An Exploratory study: gender inequities in substance abuse treatment and recovery among incarcerated African-American women at risk for HIV and AIDS infection

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ABSTRACT

SOCIAL WORK

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AN EXPLORATORY STUDY: GENDER INEQUITIES IN SUBSTANCE ABUSE TREATMENT AND RECOVERY AMONG INCARCERATED AFRICAN-AMERICAN WOMEN AT RISK FOR HIV AND AIDS INFECTION

Advisor: Dr. Sarita Davis
Dissertation dated July 2009

There is a need for the continued exploration of gender inequities within substance abuse treatment centers that affect service delivery, and recovery among incarcerated African-American women. As a result of incarceration, these populations of African-American women are forced into recovery and are less likely to sustain their abstinence and relapse which increases their risk of Human Immunodeficiency Virus (HIV) upon release. This phenomenon of exploration also addressed how these women perceived their susceptibility of risk to HIV and Acquired Immune Deficiency Syndrome (AIDS) infection. In addition, there are various factors as well as programmatic barriers that existed which pose as barriers to women who seek treatment for substance abuse. Eliason (2006) reported that African-American women have decreased recovery rates in
substance abuse treatment due to gender inequities and culturally insensitive interventions. This study explored the factors that contribute to the manner in which African-American women seek and complete substance abuse treatment services as well as address service delivery, relapse, and overall perception of HIV risk among 20 incarcerated African-American women who are over the age of 18 and self identified as having used an illegal drug such as crack/cocaine, marijuana, methamphetamines, and heroin. Each participant was carefully screened and selected to ensure meeting the criteria for participation in the study.

Finally, the significance of the findings is discussed along with the implications for Social Work Policy, Planning, and Administration.
AN EXPLORATORY STUDY: GENDER INEQUITIES IN SUBSTANCE ABUSE TREATMENT AND RECOVERY AMONG INCARCERATED AFRICAN-AMERICAN WOMEN AT RISK FOR HIV AND AIDS INFECTION

A DISSERTATION

SUBMITTED TO THE FACULTY OF CLARK ATLANTA UNIVERSITY IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF DOCTOR OF PHILOSOPHY

BY

YARNECCIA D. HAMILTON

WHITNEY M. YOUNG, JR. SCHOOL OF SOCIAL WORK

ATLANTA, GEORGIA

JULY 2009
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I give high honor to GOD for blessing me with the desires of my heart! I will continue to trust in HIM, live purposefully, and keep the faith!

This dissertation is dedicated to my grandparents, Mr. Albert Lee Hamilton and Mrs. Selma P. Hall-Hamilton; I thank you and love you! To my dear and loving mother, E. Regina, thank you so much for all of your support and love. To my uncle, Rev. Jeffrey Hamilton and Aunt Marie, Aunt Michelle, Uncle Alvin, Johnny, Johneka, Jabari and Regina, thank you for your love and support; I love you all dearly. To the rest of my family, thank you all for your continued love and affirmation!

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# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>ACKNOWLEDGMENTS</th>
<th>ii</th>
</tr>
</thead>
<tbody>
<tr>
<td>LIST OF FIGURES</td>
<td>vi</td>
</tr>
<tr>
<td>LIST OF TABLES</td>
<td>vii</td>
</tr>
</tbody>
</table>

## CHAPTER

### I. INTRODUCTION

- Background .................................................. 4
- Problem Statement ......................................... 6
- Purpose of the Study ....................................... 8
- Significance of the Study ................................ 9
- Nature of the Study ........................................ 11
- Research Questions ........................................ 12
- Theoretical Framework ..................................... 13
- Definitions .................................................. 14
- Assumptions ................................................ 15
- Scope, Limitations, and Delimitations .................. 16
- Summary ....................................................... 17

### II. LITERATURE REVIEW

- Current Findings ........................................... 20
- Impact of Substance Abuse ................................ 21
- The Concept of Gender in Today’s Society .............. 23
- African-American Women and Substance Abuse .......... 25
- Gender Issues and Substance Abuse Treatment .......... 26
- Women, Substance Abuse, and HIV Rates ................. 37
- Substance Abuse Treatment Challenges .................. 41
- Incarceration and African-American Women ............... 50
- Substance Abuse Treatment for Incarcerated Women .... 52
- The Notion of Forced Recovery ......................... 53
- Outcomes of Therapeutic Communities for Men .......... 55
- Outcomes of Therapeutic Communities for Women ....... 56
- Components of Successful Substance Abuse Treatment for Women ........................................... 58
- HIV Prevention and Substance Abuse Treatment .......... 59
- The Health Belief Model and Black Feminist Theory ... 60
- Black Feminist Theory ....................................... 62
### Table of Contents (continued)

