned in (9) whose word you could trust about drugs?

_____ *Q95*

13. Here are some views on people taking drugs which have not been prescribed for them by a doctor. With some you may agree and others not. Please read each one and tick the column which shows how you feel about drugs.

Key: AS = Agree strongly
A = Agree
N = Not sure
D = Disagree
DS = Disagree strongly

	SA	A	N	D	SD	
Taking drugs makes you into a different kind of person						Q1
People who take one drug will want to take others						Q2
Drugs make you feel good						Q3
Drug-taking leads to illness						Q4
All drug takers get hooked						Q5
Drugs often lead to frightening experiences						Q6
Drugs lead to mental illness						Q7
Some drugs are harmless						Q8
Drugs are only harmful if taken regularly						Q9
Even experimenting with drugs is dangerous						Q10
Drugs help you to do things better						Q11
People who start taking drugs can't stop						Q12
Drugs are not a danger to health						Q13
People who take drugs become failures						Q14
Drugs help you relax						Q15
Drugs lose their effect if taken regularly						Q16
Drug takers make lots of friends						Q17
Certain drugs are worth trying						Q18
People start to take drugs because they lack self-confidence						Q19
The dangers of drugs are very much exaggerated in the press and on TV						Q20
Most people only start taking drugs because they are bored						Q21

	AS	A	N	D	DS	
Smoking cannabis is better than drinking alcohol						Q22
People usually start on drugs out of curiosity						Q23
A person who 'pushes' drugs is not much better than a murderer						Q24
If I had a friend who used cannabis, I would be very worried						Q25

You are now going to be asked about 3 kinds of drugs. If you do not know the answer, just say so - please do not just guess.

DRUG 1 - AMPHETAMINE: Also called whizz, speed, sulphate, etc

14. Is it

very harmless ( )
quite harmless ( )
quite dangerous ( )
very dangerous ( )

Please tick one box

Q73

15. How do people take amphetamines? _____

_____ Q74

16. If you said amphetamines are dangerous, in what ways are they?

Q75

DRUG 2 - CANNABIS: Also called grass, hash, dope, leb, blow, pot, etc

17. Is it

very harmless	( )	
quite harmless	( )	Please tick **one** box
quite dangerous	( )	
very dangerous	( )	*Q76*

18. How do people take cannabis? _____

_____ *Q77*

19. If you said cannabis is dangerous, in what ways is it?

Q78

DRUG 3 - HEROIN: Also called skag, smack, etc

20. Is it

very harmless	( )	
quite harmless	( )	Please tick one box
quite dangerous	( )	
very dangerous	( )	*Q79*

21. How do people take heroin? _____

_____ *Q80*

22. If you said heroin is dangerous, in what ways is it?

Q81

23. Can you think of any reasons why people take drugs?

24. Can you think of any reasons for not taking drugs?

Now we want you to answer some question about AIDS. Don't worry too much about whether you are right or wrong, just say what you think

25. AIDS is talked about a lot these days by lots of different people.
Go down the list below and put a tick against ALL the people whose word you would trust about AIDS. *Q96*

( ) your brothers and sisters
( ) your parents
( ) your teachers
( ) your friends
( ) older boys and girls
( ) people who have got the AIDS virus
( ) doctors
( ) policemen
( ) people on radio and TV

26. Of all these who would you trust most?_____ *Q97*

_____

27. Who would you trust least of these?_____ *Q98*

_____

28. Is there anyone else not mentioned in (19) whose word you could trust about AIDS?

_____ *Q99*

29. Here are some views about AIDS and HIV (Human Immunodeficiency Virus- the virus which can lead to AIDS). Please read each one and tick the column that best fits how you feel about the statement.

Key:
AS = Agree strongly
A = Agree
N = Not sure
D = Disagree
DS = Disagree strongly

	AS	A	N	D	DS	
People are panicking too much about AIDS						Q26
AIDS worries me						Q27
If I knew someone with AIDS, I would avoid him/her						Q28
Most people who get AIDS deserve it						Q29
Everyone is at risk from AIDS						Q30
If I knew someone with HIV, I would avoid him/her						Q31
Everyone should be tested for HIV						Q32
It is obvious when someone is carrying the virus						Q33
People with the virus should carry identification cards						Q34
People with the virus should be kept away from everyone else						Q35
HIV always kills						Q36
Homosexuals (gays) have only themselves to blame if they get AIDS						Q37
Everyone should be taught about AIDS						Q38

30. Please put a tick in the column which best shows how much at risk these people are from AIDS.

Key: 1 = at very great risk
2 = at some risk
3 = not sure
4 = at very little risk
5 = at no risk at all

	1	2	3	4	5	
homosexuals (gays)						Q39
people who have blood transfusions						Q40
people who have sex with lots of partners						Q41
anyone who has sex with another person						Q42
people in hospitals						Q43
people who work with homosexuals						Q44
people who work with haemophiliacs						Q45
nurses						Q46
doctors						Q47
prostitutes						Q48
anyone who uses any illegal drug						Q49
people who use heroin in any way						Q50
people who inject heroin						Q51
people who inject any drug						Q52
people who share needles to inject drugs						Q53
people who work with drug users						Q54
the general public						Q55

31. Please tick TRUE, FALSE or DON'T KNOW for the following statements.
TRY NOT TO GUESS.

	TRUE	FALSE	DON'T KNOW	
You can get AIDS from sharing cups or glasses with infected people				Q56
You can get AIDS if blood from an infected person enters your blood				Q57
You can get AIDS from having sex with an infected person				Q58
You can get AIDS from having sex with any homosexual man				Q59
You can get AIDS from having sex with anyone who injects heroin				Q60
You can get AIDS from toilet seats				Q61
You can get AIDS from being near someone with the virus				Q62
You can get AIDS from touching someone with the virus				Q63
You can get AIDS from insects that bite				Q64
You can get AIDS if you share a towel with someone who has the virus				Q65
You can get AIDS if you share a needle for injecting a drug with someone who hs the virus				Q66
You can get AIDS from kissing someone with the virus				Q67

32. What do you think of the following pieces of advice on protecting yourself from AIDS in a sexual relationship? (Please note, these are some people's points of view, not accepted truths).

Please tick ONE column ONLY for each statement

	GOOD ADVICE	NOT GOOD ADVICE	DON'T KNOW	
Only ever have sex with one partner				*Q68*
Always use a condom when having sex with someone whose sexual background is not known				*Q69*
Don't have sex outside marriage				*Q70*
Don't have sex with a man who has been involved in a homosexual relationship				*Q71*
Keep the number of sexual partners low				*Q72*

Table 2.5.1 : Results of chi-square analysis of differences between Control and Study Group responses to the first questionnaire

*** indicates a significant result**

Question Number	Chi-Square	Degrees of Freedom	Level of significance p =	
Q1	18.5	4	0.0009854*	
Q2	4.38	3	0.22294857	combines degree categories
Q3	4.31	4	0.3656446	
Q4	10.37	4	0.034***	
Q5	8.58	4	0.07241216	
Q6	12.25	3	0.0065489*	combines degree categories
Q7	2.78	4	0.5836778	
Q8	5.23	4	0.26418797	
Q9	9.67	4	0.04627625	
Q10	8.75	4	0.06776896	
Q11	8.35	4	0.07*****6	
Q12	6.74	4	0.150*3262	
Q13	2.74	4	0.6029*462	
Q14	4.06	4	0.39***4765	
Q15	5.58	4	0.232***645	
Q16	2.21	4	0.69****836	
Q17	4.67	4	0.32280662	
Q18	3.96	4	0.41134969	
Q19	4.60	4	0.33040912	
Q20	7.75	4	0.10097988	
Q21	2.82	4	0.5864616	
Q22	6.78	4	0.15108091	
Q23	6.2	4	0.1*445*99	
Q24	1.93	4	0.7*****96	
Q25	4.27	3	0.23341360	combines degree categories
Q26	3.70	4	0.543*6404	
Q27	3.93	4	0.429*8219	
Q28	3.51	4	0.47681250	
Q29	17.29	4	0.001698*9*	
Q30	7.96	4	0.09*79***	
Q31	0.93	4	0.919830**	

Question Number	Chi-Square	Degrees of Freedom	Level of significance p =	
Q32	1.91	3	0.59203685	combines degree categories
Q33	2.29	4	0.68198800	
Q34	5.15	4	0.27*******	
Q35	6.16	4	0.18765224	
Q36	2.37	4	0.66743070	
Q37	16.19	4	0.0027773*	
Q38	1.53	3	0.67612571	combines degree categories
Q39	6.08	2	0.04758425*	combines not sure, low risk and no risk categories
Q40	9.38	3	0.02466669*	combines low risk and no risk categories
Q41	3.75	3	0.29008696	combines low risk and no risk categories
Q42	10.35	4	0.03489979*	
Q43	11.45	4	0.02019472*	
Q44	2.26	4	0.68799282	
Q45	11.37	4	0.02267190*	
Q46	15.41	4	0.00391737*	
Q47	9.61	4	0.04749950*	
Q48	3.72	3	0.29285432	combines very little and no risk
Q49	3.29	4	0.50975690	
Q50	6.41	4	0.17070799	
Q51	1.77	3	0.62140630	combines very little and no risk
Q52	3.24	3	0.35546965	combines very little and no risk
Q53	2.56	2	0.27738851	combines not sure, very little and no risk
Q54	5.24	4	0.26369481	
Q55	5.85	4	0.21089754	
Q56	8.25	2	0.01616193*	
Q57	0.75	2	0.6856*833	
Q58	5.20	2	0.07387205	
Q59	0.33	2	0.84956337	
Q60	1.49	2	0.47362511	
Q61	4.31	2	0.11591290	
Q62	1.13	2	0.56958339	

Question Number	Chi-Square	Degrees of Freedom	Level of significance p =
Q63	1.52	2	0.46790827
Q64	5.60	2	0.06081106
Q65	7.44	2	0.02424401*
Q66	1.53	2	0.46564996
Q67	4.44	2	0.10872778
Q68	8.31	2	0.01569298*
Q69	8.43	2	0.01477681*
Q70	8.44	2	0.01472809*
Q71	0.09	2	0.95574799
Q72	1.62	2	0.44623890
Q73	1.66	2	0.44491868
Q74	11.79	5	0.03***6*9*
Q75	97.67	4	0.00*******
Q77	5.18	5	0.3916*049
Q79	2.03	4	0.72*****9
Q80	3.63	5	0.6341*043
Q86	146	3	0.00000000*
Q87	12.89	6	0.04488*64*
Q88	5.36	4	0.25019*67*
Q89	6.46	4	0.16751633
Q90	1.63	5	0.89723428
Q91	9.43	4	0.05120430

Table 2.5.2 : Results of chi-square analysis of differences between Control and Study Group responses to the second questionnaire

*** indicates a significant result**

Question Number	Chi-square	Degrees of Freedom	Level of significance p =	
Q1	14.59	4	0.00563659*	
Q2	2.94	4	0.56746397	
Q3	3.27	4	0.51375671	
Q4	3.44	4	0.48755535	
Q5	9.95	4	0.04235608	
Q6	12.18	3	0.00673013*	combine disagree categories
Q7	1.19	4	0.88042181	
Q8	17.4	4	0.00161738*	
Q9	7.54	4	0.11015446	
Q10	1.29	4	0.86354578	
Q11	12.75	4	0.01286790*	
Q12	2.49	4	0.64777755	
Q13	1.33	4	0.85637836	
Q14	4.66	4	0.32392566	
Q15	10.13	4	0.03816402*	
Q16	9.36	4	0.05227133	
Q17	8.51	4	0.07673067	
Q18	16.38	4	0.00254651*	
Q19	6.15	4	0.18836557	
Q20	8.84	4	0.06511484	
Q21	2.45	4	0.65312978	
Q22	5.88	4	0.20905516	
Q23	10.61	4	0.03136239*	
Q24	4.67	4	0.32238178	
Q25	2.46	4	0.65715757	
Q26	5.28	4	0.25983746	
Q27	3.07	4	0.54622647	
Q28	9.73	4	0.04527559*	
Q29	7.26	4	0.12269624	
Q30	10.31	4	0.03551325*	
Q31	9.26	4	0.05485278	

Question Number	Chi-square	Degrees of Freedom	Level of significance p =	
Q32	2.42	4	0.65837616	
Q33	3.95	4	0.41298394	
Q34	14.76	4	0.00525573*	
Q35	19.19	4	0.00113495*	
Q36	14.26	4	0.00652348*	
Q37	10.66	4	0.03060176*	
Q38	85.00	3	0.00000000*	combine disagree categories
Q39	1.74	2	0.41821732	combine low risk and no risk
Q40	35.95	4	0.00000031*	
Q41	1.13	2	0.56796919	combine not sure, very little and no risk categories
Q42	3.36	4	0.49942508	
Q43	2.77	4	0.59693868	
Q44	4.38	4	0.35776267	
Q45	6.40	4	0.17088236	
Q46	5.45	4	0.24379108	
Q47	2.63	4	0.62178378	
Q48	0.20	3	0.97732712	combine very little and no risk
Q49	5.72	4	0.22560049	
Q50	2.04	4	0.72012742	
Q51	3.17	4	0.52948180	
Q52	1.79	4	0.77198336	
Q53	0.49	2	0.78103313	combine not sure, very little and no risk categories
Q54	0.49	2	0.78103313	
Q55	10.80	4	0.02889168*	
Q56	1.43	4	0.83861766	
Q57	9.56	2	0.00839768*	
Q58	0.96	2	0.61744051	
Q59	0.48	2	0.78742847	
Q60	4.68	2	0.09637026	
Q61	3.59	2	0.16586607	
Q62	1.76	2	0.41691288	

Question Number	Chi-square	Degrees of Freedom	Level of significance p =
Q63	2.46	2	0.29194137
Q64	8.47	2	0.01449
Q65	0.93	2	0.62719072
Q66	0.49	2	0.78[illegible]
Q67	2.28	2	0.32019042
Q68	6.96	2	0.03081477*
Q69	3.04	2	0.21919092
Q70	24.75	2	0.00000627*
Q71	2.12	2	0.34649[illegible]
Q72	3.04	2	0.2679[illegible]
Q73	14.57	4	0.00569[illegible]*
Q74	19.99	5	0.00125619*
Q76	191.99	4	0.00000[illegible]*
Q77	3.79	5	0.58046223
Q78	3.726	4	0.51403193
Q80	4.3	5	0.50[illegible]
Q86	128.86	3	0.0000007*
Q87	10.53	5	0.06163142
Q88	8.32	5	0.14644136
Q89	2.45	4	0.65130478
Q90	0.79	5	0.97[illegible]
Q91	1.69	4	0.79256752

Table 2.5.3 : Results of Wilcoxon signed-ranks test for Control Group responses on the two questionnaires

Question Number	-	+	Tie	Z Score	Probability
1	32.1	32.1	35.7	.000	1.000
2	32.1	35.7	32	-.853	.6976
3	42.9	35	22.4	-1.938	.2625
4	41.4	46.7	11.9	-.707	.4798*
5	46	46.4	7.4	-1.4132	.1580
6	42.9	32	25.0	-1.3441	.1789
7	32.1	32	35.7	-.2828	.7773
8	39.3	46.4	14.3	-.7698	.4414
9	39.3	42.9	17.9	-1.2630	.2066
10	32.1	35	32.1	-.5345	.5929
11	39.3	42.9	17.9	-.5345	.5929
12	42.9	33.3	23.8	-1.1905	.2339
13	39.3	35	25.0	-.5345	.5929
14	33.3	32	34.5	-.1890	.8501
15	32.1	32	35.7	-.2828	.7773
16	42.9	33.3	23.8	-1.1905	.2339
17	32.1	32	35.7	-.2828	.7773
18	39.3	35	25.0	-.5345	.5929
19	39.3	42.9	17.9	-.5345	.5929
20	32.1	32	35.7	-.2828	.7773
21	39.3	42.9	17.9	-.5345	.5929
22	42.9	33.3	23.8	-1.1905	.2339
23	39.3	35	25.0	-.5345	.5929
24	33.3	32	34.5	-.1890	.8501
25	32.1	32	35.7	-.2828	.7773
26	42.9	33.3	23.8	-1.1905	.2339
27	32.1	32	35.7	-.2828	.7773
28	39.3	35	25.0	-.5345	.5929
29	39.3	42.9	17.9	-.5345	.5929
30	32.1	32	35.7	-.2828	.7773
31	39.3	42.9	17.9	-.5345	.5929
32	42.9	33.3	23.8	-1.1905	.2339
33	39.3	35	25.0	-.5345	.5929
34	33.3	32	34.5	-.1890	.8501
35	46	39.3	14.3	-.7698	.4414
36	32.1	32	35.7	-.2828	.7773
37	39.3	42.9	17.9	-.5345	.5929
38	32.1	35	32.1	-.5345	.5929
39	42.9	46.4	10.7	-.7071	.4798*
40	46	39.3	14.3	-.7698	.4414
41	39.3	42.9	17.9	-.5345	.5929
42	39.3	33.3	27.4	-.9449	.3448
43	46.4	42.9	10.7	-.3780	.7057
44	42.9	35.7	21.4	-1.3416	.1797
45	42.9	39.3	17.9	-.5345	.5929
46	46.4	32.1	21.4	-1.5118	.1305
47	46.4	32.1	21.4	-1.5118	.1305
48	46.4	35.7	17.9	-1.2247	.2207
49	39.3	35.7	25.0	-.5345	.5929
50	46.4	39.3	14.3	-.7698	.4414
51	39.3	32.1	28.6	-1.1667	.2433
52	39.3	32.1	28.6	-1.1667	.2433
53	32.1	35.7	32.1	-.5345	.5929
54	39.3	39.3	21.4	-.7559	.4497
55	46.4	39.3	14.3	-.7698	.4414
56	46.4	39.3	14.3	-.7698	.4414
57	46.4	42.9	10.7	-.3780	.7057
58	42.9	39.3	17.9	-.5345	.5929
59	46.4	42.9	10.7	-.3780	.7057
60	39.3	39.3	21.4	-.7559	.4497
61	39.3	42.9	17.9	-.5345	.5929
62	35.7	39.3	25.0	-.5345	.5929
63	42.9	39.3	17.9	-.5345	.5929
64	39.3	42.9	17.9	-.5345	.5929
65	42.9	35.7	21.4	-1.3416	.1797
66	46.4	42.9	10.7	-.3780	.7057
67	42.9	35.7	21.4	-1.3416	.1797
68	42.9	33.3	23.8	-1.1905	.2339
69	39.3	46.4	14.3	-.7698	.4414
70	39.3	42.9	17.9	-.5345	.5929
71	35.7	46.4	17.9	-1.0690	.2850
72	46.4	42.9	10.7	-.3780	.7057
73a	46.4	33.3	20.2	-1.5118	.1305

Table 2.5.4 : Results of Wilcoxon signed-ranks test for Study Group responses on the two questionnaires

Question Number	-	+	Tie	Z Score	Probability
1	26.9	37.5	35.7	-2.3441	.0190*
2	33.5	40.1	26.3	-1.2643	.2067
3	37.1	37.5	25.3	-1.763	.0781
4	37.5	37.1	37.1	-.5553	.5788
5	36.2	29.9	33.5	-4.489	.0000*
6	26.6	37.9	37.5	-3.8140	.0001*
7	33.9	33.9	32.5	-.2164	.8288
8	38.1	39.3	22.6	-.5698	.5688
9	41.9	31.9	26.1	-1.3039	.1923
10	28.5	39.5	33.9	-2.8327	.0046*
11	35.5	33.9	30.4	-.4439	.6568
12	40.1	36.5	23.4	-1.631	.1062
13	30.9	25.9	43.1	-1.2574	.2086
14	36.9	36.9	26.1	-.3882	.6979
15	33.9	39.9	26.3	-1.1816	.2376
16	42.9	39.1	18.0	-.7569	.4491
17	34.3	39.9	25.8	-1.2435	.2102
18	36.5	37.5	25.9	-1.0033	.3051
19	37.5	38.1	24.4	-1.1791	.2388
20	42.3	33.3	24.3	-1.5087	.1317
21	31.3	41.9	26.8	-2.4546	.0141*
22	35.3	37.5	27.1	-.9021	.6633
23	25.9	39.1	35.0	-2.8448	.0044*
24	39.1	33.1	27.8	-.5447	.5858
25	37.1	35.3	27.6	-.3179	.7504
26	44.3	29.9	25.8	-2.9135	.0036*
27	34.1	36.9	29.0	-.4664	.6412
28	44.3	29.9	25.8	-2.9135	.0036*
29	36.9	34.1	29.0	-.4664	.6412
30	35.5	40.7	23.8	-1.4446	.1485
31	44.3	26.5	29.1	-4.6611	.0000*
32	33.9	34.3	31.9	-.4459	.6558
33	41.1	25.1	33.7	-3.9338	.0001*
34	38.7	37.3	24.3	-.5338	.5933
35	39.1	31.7	29.1	-2.3579	.0184*
36	34.1	32.4	33.5	-.3.5469	.0004*
37	37.5	38.3	23.6	-.2159	.8290
38	30.4	25.7	33.9	-1.9838	.0473
39	35.6	32.4	31.1	-2.4436	.0145*
40	36.9	29.1	34.0	-3.1164	.0018*
41	31.3	24.1	34.9	-1.9119	.0558
42	32.9	37.3	29.9	-1.962	.0498
43	39.1	31.5	29.3	-2.6136	.0090*
44	44.1	32.9	23.3	-3.9467	.0001*
45	41.9	33.3	24.8	-1.9286	.0538*
46	38.1	33.3	28.5	-.3109	.7560
47	38.1	33.1	28.7	-1.0288	.3036
48	33.2	31.4	35.5	-2.2430	.0249*
49	37.7	37.1	25.1	-.2481	.8038
50	38.7	34.9	26.3	-1.3798	.1677
51	26.3	34.9	38.7	-2.3309	.0198*
52	28.1	37.5	34.1	-2.0697	.0385*
53	32.8	36.6	30.7	-1.6760	.0938
54	48.3	30.1	21.6	-4.0530	.0001*
55	41.7	34.3	23.4	-1.6062	.1597
56	52	36.2	30.6	-4.2171	.0000*
57	54	54	23.2	-.0974	.9385
58	53	48	30.2	-.9425	.6144
59	26.7	41.1	32.1	-3.9348	.0001*
60	39.5	39.9	30.5	-.25137	.0116*
61	37.4	33.6	29.0	-2.3681	.0180*
62	58	30.6	31.6	-2.3348	.0194*
63	56	34	46.0	-1.9336	.0531
64	39.7	35.0	46.3	-1.5597	.1188
65	36.6	32.8	62.9	-2.0420	.0412*
66	50	44	38.6	-.1416	.8874
67	33.8	29.3	58.9	-4.5579	.0000*
68	35.6	33.2	61.3	-1.8694	.0616
69	40	36	65.4	-1.3162	.1881
70	29.9	36.1	39.9	-2.1231	.0337*
71	27.6	32.4	60.1	-.9639	.3351
72	30.8	32.8	76.4	-.3155	.7524
73	55.7	19.2	25.2	-5.1139	.0000*
74	40.1	28.9	29.9	-3.5321	.0004*
75	38.5	29.5	31.9	-3.1343	.0017*
76	33.9	38.9	27.1	-2.2033	.0345*
73a	28.5	38.7	29.5	-3.1098	.0019*
74a	30.7	33.1	32.9	-1.5033	.1328
75a	29.5	38.1	39.5	-4.186	.0000*
76a	40.9	41.9	14.2	-.2431	.8107

SMOKING AND DRINKING BEHAVIOUR

Table 2.6.1: Smoking behaviour - Study Group

	never tried	tried once or twice	smoke occasionally	smoke - less than ten a week	smoke - more than ten a week	smoke - more than twenty a week
Before	63%	25%	13%	2%	3%	4%
After	39%	34%	[illegible]%	4%	3%	7%

Table 2.6.2 : Smoking behaviour - Control Group

	never tried	tried once or twice	smoke occasionally	smoke - less than ten a week	smoke - more than ten a week	smoke - more than twenty a week
First	39%	38%	12%	4%	3%	4%
Second	38%	37%	11%	3%	3%	4%

Table 2.6.3 : How many cigarettes did you smoke in the last week? (summary of Balding, 1991 p.45)

	YEAR THREE		YEAR FOUR	
	girls (%)	boys (%)	girls (%)	boys (%)
1-10	[illegible]	6.3	[illegible]4	7.9
11-15	[illegible]5	[illegible]5	[illegible]1	[illegible]3
16-25	[illegible]2	[illegible]2	[illegible]7	[illegible]2
26+	3.1	1.6	0.2	0.8

Responses to 'How many of your friends smoke cigarettes?'

