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Coping of African-American Women at Risk for AIDS

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Abstract A qualitative study using focus group approach reveals major concerns, personal beliefs, and coping responses of African-American women at risk for human immunodeficiency virus infection.

Cultural groups have distinct perceptions and experiences that affect their health, coping, and psychological outcomes. Yet an understanding of those factors that relate to African-American women at risk for human immunodeficiency virus (HIV) infection is limited. The purpose of this qualitative study was to explore the concerns, personal beliefs of self-esteem and control, and coping responses of African-American women whose lifestyles place them at risk for HIV infection. The conceptual basis for this paper is the Lazarus and Folkman¹ Stress and Coping Paradigm, which conceptualizes coping as constantly changing cognitive and behavioral efforts made to manage specific demands that tax or exceed the resources of the person. Such coping efforts are affected by a constellation of variables that include situational factors such as adequate food and shelter, personal beliefs of self-esteem, and perceived sense of control and coping resources, including physical health, mental health, and financial, spiritual, and social support. The findings from this study could influence the development of culturally sensitive and preventive health educational interventions for this population.

AFRICAN-AMERICAN WOMEN AND AIDS

Today over 13,000 woman have acquired immunodeficiency syndrome (AIDS).² The major risk factor for women in acquiring HIV infection is being an intravenous drug user (IVDU) or a sexual partner of an individual infected with the HIV. The number of women who contracted AIDS through heterosexual contact has increased from 12% to 26% between 1982 and 1986.³ Further transmission to their sexual partners and babies becomes an unfortunate reality.

African-American women with high-risk behaviors have been dispropor-

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portionately affected with AIDS. Such women account for 52% of adult women with AIDS, and 53% of children with AIDS are African-American.² The Centers for Disease Control report that 58% of African-American women acquire the HIV through intravenous drug use and 34% through heterosexual contact.² Of the 34% who were sexual partners of men in risk groups, over one-half reported their partners were IVDUs. African-American IVDUs not only have a greater HIV seroprevalence than do other cultures, but they also have a shorter survival time once infected with the HIV.⁴ Homeless individuals with AIDS tend to be African-American or Hispanic and to be IVDUs as compared with nonhomeless AIDS patients.⁵ Homeless IVDUs were more likely to have traded sex or money for drugs than did IVDUs who were not homeless.⁶

It is also known that other factors may enhance women's vulnerability to stressful life situations. These factors include the critical resources of family, support, money, and self-esteem.⁷⁻⁹ The increased stress from low income, poor educational status, lack of financial resources, association with partners who use drugs, depression, and low levels of self-esteem further complicate the life of women who may already be at risk for HIV infection because of drug use.¹⁰

In a qualitative study involving focus groups of low-income African-American women attending the Public Health Foundation Women, Infants, and Children (WIC) program in Los Angeles County, Flaskerud and Rush¹¹ discovered that many of the women knew that AIDS was transmitted through sexual contact and needle sharing among IVDUs. However, they also believed people could get AIDS from lowered resistance brought on by lack of cleanliness, poor health habits, improper nutrition, and exposure to the elements. In the use of focus group strategies with African-American women and teenagers, Fullilove et al¹² noted that the women were losing ground in their ability to protect themselves sexually. Environmental factors discovered included the tremendous increase in crack cocaine with widespread sexual promiscuity, as well as a sharp decline in the economic status of African-American women in many communities.^{13,14} Whereas empowerment of these women is crucial, little is known about the concerns, stresses, and coping responses of African-American women who are homeless or recovering from drug addiction. Thus for nurses and physicians to be most effective in providing a holistic and humanistic approach to planned care, they need to be sensitive, accepting, and aware of sociocultural, physiologic, and psychosocial factors that affect the health care of African-American women.

METHODS

A qualitative study using focus groups was used to describe, analyze, and explain the concerns, beliefs, and coping responses of African-American women at risk for HIV infection. The focus group is a research technique for gathering information about population subgroups with respect to psychological and sociologic characteristics and processes.¹⁵ Within homogeneous groups of four to 12 participants, the researcher creates a permissive environment that nurtures different perceptions and points of view, without pressuring participants to reach a consensus.¹⁶

As part of a larger study designed to provide counseling and HIV testing for at-risk minority women, African-American women who were 1) homeless, 2) IVDUs or sexual partners of IVDUs, 3) diagnosed with a sexually transmitted disease, or 4) prostitutes were invited to participate. Women participated in one of six focus groups. All groups were held in private rooms in one of two homeless shelters or one of two drug rehabilitation programs.

