Supportive Counseling for HIV-Infected Drug Using Women
Gillian Walker, ACSW

Until recently, most drug users have been men, and their non-drug-using female partners have functioned as the glue that kept their families together, sheltering as best they could the next generation, often suffering abuse in the process. Today, 60 percent of crack users are women, the majority of whom are mothers of small children and the heads of single-parent households. New York City reported a 400 percent increase in maternal drug use in the period 1984 to 1989, the bulk of which was the result of maternal crack and cocaine use. It is estimated that more than half of all drug-using women in the major epicenters of the eastern United States are HIV-infected, and drug use among women is correlated to unprotected sex, injection drug use, and needle sharing.

Given the public health crisis of HIV disease, it has become clear that all drug programs should target “harm reduction” rather than the unreachable goal of eliminating drug use. Harm reduction seeks to maximize functioning with the understanding that drugs may continue to play a role in the person’s life. By focusing on increasing the drug user’s ability to carry out social responsibilities rather than focusing on drug addiction per se, harm reduction defines attainable goals and circumvents the cycle of failure that drives a huge percentage of people out of drug treatment. Because a woman’s self-esteem depends primarily on how she perceives herself in relationships, non-blaming approaches such as harm reduction are particularly effective in reaching women. This article proposes an alternative approach that incorporates harm reduction and outlines a case management approach that fosters support by building family relationships.

Why Women Use Drugs
For both sexes, drugs may be used for pleasure or to provide medication from states of depression, anxiety, restlessness, and agitation. In poor communities, men may use drugs to gain power, material possessions, or prestige. By contrast, a woman’s initiation into drugs often follows rape, domestic violence, incest, or other traumatizing events including accidents, physical illnesses, or tragic losses. Drug use for women may also be connected to a relationship, as a means of capturing, pleasing, or holding onto a partner, or of managing the degradation of being in a violent relationship. Relapse for women seems to be correlated with experiences that invoke repressed memories of trauma.

In response to drug use, women experience higher levels of guilt, shame, depression, and anxiety than men—a finding that is explained by new research showing that a woman’s identity is predicated on her ability to maintain relationships. When drug use severs family connections and interrupts a woman’s ability to nurture her family, it has a devastating effect on her fundamental self-esteem. By contrast, drug use may evoke for a man, at least initially, a sense of macho power.

Unlike heroin, which sedates and narcotizes psychic pain, crack instills an illusion of power. In response to this illusion, drug treatment must help women find authoritative and authentic voices and rebuild their lives so that they are supported by webs of meaningful, non-oppressive relationships.

Drug Treatment, Autonomy, and Connection
Drug treatment strategies have been influenced by male psychological approaches, which associate maturity with autonomy...
Women and men—it’s no surprise that they’re different and that these differences permeate everything from relationship patterns to medical care. But, while differences may be minimized by custom, habit, and socialization, and by a breaking down of traditional sex roles and sex role stereotypes, fundamental psychological distinctions become prominent when people hit bottom. Recent research has made it clear that inherent and socialized gender differences make it necessary to develop different substance abuse treatment approaches for men and women.

In this issue of FOCUS, two experts consider these differences. Gillian Walker characterizes the foundation of traditional substance abuse treatment as the belief that autonomy and independence lead to maturity and separation from family leads to adult identity. While this philosophical underpinning has proven effective for some men in recovery, it has been less applicable to women. Women define a sense of self and self-worth differently: they are more likely to define themselves in terms of their ability to build and maintain relationships with others. In the second article in this issue, Suzanne Ostermann traces the foundations of these approaches during the 20th century from the founding of Alcoholics Anonymous to federal government funding.

The contrast between the two approaches is compelling. The needs of male substance abusers—and the programs that have been designed to effectively usher them through recovery—contradict the needs of many women. The failure is two-fold. First, these programs do not acknowledge the striking psychological differences between men and women. Second, government funding has skewed those programs that do actually consider the needs of women to focus on pregnant women and women with children. While many women with HIV disease fall into these categories, programs that focus on this relationship risk overlooking the needs of the individuals in these relationships, primarily the women.