Table 2.6.4 : Study Group

	all of them	most of them	about half of them	not many of them	none of them
Before	1%	[illegible]%	[illegible]%	52%	16%
After	[illegible]%	[illegible]5%	[illegible]%	48%	[illegible]%

Table 2.6.5 : Control Group

	all of them	most of them	about half of them	not many of them	none of them
First	0%	19%	17%	45%	20%
Second	1%	26%	27%	28%	18%

Responses to 'How many of your friends drink alcohol?'

Table 2.6.6 : Study Group

	all of them	most of them	about half of them	not many of them	none of them
First	49	[illegible]16	[illegible]79	[illegible]72	45
%	9.8	23.2	23.8	34.3	9
Second	75	[illegible]60	99	134	30
%	[illegible]6.2	30.3	20.1	29	4.3

Table 2.6.7 : Control Group

	all of them	most of them	about half of them	not many of them	none of them
First	20	28	23	29	15
%	17.4	24.3	20	25.2	13.1
Second	22	30	22	41	6
%	17.9	26.8	17.9	33.3	3.3

Table 2.6.8 : Alcoholic drinks consumed in the last week (Balding, 1991)

	YEAR THREE		YEAR FOUR	
	boys	girls	boys	girls
None	43.9	[illegible]1.4	35.2	42.6
1	29.2	25.5	30.1	27.7
2	[illegible]0.5	12.3	[illegible]4.3	[illegible]5.0
3	6.5	4.5	8.0	7.2
4	3.6	2.6	5.1	3.4
5	1.9	.6	2.4	1.7
6	.9	1.7	1.7	.9
7	3.6	1.3	3.2	1.5

Table 2.6.9 : Number of alcohol units consumed in last seven days (Balding, 1991)

	YEAR THREE		YEAR FOUR	
	boys	girls	boys	girls
None	43.2	50.8	34.6	41.4
1	12.7	10.9	8.0	11.7
2	[illegible]2.1	[illegible]2.4	12.2	13.5
3	6.1	6.5	5.4	7.7
4	6.1	5.4	8.4	5.3
5	2.1	3.3	4.3	3.3
6	3.7	3.0	4.8	3.0
7-10	7.1	4.6	9.7	7.5
11-20	4.1	3.1	9.4	5.0
21+	2.7	.00	3.4	1.5

SOURCES OF INFORMATION

a] about drugs

Sources trusted for drug information (frequencies and percentages)

Table 2.6.10 : Study Group

	Siblings	Parents	Teacher	Friends	Older boys and girls	People who take drugs	Ex-addicts	Doctors	Police	Media
First	272	645	361	178	29	42	354	663	337	192
%	42.3	88.9	72.1	27.8	4.6	6.6	59.7	92.6	67.3	38.3
Second	146	376	328	61	26	38	239	414	267	175
%	35.9	91	66.7	17.5	5.6	9.2	58.4	89.6	64.3	37.9

Table 2.6.10 : Control Group

	Siblings	Parents	Teacher	Friends	Older boys and girls	People who take drugs	Ex-addicts	Doctors	Police	Media
First	79	178	74	27	8	7	99	177	71	40
%	33.9	87.8	44.3	11.5	3	4.1	60	93	61.7	34.8
Second	36	85	73	23	4	12	78	117	79	42
%	29.3	77.2	59.3	18.7	3.3	9.8	63.4	95.1	62.6	34.1

Sources trusted most for drug information? (frequencies and percentages)

Table 2.6.12 : Study Group

	Siblings	Parents	Teacher	Friends	Older boys and girls	People who take drugs	Ex-addicts	Doctors	Police	Media
First	22	230	7	3	0	2	99	179	4	3
%	4.6	65.9	1.6	0.6	0	0.4	11.9	34.1	0.8	0.6
Second	10	160	3	7	3	3	60	197	5	2
%	3.9	36.6	0.7	1.5	0.7	0.7	13	41.6	1.1	0.4

Table 2.6.13 : Control Group

	Siblings	Parents	Teacher	Friends	Older boys and girls	People who take drugs	Ex-addicts	Doctors	Police	Media
First	2	62	0	0	0	1	16	52	3	0
%	1.7	36.5	0	0	0	0.9	13.9	46.2	2.6	0
Second	3	37	1	1	0	1	22	68	0	0
%	2.6	26	0.9	0.9	0	0.8	17.9	51.2	0	0

Sources trusted least for drug information?

Table 2.6.14 : Study Group

	Siblings	Parents	Teacher	Friends	Older boys and girls	People who take drugs	Ex-addicts	Doctors	Police	Media	
First	22	4	22	58	54	272	11	3	5	20	22
%	4.6	0.8	4.6	11.6	10.8	54.3	2.2	0.6	1	5.6	4.6
Second	15	9	16	56	44	255	13	2	13	27	12
%	9.2	1.9	9.5	11.2	9.5	55.2	2.8	0.6	2.8	5.8	2.6

Table 2.6.15 : Control Group

	Siblings	Parents	Teacher	Friends	Older boys and girls	People who take drugs	Ex-addicts	Doctors	Police	Media
First	2	1	3	14	6	29	3	1	1	3
%	1.7	0.9	2.6	12.2	5.2	68.7	2.6	0.9	0.9	2.6
Second	8	2	2	10	15	29	2	1	4	8
%	4.5	1.6	1.6	8.1	12.2	56.9	1.6	0.8	3.3	6.5

Other sources trusted for drug information (Frequencies and percentages)

Table 2.6.16 : Study Group

	Government	Nurses	Other relatives	Scientists	Drug workers
First	4	3	74	3	16
%	2.8	2.6	14.9	1.9	11
Second	4	8	59	5	17
%	2.9	1.7	12.8	1.1	1.7

Table2.6.17 : Control Group

	Government	Nurses	Other relatives	Scientists	Drug workers
First	1	1	6	2	1
%	0.9	0.9	5.2	1.7	0.9
Second	2	6	2	2	0
%	1.6	4.9	1.6	1.6	0

b] about HIV

Sources trusted for HIV information

Table 2.6.18 : Study Group

	Siblings	Parents	Teacher	Friends	Older boys and girls	People with AIDS/ HIV	Doctors	Police	Media
First	359	608	334	80	31	239	479	304	223
	31.7	80.4	44.7	16	6.2	47.7	94.6	60.7	44.5
Second	146	346	280	68	32	230	426	309	184
	31.4	74.5	62.8	14.7	6.9	49.8	92.2	63.5	39.8

Table 2.6.18 : Control Group

	Siblings	Parents	Teacher	Friends	Older boys and girls	People with AIDS/ HIV	Doctors	Police	Media
First	27	91	67	22	13	59	100	68	99
%	23.5	79.1	58.3	19.1	11.3	51.3	87	61.7	33.9
Second	29	88	68	12	6	72	116	52	68
%	23.6	71.5	55.3	9.8	4.9	58.5	94.3	42.3	19

Sources trusted most for HIV information

Table 2.6.20 : Study Group

	Siblings	Parents	Teacher	Friends	Older boys and girls	People with AIDS/ HIV	Doctors	Police	Media
First	6	127	3	5	1	59	269	2	9
%	1.2	25.3	0.6	1	0.2	11.8	53.7	0.4	1.4
Second	4	110	6	5	2	59	281	2	6
%	0.9	23.8	1.3	1.1	0.4	12.8	60.8	0.4	1.3

Table 2.6.21 : Control Group

	Siblings	Parents	Teacher	Friends	Older boys and girls	People with AIDS / HIV	Doctors	Police	Media
First	0	25	0	0	0	20	66	0	0
%	0	21.7	0	0	0	17.4	57.4	0	0
Second	2	21	0	0	0	19	79	1	0
%	1.6	17.1	0	0	0	15.4	63.4	0.8	0

Sources trusted least for HIV information

Table 2.6.22 : Study Group

	Siblings	Parents	Teacher	Friends	Older boys and girls	People with AIDS / HIV	Doctors	Police	Media
First	26	11	20	131	115	79	4	10	42
%	5.2	2.2	4	26.1	23	15.8	2.8	2	8.4
Second	30	15	19	137	108	66	4	17	42
%	6.5	3.2	3.9	28.3	22.5	14.3	2.9	3.7	9.1

Table 2.6.23 : Control Group

	Siblings	Parents	Teacher	Friends	Older boys and girls	People with AIDS / HIV	Doctors	Police	Media
First	7	3	5	31	26	20	0	14	0
%	6.1	2.6	4.3	27	22.6	17.4	0	12.2	0
Second	9	4	4	20	15	17	0	1	15
%	7.3	3.3	3.3	22.8	20.5	13.8	0	0.8	12.2

Other sources trusted for HIV information

Table 2.6.24 : Study Group

	Govern-ment	Someone who knows someone with the virus	Other relatives	Scientists	Social Workers
First	4	14	53	13	5
%	0.8	3.2	10.6	2.6	1
Second	4	16	43	14	9
%	0.9	3.5	9.3	3	1.9

Table 2.6.25 : Control Group

	Govern-ment	Someone who knows someone with the virus	Other relatives	Scientists	Social Workers
First	1	1	5	5	1
%	0.9	0.9	4.3	4.3	0.9
Second	1	3	5	7	0
%	0.8	2.4	4.1	5.7	0

Table 2.6.26 : Sources of information on particular drugs - percentage of Year Three and YearFour pupils receiving information (Balding, 1991)

	Parents	Teachers	Friends	Books and Posters	TV or media	No source of info
Alcohol	59.7	52.5	23.5	36.0	32.1	2.7
Tobacco	60.0	52.2	23.6	42.9	44.1	4.1
Amphetamines	9.8	12.6	6.7	10.2	14.1	50.7
Cannabis leaf	16.6	30.8	15.9	20.6	34.8	22.6
Cannabis oil or resin	14.9	28.6	12.5	17.9	29.8	29.3
Natural hallucinogens	9.8	20.3	10.5	10.7	15.8	49.0
Synthetic hallucinogens	9.8	12.6	10.7	11.8	15.8	48.3
Heroin	27.3	18.5	17.1	32.3	50.8	19.0
Cocaine	22.8	15.2	15.1	26.9	45.0	13.6
Tranquillisers	26.3	25.2	8.9	17.0	29.3	26.1
Solvents	22.8	31.0	14.0	20.2	12.7	28.7

Table 2.6.27 : Main sources of information about sex (%) (Balding, 1991)

	YEAR THREE		YEAR FOUR	
	boys	girls	boys	girls
parents	24.2	16.8	18.4	10.0
teachers	14.2	19.3	14.6	10.9
friends	35.7	31.5	35.6	35.1
siblings	7.2	4.9	6.0	5.6
CP or FPA etc	0.6	0.2	0.6	0.3
Books/TV etc	16.8	17.2	25.3	17.6
n=	576	557	1475	1286

Table 2.7.1 : Knowledge of amphetamines

Study Group responses (frequencies and percentages)

	Very harmless	Quite harmless	Don't know	Quite dangerous	Very dangerous	
Before	3	37	337	31	93	501
%	0.6	7.4	67.3	6.2	18.6	
After	9	42	99	78	167	662
%	1.9	9.1	67.7	16.5	37.8	

Table 2.7.2 : Knowledge of amphetamines

Control Group responses (frequencies and percentages)

	Very harmless	Quite harmless	Don't know	Quite dangerous	Very dangerous	
Before	1	7	43	77	7	135
%	0.9	5.2	42	57	5.2	
After	1	14	41	40	5	123
%	0.8	11	33.3	40.8	4.1	

Table 2.7.3 : Knowledge of cannabis

Study Group responses (frequencies and percentages)

	Very harmless	Quite harmless	Don't know	Quite dangerous	Very dangerous	
Before	5	45	93	210	148	501
%	1	9	18.6	41.9	29.5	
After	28	66	98	167	148	662
%	5	10	14.8	25.1	44.7	

Table 2.7.4 : Knowledge of cannabis

Control Group responses (frequencies and percentages)

	Very harmless	Quite harmless	Don't know	Quite dangerous	Very dangerous	
Before	3	12	39	34	46	135
%	2.6	10.4	33.9	29.6	40	
After	9	19	17	50	39	123
%	5.7	9.1	13.8	40.7	31.7	

Table 2.7.5 : Knowledge of heroin

Study Group responses (frequencies and percentages)

	Very harmless	Quite harmless	Don't know	Quite dangerous	Very dangerous	
Before	56	6	55	90	294	501
%	11.2	1.2	11	18	58.7	
After	50	6	60	79	327	662
%	10.9	1.3	9.7	8.6	70.8	

Table 2.7.6 : Knowledge of heroin

Control Group responses (frequencies and percentages)

	Very harmless	Quite harmless	Don't know	Quite dangerous	Very dangerous	
Before	17	1	14	9	80	115
%	19.4	9.9	12.1	7	69.9	
After	15	1	13	5	89	123
%	12.2	0.8	10.6	4.1	72.4	

METHODS OF USE

Table 2.7.7 : responses to 'how do people take amphetamines'?

	Study Group Before	%	Study Group After	%	Control Group Before	%	Control Group After	%
Inhale	4	0.8	15	1.2	4	3.5	4	1.3
Swallow	47	9.4	120	18.0	13	11.3	69	19.8
Inject	48	9.6	99	14.9	7	6.1	15	12.2
Smoke	22	4.4	41	6.9	6	5.2	11	8.9
Don't know	395	78.8	343	51.8	87	75.7	55	44.7

Table 2.7.7 : responses to 'how do people use cannabis'?

	Study Group Before	%	Study Group After	%	Control Group Before	%	Control Group After	%
Inhale	4	0.8	2	0.3	2	1.7	1	0.8
Eat	2	0.4	0	26.0	0		2	1.6
Inject	24	4.8	65	9.7	3	2.6	11	8.2
Smoke	374	74.7	434	63.9	90	78.3	113	91.3
Don't know	102	20.4	28	4.1	25	21.7	10	8.1

Table 2.7.7 . responses to 'how do people take heroin'?

	Study Group Before	%	Study Group After	%	Control Group Before	%	Control Group After	%
Swallow	11	2.2	16	1.5	1	0.9	3	2.4
Inject	329	65.7	159	77.7	79	63.5	101	82.1
Smoke	107	61.3	320	44.9	37	47.0	62	50.4
Chasing the dragon	6	1.2	3	0.4	2	1.7	0	
Don't know	91	18.2	66	10.0	16	13.9	15	12.2

DANGERS OF DRUG USE

Table 2.7.10 : responses to 'if you said amphetamines are dangerous, in what ways are they?'

	Study Group Before	%	Study Group After	%	Control Group Before	%	Control Group After	%
can overdose	7	1.4	15	1.2	2	1.7	5	4.1
heart attack	3	0.6	9	0.9	0		0	
brain damage	6	1.2	19	4.1	3	2.6	6	4.8
lung damage	0		3	0.6	0		0	
AIDS	2	0.4	3	0.6	2	1.7	1	0.8
Hepatitis	2	0.4	2	0.4	0		0	
damage chromosomes	1	0.2	6	0.9	0		1	0.8
damage your nose	0		1	0.2	0		0	
can kill	11	2.2	21	4.5	4	3.5	7	5.7
can become addicted	12	2.4	43	9.3	9	7.8	9	7.3
ruin your life/destroy your life	51	10.2	85	18.4	14	12.2	27	22.0
illegal	0		7	1.6	0		2	1.6
rot	0		1	0.2	1	0.9	1	0.8
can lead to crime	0		1	0.2	1	0.9	1	0.8
lose friends	1	0.2	0		1	0.9	1	0.8
don't know	435	84.8	305	66.0	89	77.4	79	60.2

Table 2.7.11 : responses to 'if you said cannabis is dangerous, in what ways is it?'

	Study Group Before		Study Group After		Control Group Before		Control Group After	
can overdose	10	2.0	19	4.1	5	4.3	1	0.9
heart attack	3	0.6	9	1.9	0		2	1.6
brain damage	28	5.3	37	8.0	5	4.3	7	
lung damage	16	2.8	14	3.0	2	1.7	3	2.4
AIDS	4	0.9	3	0.6	0		3	2.4
cancer	1	0.2	0		0		1	0.9
damage chromosomes	3	0.6	7	1.5	0		2	1.6
damages your mind	1	0.2	0		0		0	
overdose temperature	0		1	0.2	0		1	0.8
affects fertility	0		0		2	1.7	2	1.6
can kill	62	12.0	48	10.3	13	11.4	19	15.4
can become addicted	58	11.0	76	16.5	23	20.0	35	28.5
causes you unpleasant ways your life	107	21.6	112	24.2	29	25.2	20	16.7
cost	2	0.4	2	0.4	3	2.6	1	0.8
can lead to crime	2	0.4	2	0.4	1	0.8	1	0.8
lose friends	2	0.4	0		2	1.7	2	1.6
don't know	270	54.1	212	45.9	17	14.4	19	15.4

Table 2.7.12 : responses to 'if you said heroin is dangerous, in what ways is it?'