A total of 66 African-American women participated in six focus groups. The majority (95%) of the women were homeless, and they ranged in age from 18 to 68. Ninety-seven percent of the women were under 50 years of age. High-risk activities practiced consisted of being an IVU (7%), being the sex partner of an IVU (12%), receiving a diagnosis of a sexually transmitted disease (23%), or practicing prostitution (24%). Thirty percent of the women reported multiple risk factors. The women were predominantly Catholic (44%), unemployed (89%), not in school (81%), and single (52%). Ninety percent of the women were born in the United States and had a mean education level of 12.3 years. Almost three quarters of the women had children; the average number of children was 3.7.

All sessions were conducted by two African-American nurse researchers who were prepared to use the focus group approach. All women who participated in the focus groups received \$10 at the completion of the 2-hour session.

DATA COLLECTION

Based on the Lazarus and Folkman¹ Stress and Coping Paradigm, and thorough review of the literature, a semistructured interview guide was developed to assess the concerns and stresses the women experienced, the coping responses utilized, perceived feelings of self-esteem and control, drug and sexual activity, and desire for AIDS education. Table 1 presents a sample of the open-ended questions.

Comprehensiveness of the interview guide was assessed by a thorough review of the literature on minority populations, particularly those at risk for HIV infection. Moreover, an expert panel composed of researchers and clinicians working with AIDS and minority populations assessed the interview guide for completeness. All focus group discussions were tape-recorded with permission and later transcribed. Major themes and categories were identified from the transcribed data through content analyses. Consistency of identification of themes and subthemes that reflected the concerns, personal beliefs, and coping responses of the women were assessed independently by two nurses involved in minority-focused AIDS research. External homogeneity was assessed by the degree to which the patterns and themes were clear, distinct, exhaustive, and mutually exclusive.¹⁷

Table 1. SAMPLE OF STRUCTURED INTERVIEW ITEMS

1. Thinking back over the last few months, what would you say have been your major concerns or problems?
2. Thinking back over the last few months:
 - a. What are some ways you have dealt with these problems or concerns?
 - b. Who/what did you find most helpful and least helpful in dealing with these problems or concerns? Probes
 - . . . talking to others
 - . . . getting information
 - . . . going to the clinic
 - c. Of all these activities, which did you use most often?
How available was it to you?
3. Thinking back over the past few months, how important do you think it is to feel good about yourself?
Why?
4. Thinking back over the past few months, how important do you think it is to feel you have control over what happens in your life?

FINDINGS

Content analysis identified and defined three major themes. The first major theme identified and defined from the data was powerlessness, which was associated with three subthemes: intense environmental and personal concerns, loss of control, and low self-esteem. A second major theme that emerged was the predominantly emotion-focused coping responses, which were characterized by three subthemes: drugs or alcohol, withdrawal from stressful situations, and religion. The third major theme discovered was problem-focused coping responses, which consisted of prostitution, seeking information and support, and stealing and scheming.

Powerlessness

Powerlessness represented a major theme that was identified from the data. The factors that contributed to powerlessness were intense environmental and personal concerns experienced, loss of control, and low self-esteem.

Intense Environmental and Personal Concerns Experienced

The environmental and personal concerns experienced by African-American women in this study was one subtheme discovered. The basic necessities of food, money, and a place to sleep represented immediate concerns that promoted a sense of powerlessness for the majority of women. For some women, the homeless environment was likened to a pit called limbo where no one wanted to be. One woman was ashamed for putting herself in the situation and reported being very lonely. This woman felt her life was wrecked by doing "unrepairable damage to myself physically, in terms of sex." Furthermore, being on welfare represented a concern that provoked a further sense of powerlessness. Life was not easy being on general relief. Most often the monthly check was barely enough to pay rent, leaving little to no money for food, clothing, and transportation to find a job. One woman wondered, "why put me in the most God awful mess and then expect me to cope and get better. How can you better your condition when everything is so negative?"