This issue is particularly fascinating not simply because it pinpoints a critical challenge for many women with HIV disease, but also because it shows how therapeutic strategies developed irrespective of gender differences can sabotage themselves. Just because something works for men does not mean it will work for women.

and independence, and adult identity with separation from family of origin. These models define maturity in terms of self-sufficiency rather than as the capacity for attachment and the commitment to navigating difficult relationships. Drug treatment typically separates drug users from family and street associates to create the space and time necessary to develop an autonomous self and to eliminate behaviors that are seen as infantile, irresponsible, and powerfully reinforced by drug use.

Feminist psychologists like Carol Gilligan assert the importance of relationships in the psychology of women. They believe that girls form a sense of self, self-worth, and feminine identity through the ability to build and maintain relationships with others. By contrast, boys are occupied by issues of differentiation and action in the external world, repressing their relational capacities in order to become male. These theorists suggest that the mother-daughter relationship is critical to the psychological well-being of women of all races, a relationship that is replicated in the mothering of the next generation. It is this relationship that is most vulnerable to fracturing by the male psychological approaches that inform most drug treatment programs.

Gilligan goes on to propose that these differences are so basic as to affect moral decision-making. Men make moral judgments on the basis of “justice” as defined by rules, while women make judgments based on the obligations of interpersonal connection. From this “care” perspective, rules may be violated to honor the demands of relationships. To maintain order and achieve the goal of abstinence, drug treatment programs usually emphasize justice over care. The drug user is perceived as a potential manipulator who, if not watched closely, will subvert treatment goals by playing on feelings of care and compassion. Treatment often involves coercive and shaming corrective interventions—including rejection, sign-wearing, prescribed haircuts, group confrontations of attitude and behavior—to identify and eradicate negative behaviors thought to be associated with immaturity and continuing susceptibility to drug use. These interventions are particularly destructive for women drug users in treatment.

Children and Affirming Relationships
Children may be the strongest and most loving attachment for drug-using women, an attachment that is filled with hope for a better future. Although there has been
an increase in the number of treatment programs for women with children, there remains a critical shortage, and few programs take advantage of the powerful motivating factor inherent in the mother-child bond. As a result, there are few treatment options appropriate for women who are pregnant or have young children. The absence of appropriate treatment slots for crack-using mothers poses an impossible choice for these women: losing their children if they seek treatment or risking neglect and state intervention if they do not. The psychological damage of these dislocations for both mother and children is severe. In all of this, it is crucial to remember that many drug-using women are able, with the support of their families, to be, in the famous phrase of the British psychoanalyst Donald Woods Winnicott, "a good enough mother," even though they use drugs. When both a woman and her partner use drugs, she risks separation not only from her children, but also from her partner, which may cost her economic or social support, aspects that are frequently obscured when drug-using behavior is seen as the central dynamic in the relationship.

Drug treatment for women should seek to be: empowering; family-centered; caregiving, that is, helping women to feel genuinely cared for; and liberating, that is, providing opportunities for self-development, employment, and education to balance traditional caretaking roles. By nurturing the bonds between clients and their families, therapy centers on supporting behaviors that develop the "self-in-connection" rather than working to achieve insight or to confront problematic behaviors. An eco-systemic approach is a tool in this process. It is essentially a resource model that seeks to identify and utilize strengths in both the person with the identified "problems" and members of his or her intimate network. One approach, network therapy, which has been used extensively in the care of people with HIV disease, largely bypasses traditional ongoing professional input by identifying family leaders and coaching them to become family problem-solvers who organize the family to support a family member who is ill or in trouble. Effective programs such as the Women's Center at Montefiore Hospital—an outreach and drug treatment center for HIV-infected women in the Bronx—create women's networks where ex-drug using women reach out to other women and to their families and even to their partners. Staffed by licensed practitioners and HIV-infected women who have used drugs, the Women's Center fosters a non-punitive atmosphere, the promise of rebuilding family life and opening opportunities for education and work while not insisting on separating women from their children in order to obtain drug treatment. The staff emphasize education, vocational training, and parenting abilities. If a woman returns to drug use, she is not dropped from the program nor does she have to jump through hoops to return. Rather, staff members regard recidivism as a crisis requiring increased outreach to the woman and her family.