	Study Group Before		Study Group After		Control Group Before		Control Group After	
can overdose	21	4.2	36	7.8	14	12.2	8	6.8
heart attack	3	0.6	8	1.7	0		0	
brain damage	38	7.9	34	7.4	10	8.7	7	5.7
lung damage	3	0.6	12	2.6	3	2.9	3	2.5
AIDS	27	5.6	27	5.8	5	4.3	15	12.3
Hepatitis	5	1.0	8	1.7	2	1.7	3	2.5
liver damage	1	0.2	0		2	1.7	0	
damage chromosomes	11	2.2	26		2	1.7	4	3.3
damages your mind	0		3	0.6	0		0	
overdose temperature	1	0.2	1	0.2	2	1.7	1	0.8
affects fertility	0		0		1	0.9	0	
can kill	129	25.5	120	24.1	32	27.0	34	27.5
can become addicted	101	20.2	107	21.2	40	34.8	45	36.6
causes you unpleasant ways your life	176	35.1	166	33.2	36	31.3	38	30.7
illegal	0		3	0.6	1	0.9	0	
cost	5	1.0	3	0.6	2	1.7	4	3.3
can lead to crime	4	0.8	2	0.4	2	1.7	4	4.0
lose friends	4	0.8	3	0.6	2	1.7	1	0.8
don't know	170	34.7	139	27.9	37	32.5	38	30.9

Table 2.7.13 : Reasons for taking drugs

	Study Group Before %		Study Group After %		Control Group Before %		Control Group After %	
excitement (kicks, thrills, take whats in/self)	117	23.4	142	30.7	25	21.7	34	27.6
curiosity	94	18.8	145	31.8	24	20.9	29	23.6
lacking self-confidence	18	3.6	32	6.9	6	5.2	12	9.8
depression/ sadness	152	30.3	129	27.9	51	44.3	60	48.8
showing off (to impress others)	119	23.8	105	22.7	34	29.6	23	18.7
have no friends	6	1.2	8	1.7	2	1.7	7	5.7
influenced by others	254	50.7	185	40.0	58	50.4	49	39.8
bullied	2	0.4	0		0		0	
to rebel	5	1.0	2	0.4	4	3.5	1	0.8
broken home	13	2.6	7	1.5	6	5.2	6	4.9
no job	10	2.0	8	1.7	2	1.7	1	0.8
easy to get hold of	3	0.6	3	0.6	2	1.7	0	
cheaper than alcohol	2	0.4	3	0.6	1	0.9	0	
harms you more than alcohol	2	0.4	5	1.1	0		0	
addiction	3	0.6	3	0.6	0		0	
to get energy	0		0		1	0.9	0	
ill/need medical support	9	1.8	4	0.9	0		1	0.8
don't know	66	13.2	51	11.0	4	3.5	10	8.1

You can get AIDS from sharing cups or glasses with infected people

Table 2.7.14 : Study Group responses

	True	False	Don't know	
Before	[illegible]	[illegible]	[illegible]	501
	[illegible]	[illegible]	[illegible]	
After	[illegible]	[illegible]	[illegible]	462
	[illegible]	[illegible]	[illegible]	

Table 2.7.15 : Control Group responses

	True	False	Don't know	
First	[illegible]	[illegible]	[illegible]	115
	[illegible]	[illegible]	[illegible]	
Second	[illegible]	[illegible]	[illegible]	123
	[illegible]	[illegible]	[illegible]	

You can get AIDS if blood from an infected person enters your blood

Table 2.7.16 : Study Group responses

	True	False	Don't know	
Before	[illegible]	[illegible]	[illegible]	501
	[illegible]	[illegible]	[illegible]	
After	[illegible]	[illegible]	[illegible]	462
	[illegible]	[illegible]	[illegible]	

Table 2.7.17 : Control Group responses

	True	False	Don't know	
First	[illegible]	[illegible]	[illegible]	115
	[illegible]	[illegible]	[illegible]	
Second	[illegible]	[illegible]	[illegible]	123
	[illegible]	[illegible]	[illegible]	

You can get AIDS from having sex with an infected person

Table 2.7.18 : Study Group responses

	True	False	Don't know	
Before	[illegible]	[illegible]	[illegible]	501
	[illegible]	[illegible]	[illegible]	
After	[illegible]	[illegible]	[illegible]	462
	[illegible]	[illegible]	[illegible]	

Table 2.7.19 : Control Group responses

	True	False	Don't know	
First	[illegible]	[illegible]	[illegible]	115
	[illegible]	[illegible]	[illegible]	
Second	[illegible]	[illegible]	[illegible]	123
	[illegible]	[illegible]	[illegible]	

You can get AIDS from having sex with any homosexual man

Table 2.7.20 : Study Group responses

	True	False	Don't know	
Before	236	132	133	501
	47.1	26.3	26.5	
After	192	190	80	462
	41.6	41.1	17.3	

Table 2.7.21 : Control Group responses

	True	False	Don't know	
First	51	31	33	115
	44.3	27	28.7	
Second	39	63	21	123
	31.7	51.2	17.1	

You can get AIDS from having sex with anyone who injects heroin

Table 2.7.22 : Study Group responses

	True	False	Don't know	
Before	132	154	215	501
	26.3	30.7	42.9	
After	131	205	126	462
	28.4	44.4	27.3	

Table 2.7.23 : Control Group responses

	True	False	Don't know	
First	25	41	49	115
	21.7	35.7	42.6	
Second	25	64	34	123
	20.3	52	27.6	

You can get AIDS from toilet seats

Table 2.7.24 : Study Group responses

	True	False	Don't know	
Before	10	427	64	501
	2	85.2	12.8	
After	12	421	29	462
	2.6	91.1	6.3	

Table 2.7.25 : Control Group responses

	True	False	Don't know	
First	3	89	23	115
	2.6	77.4	20	
Second	2	110	11	123
	1.6	89.4	8.9	

You can get AIDS from being near someone with the virus

Table 2.7.26 : Study Group responses

	True	False	Don't know	
Before	7	440	54	501
	1.4	87.8	10.8	
After	6	427	29	462
	1.3	92.4	6.3	

Table 2.7.27 : Control Group responses

	True	False	Don't know	
First	1	[illegible]	9	115
	0.9	[illegible]	7.8	
Second	0	[illegible]	9	123
	0	[illegible]	7.3	

You can get AIDS from touching someone with the virus

Table 2.7.28 : Study Group Responses

	True	False	Don't know	
Before	5	[illegible]	39	501
	1	[illegible]	7.8	
After	0	433	29	462
	1.9	[illegible]	6.3	

Table 2.7.29 : Control Group Responses

	True	False	Don't know	
First	2	[illegible]	11	115
	1.7	[illegible]	9.6	
Second	0	119	5	123
	0	[illegible]	4.1	

You can get AIDS from insects that bite

Table 2.7.30 : Study Group Responses

	True	False	Don't know	
Before	14	[illegible]	49	501
	2.8	[illegible]	9.8	
After	48	382	254	462
	10	[illegible]	55.3	

Table 2.7.31 : Control Group Responses

	True	False	Don't know	
First	11	56	48	115
	9.6	[illegible]	41.9	
Second	19	89	35	123
	14.6	65	28.5	

You can get AIDS if you share a towel with someone who has the virus

Table 2.7.32 : Study Group Responses

	True	False	Don't know	
Before	29	366	106	501
	5.8	[illegible]	21.2	
After	20	370	72	462
	4.3	[illegible]	15.6	

Table 2.7.33 : Control Group Responses

	True	False	Don't know	
First	5	[illegible]	30	115
	4.3	[illegible]	26	
Second	3	100	19	123
	2.4	[illegible]	15.4	

You can get AIDS if you share a needle for injecting a drug with someone who has the virus

Table 2.7.34 : Study Group Responses

	True	False	Don't know	
Before	466	3	32	501
	93	0.6	6.4	
After	433	5	24	462
	[illegible]	1.1	5.2	

Table 2.7.35 : Control Group Responses

	True	False	Don't know	
First	110	1	4	115
	95.7	0.9	3.5	
Second	116	2	5	123
	94.3	1.6	4.1	

You can get AIDS from kissing someone with the virus

Table 2.7.36 : Study Group responses

	True	False	Don't know	
Before	47	339	115	501
	9.4	67.7	23	
After	27	343	72	462
	5.8	74.6	15.6	

Table 2.7.37 : Control Group responses

	True	False	Don't know	
First	15	66	34	115
	13	57.4	29.6	
Second	6	104	13	123
	4.9	84.6	10.6	

PERCEPTION OF GROUPS AT RISK OF CONTRACTING HIV
(frequencies and percentages)

homosexuals (gays)

Table 2.8.1 : Study Group

	Very great risk	At some risk	Not sure	At very little risk	At no risk at all	
Before	348	126	28	1	1	504
%	79.5	11.2	5	0.2	0.2	
After	378	46	25	1	2	462
%	87.8	10.3	3.2	0.2	0.4	

Table 2.8.2 : Control Group responses

	Very great risk	At some risk	Not sure	At very little risk	At no risk at all	
Before	97	15	3	0	0	115
%	84.3	13	2.6	0	0	
After	99	20	5	0	0	124
%	79.8	16.1	4.1	0	0	

haemophiliacs

Table 2.8.3 : Study Group responses

	Very great risk	At some risk	Not sure	At very little risk	At no risk at all	
Before	64	279	43	96	5	504
%	79.2	64.9	12.6	19.2	1	
After	53	261	76	119	25	462
%	11.5	56.5	16.2	25.8	5.4	

Table 2.8.4 : Control Group responses

	Very great risk	At some risk	Not sure	At very little risk	At no risk at all	
Before	19	46	20	19	0	115
%	16.5	40.0	17.0	16.5	0	
After	19	53	26	26	2	126
%	14.8	42.1	20.1	19.5	1.6	

people who have sex with lots of partners

Table 2.8.5 : Study Group responses

	Very great risk	At some risk	Not sure	At very little risk	At no risk at all	
Before	148	329	25	0	0	504
%	29.5	65	5	1.6	0	
After	227	176	56	3	2	462
%	49.8	38.7	12.5	0.6	0.4	

Table 2.8.6 : Control Group responses

	Very great risk	At some risk	Not sure	At very little risk	At no risk at all	
Before	79	36	3	1	0	115
%	68.7	31.3	2.6	0.9	0	
After	90	30	3	0	0	123
%	73.2	24.4	2.4	0	0	

anyone who has sex with another person

Table 2.8.7 : Study Group responses

	Very great risk	At some risk	Not sure	At very little risk	At no risk at all	
Before	19	273	98	107	5	504
%	3.8	54.2	19.4	21.2	1	
After	25	279	49	106	3	462
%	5.4	60.4	10.6	22.9	0.6	

Table 2.8.8 : Control Group responses

	Very great risk	At some risk	Not sure	At very little risk	At no risk at all	
Before	3	34	27	47	4	115
%	2.6	29.6	23.5	40.9	3.5	
After	5	49	17	47	5	123
%	4.1	39.8	13.8	38.2	4.1	

people in hospitals

Table 2.8.9 : Study Group responses

	Very great risk	At some risk	Not sure	At very little risk	At no risk at all	
Before	8	75	147	184	90	504
%	1.9	15	29.3	37.1	17.9	
After	7	72	80	213	90	462
%	15.2	15.6	17.3	46.1	19.5	

Table 2.8.10 : Control Group responses

	Very great risk	At some risk	Not sure	At very little risk	At no risk at all	
Before	1	29	33	43	9	115
%	0.9	25.2	28.7	37.4	7.8	
After	0	19	29	55	20	123
%	0	15.4	16.3	44.7	23.6	

people who work with homosexuals

Table 2.8.11 : Study Group responses

	Very great risk	At some risk	Not sure	At very little risk	At no risk at all	
Before	7	89	118	161	128	504
%	1.4	17.5	23.6	32.1	25.1	
After	15	69	69	179	130	462
%	3.2	14.9	14.9	37.4	29.4	

Table 2.8.12 : Control Group responses

	Very great risk	At some risk	Not sure	At very little risk	At no risk at all	
Before	2	27	26	35	25	115
%	1.7	23.5	22.6	30.4	21.7	
After	2	13	21	42	45	123
%	1.6	10.6	17.1	34.1	36.6	

people who work with haemophiliacs

Table 2.8.13 : Study Group responses

	Very great risk	At some risk	Not sure	At very little risk	At no risk at all	
Before	10	54	269	83	88	504
%	2	10.8	53.7	16.7	17	
After	12	70	168	128	84	462
%	2.6	15.2	36.4	27.7	18.2	

Table 2.8.14 : Control Group responses

	Very great risk	At some risk	Not sure	At very little risk	At no risk at all	
Before	2	23	45	24	21	115
%	1.7	20	39.1	20.9	18.3	
After	4	13	40	32	34	123
%	3.3	10.6	32.5	26	27.6	

nurses

Table 2.8.15 : Study Group responses

	Very great risk	At some risk	Not sure	At very little risk	At no risk at all	
Before	6	16	15	100	111	501
%	1.2	3.2	3	19.9	22.6	
After	6	13	43	130	110	442
%	1.3	2.9	9.6	29.1	24.9	

Table 2.8.16 : Control Group responses

	Very great risk	At some risk	Not sure	At very little risk	At no risk at all	
Before	2	41	19	34	39	135
%	1.6	30.4	14.1	25.2	28.9	
After	3	37	11	54	37	122
%	2	30.1	9.8	43.9	30.1	

doctors

Table 2.8.17
Study Group responses

	Very great risk	At some risk	Not sure	At very little risk	At no risk at all	
Before	4	120	31	130	113	501
%	0.8	24.6	6.2	25.9	22.6	
After	5	35	45	130	227	442
%	1.1	7.9	10.1	29.1	51.3	

Table 2.8.18 : Control Group responses

	Very great risk	At some risk	Not sure	At very little risk	At no risk at all	
Before	1	39	19	35	31	135
%	0.9	33.9	16.5	30.4	19.3	
After	2	21	13	53	30	120
%	1.6	17.1	10.6	43.1	27.6	

prostitutes

Table 2.8.19 : Study Group responses

	Very great risk	At some risk	Not sure	At very little risk	At no risk at all	
Before	340	97	42	8	2	501
%	79.6	19	8.4	1.6	0.4	
After	397	39	31	4	6	442
%	87.7	8.6	6.9	0.9	1.3	

Table 2.8.20 : Control Group responses

	Very great risk	At some risk	Not sure	At very little risk	At no risk at all	
Before	94	16	5	1	1	115
%	81.7	13.9	4.3	0.9	0.9	
Second	122	10	0	1	1	123
%	97.9	8.1	7.3	0.8	0.8	

anyone who uses any illegal drug

Table 2.8.21 : Study Group responses

	Very great risk	At some risk	Not sure	At very little risk	At no risk at all	
Before	134	199	139	21	8	501
%	26.7	39.7	24.5	4.2	2.9	
After	135	219	87	40	15	442
%	24.9	40.5	17.9	8.9	7.7	

Table 2.8.22 : Control Group responses

	Very great risk	At some risk	Not sure	At very little risk	At no risk at all	
First	37	47	25	5	1	115
%	32.2	40.9	21.7	4.3	0.9	
Second	33	69	23	9	9	123
%	26.9	39.8	18.7	7.3	7.3	

people who use heroin in any way

Table 2.8.23 : Study Group responses

	Very great risk	At some risk	Not sure	At very little risk	At no risk at all	
Before	97	192	159	39	14	501
%	19.4	38.3	31.7	7.8	2.8	
After	89	179	116	40	18	442
%	19.3	38.7	25.1	13	3.9	

Table 2.8.24 : Control Group responses

	Very great risk	At some risk	Not sure	At very little risk	At no risk at all	
First	21	58	27	6	3	115
%	18.3	50.4	23.5	5.2	2.6	
Second	21	50	28	16	8	123
%	17.1	40.7	22.8	13	6.5	

people who inject heroin

Table 2.8.25 : Study Group responses

	Very great risk	At some risk	Not sure	At very little risk	At no risk at all	
Before	235	176	71	14	5	501
%	46.9	35.1	14.2	2.8	1	
After	246	158	38	9	11	442
%	53.2	34.2	8.2	1.9	2.4	

Table 2.8.26 : Control Group responses

	Very great risk	At some risk	Not sure	At very little risk	At no risk at all	
Before	55	45	12	3	0	115
%	47.8	39.1	10.4	2.6	0	
After	59	46	14	3	1	123
%	48	37.4	11.4	2.4	0.8	

people who inject any drug

Table 2.8.27 : Study Group responses

	Very great risk	At some risk	Not sure	At very little risk	At no risk at all	
Before	207	183	86	19	6	501
%	41.3	22.6	17.2	3.8	1.2	
After	223	166	50	14	10	442
%	48.3	35.7	10.8	3	2.2	

Table 2.8.28
Control Group responses

	Very great risk	At some risk	Not sure	At very little risk	At no risk at all	
Before	52	46	14	3	0	115
%	45.2	40	12.2	2.6	0	
After	56	47	16	3	1	123
%	45.5	38.2	13	2.4	0.8	

people who share needles to inject drugs

Table 2.8.29 : Study Group responses

Table 2.8.30
Control Group responses

people who work with drug users

Table 2.8.31 : Study Group responses

Table 2.8.32 : Control Group responses

the general public

Table 2.8.33 : Study Group responses

Table 2.8.34 : Control Group responses

AIDS-RELATED BEHAVIOUR

How much notice would you take of the following pieces of advice on protecting yourself from AIDS in a sexual relationship.

Only ever have sex with one partner

Table 2.8.35 : Study Group responses

Table 2.8.36 : Control Group responses

Always use a condom when having sex with someone whose sexual background is not known

Table 2.8.37 : Study Group responses

Table 2.8.38 : Control Group responses

Don't have sex outside marriage

Table 2.8.39 : Study Group responses

Table 2.8.40 : Control Group responses

Don't have sex with a man who has been involved in a homosexual relationship

Table 2.8.41 : Study Group responses

	Take notice	Ignore it	Don't know	
Before	761	25	115	901
%	79.1	5	23	
After	354	28	80	462
%	76.6	6.1	17.3	

Table 2.8.42 : Control Group responses

	Take notice	Ignore it	Don't know	
Before	93	5	27	115
%	79.2	4.3	23.5	
After	93	7	23	123
%	75.6	5.7	18.7	

Keep the number of sexual partners low

Table 2.8.43 : Study Group responses

	Take notice	Ignore it	Don't know	
Before	431	23	47	501
%	86	4.6	9.4	
After	406	26	32	462
%	87.6	5.6	6.9	

Table 2.8.44 : Control Group responses

	Take notice	Ignore it	Don't know	
Before	101	7	7	115
%	87.8	6.1	6.1	
After	110	9	4	123
%	89.4	7.3	3.4	

ATTITUDES TO DRUG USE

(frequencies and percentages of responses)

Taking drugs makes you into a different kind of person

Table 2.9.1 : Study Group responses

Before	139	219	119	31	17	505
	27.5	43.4	23.6	6.1	3.4	
After	199	183	56	19	5	462
	43.1	39.6	12.1	4.1	1.1	

Table 2.9.2 : Control Group responses

First	53	45	9	0	0	115
	46.1	39.1	7.8	0	0	
Second	57	47	13	3	3	123
	46.3	38.2	10.6	2.4	2.4	

People who take one drug will want to take others

Table 2.9.3 : Study Group responses

Before	49	142	137	91	6	505
	9.7	28.1	27.1	18.0	17.0	
After	76	198	119	62	7	462
	16.5	42.9	25.8	13.4	1.5	

Table 2.9.4 : Control Group responses

First	35	66	47	17	2	115
	30.4	57.4	4.3	14.8	1.7	
Second	49	55	10	9	0	123
	39.8	44.7	8.1	7.3	0	

Drugs make you feel good

Table 2.9.5 : Study Group responses

Before	37	87	180	96	105	505
	7.3	17.2	35.6	19.0	20.8	
After	29	88	159	98	88	462
	6.3	19.0	34.4	21.2	19.0	

Table 2.9.6 : Control Group responses

First	4	28	48	28	27	115
	3.5	24.3	41.7	24	23.5	
Second	9	30	37	22	25	123
	7.3	24.4	30.1	17.9	20.3	

Drug-taking leads to illness

Table 2.9.7 : Study Group responses

Before	274	178	46	17	10	505
	54.3	35.2	9.1	3.4	2	
After	189	179	59	28	7	462
	40.9	38.7	12.8	6.1	1.5	

Table 2.9.8 : Control Group responses

First	61	45	9	0	0	115
	53	39.1	7.8	0	0	
Second	57	47	13	3	3	123
	46.3	38.2	10.6	2.4	2.4	

All drug takers get hooked

Table 2.9.9 : Study Group responses

Before	99	113	147	137	25	501
	19.8	22.6	29.3	27.3	5	
After	61	90	115	169	27	462
	13.2	19.5	24.9	36.6	5.8	

Table 2.9.10 : Control Group responses

First	28	30	32	23	2	115
	24.3	26.1	27.8	20	1.7	
Second	21	36	25	33	8	123
	17.1	29.3	20.3	26.8	6.5	

Drugs often lead to frightening experiences

Table 2.9.11 : Study Group responses

Before	90	235	161	14	1	501
	18	46.9	32.1	2.8	0.2	
After	108	229	104	19	3	462
	23.4	49.6	22.5	3.9	0.6	

Table 2.9.12 : Control Group responses

First	34	57	22	2	0	115
	29.6	49.6	19.1	1.7	0	
Second	48	59	17	1	1	123
	36.7	48	13.8	0.8	0.8	

Drugs lead to mental illness

Table 2.9.13 : Study Group responses

Before	53	137	266	38	7	501
	10.6	27.3	53.1	7.6	1.4	
After	51	132	228	46	5	462
	11	28.6	49.7	10	1.7	

Table 2.9.14 : Control Group responses

First	18	29	60	7	2	115
	15.7	26.3	52.2	6.1	1.7	
Second	11	35	62	14	1	123
	8.9	28.5	50.4	11.4	0.8	

Some drugs are harmless

Table 2.9.15 : Study Group responses

Table 2.9.16 : Control Group responses

Drugs are only harmful if taken regularly

Table 2.9.17 : Study Group responses

Table 2.9.18 : Control Group responses

Even experimenting with drugs is dangerous

Table 2.9.19 : Study Group responses

Table 2.9.20 : Control Group responses

Drugs help you to do things better

Table 2.9.21 : Study Group responses

Table 2.9.22 : Control Group responses

	Agree Strongly	Agree	Not sure	Disagree	Disagree Strongly	
Before	1	8	14	44	48	115
	0.9	7	12.2	38.3	41.7	
Second	3	8	11	49	54	123
	2.9	6.5	8.9	39.8	43.9	

People who start taking drugs can't stop

Table 2.9.23 : Study Group responses

	Agree Strongly	Agree	Not sure	Disagree	Disagree Strongly	
Before	41	137	124	166	39	501
	8.2	26.1	24.8	33.1	7.8	
After	60	112	97	144	29	442
	8.9	24.2	22	39.8	6.3	

Table 2.9.24 : Control Group responses

	Agree Strongly	Agree	Not sure	Disagree	Disagree Strongly	
Before	15	27	26	45	4	115
	13	23.5	22.6	39.1	3.5	
Second	8	36	22	48	11	125
	6.5	27.6	17.9	39	8.9	