In this state of powerlessness, the dangers of unprotected sex with multiple partners were real for several women; for others, concern about AIDS was nonexistent. Rather, worry about getting a next meal, how the children are doing, and how one is to survive was of paramount importance.

Similarly, powerlessness was further reflected by the concern that the need for drugs controlled the sexual practices of the women and increased the resultant risk for acquiring the AIDS virus. To many, indiscriminate sex was simply a matter of gambling or risk taking. As one woman expressed:

For the risk of AIDS . . . I suppose if you get hungry enough, you'd think . . . I'll be lucky this one time. Maybe I'll go have sex with somebody. They'll supply my needs and maybe I won't catch AIDS.

Another woman who usually used condoms stated that "all this good sense I got [using condoms], when I get high, it vanishes."

For many women, their children represented another major source of concern that left them intensely powerless. Major concerns ranged from not being able to provide motherly love to worrying about the children being brought up by family members. To one woman, the greatest fear she had was "I might get back there and they [the children] won't even know me." Physical safety was yet another aspect of life these women dealt with on a daily basis. To survive, women would "be talking tough but be really scared." The

dangers related to trying to get drugs became an incentive to break the habit for one woman:

I came to realize . . . this is the hardest job I ever had in my life, trying to get some drugs everyday. And if I put some of that energy into straightening out my life, I got to win.

As a result of their desperate situation, the most predominant moods the women expressed were being nervous, tired, confused, miserable, exhausted, depressed, lonely, frightened, and overwhelmed.

Loss of Control

The second subtheme identified was loss of control. There were only six women who stated they had control over their lives. There was universal agreement with all African-Americans of the importance of control. One woman felt that one would need to have control over her life if she wanted to change her situation. Some women equated feeling in control with feeling hope. One woman expressed the importance of feeling control in this way:

Once you have the feeling that you are not in control, then you are admitting that you are in defeat, that you've lost all control of your own life. And nobody can take that control from your life. . . . We're still in control of our lives, even though we are here.

To several women, the county represented a threat to control because the county takes control away from people. To another woman, one of the most devastating aspects of homelessness was the fact that people who reportedly are present to assist women subsequently assume total control of their lives. One woman vividly provides an account of these feelings:

One of the most devastating aspects of homelessness is the fact that people who want to help you, or claim to help you, want to assume total control for your life, as far as telling you when to come in, when to go out, what to do, who to see, and where to go. And there's a lot of responsibility and rights they expect you to relinquish and turn over, assuming that the reason you are homeless is because you did not know how to control yourself, or you abused the control that you had with your life.

For this woman and others, a sense of control could be enhanced by allowing the women more freedom to decide in which shelters to reside and the ability to manage their monthly county checks. For other women, the provision of self-assertion training was a welcomed skill many women felt would assist them in regaining a sense of control, improved self-esteem, and ability to function in their environment in a positive manner.

Low Self-Esteem

Low self-esteem was the third subtheme under the major finding of powerlessness. The women were all in agreement that feeling good about oneself was important. The most consistent response the women verbalized was that feeling good about oneself provided the incentive to help themselves out of a bad situation, whether it be dealing drugs or being homeless. As one woman expressed:

If you feel good about yourself, you can look at your situation, meet it head on, and come out of it. But you've got to feel good about yourself.

Several women described situations that lowered self-esteem. For one woman, being in the homeless situation and feeling inadequate as a parent caused her self-esteem to suffer tremendously. Other women reported that self-esteem was affected by major events that occurred in their lives, such as

accidents, difficulties with parents, and losing jobs. As a result, many women started to hate themselves. To some women, feeling good was a constant struggle, and for one woman the struggle left her with a feeling that she did not care if she lived or died.

Several women commented on events that helped improve self-esteem. Accepting mistakes made in life was important for several women, as well as the fight to maintain dignity despite how friends and others view them.

I used to didn't love myself. I used to deal drugs. I used to smoke drugs. I used to walk down the street with guns in my hands, shooting at people who sneezed hard at me. But I'm not like that no more, because I love me.

Finally, being told how worthwhile and valuable they were by dedicated health professionals who further supplemented their coping repertoire with useful skills, such as job placement and partner negotiation, were strategies that were effective in enhancing self-esteem.