**Michelle and Andrea**

Consider the true story of Andrea and Michelle (not their real names), an African-American lesbian couple referred for couples counseling while in drug treatment. Each has a history of drug use that goes back to adolescence and has been the victim of incest. Michelle is 30-years-old, HIV-infected, has 10 children, all of whom are in some form of foster care, and has battled depression and suicidal ideation. Andrea, 33-years-old, is childless. Michelle and Andrea fall in love while in treatment and make a pact to get Michelle's children out of foster care and make a home for them. Michelle and Andrea are referred for couples counseling by their drug treatment counselor who follows her instincts and breaks the rules. The counselor intuits that the relationship between these two women—while forbidden in treatment—is a solid one that is crucial to building self-esteem, the basis of recovery. In Gilligan's terms, the counselor uses a care rather than a justice approach to moral reasoning. Shortly after starting couples work, Michelle and Andrea leave the program and move in together.

As Michelle has lost each child to the system, she fills the loss with another pregnancy. Becoming a mother enacts the fantasy that Michelle will ultimately be mothered by her children. It is easy to be disturbed by what seems to be selfish irresponsibility when drug-using women say they want a baby because it is something that "is really mine." For these women who live in a world of torn relationships, however, becoming pregnant is an attempt to create a sense of identity predicated both on the societal respect for mothering and

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**References**


on the intuitive understanding that the mother-child relationship is central to a woman’s development of a sense of self. The destruction of effective and supportive connections with her children increasingly weakens Michelle’s sense of self.

HIV infection is the final—one could say, inevitable—shame. Yet paradoxically, it is HIV that motivates Michelle to find a way to raise her children. For Michelle as for many women whose lives are foreshortened by HIV disease, her children are a promise of life and the future. She wants to build for them a solid home and to leave them with a woman she loves rather than to the vicissitudes of the foster care system.

Couples therapy outside the recovery program capitalizes on the ability of each partner to support the other. Unlike drug treatment counselors, whom Michelle sees as confrontational and overwhelmingly negative, Andrea recognizes each small success, thereby countering Michelle’s long-standing feelings of hopelessness. Andrea’s redemptive love builds Michelle’s sense of self-in-connection by creating the first bond that she can trust. The support the women give each other is mutual. As a child, because no one cared what happened to Andrea at school or at home, she grew up illiterate. “One day instead of holding it in, I asked Michelle to help me with my reading. And it was no problem. She takes her time with me.” In addition to cementing their own relationship, Michelle and Andrea seek to gain the support of their extended family networks, knowing this is necessary to create the system that will permit them to raise children in the face of HIV disease.

Since Michelle and Andrea have gone against received drug treatment wisdom by leaving an in-patient program in order to live together and raise Michelle’s children, the therapist must deal with the issue of how relapse can be handled in a non-structured environment. The therapist’s message is that a lapse is not the end of the world, unless the drug user allows guilt and shame to undermine her sense that she is making real gains in increased ability to assume responsibility for work and child-care. Contrary to the beliefs of most drug treatment programs, studies have shown that a large number of active heroin users are able to hold jobs and take family responsibilities. Reducing the anxiety about relapse, and reassuring them that the therapist will be accepting rather than punitive if that should occur, actually seems to help Andrea and Michelle maintain their resolve not to return to drug use.

Conclusion

Michelle and Andrea had to leave their drug treatment program in order to achieve these goals, but it is possible to design programs that meet the needs of HIV-infected women with children. The community formed by women in the Women’s Center at Montefiore Hospital, for example, provides a remarkable support system for women, and was the model for intervention that the case of Michelle and Andrea exemplifies.

Michelle and Andrea’s story shows that often, counseling need only provide a supportive environment for clients to focus on solutions and muster their inner resources. It sounds a lot like a fairy tale, but this story is true. The partners seem exceptional only because they were given a chance through therapy to harness a powerful impulse to acknowledge and develop supportive relationships. Through their love for each other and for Michelle’s children, their willingness to reconnect with their parents, and the sustenance of the African-American community and church, they were able to maintain sobriety and respond to HIV disease.