Drugs are not a danger to health

Table 2.9.25 : Study Group responses

	Agree Strongly	Agree	Not sure	Disagree	Disagree Strongly	
Before	17	16	42	133	293	501
	3.4	3.2	8.4	26.5	58.5	
After	10	15	19	121	289	462
	3.9	3.2	4.1	26.2	62.6	

Table 2.9.26 : Control Group responses

	Agree Strongly	Agree	Not sure	Disagree	Disagree Strongly	
Before	3	5	5	33	69	115
	2.6	4.3	4.3	28.7	60	
Second	5	5	4	27	82	123
	4.1	4.1	3.3	22	66.7	

People who take drugs become failures

Table 2.9.27 : Study Group responses

	Agree Strongly	Agree	Not sure	Disagree	Disagree Strongly	
Before	48	146	101	106	22	501
	9.6	29.1	20.1	20.9	4.4	
After	53	136	123	108	32	462
	11.5	29.4	26.8	23.4	6.9	

Table 2.9.28 : Control Group responses

	Agree Strongly	Agree	Not sure	Disagree	Disagree Strongly	
Before	11	35	41	31	7	115
	9.6	31.7	35.7	27	6.1	
Second	10	32	31	37	5	125
	14.6	26	25.2	30.1	4.1	

Drugs help you relax

Table 2.9.29 : Study Group responses

Table 2.9.30 : Control Group responses

Drugs lose their effect if taken regularly

Table 2.9.31 : Study Group responses

Table 2.9.32 : Control Group responses

Drug-takers make lots of friends

Table 2.9.33 : Study Group responses

Table 2.9.34 : Control Group responses

Certain drugs are worth trying

Table 2.9.35 : Study Group responses

Table 2.9.36 : Control Group responses

	Agree Strongly	Agree	Not sure	Disagree	Disagree Strongly	
	9	4	16	35	40	115
	7.8	3.5	13.9	30.4	52.2	
	9	9	7	33	74	132
	7	7.3	5.7	26.8	40.2	

People start to take drugs because they lack self-confidence

Table 2.9.37 : Study Group responses

	Agree Strongly	Agree	Not sure	Disagree	Disagree Strongly	
	37	172	247	39	16	501
	5.4	34.3	49.3	7.8	3.2	
	39	178	190	48	19	662
	5.6	38.1	39	10.4	4.7	

Table 2.9.38 : Control Group responses

	Agree Strongly	Agree	Not sure	Disagree	Disagree Strongly	
	6	36	52	15	6	115
	5.2	31.5	45.2	13	5.2	
	9	42	38	10	6	133
	7.2	50.4	30.9	9.1	3.3	

The dangers of drugs are very much exaggerated in the press and on TV

Table 2.9.39
Study Group responses

	Agree Strongly	Agree	Not sure	Disagree	Disagree Strongly	
	32	98	149	160	72	501
	6.4	19.6	29.7	31.9	14.4	
	25	89	106	165	77	662
	5.6	19.3	22.9	35.7	16.7	

Table 2.9.40 : Control Group responses

	Agree Strongly	Agree	Not sure	Disagree	Disagree Strongly	
	2	13	36	43	21	115
	1.7	11.3	31.3	37.4	18.3	
	2	17	30	58	16	123
	1.6	13.8	24.4	47.2	13	

Most people only start taking drugs because they are bored

Table 2.9.41 : Study Group responses

	Agree Strongly	Agree	Not sure	Disagree	Disagree Strongly	
	13	90	134	179	46	501
	2.6	18	26.7	35.5	9.2	
	14	109	154	144	41	662
	3	23.6	33.3	31.2	8.9	

Table 2.9.42 : Control Group responses

	Agree Strongly	Agree	Not sure	Disagree	Disagree Strongly	
	2	19	45	34	15	115
	1.7	16.5	39.1	29.6	13	
	2	33	34	42	12	123
	1.6	26.8	27.6	34.1	9.8	

Smoking cannabis is better than drinking alcohol

Table 2.9.43 : Study Group responses

	Agree Strongly	Agree	Not sure	Disagree	Disagree Strongly	
Before	9	13	136	159	186	501
	1.8	2.6	27.1	31.7	37.1	
After	12	30	89	160	171	462
	2.6	6.5	19.3	34.6	37.2	

Table 2.9.44 : Control Group responses

	Agree Strongly	Agree	Not sure	Disagree	Disagree Strongly	
First	4	2	22	68	79	115
	3.5	1.7	19.1	61.7	73.9	
Second	5	4	15	56	43	123
	4.1	3.3	12.2	45.5	35	

People usually start on drugs out of curiosity

Table 2.9.45 : Study Group responses

	Agree Strongly	Agree	Not sure	Disagree	Disagree Strongly	
Before	37	125	171	28	12	501
	7.4	25.3	34.3	5.6	2.4	
After	52	276	127	19	8	462
	11.3	59.7	27.5	4.1	1.7	

Table 2.9.46 : Control Group responses

	Agree Strongly	Agree	Not sure	Disagree	Disagree Strongly	
First	7	42	34	31	1	115
	6.1	37.9	29.6	9.6	2.9	
Second	0	46	36	32	1	128
	0.5	51.7	29.3	9.8	0.8	

A person who "pushes" drugs is not much better than a murderer

Table 2.9.47 : Study Group responses

	Agree Strongly	Agree	Not sure	Disagree	Disagree Strongly	
Before	237	178	41	35	10	501
	47.3	35.5	12.2	1	2	
After	230	168	47	30	13	462
	52.4	32.3	10.2	6.3	2.9	

Table 2.9.48 : Control Group responses

	Agree Strongly	Agree	Not sure	Disagree	Disagree Strongly	
First	50	44	13	6	2	115
	43.5	38.3	11.3	5.2	1.7	
Second	58	47	18	3	1	128
	47.2	35	14.6	2.4	0.8	

If I had a friend who used cannabis, I would be very worried

Table 2.9.49 : Study Group responses

	Agree Strongly	Agree	Not sure	Disagree	Disagree Strongly	
Before	256	158	47	11	6	501
	50.1	30.5	9.4	2.2	0.8	
After	252	166	29	15	11	462
	54.8	35.2	6.3	3.4	2.4	

Table 2.9.50 : Control Group responses

	Agree Strongly	Agree	Not sure	Disagree	Disagree Strongly	
First	64	37	7	6	1	115
	55.7	32.2	6.1	5.2	0.9	
Second	67	38	6	6	6	123
	54.5	30.9	4.9	4.9	4.9	

ATTITUDES TO HIV

(frequencies and percentages of responses)

People are panicking too much about AIDS

Table 2.9.51 : Study Group responses

	Agree Strongly	Agree	Not Sure	Disagree	Disagree Strongly	
Before	20 (5.8%)	250	60	172	51	508
After	28 (6.3%)	131	58	180 (39%)	75	462

Table 2.9.52 : Control Group responses

	Agree Strongly	Agree	Not Sure	Disagree	Disagree Strongly	
Before	6 (5.2%)	27	20	30	32 (27%)	115
After	7 (5.7%)	26	12	48	30	123

AIDS worries me

Table 2.9.53 : Study Group responses

	Agree Strongly	Agree	Not Sure	Disagree	Disagree Strongly	
Before	77 (15.4%)	201	128	96	6 (1.2%)	508
After	88 (19.9%)	222 (48.1%)	45	92	14 (3%)	462

Table 2.9.54 : Control Group responses

	Agree Strongly	Agree	Not Sure	Disagree	Disagree Strongly	
Before	17 (14.8%)	57 (49.6%)	27 (23.5%)	14 (12.2%)	0	115
After	15 (12.2%)	48 (39.1%)	21 (17.1%)	28 (22.8%)	2 (1.6%)	123

If I know someone with AIDS, I would avoid him/her

Table 2.9.55 : Study Group responses

	Agree Strongly	Agree	Not Sure	Disagree	Disagree Strongly	
Before	37 (7.4%)	55 (11%)	165 (33.1%)	191 (38.3%)	39 (7.8%)	501
After	22 (4.8%)	37 (8%)	122 (26.4%)	181 (41.3%)	100 (21.6%)	462

Table 2.9.56 : Control Group responses

	Agree Strongly	Agree	Not Sure	Disagree	Disagree Strongly	
Before	5 (4.3%)	16 (13.9%)	46 (40%)	37 (32.2%)	11 (9.6%)	115
After	0 (0%)	5 (4%)	37 (30%)	46 (37.4%)	35 (28.5%)	123

Most people who get AIDS deserve it

Table 2.9.57 : Study Group responses

	Agree Strongly	Agree	Not Sure	Disagree	Disagree Strongly	
Before	16 (3.2%)	38 (7.6%)	86 (17.2%)	210 (41.9%)	151 (30.1%)	501
After	22 (4.8%)	41 (8.9%)	56 (12.1%)	192 (41.6%)	151 (32.7%)	462

Table 2.9.58 : Control Group responses

	Agree Strongly	Agree	Not Sure	Disagree	Disagree Strongly	
Before	0 (0%)	5 (4.3%)	9 (7.8%)	69 (60%)	32 (27.8%)	115
After	1 (0.8%)	8 (6.5%)	20 (16.3%)	59 (48%)	36 (29.5%)	123

Everyone is at risk from AIDS

Table 2.9.59 : Study Group responses

	Agree Strongly	Agree	Not Sure	Disagree	Disagree Strongly	
Before	96 (19.2%)	208 (41.5%)	98 (19.6%)	79 (15.8%)	22 (4%)	501
After	99 (21.4%)	190 (41.1%)	47 (10.1%)	96 (20.8%)	30 (6.5%)	462

Table 2.9.60 : Control Group responses

	Agree Strongly	Agree	Not Sure	Disagree	Disagree Strongly	
Before	26 (22.6%)	55 (47.8%)	21 (18.3%)	13 (11.3%)	0 (0%)	115
After	34 (27.6%)	50 (40.7%)	18 (14.6%)	20 (16.3%)	1 (0.8%)	123

If I know someone with HIV, I would avoid him/her

Table 2.9.61 : Study Group responses

	Agree Strongly	Agree	Not Sure	Disagree	Disagree Strongly	
Before	16 (3.2%)	47 (9.4%)	244 (48.7%)	138 (27.5%)	56 (11.2%)	501
After	16 (3.5%)	37 (8%)	166 (35.9%)	157 (34%)	86 (18.6%)	462

Table 2.9.62 : Control Group responses

	Agree Strongly	Agree	Not Sure	Disagree	Disagree Strongly	
Before	5 (4.3%)	12 (10.4%)	58 (50.4%)	28 (24.3%)	12 (10.4%)	115
After	0 (0%)	6 (4.9%)	37 (30.1%)	51 (41.5%)	29 (23.6%)	123

Everyone should be tested for HIV

Table 2.9.63 : Study Group responses

	Agree Strongly	Agree	Not Sure	Disagree	Disagree Strongly	
Before	108	205	162	28	2	
After	35	206	27	27	7	

Table 2.9.64 : Control Group responses

	Agree Strongly	Agree	Not Sure	Disagree	Disagree Strongly	
Before	20	55	36	5	1	
After	26	67	15	5	2	

It is obvious when someone is carrying the virus

Table 2.9.65 : Study Group responses

	Agree Strongly	Agree	Not Sure	Disagree	Disagree Strongly	
Before	6	53	179	253	90	
After	8	9	208	250	226	

Table 2.9.66 - Control Group responses

	Agree Strongly	Agree	Not Sure	Disagree	Disagree Strongly	
Before	0	3	20	55	37	115
After	0	6	36	52	34	128

People with the virus should carry identification cards

Table 2.9.67 : Study Group responses

	Agree Strongly	Agree	Not Sure	Disagree	Disagree Strongly	
Before	35	120	154	160	30	501
After	26	100	128	128	76	462

Table 2.9.68 : Control Group responses

	Agree Strongly	Agree	Not Sure	Disagree	Disagree Strongly	
Before	2	26	20	48	17	115
After	5	25	18	46	28	128

People with the virus should be kept away from everyone else

Table 2.9.69 : Study Group responses

	Agree Strongly	Agree	Not Sure	Disagree	Disagree Strongly	
Before	10 (2%)	39 (7.8%)	108 (20.6%)	226 (45.1%)	123 (24.6%)	501
After	17 (3.7%)	28 (6.1%)	84 (18.2%)	191 (41.3%)	142 (30.7%)	462

Table 2.9.70 : Control Group responses

	Agree Strongly	Agree	Not Sure	Disagree	Disagree Strongly	
Before	2	4	33	53	23	115
After	0	0	14	63	46	123

HIV always kills

Table 2.9.71 : Study Group responses

	Agree Strongly	Agree	Not Sure	Disagree	Disagree Strongly	
Before	17 (3.4%)	67 (9.4%)	342 (68.3%)	78 (15.6%)	17 (3.4%)	501
After	17 (3.7%)	41 (8.9%)	270 (59%)	96 (20.8%)	36 (7.8%)	462

Table 2.9.72 : Control Group responses

	Agree Strongly	Agree	Not Sure	Disagree	Disagree Strongly	
Before	4 (3.5%)	6 (5.2%)	84 (73%)	18 (15.7%)	3 (2.6%)	115
After	5 (4.1%)	3 (2.4%)	62 (50.4%)	42 (34.1%)	11 (8.9%)	123

Homosexuals (gays) have only themselves to blame if they get AIDS

Table 2.9.73 : Study Group responses

	Agree Strongly	Agree	Not Sure	Disagree	Disagree Strongly	
Before	89 (17.8%)	139 (27.7%)	123 (24.6%)	95 (19%)	55 (11%)	501
After	86 (18.2%)	147 (31.8%)	76 (16.1%)	110 (23.8%)	47 (10.2%)	462

Table 2.9.74 : Control Group responses

	Agree Strongly	Agree	Not Sure	Disagree	Disagree Strongly	
Before	12 (10.4%)	49 (42.6%)	22 (19.1%)	27 (23.5%)	5 (4.3%)	115
After	14 (11.4%)	32 (26%)	31 (25.2%)	37 (30.1%)	9 (7.3%)	123

Table 2.9.75 : Study Group responses

	Agree Strongly	Agree	Not Sure	Disagree	Disagree Strongly	
Before	325 (64.9%)	130 (25.9%)	31 (6.2%)	2 (0.4%)	4 (0.8%)	501
After	324 (64.7%)	110 (22.0%)	10 (2.0%)	4 (0.8%)	4 (0.8%)	502

Table 2.9.76 : Control Group responses

	Agree Strongly	Agree	Not Sure	Disagree	Disagree Strongly	
Before	79 (69.3%)	31 (27.2%)	4 (3.5%)	0 (0%)	1 (0.9%)	115
After	53 (47.3%)	53 (47.3%)	6 (5.4%)	0 (0%)	1 (0.9%)	113

FACTOR ANALYSIS

ATTITUDES TO DRUGS FACTORS

Control and Study Group combined - Questionnaire 1

Table 2.10.1 : Rotation varimax

Factor	Eigenvalue	Pct of Var	Cum Pct
1	3.[illegible]544	15.0	15.0
2	1.[illegible]448	7.7	22.7
3	1.[illegible]544	7.1	29.8
4	1.29453	5.2	35.0
5	1.20160	4.8	39.8
6	1.13891	4.6	44.4
7	1.04376	4.2	48.5

Table 2.10.2 : Rotated Factor Matrix

	FACTOR 1	FACTOR 2	FACTOR 3	FACTOR 4
Q1	.09480	.08130	.23778	.11134
Q2	.13459	**.61808**	.13643	-.19857
Q3	.44399	.30998	.12901	.39626
Q4	-.14385	.10692	.47536	-.03380
Q5	-.07105	.79209	.19157	.03253
Q6	-.17297	.05630	**.62937**	-.38621
Q7	-.04101	.19632	**.67925**	.00489
Q8	**.30576**	-.33576	.03154	**.36812**
Q9	.15762	.35505	.05563	**.69801**
Q10	-.14145	.08592	.25250	-.55105
Q11	**.64107**	-.20245	-.25350	.11794
Q12	-.10392	**.73258**	-.00329	-.07580
Q13	**.58978**	.03675	-.12759	.14626
Q14	-.10153	**.64507**	.38116	.07923
Q15	**.50319**	-.36066	.01515	-.05997
Q16	**.26726**	.05859	.27593	.13454
Q17	**.54978**	.07064	-.16825	.12276
Q18	**.56525**	-.07150	-.19649	.22699
Q19	.05872	.01230	.11546	.02527
Q20	.09466	-.09682	-.01240	**.61179**
Q21	.18471	.23058	-.10509	.26835
Q22	.12613	-.**58323**	.00621	-.20948
Q23	.11301	-.09726	-.04958	-.04594
Q24	-.16995	-.07920	.**56598**	-.14342
Q25	-.19215	.11406	.03697	-.24377

bold indicates high loading items

Control and Study Group combined - Questionnaire 2

Table 2.10.3 : Rotation varimax

Factor	Eigenvalue	Pct of Var	Cum Pct
1	4.37791	17.5	17.5
2	2.28249	9.2	26.7
3	1.[illegible]728	7.3	33.9
4	1.34577	5.4	39.4
5	1.16163	4.6	43.9
6	1.10389	4.4	48.4
7	1.[illegible]775	4.2	52.6

Table 2.10.4 : Rotated Factor Matrix

	FACTOR 1	FACTOR 2	FACTOR 3	FACTOR 4
Q1	.06837	.04870	.05242	**.37415**
Q2	.07729	.14440	.05553	.09791
Q3	.06837	.04870	.05242	**.60379**
Q4	.18901	.27405	.03439	.07987
Q5	**.78387**	.01852	.07793	.01069
Q6	.1299	.70965	.01991	.09325
Q7	.19047	.06441	**.87489**	.06078
Q8	.21787	**.75428**	.03511	.22807
Q9	.22927	.20587	.03549	.09879
Q10	.05497	.03618	.01274	.09111
Q11	.12789	.39851	.14952	**.53839**
Q12	**.71267**	.07753	.10881	.06324
Q13	**.76199**	-.31619	-.22185	.05217
Q14	**.66825**	**.70471**	.09104	-.28515
Q15	.25369	-.09772	.01899	**.71052**
Q16	.13650	**.78425**	.12509	.07516
Q17	.19572	.11088	.23334	.17819
Q18	.11290	-.33929	.18309	.11590
Q19	.01778	.14672	.17772	.01994
Q20	.05831	-.37762	.72983	.04173
Q21	.09393	.25520	.03007	.04126
Q22	.13809	-.**54383**	.04047	.15254
Q23	.08520	.10341	-.05136	.17920
Q24	.20239	.40993	.28860	.01339
Q25	.07114	.77291	.01454	.05243

bold indicates high loading items

Study Group - Questionnaire 1

Table 2.10.5 : Rotation varimax

Factor	Eigenvalue	Pct of Var	Cum Pct
1	3.57963	14.3	14.3
2	1.99112	8.0	22.3
3	1.82907	7.3	29.6
4	1.29530	5.2	34.8
5	1.20897	4.8	39.6
6	1.14291	4.6	44.2
7	1.09675	4.4	48.6

Table 2.10.6 : Rotated Factor Matrix

	FACTOR 1	FACTOR 2	FACTOR 3	FACTOR 4	FACTOR 5
Q1	.26333	.34161	.27732	.17448	.08740
Q2	.17754	.61922	.14829	-.20692	.35427
Q3	.40899	-.36816	.13372	-.23274	.17947
Q4	-.11977	.13868	.44598	.30213	.03622
Q5	-.26930	.25436	.19272	.27748	-.04440
Q6	.10799	.02174	.62808	.04696	.17435
Q7	-.03957	.14455	.67502	.00825	-.06887
Q8	.24611	-.31983	-.15306	.41440	.17515
Q9	.08872	.09264	.03172	.69911	.30406
Q10	-.19643	.07230	.30730	-.49861	.17819
Q11	.64158	.05327	-.00804	.08125	.04237
Q12	-.10746	.72708	-.00474	-.04669	.04148
Q13	.59316	.06500	.12089	.12217	-.01143
Q14	-.14280	.38772	.49133	.05292	.03707
Q15	.56119	-.37798	.02111	-.00697	.18725
Q16	.21259	-.08748	.35287	-.04965	.17814
Q17	.58589	.04467	-.12327	.11725	-.08327
Q18	.59824	-.08260	-.17677	.23784	.08622
Q19	.03871	.01152	.16787	-.00513	.65330
Q20	.14177	-.08798	.04493	.55799	.01601
Q21	-.15772	.18821	-.08637	.31122	.65189
Q22	.18021	-.11896	.02779	.08671	.01531
Q23	.09412	-.04435	-.06497	.00845	.67785
Q24	-.22849	-.09320	.35192	-.12746	.36319
Q25	-.21333	.13381	.01118	-.38178	.37113

bold indicates high loading items

Study Group - Questionnaire 2

Table 2.10.7 : Rotation varimax

Factor	Eigenvalue	Pct of Var	Cum Pct
1	4.17924	16.7	16.7
2	2.23751	9.0	25.7
3	1.84487	7.4	33.0
4	1.33850	5.4	38.4
5	1.23760	4.9	43.3
6	1.13951	4.6	47.9