Emotion-Focused Coping

The second major theme that was identified was emotion-focused coping. The African-American women in the study described coping strategies predominantly focused on dealing with the intense emotions experienced. Many of the women were vocal about the lack of resources available to assist in dealing with the stresses of being unemployed, homeless, and faced with a lifestyle where prostitution and drug using, dealing, and selling were common. For many women, resources were scarce and, with no one to turn to, their energies were more often directed to drug or alcohol abuse, strategies to distance themselves from their situation, or prayer.

Drugs or Alcohol

One subtheme discovered with African-American women using emotion-focused coping was the abuse of drugs or alcohol. Getting high on drugs or alcohol was a common escape from harsh realities of living these African-American women experienced. However, many women realized that once they came down off their high, the problems became larger. One woman described the effect cocaine had on her life.

When I was using cocaine, cocaine was my wake up in the morning, and my go to bed at night. The pipe was my husband. I didn't want any man. I had to have that. I slept with it and I woke up with it. That was my man.

When money was no longer available to get high, stealing and prostitution became commonly used alternate coping strategies.

Withdrawal from Stressful Situations

Another popular emotion-focused coping response used by the African-American women in the study was to withdraw from the situation in any way possible. For several women, getting in a homeless shelter was a way of running away from problems at home. For some of the women, becoming homeless was a choice they made to get away from pressures at home. To others, it represented an escape from reality and a release from trying to keep enough money to support a house and expenses of a family. Involvement with drugs often led to homelessness. However, becoming homeless was not the escape many thought it to be:

I came down here because I didn't want to go back to jail. Then I found out drugs was just as prevalent down here, as a matter of fact, they're easier to get down here.

Daydreaming was a popular strategy. To one woman

Daydreaming's basically all you have left after a while. You daydream of something really nice and then of course you get depressed, you get mad, you cry and you want to hurt someone literally.

Religion

Probably the most frequent subtheme under emotion-focused coping strategy next to getting high on drugs or alcohol was prayer. Women reported praying to God to get the strength to better their situation. Such a strategy was seen by many women as a self-comforting and strengthening mechanism. Trust in God was critical as many women felt they could not help themselves without the help of God. As one woman expressed:

After I had been on drugs, I hit rock bottom. I then went into a program and my kids were taken from me. Since then, I got closer to God. I turned my back on him before. I won't turn my back on him again.

However a few women saw their religion as a mechanism for expectation of change. These women lost faith in God because he was not there when they needed him. This was particularly evident with one woman:

I've been religious most of my life, went to church Sundays, Mondays, Tuesdays, Wednesdays, Thursdays, and Fridays in every organization that the church had. And when hard times hit it was like, "okay God, I did something for you, so where are you now?" I felt kinda like I was out there all by myself.

Problem-Focused Coping

African-American women in the study reported other coping strategies that were focused on solving the problem or concern experienced. Thus problem-focused coping represented the third major theme that evolved in the findings.

Prostitution

One problem-focused way women employed to deal with their life was prostitution. While many of the women claimed to be sexually active, prostitution for drugs and other necessities was the main reason for the sexual act. Very few women were involved in personal relationships where sexual activity played a role. One woman considered the sexual act as an activity "to get my money to get my own high." To another woman, having sex was a way "to keep a roof over your head or . . . to eat, you just do what you have to do."

Seeking Assistance and Support

Several women described actively seeking assistance and support, which constituted a second subtheme under problem-focused coping. This included going from shelter to shelter to find a place to sleep and to obtain their next meal, and trying to seek out positive influences in their lives. Few women reported actively looking for jobs or seeking help from counselors, psychiatrists, or friends. Whereas a few women found that discussing their problems was helpful, the majority of women had no supporters in whom to confide. One woman received help from helping others. Another woman felt an important need for her was to be with other homeless women who were experiencing the same situation.

Stealing and Scheming

Finally, stealing and scheming were actively utilized responses for some women to survive. Several women reported these responses are acquired over time. For one woman

Maybe it won't be so bad if I just take that old lady's purse. . . . Maybe he don't need that five dollars, his billfold is sticking out. . . . You're in a desperate situation. And the longer you're out there in that situation, your morals can slip.