Clearinghouse: Women and Drugs

References


Authors

Gillian Walker, ACSW was the Co-Director of the AIDS and Families Program of the Ackerman Institute in New York from 1985 to 1991. She is the author of In the Midst of Winter: Systemic Family Therapy with Individuals, Couples and Families with AIDS (W.W. Norton, 1991).
HIV disease and substance abuse are inextricably linked particularly among women. Beyond the obvious fact that substance-related contexts represent the greatest risk of HIV infection for women, chemical dependency and HIV-specific services for women follow a parallel history. As has been true for HIV disease, chemical dependency has been viewed as a condition that primarily afflicts men. Eventually acknowledged but still viewed as exceptions, both HIV-infected and chemically dependent women have had to access information and services that have been designed for men. Ironically, in both arenas, even after lengthy battles to develop women-specific services, women have received attention most often when the health and welfare of children are an issue.

The Roots of the Recovery Movement

Basic alcohol and drug services can be traced to two distinct movements: the founding of Alcoholics Anonymous (AA) in 1935 and the creation of Synanon Foundation in 1958. The twelve-step program of AA was rooted in earlier efforts by the Oxford Group, a Christian fellowship, to work with alcoholics. Alcoholics Anonymous—the guiding textbook of AA (known as the "Big Book")—was written by the early members (predominantly men) of the group and remains the "Bible" of the movement. AA members opened "twelve-step houses," where alcoholic men could dry out, get on their feet, and launch renewed lives. These houses and the AA program of recovery, forerunners to many recovery houses that exist today, incorporated peer counseling and self-help strategies.

Synanon Foundation, founded by a disenchanted AA member, was based on the theory that effective treatment and recovery required structure and a psychoanalytic orientation. The centerpiece for this recovery philosophy was small encounter groups, dubbed "Synanons," in which members—primarily injection drug users—confronted each other, sometimes in abusive ways, with their perceived shortcomings. Synanon eventually fell apart but its service design, which recommended long-term residence in a Synanon facility, survived and became the prototype for service systems that are known as "therapeutic communities."

Many feminists see the recovery movement, as represented by these pioneering programs and their offspring, as pathologizing the effects of the socialization of women in our culture. For example, AA encourages "service" as one of the basic tenets of successful recovery. But many feel that women, particularly those in recovery, need to learn how to say "No" to the concept of serving others before themselves without experiencing guilt and fear. This is especially important for HIV-infected women who are likely to experience even greater guilt and fear regarding AIDS. While the fellowships of AA and other recovery groups offer immersion into a substance-
free “community,” these programs incorporate no strategies for successful individualization from the larger group, a critical developmental task for women who have typically lacked an independent sense of self. Additionally, many therapeutic community models still apply confrontational and punitive techniques, measures that are particularly destructive for women, who often struggle with low self-esteem.

Today, women can find programs that incorporate feminist theory, address abuse issues and multiple diagnoses, and offer comprehensive life skills curricula. While all of these components benefit women, not all women’s services incorporate any or all of these techniques. Nor are practitioners in these other disciplines necessarily well-versed in the physiology, etiology, and psychology of addiction. Although most formal programs offer participants the opportunity for HIV antibody testing, many lack the specific protocols for working with HIV-infected participants.

Governmental Intervention

Treatment services models function in the context of governmental funding and policy. In 1970, the U.S. Congress passed legislation mandating that all states increase services to underserved populations, including women. At this point in history, there were only a few women-specific programs and fewer still that offered the opportunity for women to retain custody of their children during treatment. Most were modeled after AA and Synanon. This legislation, however, provided funding opportunities for new treatment ideologies and encouraged the development of programs structured around feminist theory and women’s experiences and needs.

In the mid-1980s, an increase in prevalence of drug-affected newborns ignited a call for the criminalization of drug use during pregnancy. As women’s advocates fought to keep pregnant and parenting women who used drugs out of jail, Congress earmarked money for alcohol and drug services for the mother-child dyad. New players, most notably maternal/child health providers, came into the alcohol and drug services field at the same time as planners created residential and non-residential programs to address the needs of both women and their dependent children.