Table 2.10.8 : Rotated Factor Matrix

	FACTOR 1	FACTOR 2	FACTOR 3	FACTOR 4
Q1	.21795	.03495	.61979	.12155
Q2	.39764	.62016	.15874	.04147
Q3	.27793	-.05368	.03626	.81098
Q4	.15567	.16781	.59149	.01542
Q5	.00825	.77209	.06580	.36719
Q6	.05579	.14556	.67020	.13216
Q7	.11492	.17611	.59129	.02794
Q8	.01779	-.35593	.12837	.38410
Q9	.20801	.18590	-.25002	.59779
Q10	-.00277	-.00222	.34683	-.12682
Q11	.66096	-.20063	.08469	.37219
Q12	.04259	.66479	.18868	.04351
Q13	.58174	.04757	-.26913	.18362
Q14	.01574	.62992	.34129	.24260
Q15	.24075	.25379	.04436	.72423
Q16	.61466	-.14781	.26871	-.11422
Q17	.59689	.16514	.18426	.21604
Q18	.52490	-.15339	-.19429	.19081
Q19	.07983	.02942	.14173	.02685
Q20	.24392	-.16083	.08023	.08608
Q21	.07084	.10315	-.01887	.01875
Q22	.53599	-.10426	.01913	.24113
Q23	.01863	-.04716	-.00335	.18087
Q24	.27629	.00311	.29494	.03127
Q25	.31837	.04529	.28265	.01031

bold indicates high loading items

Control Group - Questionnaire 1

Table 2.10.9 : Rotation varimax

Factor	Eigenvalue	Pct of Var	Cum Pct
1	4.79701	19.2	19.2
2	1.97531	7.9	27.1
3	1.91601	7.7	34.9
4	1.59276	6.4	41.1
5	1.44673	5.8	46.9
6	1.37219	5.5	52.4
7	1.25936	5.0	57.4
8	1.21093	4.9	62.3
9	1.03399	4.1	66.4

Table 2.10.10 : Rotated Factor Matrix

	FACTOR 1	FACTOR 2	FACTOR 3	FACTOR 4
Q1	.04277	-.09647	.12493	.09260
Q2	-.23392	-.04752	.53599	.36196
Q3	.69500	.22432	-.11448	.25102
Q4	-.39217	-.69371	.10068	.26112
Q5	-.26637	-.15038	.64521	.19298
Q6	-.22101	-.01177	.14338	.12339
Q7	-.07190	-.06362	.23162	.17797
Q8	.24188	.10214	-.22328	-.20755
Q9	.19352	.52026	.12035	-.44391
Q10	-.20672	-.17145	.15106	.55579
Q11	.20041	.78297	-.15257	.03620
Q12	.04749	-.09106	.77941	.10433
Q13	-.12537	.53478	.02695	-.12508
Q14	-.08635	.05306	.78797	-.12809
Q15	.81046	.39578	-.28205	.25164
Q16	.30780	.15469	-.11908	.32804
Q17	.11735	.27605	-.04908	-.03371
Q18	.64298	.26555	-.09412	-.25572
Q19	-.07569	.19366	-.05538	.01357
Q20	.09916	.02748	-.09306	-.77899
Q21	.10279	-.11108	.16869	-.14311
Q22	.78148	-.06855	-.13318	-.17295
Q23	.12297	.04502	-.25291	.03495
Q24	-.12914	.04097	-.00377	.13452
Q25	-.80877	-.06471	.00575	.03156

bold indicates high loading items

Control Group - Questionnaire 2

Table 2.10.11 : Rotation varimax

Factor	Eigenvalue	Pct of Var	Cum Pct
1	5.48166	21.9	21.9
2	1.90254	7.6	29.5
3	1.80102	7.2	36.7
4	1.61784	6.4	43.2
5	1.47247	5.9	49.1
6	1.23450	5.0	54.2
7	1.13200	4.5	58.6
8	1.08856	4.4	62.9
9	1.05267	4.2	67.1

Table 2.10.12 : Rotated Factor Matrix

	FACTOR 1	FACTOR 2	FACTOR 3	FACTOR 4
Q1	-.11908	.01941	.12782	.29712
Q2	.31504	.69382	.18401	.16712
Q3	.29476	.14535	.12352	.70998
Q4	.16199	.16082	.10113	.8830
Q5	.09516	.82991	.21995	.15741
Q6	.76380	.28700	.14312	.14660
Q7	-.02714	.26480	.53998	-.14657
Q8	.32605	.22001	-.17497	.23345
Q9	.35670	.17549	-.65309	.08114
Q10	.33169	.20899	.35120	.17160
Q11	.09045	.25342	.17989	.68722
Q12	-.02646	.78297	.22221	.14661
Q13	.37985	-.18550	.05990	.13618
Q14	-.11092	.61369	.66919	-.34900
Q15	.38321	.29315	-.08459	.30286
Q16	.12234	.02412	-.02721	.20912
Q17	.02412	.06038	-.01505	.81209
Q18	.66883	.20521	.19873	.06796
Q19	-.03147	-.09386	.08463	.32460
Q20	.13468	-.13660	.00821	.24871
Q21	.78437	.10494	-.08660	-.12770
Q22	.75998	-.06737	-.10629	.10314
Q23	.04723	-.12128	-.06526	-.14916
Q24	-.19948	.04781	.11876	.09481
Q25	-.79860	.08513	.06267	-.01787

bold indicates high loading items

ATTITUDES TO HIV FACTORS

Control and Study Group combined - Questionnaire 1

Table 2.10.13 : Rotation varimax

Factor	Eigenvalue	Pct of Var	Cum Pct
1	3.02113	23.2	23.2
2	1.76802	13.6	36.8
3	1.19513	9.1	46.0
4	1.04001	8.0	54.0

Table 2.10.14 : Rotated Factor Matrix

	FACTOR 1	FACTOR 2	FACTOR 3
Q26	.77756	.21008	-.00862
Q27	.74639	.23638	.69589
Q29	.81138	-.09765	-.09037
Q29	.49446	-.42590	.11096
Q30	-.76435	.66348	.24431
Q31	.79188	-.25179	-.13086
Q32	.23011	.69199	.79940
Q33	.16392	-.32064	.77853
Q34	.59297	.15079	.13208
Q35	.73379	-.28124	.02811
Q36	.26185	.29409	-.12031
Q37	.61206	.76784	-.02629
Q38	-.11402	.69979	.21449

bold indicates high loading items

Control and Study Group combined - Questionnaire 2

Table 2.10.15 : Rotation varimax

Factor	Eigenvalue	Pct of Var	Cum Pct
1	3.45817	26.6	26.6
2	1.77280	13.6	40.2
3	1.19967	9.2	49.4
4	1.01064	7.8	57.2

Table 2.10.16 : Rotated Factor Matrix

	FACTOR 1	FACTOR 2	FACTOR 3
Q26	.78758	-.67118	-.03312
Q27	-.00284	.79220	-.02291
Q28	.86085	.08277	.19406
Q29	.53742	.19877	.04498
Q30	-.72186	.53162	-.14508
Q31	.87619	.21119	-.14804
Q32	.14170	.12721	.91086
Q33	.23481	.02382	-.89979
Q34	.69490	-.06386	.39068
Q35	.78540	-.06411	-.04091
Q36	.07496	.13918	.17439
Q37	.49116	.20486	.36369
Q38	.17785	.64798	.47916

bold indicates high loading items

Study Group - Questionnaire 1

Table 2.10.17 : Rotation varimax

Factor	Eigenvalue	Pct of Var	Cum Pct
1	3.13070	26.1	26.1
2	1.72063	14.3	37.3
3	1.16560	9.7	46.9
4	1.02691	8.6	55.6

Table 2.10.18 : Rotated Factor Matrix

	FACTOR 1	FACTOR 2	FACTOR 3
Q26	.78984	.04351	-.81181
Q27	.08536	.23260	.69158
Q28	.81087	-.10752	.09019
Q29	.51368	-.40189	.11182
Q30	-.10916	.83463	.24498
Q31	.79471	-.03450	.16230
Q32	.19860	.89691	.02479
Q33	.16268	-.91265	.03182
Q34	.68496	.15496	.13976
Q35	.72086	-.04017	.08445
Q36	.28955	.09796	-.08073
Q37	.68060	.07928	-.03438
Q38	-.12188	.66239	.72210

bold indicates high loading items

Study Group - Questionnaire 2

Table 2.10.19 : Rotation varimax

Factor	Eigenvalue	Pct of Var	Cum Pct
[illegible]			

Table 2.10.20 : Rotated Factor Matrix

	[illegible]	[illegible]	[illegible]
[illegible]			

bold indicates high loading items

Control Group - Questionnaire 1

Table 2.10.21 : Rotation varimax

Factor	Eigenvalue	Pct of Var	Cum Pct
[illegible]			

Table 2.10.22 : Rotated Factor Matrix

	FACTOR 1	FACTOR 2	FACTOR 3	FACTOR 4
[illegible]				

bold indicates high loading items

Control Group - Questionnaire 2

Table 2.10.23 : Rotation varimax

Factor	Eigenvalue	Pct of Var	Cum Pct
1	2.92597	22.5	22.5
2	2.28384	15.7	38.2
3	1.65790	11.2	49.4
4	[illegible]	[illegible]	[illegible]

Table 2.10.24 : Rotated Factor Matrix

		FACTOR 2	FACTOR 3	FACTOR 4
[illegible]	78116	-.70010	[illegible]	-.10320
[illegible]	[illegible]	[illegible]	14831	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	83093	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	66393	[illegible]	-.52139
[illegible]	[illegible]	-.34370	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	31219	[illegible]
[illegible]	83493	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	33476
[illegible]	-.11595	19175	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	-.17405	[illegible]	[illegible]	[illegible]

bold indicates high loading items

T-TESTS

FACTOR SCORES BY CLASS

First questionnaire

Table 2.10.25 : Drug Factor One

	Number of cases	Mean	Standard Deviation	Standard Error
I, II, III	422	12.9715	3.595	.175
IV, V	194	12.9124	3.677	.264

	Pooled variance estimate			Separate variance estimate			
F-value	2-tail prob	t value	degrees of freedom	2-tail prob	t value	degrees of freedom	2-tail prob
1.05	.799	.14	614	.889	.14	367.39	.889

Table 2.10.26 : Drug Factor Two

	Number of cases	Mean	Standard Deviation	Standard Error
I, II, III	422	12.3697	2.918	.142
IV, V	194	13.5309	2.867	.206

	Pooled variance estimate			Separate variance estimate			
F-value	2-tail prob	t value	degrees of freedom	2-tail prob	t value	degrees of freedom	2-tail prob
1.04	.797	-4.61	614	.000*	-4.64	380.97	.000

Table 2.10.27 : Drug Factor Three

	Number of cases	Mean	Standard Deviation	Standard Error
I, II, III	422	15.6754	2.135	.104
IV, V	194	15.7113	2.198	.157

	Pooled variance estimate			Separate variance estimate			
F-value	2-tail prob	t value	degrees of freedom	2-tail prob	t value	degrees of freedom	2-tail prob
1.05	.677	-.19	614	.847	-.19	366.70	.849

Table 2.10.28 : AIDS Factor One

	Number of cases	Mean	Standard Deviation	Standard Error
I, II, III	422	13.4289	3.767	.183
IV, V	194	13.3351	3.675	.264

	Pooled variance estimate			Separate variance estimate			
F-value	2-tail prob	t value	degrees of freedom	2-tail prob	t value	degrees of freedom	2-tail prob
1.04	.768	.29	614	.773	.29	381.51	.770

Table 2.10.29 : AIDS Factor Two

	Number of cases	Mean	Standard Deviation	Standard Error
I, II, III	422	13.3839	1.918	.093
IV, V	194	13.3697	1.946	.116

	Pooled variance estimate			Separate variance estimate			
F-value	2-tail prob	t value	degrees of freedom	2-tail prob	t value	degrees of freedom	2-tail prob
1.03	.797	.07	614	.944	.07	369.93	.944

Table 2.10.30 : AIDS Factor Three

	Number of cases	Mean	Standard Deviation	Standard Error
I, II, III	422	6.3223	1.279	.062
IV, V	194	6.4278	1.117	.080

	Pooled variance estimate			Separate variance estimate			
F-value	2-tail prob	t value	degrees of freedom	2-tail prob	t value	degrees of freedom	2-tail prob
1.05	.616	-1.11	614	.002*	-1.17	344.98	.002

Second Questionnaire

Table 2.10.31 : Drug Factor One

	Number of cases	Mean	Standard Deviation	Standard Error
I, II, III	413	12.9564	3.193	.157
IV, V	172	12.9477	3.168	.242

	Pooled variance estimate			Separate variance estimate			
F-value	2-tail prob	t value	degrees of freedom	2-tail prob	t value	degrees of freedom	2-tail prob
1.02	.920	.03	583	.984	.03	322.29	.984

Table 2.10.32 : Drug Factor Two

	Number of cases	Mean	Standard Deviation	Standard Error
I, II, III	413	20.5036	2.315	.114
IV, V	172	20.3779	2.946	.219

	Pooled variance estimate			Separate variance estimate			
F-value	2-tail prob	t value	degrees of freedom	2-tail prob	t value	degrees of freedom	2-tail prob
1.53	.001*	.56	583	.578	.51	268.31	.610

Table 2.10.33 : Drug Factor Three

	Number of cases	Mean	Standard Deviation	Standard Error
I, II, III	413	15.4489	2.176	.107
IV V	172	15.3488	2.293	.174

	Pooled variance estimate			Separate variance estimate		
F-value	2-tail prob	t value	degrees of freedom	2-tail prob	t value	degrees of freedom	2-tail prob
1.19	.442	.150	583	.135	1.67	376.63	.143

Table 2.10.34 : AIDS Factor One

	Number of cases	Mean	Standard Deviation	Standard Error
I, II, III	413	11.3220	3.670	.181
IV V	172	11.6395	4.359	.332

	Pooled variance estimate			Separate variance estimate		
F-value	2-tail prob	t value	degrees of freedom	2-tail prob	t value	degrees of freedom	2-tail prob
1.41	.306*	-1.38	583	.168	-1.29	276.89	.200

Table 2.10.35 : AIDS Factor Two

	Number of cases	Mean	Standard Deviation	Standard Error
I, II, III	413	3.8111	1.791	.088
IV, V	172	3.7035	1.720	.131

	Pooled variance estimate			Separate variance estimate		
F-value	2-tail prob	t value	degrees of freedom	2-tail prob	t value	degrees of freedom	2-tail prob
1.08	.545	.67	583	.503	.69	332.16	.496

Table 2.10.36 : AIDS Factor Three

	Number of cases	Mean	Standard Deviation	Standard Error
I, II, III	413	10.3390	1.346	.066
IV V	172	10.4186	1.302	.099

	Pooled variance estimate			Separate variance estimate		
F-value	2-tail prob	t value	degrees of freedom	2-tail prob	t value	degrees of freedom	2-tail prob
1.07	.619	-.66	583	.511	-.67	330.33	.505

FACTOR SCORES BY GENDER

Questionnaire One

TABLE 2.10.37 : Drugs Factor One

	Number of cases	Mean	Standard Deviation	Standard Error
Boys	310	13.1879	1.789	.102
Girls	272	12.3199	3.255	.197

	Pooled variance estimate			Separate variance estimate		
F-value	2-tail prob	t value	degrees of freedom	2-tail prob	t value	degrees of freedom	2-tail prob
1.15	.000	2.98	470	.003	3.02	498.96	.003*

TABLE 2.10.38 : Drug Factor Two

	Number of cases	Mean	Standard Deviation	Standard Error
Boys	330	12.5030	1.978	.146
Girls	272	12.3465	2.134	.129

	Pooled variance estimate			Separate variance estimate		
F-value	2-tail prob	t value	degrees of freedom	2-tail prob	t value	degrees of freedom	2-tail prob
1.16	.471	1.43	600	.153	-1.43	583.12	.152

TABLE 2.10.39 : Drugs Factor Three

	Number of cases	Mean	Standard Deviation	Standard Error
Boys	330	15.7879	2.231	.123
Girls	272	15.7426	1.944	.118

	Pooled variance estimate			Separate variance estimate		
F-value	2-tail prob	t value	degrees of freedom	2-tail prob	t value	degrees of freedom	2-tail prob
1.32	.010*	.24	600	.791	.25	598.13	.791

Table 2. 10. 40 : AIDS Factor One

	Number of cases	Mean	Standard Deviation	Standard Error
Boys	330	14.2488	1.758	.278
Girls	272	12.2610	3.448	.210

	Pooled variance estimate			Separate variance estimate		
F-value	2-tail prob	t value	degrees of freedom	2-tail prob	t value	degrees of freedom	2-tail prob
1.16	.216	6.72	600	.000*	6.77	591.76	.000

Table 2.10.41 : AIDS Factor Two

	Number of cases	Mean	Standard Deviation	Standard Error
Boys	330	16 1333	1 996	104
Girls	272	15 9228	[illegible]	107

	Pooled variance estimate			Separate variance estimate		
F-value	2-tail prob	t value	degrees of freedom	2-tail prob	t value	degrees of freedom	2-tail prob
[illegible]15	242	1 49	600	143	1041	590 69	160

Table 2.10.42 : AIDS Factor Three

	Number of cases	Mean	Standard Deviation	Standard Error
Boys	330	6 5364	[illegible]375	074
Girls	[illegible]	6 3235	[illegible]226	074

	Pooled variance estimate			Separate variance estimate		
F-value	2-tail prob	t value	degrees of freedom	2-tail prob	t value	degrees of freedom	2-tail prob
1 26	050	[illegible]38	600	048	2 01	596 26	045*

Questionnaire Two

Table 2.10.43 : Drug Factor One

	Number of cases	Mean	Standard Deviation	Standard Error
Boys	308	12 3377	3 147	179
Girls	274	12 7753	3 199	193

	Pooled variance estimate			Separate variance estimate		
F-value	2-tail prob	t value	degrees of freedom	2-tail prob	t value	degrees of freedom	2-tail prob
1 03	790	1 43	580	152	-1 43	569 86	153

Table 2.10.44 : Drug Factor Two

	Number of cases	Mean	Standard Deviation	Standard Error
Boys	308	20 6234	2 827	161
Girls	274	20 3066	2 087	123

	Pooled variance estimate			Separate variance estimate		
F-value	2-tail prob	t value	degrees of freedom	2-tail prob	t value	degrees of freedom	2-tail prob
1 93	000*	1 53	580	126	1 56	556 60	119

Table 2.10.45 : Drug Factor Three

	Number of cases	Mean	Standard Deviation	Standard Error
Boys	308	15 5909	2 146	135
Girls	274	15 5255	2 035	123

	Pooled variance estimate			Separate variance estimate		
F-value	2-tail prob	t value	degrees of freedom	2-tail prob	t value	degrees of freedom	2-tail prob
1 15	211*	36	540	723	36	579 35	[illegible]

Table 2.10.46 : Drug Factor Four

	Number of cases	Mean	Standard Deviation	Standard Error
Boys	330	7 3675	2 131	135
Girls	274	7 1460	1 946	[illegible]

	Pooled variance estimate			Separate variance estimate		
F-value	2-tail prob	t value	degrees of freedom	2-tail prob	t value	degrees of freedom	2-tail prob
1 24	366	4 74	580	000*	4 77	579 36	000

Table 2.10.47 : AIDS Factor One

	Number of cases	Mean	Standard Deviation	Standard Error
Boys	308	12 3117	4 099	234
Girls	274	10 5292	3 672	209

	Pooled variance estimate			Separate variance estimate		
F-value	2-tail prob	t value	degrees of freedom	2-tail prob	t value	degrees of freedom	2-tail prob
1 44	002*	5 66	580	000	5 71	[illegible]71	000

Table 2.10.48 : AIDS Factor Two

	Number of cases	Mean	Standard Deviation	Standard Error
Boys	308	9 9318	1 773	101
Girls	274	9 5949	1 758	[illegible]

	Pooled variance estimate			Separate variance estimate		
F-value	2-tail prob	t value	degrees of freedom	2-tail prob	t value	degrees of freedom	2-tail prob
1 02	900	2 30	580	022*	2 30	579 10	022

Table 2.10.49 : AIDS Factor Three

	Number of cases	Mean	Standard Deviation	Standard Error
Boys	308	10.4351	1.421	.081
Girls	274	10.2628	1.215	.073

			Pooled variance estimate			Separate variance estimate	
F-value	2-tail prob	t value	degrees of freedom	2-tail prob	t value	degrees of freedom	2-tail prob
1.37	.308*	1.56	580	1.19	1.58	579.12	.115

FACTOR SCORES BY SMOKING BEHAVIOUR

First Questionnaire - All subjects

Table 2.10.50 : Drug Factor One

	Number of cases	Mean	Standard Deviation	Standard Error
Regular smoker	56	[illegible]	[illegible]	502
Non-smoker	560	[illegible]	3.594	.152

	Pooled variance estimate			Separate variance estimate		
F-value	2-tail prob	t value	degrees of freedom	2-tail prob	t value	degrees of freedom	2-tail prob
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	1.36	65.69	[illegible]

Table 2.10.51 : Drug Factor Two

	Number of cases	Mean	Standard Deviation	Standard Error
Regular smoker	56	[illegible]	3.591	.480
Non-smoker	[illegible]	[illegible]	2.468	.121

	Pooled variance estimate			Separate variance estimate		
F-value	2-tail prob	t value	degrees of freedom	2-tail prob	t value	degrees of freedom	2-tail prob
1.57	[illegible]	2.35	614	.025	1.87	62.21	.066

Table 2.10.52 : Drug Factor Three

	Number of cases	Mean	Standard Deviation	Standard Error
Regular smoker	56	[illegible]	2.909	.399
Non-smoker	560	[illegible]	2.579	.109

	Pooled variance estimate			Separate variance estimate		
F-value	2-tail prob	t value	degrees of freedom	2-tail prob	t value	degrees of freedom	2-tail prob
1.35	.108	1.35	614	.177	1.20	63.40	.237

Table 2.10. 53: Drug Factor Four

	Number of cases	Mean	Standard Deviation	Standard Error
Regular smoker	56	[illegible]	2.208	.268
Non-smoker	560	[illegible]	2.781	.089

	Pooled variance estimate			Separate variance estimate		
F-value	2-tail prob	t value	degrees of freedom	2-tail prob	t value	degrees of freedom	2-tail prob
1.57	.766	-.41	614	.681	-.42	67.37	.675