DISCUSSION

The purpose of this study was to understand the concerns, personal beliefs, and coping responses of African-American women who were IVDUs, sexual partners of IVDUs, prostitutes, diagnosed with sexually transmitted diseases, and/or homeless. The findings of these focus group interviews revealed several insights into the life experiences of these African-American women that have implications for developing a body of scientific and humanistic knowledge base useful for all health professionals.

Findings of the study revealed that African-American women who practiced high-risk activities and/or were homeless experienced severely limiting environmental constraints that promoted within them a sense of powerlessness. These findings support the fact that the environmental component plays a definite role in the behaviors of individuals. Although it was commonly felt that using drugs and having multiple sexual partners was a lifestyle that some groups of African-American women were forced into to survive, motivation to leave this lifestyle was tremendous for these women. However, for some women, the need to have a man may supersede the cost of a relationship at any price.¹³ Understanding environmental constraints is imperative to advancing knowledge and practices of health care professionals.

African-American women recognized that self-esteem and sense of control are important for life goals, and this is important for health professionals to realize. Findings of the study suggest, however, that in order to provide helpful assistance to African-Americans, health care professionals need to fully understand the life experiences and concerns of African-American women. By assisting African-American women's active participation in seeking resources that are needed, self-esteem and self-control may be maintained. This can be accomplished by assisting the women in setting realistic objectives about management of their monthly income while providing the necessary knowledge and skills.

In promoting African-American women's coping with their life situation, nurses and other health professionals need to appreciate the usual coping strategies of different cultures and the factors that facilitate or hinder coping. Boyle¹⁸ contends that coping abilities of African-Americans vary depending on what is viewed as appropriate behavior in different situations. Findings in this study provide some information that the African-American women studied used emotion-focused coping strategies most frequently. These primarily include drugs and alcohol, withdrawal or distancing strategies such as sleep, daydreaming, and escape mechanisms, and religion to seek comfort and strength or to effect change. A predominant problem-focused coping response used by the women was prostitution, with few women reporting seeking assistance and information. It is quite possible that the women quickly became frustrated when lawful problem-focused strategies were unsuccessful in changing their situation.

As a result of the extreme environmental and personal concerns these

African-American women experienced on a daily basis, it is possible that factors such as low self-esteem and loss of control may lead to the need for more emotion-focused coping strategies. This may be particularly true for African-American women who may struggle to survive through the use of prostitution. Some of these women may seek drugs to forget the feelings of worthlessness rather than to seek assistance or support from counselors, other health professionals, or women in similar situations. For others, prostitution represents an easy means to support their habit.

Mays and Cochran¹⁴ contend that impoverished African-American women who use drugs or are prostitutes have always lived with risk and, as a result, the threat of AIDS simply becomes an additional risk. An important question is: How much more threatening can the risk for AIDS become for women who are desperately attempting to survive? What might the effect of building self-esteem and providing more control have on these women? However, it was clear that while financial and supportive resources were scarce, the inspiration and dedication most women had for God was a powerful strategy to them, and it needs to be considered by health professionals in caring for African-American women. Providers may have a greater impact on creating behavioral changes with the explicit use of religion in care practices.

Implications for intervention by health care professionals are apparent because a relationship exists between life stresses, coping, and feelings of self-esteem and sense of control. One of the many benefits of the focus group discussion was identifying the ways the women in the study dealt with hardships. For example, such knowledge can provide new direction in culturally relevant nursing intervention. More specifically, providers should consider the barriers that commonly exist for African-American women and actively work with the system and the women to demonstrate the effectiveness of select problem-focused coping strategies. Emphasizing the motivation these women have to overcome their desperate situation while providing the resources necessary to make positive changes is needed. Furthermore, unless a comprehensive approach is utilized to assess all variables and to implement strategies to enhance sense of control, feelings of self-esteem, and effective coping, education programs to prevent AIDS may not achieve desired goals.

Further studies focused on the environment are needed to address culturally based data and the needs of diverse cultures within and outside the United States of America. Cultures involved in drug abuse pose new challenges, especially with AIDS. As a result, more studies are needed to account for ethnic variations in patterns of drug use and descriptive studies of characteristics of African-American drug users. This is particularly evident for women who may have access to little or no AIDS education, who lack critical resources, and who suffer from extreme environmental and emotional hardships. The provision of such information with the understanding of the specific culture of women could ensure positive educational outcomes.

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