Reflecting an effort to reduce the incidence of adverse effects of alcohol and drug use during pregnancy or while breastfeeding, public funding is currently focused on pregnant and parenting women. Nonetheless, need most often exceeds the availability of these services. Many pregnant women use methadone maintenance programs—which are safer during pregnancy and reduce HIV-related risk—while waiting for slots in other treatment programs.

Women who are not pregnant or who do not have custody of minor children are finding fewer services available to them, especially in the current climate of social service cutbacks. This parallels the situation for HIV-related services: women with HIV disease receive the greatest attention when they are pregnant or have children.

Finally, the trend is toward cost-containment and shortened stays in residential programs, a development that can be especially harmful to women. Women in the recovery programs of today are generally young, use a variety of drugs and alcohol, are single parents, have experienced abuse, often exhibit arrested emotional development, have minimal life skills, and are only marginally employable.

The Ideal Program

In response to this profile, women’s advocates see a need for a long-term continuum of care strategies that basically “habilitate,” rather than simply re-habilitate, women in need of services. To accomplish this, services need to incorporate mentoring, address long-term issues of parenting children who might have developmental problems, assist women with finding safe and affordable housing, provide broad occupational training, and offer “safe haven,” to which women may return without shame and stigma during life crises. They must acknowledge that many chemically dependent women have other health problems, including HIV disease, that require anticipating and answering concerns about disability and planning for their own and their children’s future.

References


Authors

Suzanne Ostermann has worked in the alcohol and drug services field for more than 20 years, specializing in women’s issues. Her consulting firm is currently working with the State of California to develop a statewide inter-agency, inter-disciplinary task force addressing collaborative service designs for addicted women.

Correction

The August issue of FOCUS included a Recent Report that was published with two errors. On page 8, the title of the abstract of the Cochran, Mays article should have read: “Distress in Homosexually Active Black Americans.”

In addition, the abstract should have identified the survey as a national sample. We apologize for any inconvenience or misunderstanding these errors may have caused.
Gender Differences and Drug Treatment

Unlike men, who typically use drugs in the context of social activities, women often resort to substance abuse to cope with specific negative environmental influences, and since they tend to have a more limited social network, they are more likely to use drugs at home. According to a substantial review of the literature, substance abuse treatment should reflect and respond to the gender-specific factors of female addiction.

While male addiction often occurs over time, following a progressive pattern of use, women become dependent after a "sudden and heavy" onset of drug use. Drug use tends to follow a specific traumatic event such as rape or sudden physical illness. Interpersonal stressors such as an intimate relationship with an addict, disruptions in family of origin, and overwhelming family responsibilities are reported more often by addicted women than men. Chemically dependent women are more likely than their male counterparts to experience psychological problems related to negative self-esteem and shame about their addiction. Forced by a lack of financial and social resources to be dependent upon others for survival, addicted women report lower expectations about their lives, lack of confidence, and feelings of hopelessness more often than men. These feelings of lack of control are accompanied by high levels of guilt, shame, depression, and anxiety about addiction.

Women have fared poorly in drug treatment programs compared to men. A female-oriented alternative should first identify environmental factors that trigger substance abuse so women can be helped to develop alternative coping strategies. It must incorporate education and referrals about medical, financial, and legal resources so that women are aware of the options available to them. In addition, the program’s setting should address issues that prevent women from seeking treatment, for example, by providing on-site child care and an all-female environment.

Group Support for Drug-Using Women
Hardesty L, Greif GL. Common themes in a group for female IV drug users who are HIV positive. *Journal of Psychoactive Drugs.* 1994; 26(3) 289-293. (University of Maryland, Baltimore.)

Recurring themes of victimization, distrust, and fear of loss emerged in an ongoing support group for female seropositive injection drug users enrolled in a methadone-maintenance program. The Baltimore program focused primarily on African-American women, with weekly group attendance ranging from four to seven and membership changing as clients dropped out, were released from treatment, or died.