TABLE 2.10.54 : AIDS Factor One

	Number of cases	Mean	Standard Deviation	Standard Error
Regular smoker	56	[illegible]	[illegible]	[illegible]
Non-smoker	560	[illegible]	[illegible]	[illegible]

	Pooled variance estimate			Separate variance estimate		
F-value	2-tail prob	t value	degrees of freedom	2-tail prob	t value	degrees of freedom	2-tail prob
[illegible]	.455	.82	614	.679	.81	[illegible]	[illegible]

TABLE 2.10.55 : AIDS Factor Two

	Number of cases	Mean	Standard Deviation	Standard Error
Regular smoker	56	[illegible]	[illegible]	[illegible]
Non-smoker	560	[illegible]	[illegible]	[illegible]

	Pooled variance estimate			Separate variance estimate		
F-value	2-tail prob	t value	degrees of freedom	2-tail prob	t value	degrees of freedom	2-tail prob
1.28	.187	1.9	614	.952	-.17	63.91	.867

TABLE 2.10.56 : AIDS Factor Three

	Number of cases	Mean	Standard Deviation	Standard Error
Regular smoker	56	[illegible]	1.201	.161
Non-smoker	560	[illegible]	1.310	.055

	Pooled variance estimate			Separate variance estimate		
F-value	2-tail prob	t value	degrees of freedom	2-tail prob	t value	degrees of freedom	2-tail prob
1.19	.429	.24	614	.816	.25	[illegible]	[illegible]

TABLE 2.10. 57: AIDS Factor Four

	Number of cases	Mean	Standard Deviation	Standard Error
Regular smoker	56	[illegible]	1.645	.220
Non-smoker	560	[illegible]	1.636	.069

	Pooled variance estimate			Separate variance estimate		
F-value	2-tail prob	t value	degrees of freedom	2-tail prob	t value	degrees of freedom	2-tail prob
1.06	.810	.46	614	.646	.45	[illegible]	[illegible]

Second Questionnaire - All Subjects

Table 2.10.58 : Drug Factor One

	Number of cases	Mean	Standard Deviation	Standard Error
Regular smoker	79	[illegible]	5.391	[illegible]
Non-smoker	458	[illegible]	[illegible]	[illegible]

	Pooled variance estimate			Separate variance estimate		
F-value	2-tail prob	t value	degrees of freedom	2-tail prob	t value	degrees of freedom	2-tail prob
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]

Table 2.10.59 : Drug Factor Two

	Number of cases	Mean	Standard Deviation	Standard Error
Regular smoker	79	[illegible]	[illegible]	[illegible]
Non-smoker	458	[illegible]	[illegible]	[illegible]

	Pooled variance estimate			Separate variance estimate		
F-value	2-tail prob	t value	degrees of freedom	2-tail prob	t value	degrees of freedom	2-tail prob
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]

Table 2.10.60 : Drug Factor Three

	Number of cases	Mean	Standard Deviation	Standard Error
Regular smoker	79	[illegible]	[illegible]	[illegible]
Non-smoker	458	[illegible]	[illegible]	[illegible]

	Pooled variance estimate			Separate variance estimate		
F-value	2-tail prob	t value	degrees of freedom	2-tail prob	t value	degrees of freedom	2-tail prob
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]

Table 2.10.61 : Drug Factor Four

	Number of cases	Mean	Standard Deviation	Standard Error
Regular smoker	79	[illegible]	[illegible]	[illegible]
Non-smoker	458	[illegible]	[illegible]	[illegible]

	Pooled variance estimate			Separate variance estimate		
F-value	2-tail prob	t value	degrees of freedom	2-tail prob	t value	degrees of freedom	2-tail prob
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]

TABLE 2.10.62 : AIDS Factor One

	Number of cases	Mean	Standard Deviation	Standard Error
Regular smoker	79	15.0253	5.301	.596
Non-smoker	506	14.4067	4.504	.200

	Pooled variance estimate			Separate variance estimate		
F-value	2-tail prob	t value	degrees of freedom	2-tail prob	t value	degrees of freedom	2-tail prob
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]

TABLE 2.10.63 : AIDS Factor Two

	Number of cases	Mean	Standard Deviation	Standard Error
Regular smoker	79	[illegible]	[illegible]	[illegible]
Non-smoker	[illegible]	[illegible]	[illegible]	[illegible]

	Pooled variance estimate			Separate variance estimate		
F-value	2-tail prob	t value	degrees of freedom	2-tail prob	t value	degrees of freedom	2-tail prob
1.21	.233	.61	583	.541	-.57	99.11	.570

TABLE 2.10.64 : AIDS Factor Three

	Number of cases	Mean	Standard Deviation	Standard Error
Regular smoker	79	6.4810	1.551	.175
Non-smoker	506	6.1779	1.207	.054

	Pooled variance estimate			Separate variance estimate		
F-value	2-tail prob	t value	degrees of freedom	2-tail prob	t value	degrees of freedom	2-tail prob
1.65	.002*	-1.99	583	.047	-1.66	93.32	.100

TABLE 2.10.65 : AIDS Factor Four

	Number of cases	Mean	Standard Deviation	Standard Error
Regular smoker	79	5.0253	1.577	.177
Non-smoker	506	4.7629	1.254	.056

	Pooled variance estimate			Separate variance estimate		
F-value	2-tail prob	t value	degrees of freedom	2-tail prob	t value	degrees of freedom	2-tail prob
1.58	.004*	-1.67	583	.096	-1.41	94.01	.161

Questionnaire One - Study Group

Table 2.10.66 : Drug Factor One

	Number of cases	Mean	Standard Deviation	Standard Error
Regular smoker	66	-1.7424	1.1681	.1438
Non-smoker	457	-1.3963	1.1795	.0552

	Pooled variance estimate			Separate variance estimate		
F-value	2-tail prob.	t value	degrees of freedom	2-tail prob.	t value	degrees of freedom	2-tail prob.
1.10	.348	-1.76	521	.079	-1.93	83.99	.057

Table 2.10.67 : Drug Factor Two

	Number of cases	Mean	Standard Deviation	Standard Error
Regular smoker	66	-1.4394	1.0618	.1307
Non-smoker	457	-1.1954	1.1367	.0532

	Pooled variance estimate			Separate variance estimate		
F-value	2-tail prob.	t value	degrees of freedom	2-tail prob.	t value	degrees of freedom	2-tail prob.
1.17	.280	-1.51	521	.131	-1.31	84.49	.194

Table 2.10.68 : Drug Factor Three

	Number of cases	Mean	Standard Deviation	Standard Error
Regular smoker	66	-1.4091	1.1735	.1445
Non-smoker	457	-1.1948	1.1219	.0525

	Pooled variance estimate			Separate variance estimate		
F-value	2-tail prob.	t value	degrees of freedom	2-tail prob.	t value	degrees of freedom	2-tail prob.
1.09	.298	-1.31	521	.192	-1.16	84.99	.249

Table 2.10.69 : Drug Factor Four

	Number of cases	Mean	Standard Deviation	Standard Error
Regular smoker	66	-1.4242	1.1681	.1438
Non-smoker	457	-1.1930	1.1219	.0525

	Pooled variance estimate			Separate variance estimate		
F-value	2-tail prob.	t value	degrees of freedom	2-tail prob.	t value	degrees of freedom	2-tail prob.
1.08	.298	-1.31	521	.192	-1.16	84.99	.249

TABLE 2.10.70 : AIDS Factor One

	Number of cases	Mean	Standard Deviation	Standard Error
Regular smoker	66	15.5000	4.429	.438
Non-smoker	457	15.6890	4.308	.202

	Pooled variance estimate			Separate variance estimate		
F-value	2-tail prob.	t value	degrees of freedom	2-tail prob.	t value	degrees of freedom	2-tail prob.
1.06	.479	-.72	521	.396	-.72	84.44	.487

TABLE 2.10.71 : AIDS Factor Two

	Number of cases	Mean	Standard Deviation	Standard Error
Regular smoker	66	13.9318	2.192	.329
Non-smoker	457	13.7636	1.946	.091

	Pooled variance estimate			Separate variance estimate		
F-value	2-tail prob.	t value	degrees of freedom	2-tail prob.	t value	degrees of freedom	2-tail prob.
1.60	.106	.73	521	.899	.71	69.11	.319

TABLE 2.10.72 : AIDS Factor Three

	Number of cases	Mean	Standard Deviation	Standard Error
Regular smoker	66	6.6773	1.267	.191
Non-smoker	457	6.4333	1.331	.062

	Pooled variance estimate			Separate variance estimate		
F-value	2-tail prob.	t value	degrees of freedom	2-tail prob.	t value	degrees of freedom	2-tail prob.
1.10	.356	1.21	521	.226	1.22	92.58	.227

TABLE 2.10.73 : AIDS Factor Four

	Number of cases	Mean	Standard Deviation	Standard Error
Regular smoker	66	5.0455	1.346	.203
Non-smoker	457	5.1751	1.158	.054

	Pooled variance estimate			Separate variance estimate		
F-value	2-tail prob.	t value	degrees of freedom	2-tail prob.	t value	degrees of freedom	2-tail prob.
1.35	.168	.79	521	.485	.62	69.13	.540

Questionnaire Two - Study Group

Table 2.10.74 : Drug Factor One

	Pooled variance estimate			Separate variance estimate		

Table 2.10.75 : Drug Factor Two

	Pooled variance estimate			Separate variance estimate		

Table 2.10.76 : Drug Factor Three

	Pooled variance estimate			Separate variance estimate		

Table 2.10.77 : Drug Factor Four

	Pooled variance estimate			Separate variance estimate		

TABLE 2.10.78 : AIDS Factor One

	Pooled variance estimate			Separate variance estimate		

TABLE 2.10.79 : AIDS Factor Two

	Pooled variance estimate			Separate variance estimate		

TABLE 2.10.80 : AIDS Factor Three

	Pooled variance estimate			Separate variance estimate		

Questionnaire One - Control Group

Table 2.10.81 : Drug Factor One

	Pooled variance estimate			Separate variance estimate		

Table 2.10.82 : Drug Factor Two

	Number of cases	Mean	Standard Deviation	Standard Error
Regular smoker	12	14.9333	1.929	.557
Non-smoker	118	14.6695	1.921	.177

	Pooled variance estimate			Separate variance estimate		
F-value	2-tail prob.	t value	degrees of freedom	2-tail prob.	t value	degrees of freedom	2-tail prob.
1.09	.298	.61	128	.543	.67	15.78	.513

Table 2.10.83 : Drug Factor Three

	Number of cases	Mean	Standard Deviation	Standard Error
Regular smoker	12	14.7500	1.960	.566
Non-smoker	118	14.6356	1.913	.176

	Pooled variance estimate			Separate variance estimate		
F-value	2-tail prob.	t value	degrees of freedom	2-tail prob.	t value	degrees of freedom	2-tail prob.
1.05	.306	.19	128	.848	.20	13.36	.844

Table 2.10.84 : Drug Factor Four

	Number of cases	Mean	Standard Deviation	Standard Error
Regular smoker	12	14.4750	1.782	.515
Non-smoker	118	14.6780	1.930	.178

	Pooled variance estimate			Separate variance estimate		
F-value	2-tail prob.	t value	degrees of freedom	2-tail prob.	t value	degrees of freedom	2-tail prob.
1.17	.281	-.36	128	.722	-.39	13.41	.704

TABLE 2.10.85 : AIDS Factor One

	Number of cases	Mean	Standard Deviation	Standard Error
Regular smoker	12	19.4750	1.422	.411
Non-smoker	118	19.4576	1.911	.176

	Pooled variance estimate			Separate variance estimate		
F-value	2-tail prob.	t value	degrees of freedom	2-tail prob.	t value	degrees of freedom	2-tail prob.
1.81	.180	.03	128	.977	.04	13.39	.972

TABLE 2.10.86 : AIDS Factor Two

	Number of cases	Mean	Standard Deviation	Standard Error
Regular smoker	12	19.7500	1.658	.479
Non-smoker	118	19.6017	2.179	.214

	Pooled variance estimate			Separate variance estimate		
F-value	2-tail prob.	t value	degrees of freedom	2-tail prob.	t value	degrees of freedom	2-tail prob.
1.79	.323	.23	128	.820	.28	15.76	.781

TABLE 2.10.87 : AIDS Factor Three

	Number of cases	Mean	Standard Deviation	Standard Error
Regular smoker	12	19.5833	1.443	.417
Non-smoker	118	19.4831	1.918	.177

	Pooled variance estimate			Separate variance estimate		
F-value	2-tail prob.	t value	degrees of freedom	2-tail prob.	t value	degrees of freedom	2-tail prob.
1.39	.300	-.22	128	.827	-.22	13.79	.830

TABLE 2.10.88 : AIDS Factor Four

	Number of cases	Mean	Standard Deviation	Standard Error
Regular smoker	12	19.5833	2.151	.621
Non-smoker	118	19.4661	1.979	.165

	Pooled variance estimate			Separate variance estimate		
F-value	2-tail prob.	t value	degrees of freedom	2-tail prob.	t value	degrees of freedom	2-tail prob.
1.64	.196	-.16	128	.876	.21	12.61	.835

Questionnaire Two - Control Group

Table 2.10.89 : Drug Factor One

	Number of cases	Mean	Standard Deviation	Standard Error
Regular smoker	49	14.9235	2.767	.671
Non-smoker	136	14.3309	2.796	.272

	Pooled variance estimate			Separate variance estimate		
F-value	2-tail prob.	t value	degrees of freedom	2-tail prob.	t value	degrees of freedom	2-tail prob.
1.22	.300	-3.43	131	.001*	-3.46	71.58	.002

Table 2.18.90 : Drug Factor Two

Table 2.18.91 : Drug Factor Three

Table 2.18.92 : Drug Factor Four

TABLE 2.18.93 : AIDS Factor One

TABLE 2.18.94 : AIDS Factor Two

TABLE 2.18.95 : AIDS Factor Three

TABLE 2.18.96 : AIDS Factor Four

FACTOR SCORES BY FRIENDS SMOKING BEHAVIOUR

Questionnaire One - continued Study and Control Group

Table 2.18.97 : Drug factor One

		Pooled variance estimate			Separate variance estimate		
F-value	2-tail prob	t value	degrees of freedom	2-tail prob	t value	degrees of freedom	2-tail prob

Table 2.18.98 : Drug Factor Two

		Pooled variance estimate			Separate variance estimate		
F-value	2-tail prob	t value	degrees of freedom	2-tail prob	t value	degrees of freedom	2-tail prob

Table 2.18.99 : Drug Factor Three

		Pooled variance estimate			Separate variance estimate		
F-value	2-tail prob	t value	degrees of freedom	2-tail prob	t value	degrees of freedom	2-tail prob

Table 2.18.100 : Drug Factor Four

		Pooled variance estimate			Separate variance estimate		
F-value	2-tail prob	t value	degrees of freedom	2-tail prob	t value	degrees of freedom	2-tail prob

TABLE 2.18.101 : AIDS Factor One

		Pooled variance estimate			Separate variance estimate		
F-value	2-tail prob	t value	degrees of freedom	2-tail prob	t value	degrees of freedom	2-tail prob

TABLE 2.18.102 : AIDS Factor Two

		Pooled variance estimate			Separate variance estimate		
F-value	2-tail prob	t value	degrees of freedom	2-tail prob	t value	degrees of freedom	2-tail prob

TABLE 2.18.103 : AIDS Factor Three

		Pooled variance estimate			Separate variance estimate		
F-value	2-tail prob	t value	degrees of freedom	2-tail prob	t value	degrees of freedom	2-tail prob

TABLE 2.18.104 : AIDS Factor Four

		Pooled variance estimate			Separate variance estimate		
F-value	2-tail prob	t value	degrees of freedom	2-tail prob	t value	degrees of freedom	2-tail prob

Questionnaire Two - All

Table 2.10.108 : Drug Factor One

Table 2.10.109 : Drug Factor Two

Table 2.10.107 : Drug Factor Three

Table 2.10.108 : Drug Factor Four

TABLE 2.10.109 : AIDS Factor One

TABLE 2.10.110 : AIDS Factor Two

TABLE 2.10.111 : AIDS Factor Three

TABLE 2.10.112 : AIDS Factor Four

Questionnaire One - Study Group

Table 2.10.113 : Drug Factor One

	Number of cases	Mean	Standard Deviation	Standard Error
Half or more friends smoke	159	13.2893	3.832	.304
Less than half friends smoke	342	12.9357	3.531	.191

	Pooled variance estimate			Separate variance estimate			
F-value	2-tail prob.	t value	degrees of freedom	2-tail prob.	t value	degrees of freedom	2-tail prob.
1.18	.218	1.02	499	.310	.99	286.60	.325

Table 2.10.114 : Drug Factor Two

	Number of cases	Mean	Standard Deviation	Standard Error
Half or more friends smoke	159	21.5849	2.895	.230
Less than half friends smoke	342	21.2339	3.190	.172

	Pooled variance estimate			Separate variance estimate			
F-value	2-tail prob.	t value	degrees of freedom	2-tail prob.	t value	degrees of freedom	2-tail prob.
1.21	.166	1.10	499	.239	1.22	336.89	.222

Table 2.10.115 : Drug Factor Three

	Number of cases	Mean	Standard Deviation	Standard Error
Half or more friends smoke	159	17.3899	2.595	.206
Less than half friends smoke	342	17.2193	2.559	.138

	Pooled variance estimate			Separate variance estimate			
F-value	2-tail prob.	t value	degrees of freedom	2-tail prob.	t value	degrees of freedom	2-tail prob.
1.03	.824	.69	499	.489	.69	304.33	.492

Table 2.10.116 : Drug Factor Four

	Number of cases	Mean	Standard Deviation	Standard Error
Half or more friends smoke	159	16.3270	2.360	.178
Less than half friends smoke	342	16.2515	2.368	.128

	Pooled variance estimate			Separate variance estimate			
F-value	2-tail prob.	t value	degrees of freedom	2-tail prob.	t value	degrees of freedom	2-tail prob.
1.12	.428	.34	499	.735	.35	324.25	.730

TABLE 2.10.117 : AIDS Factor One

	Number of cases	Mean	Standard Deviation	Standard Error
Half or more friends smoke	159	16.6918	4.617	.366
Less than half friends smoke	342	14.9298	4.081	.221

	Pooled variance estimate			Separate variance estimate			
F-value	2-tail prob.	t value	degrees of freedom	2-tail prob.	t value	degrees of freedom	2-tail prob.
1.28	.064	4.31	499	.000	4.12	274.39	.000

TABLE 2.10.118 : AIDS Factor Two

	Number of cases	Mean	Standard Deviation	Standard Error
Half or more friends smoke	159	14.0377	2.101	.167
Less than half friends smoke	342	13.0029	1.763	.095

	Pooled variance estimate			Separate variance estimate			
F-value	2-tail prob.	t value	degrees of freedom	2-tail prob.	t value	degrees of freedom	2-tail prob.
1.42	.008	5.0	499	.540	5.5	265.12	.000

TABLE 2.10.119 : AIDS Factor Three

	Number of cases	Mean	Standard Deviation	Standard Error
Half or more friends smoke	159	6.5849	1.342	.106
Less than half friends smoke	342	6.3684	1.313	.071

	Pooled variance estimate			Separate variance estimate			
F-value	2-tail prob.	t value	degrees of freedom	2-tail prob.	t value	degrees of freedom	2-tail prob.
1.05	.731	1.71	499	.089	1.69	307.10	.092

TABLE 2.10.120 : AIDS Factor Four

	Number of cases	Mean	Standard Deviation	Standard Error
Half or more friends smoke	159	5.4277	1.270	.101
Less than half friends smoke	342	5.0409	1.108	.060

	Pooled variance estimate			Separate variance estimate			
F-value	2-tail prob.	t value	degrees of freedom	2-tail prob.	t value	degrees of freedom	2-tail prob.
1.31	.041*	3.47	499	.001	3.10	273.90	.001*

Questionnaire Two - Study Group

Table 2.10.121 : Drug Factor One

	Number of cases	Mean	Standard Deviation	Standard Error
Half or more friends smoke	180	12.0889	3.850	287
Less than half friends smoke	282	12.0248	3.508	209

	Pooled variance estimate			Separate variance estimate			
F-value	2-tail prob	t value	degrees of freedom	2-tail prob	t value	degrees of freedom	2-tail prob
1.20	.166	.19	460	.954	.18	355.47	.957

Table 2.10.122 : Drug Factor Two

	Number of cases	Mean	Standard Deviation	Standard Error
Half or more friends smoke	180	12.5000	3.366	.243
Less than half friends smoke	282	12.4326	3.084	.181

	Pooled variance estimate			Separate variance estimate			
F-value	2-tail prob	t value	degrees of freedom	2-tail prob	t value	degrees of freedom	2-tail prob
1.16	.271	.23	460	.921	.22	360.84	.824

Table 2.10.123 : Drug Factor Three

	Number of cases	Mean	Standard Deviation	Standard Error
Half or more friends smoke	180	15.3944	2.696	.186
Less than half friends smoke	282	15.4752	2.062	.123

	Pooled variance estimate			Separate variance estimate			
F-value	2-tail prob	t value	degrees of freedom	2-tail prob	t value	degrees of freedom	2-tail prob
1.47	.004*	-.38	460	.706	-.36	329.11	.717

Table 2.10.124 : Drug Factor Four

	Number of cases	Mean	Standard Deviation	Standard Error
Half or more friends smoke	180	14.1167	3.250	.242
Less than half friends smoke	282	13.6525	3.382	.201

	Pooled variance estimate			Separate variance estimate			
F-value	2-tail prob	t value	degrees of freedom	2-tail prob	t value	degrees of freedom	2-tail prob
1.08	.544	2.00	460	.047*	2.01	397.54	.045

TABLE 2.10.125 : AIDS Factor One

	Number of cases	Mean	Standard Deviation	Standard Error
Half or more friends smoke	180	15.5333	5.054	.377
Less than half friends smoke	282	14.6241	4.628	.276

	Pooled variance estimate			Separate variance estimate			
F-value	2-tail prob	t value	degrees of freedom	2-tail prob	t value	degrees of freedom	2-tail prob
1.19	.189	1.99	460	.048*	1.95	354.85	.052

TABLE 2.10.126 : AIDS Factor Two

	Number of cases	Mean	Standard Deviation	Standard Error
Half or more friends smoke	180	16.4389	2.058	.153
Less than half friends smoke	282	16.3404	2.028	.121

	Pooled variance estimate			Separate variance estimate			
F-value	2-tail prob	t value	degrees of freedom	2-tail prob	t value	degrees of freedom	2-tail prob
1.03	.817	.51	460	.613	.50	377.26	.616

TABLE 2.10.127 : AIDS Factor Three

	Number of cases	Mean	Standard Deviation	Standard Error
Half or more friends smoke	180	10.4611	1.388	.103
Less than half friends smoke	282	10.3511	1.288	.077

	Pooled variance estimate			Separate variance estimate			
F-value	2-tail prob	t value	degrees of freedom	2-tail prob	t value	degrees of freedom	2-tail prob
1.16	.264	.87	460	.385	.85	340.58	.397

TABLE 2.10.128 : AIDS Factor Four

	Number of cases	Mean	Standard Deviation	Standard Error
Half or more friends smoke	40	14.5250	2.278	.360
Less than half friends smoke	75	14.5467	2.578	.297

	Pooled variance estimate			Separate variance estimate			
F-value	2-tail prob	t value	degrees of freedom	2-tail prob	t value	degrees of freedom	2-tail prob
1.29	.402	-.04	113	.966	-.05	89.46	.963

TABLE 2.10.133 : AIDS Factor One

	Number of cases	Mean	Standard Deviation	Standard Error
Half or more friends smoke	40	7.7500	2.580	.408
Less than half friends smoke	75	7.5333	2.392	.365

	Pooled variance estimate				Separate variance estimate		
F-value	2-tail prob.	t value	degrees of freedom	2-tail prob.	t value	degrees of freedom	2-tail prob.
1.17	.379	.44	113	.445	.45	72.72	.657

TABLE 2.10.134 : AIDS Factor Two

	Number of cases	Mean	Standard Deviation	Standard Error
Half or more friends smoke	40	18.7500	2.085	.322
Less than half friends smoke	75	18.5467	2.170	.251

	Pooled variance estimate				Separate variance estimate		
F-value	2-tail prob.	t value	degrees of freedom	2-tail prob.	t value	degrees of freedom	2-tail prob.
1.14	.670	.49	113	.626	.50	64.32	.619

TABLE 2.10.135 : AIDS Factor Three

	Number of cases	Mean	Standard Deviation	Standard Error
Half or more friends smoke	40	4.7250	1.664	.263
Less than half friends smoke	75	4.3733	1.333	.154

	Pooled variance estimate				Separate variance estimate		
F-value	2-tail prob.	t value	degrees of freedom	2-tail prob.	t value	degrees of freedom	2-tail prob.
1.56	.102	1.23	113	.220	1.15	66.19	.253

TABLE 2.10.136 : AIDS Factor Four

	Number of cases	Mean	Standard Deviation	Standard Error
Half or more friends smoke	40	8.5000	2.075	.328
Less than half friends smoke	75	8.4400	1.518	.175

	Pooled variance estimate				Separate variance estimate		
F-value	2-tail prob.	t value	degrees of freedom	2-tail prob.	t value	degrees of freedom	2-tail prob.
1.87	.021*	.18	113	.860	.16	61.79	.872

Questionnaire Two - Control Group

Table 2.10.137 : Drug Factor One

	Number of cases	Mean	Standard Deviation	Standard Error
Half or more friends smoke	50	15.4800	3.012	.426
Less than half friends smoke	75	14.1096	2.726	.318

	Pooled variance estimate				Separate variance estimate		
F-value	2-tail prob.	t value	degrees of freedom	2-tail prob.	t value	degrees of freedom	2-tail prob.
1.22	.436	2.42	123	.017*	2.50	98.35	.013

Table 2.10.138 : Drug Factor Two

	Number of cases	Mean	Standard Deviation	Standard Error
Half or more friends smoke	50	12.2000	3.298	.466
Less than half friends smoke	75	13.0274	3.362	.194

	Pooled variance estimate				Separate variance estimate		
F-value	2-tail prob.	t value	degrees of freedom	2-tail prob.	t value	degrees of freedom	2-tail prob.
1.04	.891	-1.35	123	.179	1.36	176.83	.176

Table 2.10.139 : Drug Factor Three

	Number of cases	Mean	Standard Deviation	Standard Error
Half or more friends smoke	50	13.1400	2.378	.336
Less than half friends smoke	75	13.2829	2.006	.232

	Pooled variance estimate				Separate variance estimate		
F-value	2-tail prob.	t value	degrees of freedom	2-tail prob.	t value	degrees of freedom	2-tail prob.
1.40	.166	-.23	123	.815	-.23	91.37	.821

Table 2.10.140 : Drug Factor Four

	Number of cases	Mean	Standard Deviation	Standard Error
Half or more friends smoke	50	13.1200	2.116	.299
Less than half friends smoke	75	12.7120	2.160	.252

	Pooled variance estimate				Separate variance estimate		
F-value	2-tail prob.	t value	degrees of freedom	2-tail prob.	t value	degrees of freedom	2-tail prob.
1.05	.478	1.04	123	.302	1.04	104.98	.301

TABLE 2.10.141 : AIDS Factor One

	Number of cases	Mean	Standard Deviation	Standard Error
Half or more friends smoke	50	8.1200	2.318	.328
Less than half friends smoke	78	7.9315	2.406	.282

	Pooled variance estimate			Separate variance estimate			
F-value	2-tail prob	t value	degrees of freedom	2-tail prob	t value	degrees of freedom	2-tail prob
1.78	.791	.43	121	.666	.44	107.97	.664

TABLE 2.10.142 : AIDS Factor Two

	Number of cases	Mean	Standard Deviation	Standard Error
Half or more friends smoke	50	10.2200	2.324	.329
Less than half friends smoke	78	10.0000	3.134	.350

	Pooled variance estimate			Separate variance estimate			
F-value	2-tail prob	t value	degrees of freedom	2-tail prob	t value	degrees of freedom	2-tail prob
1.59	.508	.54	121	.589	.53	99.60	.595

TABLE 2.10.143 : AIDS Factor Three

	Number of cases	Mean	Standard Deviation	Standard Error
Half or more friends smoke	50	9.9400	2.763	.391
Less than half friends smoke	78	10.1667	2.593	.309

	Pooled variance estimate			Separate variance estimate			
F-value	2-tail prob	t value	degrees of freedom	2-tail prob	t value	degrees of freedom	2-tail prob
1.14	.617	-.42	121	.677	-.41	102.96	.680

TABLE 2.10.144 : AIDS Factor Four

	Number of cases	Mean	Standard Deviation	Standard Error
Half or more friends smoke	50	8.4800	1.515	.214
Less than half friends smoke	78	8.3205	1.510	.177

	Pooled variance estimate			Separate variance estimate			
F-value	2-tail prob	t value	degrees of freedom	2-tail prob	t value	degrees of freedom	2-tail prob
1.01	.968	.54	121	.587	.54	105.20	.587

FACTOR SCORES BY FRIENDS DRINKING BEHAVIOUR

Questionnaire One - Study and Control Groups combined

Table 2.10.145 : Drugs Factor One

	Number of cases	Mean	Standard Deviation	Standard Error
Half or more friends drink alcohol	354	13.2797	3.770	.201
Less than half friends drink alcohol	262	12.3969	3.338	.206

	Pooled variance estimate			Separate variance estimate			
F-value	2-tail prob	t value	degrees of freedom	2-tail prob	t value	degrees of freedom	2-tail prob
1.28	.139	3.44	614	.001	3.47	580.54	.001

Table 2.10.146 : Drugs Factor Two

	Number of cases	Mean	Standard Deviation	Standard Error
Half or more friends drink alcohol	354	14.3785	2.151	.114
Less than half friends drink alcohol	262	14.4679	2.232	.138

	Pooled variance estimate			Separate variance estimate			
F-value	2-tail prob	t value	degrees of freedom	2-tail prob	t value	degrees of freedom	2-tail prob
1.20	.519	-.62	614	.535	-.62	550.75	.537

Table 2.10.147 : Drugs Factor Three

	Number of cases	Mean	Standard Deviation	Standard Error
Half or more friends drink alcohol	354	12.4944	2.915	.155
Less than half friends drink alcohol	262	13.061	2.868	.183

	Pooled variance estimate			Separate variance estimate			
F-value	2-tail prob	t value	degrees of freedom	2-tail prob	t value	degrees of freedom	2-tail prob
1.04	.707	-2.37	614	.018*	-2.36	556.77	.019

Table 2.10.148 : Drugs Factor Four

	Number of cases	Mean	Standard Deviation	Standard Error
Half or more friends drink alcohol	354	12.3870	2.008	.106
Less than half friends drink alcohol	262	12.2710	2.167	.134

	Pooled variance estimate			Separate variance estimate			
F-value	2-tail prob	t value	degrees of freedom	2-tail prob	t value	degrees of freedom	2-tail prob
1.17	.169	.69	614	.491	.68	536.99	.498

Table 2.10.149 : AIDS Factor One

	Number of cases	Mean	Standard Deviation	Standard Error
Half or more friends drink alcohol	354	15.7260	4.398	.234
Less than half friends drink alcohol	262	15.1374	3.868	.239

	Pooled variance estimate			Separate variance estimate			
F-value	2-tail prob	t value	degrees of freedom	2-tail prob	t value	degrees of freedom	2-tail prob
1.29	.28	1.73	614	.085	1.76	595.94	.079

Table 2.10.150 : AIDS Factor Two

	Number of cases	Mean	Standard Deviation	Standard Error
Half or more friends drink alcohol	354	14.0282	1.942	.103
Less than half friends drink alcohol	262	13.9427	1.708	.106

	Pooled variance estimate			Separate variance estimate			
F-value	2-tail prob	t value	degrees of freedom	2-tail prob	t value	degrees of freedom	2-tail prob
1.29	.020	.57	614	.570	.58	595.97	.563

Table 2.10.151 : AIDS Factor Three

	Number of cases	Mean	Standard Deviation	Standard Error
Half or more friends drink alcohol	354	7.1356	1.971	105
Less than half friends drink alcohol	262	7.2290	1.910	118

	Pooled variance estimate			Separate variance estimate			
F-value	2-tail prob	t value	degrees of freedom	2-tail prob	t value	degrees of freedom	2-tail prob
1.06	.521	-.59	614	.556	-.59	579.98	.554

Table 2.10.152 : AIDS Factor Four

	Number of cases	Mean	Standard Deviation	Standard Error
Half or more friends drink alcohol	354	8.8305	1.683	.089
Less than half friends drink alcohol	262	8.6565	1.570	.097

	Pooled variance estimate			Separate variance estimate			
F-value	2-tail prob	t value	degrees of freedom	2-tail prob	t value	degrees of freedom	2-tail prob
1.15	.232	1.31	614	.192	1.32	582.36	.188

Questionnaire Two - All

Table 2.10.153 : Drugs Factor One

	Number of cases	Mean	Standard Deviation	Standard Error
Half or more friends drink alcohol	381	12.2415	3.119	.160
Less than half friends drink alcohol	206	13.0049	3.213	.225

	Pooled variance estimate			Separate variance estimate			
F-value	2-tail prob	t value	degrees of freedom	2-tail prob	t value	degrees of freedom	2-tail prob
1.06	.620	-2.79	585	.005*	-2.77	404.53	.006

Table 2.10.154 : Drugs Factor Two

	Number of cases	Mean	Standard Deviation	Standard Error
Half or more friends drink alcohol	381	20.3806	2.516	.129
Less than half friends drink alcohol	206	20.6214	2.431	.170

	Pooled variance estimate			Separate variance estimate			
F-value	2-tail prob	t value	degrees of freedom	2-tail prob	t value	degrees of freedom	2-tail prob
1.37	.586	-1.16	585	.247	-1.18	427.53	.240

Table 2.10.155 : Drugs Factor Three

	Number of cases	Mean	Standard Deviation	Standard Error
Half or more friends drink alcohol	381	11.5046	1.978	.101
Less than half friends drink alcohol	206	11.5392	1.656	.116

	Pooled variance estimate			Separate variance estimate			
F-value	2-tail prob	t value	degrees of freedom	2-tail prob	t value	degrees of freedom	2-tail prob
1.42	.035	-.20	585	.841	-.21	481.96	.837

Table 2.10.156 : Drugs Factor Four

	Number of cases	Mean	Standard Deviation	Standard Error
Half or more friends drink alcohol	381	10.3622	2.858	.146
Less than half friends drink alcohol	206	10.2667	2.858	.200

	Pooled variance estimate			Separate variance estimate			
F-value	2-tail prob	t value	degrees of freedom	2-tail prob	t value	degrees of freedom	2-tail prob
1.00	1.000	.39	585	.694	.39	419.08	.694

Table 2.10.157 : AIDS Factor One

	Number of cases	Mean	Standard Deviation	Standard Error
Half or more friends drink alcohol	391	14.6803	4.345	.348
Less than half friends drink alcohol	206	14.6117	4.167	.292

	Pooled variance estimate			Separate variance estimate		
F-value	2-tail prob	t value	degrees of freedom	2-tail prob	t value	degrees of freedom	2-tail prob
1.09	.916	.19	595	.847	.20	439.37	.840

Table 2.10.158 : AIDS Factor Two

	Number of cases	Mean	Standard Deviation	Standard Error
Half or more friends drink alcohol	391	14.2551	2.153	.110
Less than half friends drink alcohol	206	13.8301	1.992	.139

	Pooled variance estimate			Separate variance estimate		
F-value	2-tail prob	t value	degrees of freedom	2-tail prob	t value	degrees of freedom	2-tail prob
1.17	.295	1.99	595	.234	1.92	443.45	.223

Table 2.10.159 : AIDS Factor Three

	Number of cases	Mean	Standard Deviation	Standard Error
Half or more friends drink alcohol	391	6.2520	1.310	.066
Less than half friends drink alcohol	206	6.1553	1.151	.081

	Pooled variance estimate			Separate variance estimate		
F-value	2-tail prob	t value	degrees of freedom	2-tail prob	t value	degrees of freedom	2-tail prob
1.31	.231*	.87	595	.385	.90	445.61	.366

Table 2.10.160 : AIDS Factor Four

	Number of cases	Mean	Standard Deviation	Standard Error
Half or more friends drink alcohol	391	4.7034	1.321	.068
Less than half friends drink alcohol	206	4.9757	1.253	.088

	Pooled variance estimate			Separate variance estimate		
F-value	2-tail prob	t value	degrees of freedom	2-tail prob	t value	degrees of freedom	2-tail prob
1.11	.400	-2.42	595	.016	-2.45	434.35	.014

Questionnaire One - Study Group

Table 2.10.161 : Drugs Factor One

	Number of cases	Mean	Standard Deviation	Standard Error
Half or more friends drink alcohol	283	13.4912	3.823	.227
Less than half friends drink alcohol	218	12.4725	3.281	.222

	Pooled variance estimate			Separate variance estimate		
F-value	2-tail prob	t value	degrees of freedom	2-tail prob	t value	degrees of freedom	2-tail prob
1.36	.018*	3.14	499	.002	3.21	493.15	.001*

Table 2.10.162 : Drugs Factor Two

	Number of cases	Mean	Standard Deviation	Standard Error
Half or more friends drink alcohol	283	21.4311	2.938	.175
Less than half friends drink alcohol	218	21.2339	3.304	.224

	Pooled variance estimate			Separate variance estimate		
F-value	2-tail prob	t value	degrees of freedom	2-tail prob	t value	degrees of freedom	2-tail prob
1.27	.264	.71	499	.481	.69	437.77	.488

Table 2.10.163 : Drugs Factor Three

	Number of cases	Mean	Standard Deviation	Standard Error
Half or more friends drink alcohol	283	17.2862	2.462	.158
Less than half friends drink alcohol	218	17.2569	2.462	.167

	Pooled variance estimate			Separate variance estimate			
F-value	2-tail prob.	t value	degrees of freedom	2-tail prob.	t value	degrees of freedom	2-tail prob.
1.16	.249	.13	499	.990	.13	497.98	.998

Table 2.10.164 : Drugs Factor Four

	Number of cases	Mean	Standard Deviation	Standard Error
Half or more friends drink alcohol	283	16.2933	2.352	.140
Less than half friends drink alcohol	218	16.2523	2.297	.156

	Pooled variance estimate			Separate variance estimate			
F-value	2-tail prob.	t value	degrees of freedom	2-tail prob.	t value	degrees of freedom	2-tail prob.
1.05	.774	.20	499	.845	.20	472.13	.845

Table 2.10.165 : AIDS Factor One

	Number of cases	Mean	Standard Deviation	Standard Error
Half or more friends drink alcohol	283	15.8198	4.534	.270
Less than half friends drink alcohol	218	15.0596	4.024	.273

	Pooled variance estimate			Separate variance estimate			
F-value	2-tail prob.	t value	degrees of freedom	2-tail prob.	t value	degrees of freedom	2-tail prob.
1.27	.064	1.95	499	.051	1.98	489.05	.048*

Table 2.10.166 : AIDS Factor Two

	Number of cases	Mean	Standard Deviation	Standard Error
Half or more friends drink alcohol	283	13.9894	1.996	.119
Less than half friends drink alcohol	218	13.9358	1.711	.116

	Pooled variance estimate			Separate variance estimate			
F-value	2-tail prob.	t value	degrees of freedom	2-tail prob.	t value	degrees of freedom	2-tail prob.
1.36	.019*	.32	499	.751	.32	497.20	.749

Table 2.10.167 : AIDS Factor Three

	Number of cases	Mean	Standard Deviation	Standard Error
Half or more friends drink alcohol	283	6.5018	1.308	.077
Less than half friends drink alcohol	218	6.3532	1.351	.091

	Pooled variance estimate			Separate variance estimate			
F-value	2-tail prob.	t value	degrees of freedom	2-tail prob.	t value	degrees of freedom	2-tail prob.
1.07	.570	1.25	499	.216	1.24	468.19	.216

Table 2.10.168 : AIDS Factor Four

	Number of cases	Mean	Standard Deviation	Standard Error
Half or more friends drink alcohol	283	5.2408	1.257	.075
Less than half friends drink alcohol	218	5.0642	1.084	.073

	Pooled variance estimate			Separate variance estimate			
F-value	2-tail prob.	t value	degrees of freedom	2-tail prob.	t value	degrees of freedom	2-tail prob.
1.42	.006*	1.67	499	.096	1.70	491.99	.090

Questionnaire Two - Study Group

Table 2.10.169 : Drugs Factor One

	Number of cases	Mean	Standard Deviation	Standard Error
Half or more friends drink alcohol	306	11.9967	3.709	.213
Less than half friends drink alcohol	158	12.1519	3.516	.280

		Pooled variance estimate			Separate variance estimate		
F-value	2-tail prob.	t value	degrees of freedom	2-tail prob.	t value	degrees of freedom	2-tail prob.
1.11	.452	.43	460	.664	.44	333.61	.659

Table 2.10.170 : Drugs Factor Two

	Number of cases	Mean	Standard Deviation	Standard Error
Half or more friends drink alcohol	306	12.2730	3.127	.179
Less than half friends drink alcohol	158	12.8165	3.095	.246

		Pooled variance estimate			Separate variance estimate		
F-value	2-tail prob.	t value	degrees of freedom	2-tail prob.	t value	degrees of freedom	2-tail prob.
1.02	.934	-1.78	460	.076	-1.78	330.97	.075

Table 2.10.171 : Drugs Factor Three

	Number of cases	Mean	Standard Deviation	Standard Error
Half or more friends drink alcohol	306	15.4608	2.398	.138
Less than half friends drink alcohol	158	15.274	1.900	.151

		Pooled variance estimate			Separate variance estimate		
F-value	2-tail prob.	t value	degrees of freedom	2-tail prob.	t value	degrees of freedom	2-tail prob.
1.59	.001*	.49	460	.627	.52	317.20	.601

Table 2.10.172 : Drugs Factor Four

	Number of cases	Mean	Standard Deviation	Standard Error
Half or more friends drink alcohol	306	13.8191	3.399	.195
Less than half friends drink alcohol	158	13.5570	3.233	.257

		Pooled variance estimate			Separate variance estimate		
F-value	2-tail prob.	t value	degrees of freedom	2-tail prob.	t value	degrees of freedom	2-tail prob.
1.11	.481	.80	460	.424	.81	333.18	.419

Table 2.10.173 : AIDS Factor One

	Number of cases	Mean	Standard Deviation	Standard Error
Half or more friends drink alcohol	306	15.0954	5.020	.288
Less than half friends drink alcohol	158	14.7532	4.398	.350

		Pooled variance estimate			Separate variance estimate		
F-value	2-tail prob.	t value	degrees of freedom	2-tail prob.	t value	degrees of freedom	2-tail prob.
1.30	.063	.77	460	.469	.76	354.61	.451

Table 2.10.174 : AIDS Factor Two

	Number of cases	Mean	Standard Deviation	Standard Error
Half or more friends drink alcohol	306	14.3648	2.084	.170
Less than half friends drink alcohol	158	14.3671	1.953	.155