Victimization took the form of physical and sexual abuse both in families and current relationships, and instilled feelings of worthlessness and inadequacy among many of the women. Distressed by a sense of incompetence, most of the women felt dependent on their mothers and grandmothers for food, housing, and child-care. In some cases, women were infected by their partners, who refused to have protected sex, and few of the women felt sufficiently comfortable with their partners to discuss condom use. Despite the prevalence of family dysfunction, most of the women shared a fantasy of family as haven. Accordingly, many refused to disclose their serostatus for fear of being rejected.

Many of the women also had a long-standing distrust of the social welfare system and of women in general. Fear and misunderstanding about their diagnosis manifested in verbal attacks upon each other, and it took eight months for the original group members to disclose their serostatus to each other. Even after disclosure, the women would speak of HIV disease only euphemistically as "personal issues," "my illness," or "this thing." Despite these challenges, the compassionate group setting proved effective in countering the isolation these women experienced.

Culture and Women’s Risk Behavior

A large study of African-American and Latina homeless and drug-addicted women

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found that psychosocial predictors of HIV-related risk behavior varied in degree of influence between the two ethnicities.

The sample consisted of 714 African-American women and 691 Latina women (assessed separately according to acculturation). The African-American women, predominantly Protestant, had completed an average of 12 years of school. Seventy percent of all Latina women were Catholic. The average education level of the more acculturated Latinas was 11 years of school; for the less acculturated Latinas, the average was seven years. Interviews evaluated self-esteem, threat appraisal, barriers to condom use, and coping.

For both African-American and Latina women, there were predictable relationships between psychosocial factors and risk behavior. For both populations, environmental conditions, such as being considered useless by others, having insufficient money, and being involved in illegal activities were correlated with HIV-related risk, including having multiple sex partners, using condoms less often, and sharing needles.

But it was notable that some psychosocial factors differed in influence between the cultures. Among African-American women, low self-esteem was correlated to barriers to condom use, and the lack of a social network was correlated to increased HIV-related risk. For Latina women, however, low self-esteem had no direct relationship to barriers to condom use, although it did relate to an increased general risk. In accordance with Latin culture, where social norms condemn condom use, women who had social networks were more likely to experience barriers to condom use than those who did not.

For Latina women, level of acculturation also affected risk behavior. Though typically more educated, Latina women who were more acculturated had a higher incidence of HIV-related risk behavior than did the less acculturated women. Acculturation was also correlated to active coping skills and greater social resources. Since active coping skills predicted decreased HIV-related risk behavior and social resources predicted more barriers to condom use, this study suggests that acculturation in this context is a "mixed blessing" for Latina women.

Gender-Sensitive Therapy


Although women constitute one-third of all alcoholics, they continue to be underrepresented and underserved in substance abuse treatment programs, according to an essay on alternative treatment strategies. To respond, programs must address the specific barriers women encounter when seeking treatment.

Successful treatment should incorporate elements of empowerment, nurturance, the importance of relationships, and a safe environment. Treatment centers should provide on-site child care and transportation in order to counter the financial obstacles. Counseling should emphasize empowerment and independence by helping women distinguish problems that are socially-instituted, such as sexism, from those problems that are under their own control.

All-female treatment environments allow women to establish new support networks and positive role models. Since relationships and social support are important for women, programs should enable women to maintain involvement with family members and friends. Because women often feel their identities are established by family roles, exploring new role options is an integral part of helping women become independent and create self-images that are distinct from their drug use. Other services that counter gender-specific factors of substance abuse include medical services, assertiveness and social skills training, and self-esteem building.

Next Month

Blessed sleep: repose, rejuvenation, escape; perhaps no drug provides the rewards of an untroubled night of sleep. Likewise, few forms of torture are more effective than sleep deprivation. Yet, sleep disturbance is common among people with HIV disease, even in the absence of serious medical symptoms. In the October issue of FOCUS, Andres Sciolla, MD, a researcher at the the University of California, San Diego, describes the phenomenon, its relationship to mental health, and its role in HIV disease. He focuses on the diagnosis and treatment of HIV-related sleep disturbance.

Also in the October issue, Jeannine L. White, PhD, Merrill M. Mitler, PhD, and Denis F. Darko, MD, all from the Scripps Institute in La Jolla, California, discuss the biochemical role of HIV itself in HIV-related sleep disturbance, particularly in the early stages of disease.
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