		Pooled variance estimate			Separate variance estimate		
F-value	2-tail prob.	t value	degrees of freedom	2-tail prob.	t value	degrees of freedom	2-tail prob.
1.14	.361	.00	460	.999	.00	314.76	.999

Table 2.10.175 : AIDS Factor Three

	Number of cases	Mean	Standard Deviation	Standard Error
Half or more friends drink alcohol	306	10.4112	1.366	078
Less than half friends drink alcohol	158	10.3608	1.353	108

		Pooled variance estimate		Separate variance estimate		
F-value	2-tail prob	t value	degrees of freedom	2-tail prob	t value	degrees of freedom	2-tail prob
[illegible]	[illegible]	19	660	699	65	143.13	691

Questionnaire One - Control Group

Table 2.10.176 : Drugs Factor One

	Number of cases	Mean	Standard Deviation	Standard Error
Half or more friends drink alcohol	71	13.6356	2.670	293
Less than half friends drink alcohol	44	13.1918	2.518	380

		Pooled variance estimate		Separate variance estimate		
F-value	2-tail prob	t value	degrees of freedom	2-tail prob	t value	degrees of freedom	2-tail prob
1.04	877	89	113	377	88	99.93	379

Table 2.10.177 : Drugs Factor Two

	Number of cases	Mean	Standard Deviation	Standard Error
Half or more friends drink alcohol	71	14.5493	1.984	236
Less than half friends drink alcohol	44	14.4773	1.607	242

		Pooled variance estimate		Separate variance estimate		
F-value	2-tail prob	t value	degrees of freedom	2-tail prob	t value	degrees of freedom	2-tail prob
1.53	138	20	113	840	21	105.35	832

Table 2.10.178 : Drugs Factor Three

	Number of cases	Mean	Standard Deviation	Standard Error
Half or more friends drink alcohol	71	9.5775	2.234	265
Less than half friends drink alcohol	44	10.8408	2.220	335

		Pooled variance estimate		Separate variance estimate		
F-value	2-tail prob	t value	degrees of freedom	2-tail prob	t value	degrees of freedom	2-tail prob
1.01	381	-2.95	113	004*	2.36	11.**	3**

Table 2.10.179 : Drugs Factor Four

	Number of cases	Mean	Standard Deviation	Standard Error
Half or more friends drink alcohol	71	14.5070	2.546	302
Less than half friends drink alcohol	44	14.5908	2.356	355

		Pooled variance estimate		Separate variance estimate		
F-value	2-tail prob	t value	degrees of freedom	2-tail prob	t value	degrees of freedom	2-tail prob
1.17	590	-.18	113	860	-.18	94.67	858

Table 2.10.180 : AIDS Factor One

	Number of cases	Mean	Standard Deviation	Standard Error
Half or more friends drink alcohol	71	7.6338	2.451	291
Less than half friends drink alcohol	44	7.5682	2.307	348

		Pooled variance estimate		Separate variance estimate		
F-value	2-tail prob	t value	degrees of freedom	2-tail prob	t value	degrees of freedom	2-tail prob
1.13	677	14	113	887	14	95.50	885

Table 2.10.181 : AIDS Factor Two

	Number of cases	Mean	Standard Deviation	Standard Error
Half or more friends drink alcohol	71	18.6479	2.385	.359
Less than half friends drink alcohol	66	18.5682	2.089	.386

	Pooled variance estimate			Separate variance estimate		
F-value	2-tail prob	t value	degrees of freedom	2-tail prob	t value	degrees of freedom	2-tail prob
.116	.478	.141	135	.445	.141	134.47	.443

Table 2.10.182 : AIDS Factor Three

	Number of cases	Mean	Standard Deviation	Standard Error
Half or more friends drink alcohol	71	6.3944	1.459	.173
Less than half friends drink alcohol	66	6.6667	1.663	.205

	Pooled variance estimate			Separate variance estimate		
F-value	2-tail prob	t value	degrees of freedom	2-tail prob	t value	degrees of freedom	2-tail prob
1.30	.979	-.95	135	.347	-.94	91.13	.347

Table 2.10.183 : AIDS Factor Four

	Number of cases	Mean	Standard Deviation	Standard Error
Half or more friends drink alcohol	71	8.5915	1.883	.218
Less than half friends drink alcohol	66	8.2500	1.527	.206

	Pooled variance estimate			Separate variance estimate		
F-value	2-tail prob	t value	degrees of freedom	2-tail prob	t value	degrees of freedom	2-tail prob
1.64	.202	1.09	135	.276	1.08	128.42	.283

Questionnaire Two - Control Group

Table 2.10.184 : Drugs Factor One

	Number of cases	Mean	Standard Deviation	Standard Error
Half or more friends drink alcohol	77	16.6623	2.873	.327
Less than half friends drink alcohol	66	16.6739	3.013	.444

	Pooled variance estimate			Separate variance estimate		
F-value	2-tail prob	t value	degrees of freedom	2-tail prob	t value	degrees of freedom	2-tail prob
1.370	.976	.02	121	.983	-.02	91.26	.981

Table 2.10.185 : Drugs Factor Two

	Number of cases	Mean	Standard Deviation	Standard Error
Half or more friends drink alcohol	77	12.1169	3.108	.354
Less than half friends drink alcohol	66	13.6522	3.568	.523

	Pooled variance estimate			Separate variance estimate		
F-value	2-tail prob	t value	degrees of freedom	2-tail prob	t value	degrees of freedom	2-tail prob
1.31	.301	2.52	121	.013*	-2.43	95.02	.017

Table 2.10.186 : Drugs Factor Three

	Number of cases	Mean	Standard Deviation	Standard Error
Half or more friends drink alcohol	77	12.9870	2.010	.229
Less than half friends drink alcohol	66	13.5455	2.354	.347

	Pooled variance estimate			Separate variance estimate		
F-value	2-tail prob	t value	degrees of freedom	2-tail prob	t value	degrees of freedom	2-tail prob
1.37	.227	-1.39	121	.166	-1.34	83.36	.185

Table 2.10.187 : Drugs Factor Four

	Number of cases	Mean	Standard Deviation	Standard Error
Half or more friends drink alcohol	77	12.7013	2.389	.260
Less than half friends drink alcohol	46	13.1739	2.196	.323

	Pooled variance estimate			Separate variance estimate		
F-value	2-tail prob	t value	degrees of freedom	2-tail prob	t value	degrees of freedom	2-tail prob
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]

Table 2.10.188 : AIDS Factor One

	Number of cases	Mean	Standard Deviation	Standard Error
Half or more friends drink alcohol	77	[illegible]	2.335	.266
Less than half friends drink alcohol	46	9.3696	2.457	.355

	Pooled variance estimate			Separate variance estimate		
F-value	2-tail prob	t value	degrees of freedom	2-tail prob	t value	degrees of freedom	2-tail prob
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]

Table 2.10.189 : AIDS Factor Two

	Number of cases	Mean	Standard Deviation	Standard Error
Half or more friends drink alcohol	77	10.1766	2.090	.238
Less than half friends drink alcohol	46	17.6087	2.353	.366

	Pooled variance estimate			Separate variance estimate		
F-value	2-tail prob	t value	degrees of freedom	2-tail prob	t value	degrees of freedom	2-tail prob
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]

Table 2.10.190 : AIDS Factor Three

	Number of cases	Mean	Standard Deviation	Standard Error
Half or more friends drink alcohol	77	9.9052	2.833	.323
Less than half friends drink alcohol	46	10.5435	2.277	.336

	Pooled variance estimate			Separate variance estimate		
F-value	2-tail prob	t value	degrees of freedom	2-tail prob	t value	degrees of freedom	2-tail prob
1.55	.115	1.50	121	.136	1.50	110.46	.116

Table 2.10.191 : AIDS Factor Four

	Number of cases	Mean	Standard Deviation	Standard Error
Half or more friends drink alcohol	77	8.4156	1.533	.175
Less than half friends drink alcohol	46	8.3478	1.479	.218

	Pooled variance estimate			Separate variance estimate		
F-value	2-tail prob	t value	degrees of freedom	2-tail prob	t value	degrees of freedom	2-tail prob
1.07	.905	.24	121	.811	.24	97.54	.970

FACTOR SCORES AND SOURCES OF INFORMATION

Those rating formal sources highest (parents, teachers, doctors, police) = Group 2
Those rating informal sources highest (siblings, friends, older boys and girls, people who take drugs, people who used to be addicts)

First Questionnaire

Factor scores for those trusting formal sources of information about drug use most compared with those trusting informal sources most

Table 2.10.192 : Drugs Factor One

	Number of cases	Mean	Standard deviation	Standard error
Group1	105	13.1238	3.060	.307
Group2	484	12.6798	3.455	.158

	Pooled Variance Estimate			Separate Variance Estimate		
F value	2-tail prob	t-value	degrees of freedom	2-tail prob	t-value	degrees of freedom	2-tail prob
1.14	.715	.97	587	.332	.96	137.17	.338

Table 2.10.193 : Drug Factor Two

	Number of cases	Mean	Standard deviation	Standard error
Group1	105	12.6762	3.351	.298
Group2	484	12.8223	3.360	.134

	Pooled Variance Estimate			Separate Variance Estimate		
F value	2-tail prob	t-value	degrees of freedom	2-tail prob	t-value	degrees of freedom	2-tail prob
1.007	.681	-.43	587	.670	-.43	149.11	.671

Table 2.10.194 : Drug Factor Three

	Number of cases	Mean	Standard deviation	Standard error
Group1	105	15.6286	2.300	.232
Group2	484	15.8161	2.285	.103

	Pooled Variance Estimate			Separate Variance Estimate		
F value	2-tail prob	t-value	degrees of freedom	2-tail prob	t-value	degrees of freedom	2-tail prob
1.27	.287	-.81	587	.361	-.77	138.87	.440

Table 2.10.195 : AIDS Factor One

	Number of cases	Mean	Standard deviation	Standard error
Group1	105	12.7429	4.301	.420
Group2	484	13.5248	3.672	.144

	Pooled Variance Estimate			Separate Variance Estimate		
F value	2-tail prob	t-value	degrees of freedom	2-tail prob	t-value	degrees of freedom	2-tail prob
1.37	.015	1.94	587	.052	1.74	137.17	.085

Table 2.10.196 : AIDS Factor Two

	Number of cases	Mean	Standard deviation	Standard error
Group1	105	14.0667	2.132	.208
Group2	484	14.3636	1.762	.080

	Pooled Variance Estimate			Separate Variance Estimate		
F value	2-tail prob	t-value	degrees of freedom	2-tail prob	t-value	degrees of freedom	2-tail prob
1.46	.009	-1.2	587	.906	-1.0	114.49	.317

Table 2.10.197 : AIDS Factor Three

	Number of cases	Mean	Standard deviation	Standard error
Group1	105	6.3619	1.360	.133
Group2	484	6.4380	1.301	.059

	Pooled Variance Estimate			Separate Variance Estimate		
F value	2-tail prob	t-value	degrees of freedom	2-tail prob	t-value	degrees of freedom	2-tail prob
1.09	.537	.54	587	.590	.52	148.14	.601

Table 2.10.198 : AIDS Factor Four

	Number of cases	Mean	Standard deviation	Standard error
Group1	[illegible]	[illegible]	[illegible]	[illegible]
Group2	[illegible]	[illegible]	[illegible]	[illegible]

	Pooled Variance Estimate			Separate Variance Estimate		
F value	2-tail prob	t-value	degrees of freedom	2-tail prob	t-value	degrees of freedom	2-tail prob
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]

Factor scores for those trusting formal sources of information about HIV most compared with those trusting informal sources most

Table 2.10.199 : Drugs Factor One

	Number of cases	Mean	Standard deviation	Standard error
Group1	[illegible]	[illegible]	[illegible]	[illegible]
Group2	[illegible]	[illegible]	[illegible]	[illegible]

	Pooled Variance Estimate			Separate Variance Estimate		
F value	2-tail prob	t-value	degrees of freedom	2-tail prob	t-value	degrees of freedom	2-tail prob
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]

Table 2.10.200 : Drug Factor Two

	Number of cases	Mean	Standard deviation	Standard error
Group1	[illegible]	[illegible]	[illegible]	[illegible]
Group2	[illegible]	[illegible]	[illegible]	[illegible]

	Pooled Variance Estimate			Separate Variance Estimate		
F value	2-tail prob	t-value	degrees of freedom	2-tail prob	t-value	degrees of freedom	2-tail prob
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]

Table 2.10.201 : Drug Factor Three

	Number of cases	Mean	Standard deviation	Standard error
Group1	[illegible]	[illegible]	[illegible]	[illegible]
Group2	[illegible]	[illegible]	[illegible]	[illegible]

	Pooled Variance Estimate			Separate Variance Estimate		
F value	2-tail prob	t-value	degrees of freedom	2-tail prob	t-value	degrees of freedom	2-tail prob
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]

Table 2.10.202 : AIDS Factor One

	Number of cases	Mean	Standard deviation	Standard error
Group1	12	12.5833	3.919	1.131
Group2	492	13.5407	3.671	.166

	Pooled Variance Estimate			Separate Variance Estimate		
F value	2-tail prob	t-value	degrees of freedom	2-tail prob	t-value	degrees of freedom	2-tail prob
1.14	.656	-.99	502	.373	-.94	11.48	.419

Table 2.10.203 : AIDS Factor Two

	Number of cases	Mean	Standard deviation	Standard error
Group1	12	14.5667	1.949	.549
Group2	492	13.9756	1.912	.182

	Pooled Variance Estimate			Separate Variance Estimate		
F value	2-tail prob	t-value	degrees of freedom	2-tail prob	t-value	degrees of freedom	2-tail prob
1.19	.594	1.30	502	.193	1.20	11.46	.253

Table 2.10.204 : AIDS Factor Three

	Number of cases	Mean	Standard deviation	Standard error
Group1	12	6.2500	1.357	.392
Group2	492	6.6481	1.317	.059

	Pooled Variance Estimate			Separate Variance Estimate		
F value	2-tail prob	t-value	degrees of freedom	2-tail prob	t-value	degrees of freedom	2-tail prob
1.06	.782	-.51	502	.613	.49	11.51	.632

Table 2.10.205 : AIDS Factor Four

	Number of cases	Mean	Standard deviation	Standard error
Group1	12	5.1667	.937	.271
Group2	492	5.1524	1.144	.052

	Pooled Variance Estimate			Separate Variance Estimate		
F value	2-tail prob	t-value	degrees of freedom	2-tail prob	t-value	degrees of freedom	2-tail prob
1.54	.425	.04	502	.967	.05	11.54	.960

Second Questionnaire

Factor scores for those trusting formal sources of information about drug use most compared with those trusting informal sources most

Table 2.10.206 : Drugs Factor One

	Number of cases	Mean	Standard deviation	Standard error
Group1	118	-.1682	.891	.082
Group2	454	.0463	.799	.045

	Pooled Variance Estimate			Separate Variance Estimate		
F value	2-tail prob	t-value	degrees of freedom	2-tail prob	t-value	degrees of freedom	2-tail prob
1.16	.181	-1.97	570	.049	-1.72	169.19	.085

Table 2.10.207 : Drugs Factor Two

	Number of cases	Mean	Standard deviation	Standard error
Group1	118	.35842	2.783	.256
Group2	454	-.08787	2.619	.123

	Pooled Variance Estimate			Separate Variance Estimate		
F value	2-tail prob	t-value	degrees of freedom	2-tail prob	t-value	degrees of freedom	2-tail prob
1.19	.781	1.36	570	.176	1.35	168.27	.195

Table 2.10.208 : Drugs Factor Three

	Number of cases	Mean	Standard deviation	Standard error
Group1	118	.15.3529	2.364	.216
Group2	454	-.05859	2.791	.131

	Pooled Variance Estimate			Separate Variance Estimate		
F value	2-tail prob	t-value	degrees of freedom	2-tail prob	t-value	degrees of freedom	2-tail prob
1.16	.316	-1.17	570	.242	-1.13	179.60	.262

Table 2.10.209 : Drugs Factor Four

	Number of cases	Mean	Standard deviation	Standard error
Group1	118	11.8305	2.354	.208
Group2	454	11.5600	2.343	.110

	Pooled Variance Estimate			Separate Variance Estimate		
F value	2-tail prob	t-value	degrees of freedom	2-tail prob	t-value	degrees of freedom	2-tail prob
1.28	.422	1.09	570	.276	1.12	187.78	.265

Table 2.10.210 : AIDS Factor One

	Number of cases	Mean	Standard deviation	Standard error
Group1	118	8.5000	2.794	.257
Group2	454	9.5506	3.156	.159

	Pooled Variance Estimate			Separate Variance Estimate		
F value	2-tail prob	t-value	degrees of freedom	2-tail prob	t-value	degrees of freedom	2-tail prob
1.44	.017	-3.13	572	.002	3.48	231.72	.001

Table 2.10.211 : AIDS Factor Two

	Number of cases	Mean	Standard deviation	Standard error
Group1	118	9.6695	1.460	.134
Group2	454	9.8136	1.760	.083

	Pooled Variance Estimate			Separate Variance Estimate		
F value	2-tail prob	t-value	degrees of freedom	2-tail prob	t-value	degrees of freedom	2-tail prob
1.09	.521	-.79	572	.433	-.77	174.61	.445

Table 2.10.212 : AIDS Factor Three

	Number of cases	Mean	Standard deviation	Standard error
Group1	118	10.2627	1.342	.124
Group2	454	10.3794	1.330	.062

	Pooled Variance Estimate			Separate Variance Estimate		
F value	2-tail prob	t-value	degrees of freedom	2-tail prob	t-value	degrees of freedom	2-tail prob
1.02	.879	-.95	572	.397	-.94	181.77	.400

Table 2.10.213 : AIDS Factor Four

	Number of cases	Mean	Standard deviation	Standard error
Group1	118	5.5847	1.761	.140
Group2	454	6.0639	1.623	.076

	Pooled Variance Estimate			Separate Variance Estimate		
F value	2-tail prob	t-value	degrees of freedom	2-tail prob	t-value	degrees of freedom	2-tail prob
1.18	.320	-2.70	572	.007	-2.58	179.11	.010

Factor scores for those trusting formal sources of information about HIV most compared with those trusting informal sources most

Table 2.10.214 : Drugs Factor One

	Number of cases	Mean	Standard deviation	Standard error
Group1	13	12.9462	6.260	1.736
Group2	666	11.7648	3.177	.144

	Pooled Variance Estimate		Separate Variance Estimate			
F value	2-tail prob	t-value	degrees of freedom	2-tail prob	t-value	degrees of freedom	2-tail prob
3.49	.000	2.11	677	.035	1.38	12.36	.194

Table 2.10.215 : Drugs Factor Two

	Number of cases	Mean	Standard deviation	Standard error
Group1	13	11.9970	2.879	.798
Group2	666	10.7696	2.439	.095

	Pooled Variance Estimate		Separate Variance Estimate			
F value	2-tail prob	t-value	degrees of freedom	2-tail prob	t-value	degrees of freedom	2-tail prob
1.35	.239	1.49	677	.136	2.27	12.50	.043

Table 2.10.216 : Drugs Factor Three

	Number of cases	Mean	Standard deviation	Standard error
Group1	13	15.3077	3.750	1.040
Group2	666	15.6760	2.112	.082

	Pooled Variance Estimate		Separate Variance Estimate			
F value	2-tail prob	t-value	degrees of freedom	2-tail prob	t-value	degrees of freedom	2-tail prob
3.15	.220	.60	677	.546	-.35	12.27	.730

Table 2.10.217 : Drugs Factor Four

	Number of cases	Mean	Standard deviation	Standard error
Group1	13	12.5385	1.854	.514
Group2	666	11.5180	2.307	.089

	Pooled Variance Estimate		Separate Variance Estimate			
F value	2-tail prob	t-value	degrees of freedom	2-tail prob	t-value	degrees of freedom	2-tail prob
1.54	.430	1.68	677	.160	1.91	13.05	.393

Table 2.10.218 : AIDS Factor One

	Number of cases	Mean	Standard deviation	Standard error
Group1	13	9.5385	2.672	.722
Group2	666	9.5139	3.248	.151

	Pooled Variance Estimate		Separate Variance Estimate			
F value	2-tail prob	t-value	degrees of freedom	2-tail prob	t-value	degrees of freedom	2-tail prob
1.58	.372	1.06	677	.287	1.32	13.08	.208

Table 2.10.219 : AIDS Factor Two

	Number of cases	Mean	Standard deviation	Standard error
Group1	13	9.9462	2.230	.619
Group2	666	9.9385	1.796	.070

	Pooled Variance Estimate		Separate Variance Estimate			
F value	2-tail prob	t-value	degrees of freedom	2-tail prob	t-value	degrees of freedom	2-tail prob
1.54	.210	.03	677	.975	.03	12.46	.980

Table 2.10.220 : AIDS Factor Three

	Number of cases	Mean	Standard deviation	Standard error
Group1	13	9.8462	2.230	.619
Group2	666	9.8305	1.796	.070

	Pooled Variance Estimate		Separate Variance Estimate			
F value	2-tail prob	t-value	degrees of freedom	2-tail prob	t-value	degrees of freedom	2-tail prob
1.54	.210	.03	677	.975	.03	12.46	.980

Table 2.10.221 : AIDS Factor Four

	Number of cases	Mean	Standard deviation	Standard error
Group1	13	6.6923	1.750	.485
Group2	666	6.0837	1.641	.064

	Pooled Variance Estimate		Separate Variance Estimate			
F value	2-tail prob	t-value	degrees of freedom	2-tail prob	t-value	degrees of freedom	2-tail prob
1.14	.653	1.32	677	.189	1.74	12.60	.218