<table>
<thead>
<tr>
<th>CHAPTER</th>
<th>PAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Health Belief Model</td>
<td>66</td>
</tr>
<tr>
<td>Constructs of the Health Belief Model</td>
<td>68</td>
</tr>
<tr>
<td>Constructs of Black Feminist Theory</td>
<td>69</td>
</tr>
<tr>
<td>Summary</td>
<td>71</td>
</tr>
<tr>
<td>III. METHODOLOGY</td>
<td>73</td>
</tr>
<tr>
<td>Mixed Method Research Design</td>
<td>73</td>
</tr>
<tr>
<td>Appropriateness of the Research Design</td>
<td>76</td>
</tr>
<tr>
<td>Logic of Data Collection</td>
<td>80</td>
</tr>
<tr>
<td>Quantitative Research Design: Use of Surveys</td>
<td>81</td>
</tr>
<tr>
<td>Similarities and Differences of Research Designs</td>
<td>82</td>
</tr>
<tr>
<td>Advantages of Quantitative Research</td>
<td>83</td>
</tr>
<tr>
<td>Disadvantages of Quantitative Research</td>
<td>83</td>
</tr>
<tr>
<td>Qualitative Research Design: Use of Interviews and Focus Groups</td>
<td>84</td>
</tr>
<tr>
<td>Interviews</td>
<td>84</td>
</tr>
<tr>
<td>Focus Groups</td>
<td>86</td>
</tr>
<tr>
<td>Advantages of Qualitative Research</td>
<td>87</td>
</tr>
<tr>
<td>Disadvantages of Qualitative Research</td>
<td>87</td>
</tr>
<tr>
<td>Criteria of Sample Selection</td>
<td>88</td>
</tr>
<tr>
<td>Agency Description</td>
<td>89</td>
</tr>
<tr>
<td>Limitations of Sample Selection</td>
<td>92</td>
</tr>
<tr>
<td>Data Analysis</td>
<td>93</td>
</tr>
<tr>
<td>Validity and Reliability</td>
<td>94</td>
</tr>
<tr>
<td>Construct Validity</td>
<td>94</td>
</tr>
<tr>
<td>Internal Validity</td>
<td>95</td>
</tr>
<tr>
<td>External Validity</td>
<td>95</td>
</tr>
<tr>
<td>Summary</td>
<td>95</td>
</tr>
<tr>
<td>IV. PRESENTATION AND ANALYSIS OF DATA</td>
<td>97</td>
</tr>
<tr>
<td>Population Demographics</td>
<td>100</td>
</tr>
<tr>
<td>Individual Participant Profiles</td>
<td>104</td>
</tr>
<tr>
<td>Data Analysis and Findings</td>
<td>111</td>
</tr>
<tr>
<td>Reliability Analysis</td>
<td>113</td>
</tr>
<tr>
<td>Overview of the Emergent Themes</td>
<td>114</td>
</tr>
<tr>
<td>Influence of Gender Inequities</td>
<td>117</td>
</tr>
<tr>
<td>Prostitution</td>
<td>118</td>
</tr>
<tr>
<td>Power and Sexual Decision Making</td>
<td>121</td>
</tr>
<tr>
<td>Relationships</td>
<td>124</td>
</tr>
</tbody>
</table>
Table of Contents (continued)

<table>
<thead>
<tr>
<th>CHAPTER</th>
<th>PAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Forced Recovery</td>
<td>126</td>
</tr>
<tr>
<td>Past Relapse</td>
<td>126</td>
</tr>
<tr>
<td>Individual Perceptions of Substance Abuse</td>
<td>127</td>
</tr>
<tr>
<td>Perceived Susceptibility of Risk</td>
<td>128</td>
</tr>
<tr>
<td>Younger Participants and Perceived HIV Risk</td>
<td>129</td>
</tr>
<tr>
<td>Older Participants and Perceived HIV Risk</td>
<td>130</td>
</tr>
<tr>
<td>Successful Treatment Completion</td>
<td>132</td>
</tr>
<tr>
<td>HIV Prevention Education</td>
<td>133</td>
</tr>
<tr>
<td>Analysis of Themes from Interviews</td>
<td>135</td>
</tr>
<tr>
<td>Preponderance of Data</td>
<td>139</td>
</tr>
<tr>
<td>Summary</td>
<td>140</td>
</tr>
</tbody>
</table>

V. CONCLUSIONS, IMPLICATIONS, AND RECOMMENDATIONS ... 141

<table>
<thead>
<tr>
<th>APPENDIX</th>
<th>RELATED PAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Institutional Review Board (IRB) Approval Letter</td>
<td>162</td>
</tr>
<tr>
<td>B. Approval Letter from the Deputy Chief, Atlanta Detention Center</td>
<td>163</td>
</tr>
<tr>
<td>C. Consent Forms</td>
<td>164</td>
</tr>
<tr>
<td>D. Demographics of Participants</td>
<td>168</td>
</tr>
<tr>
<td>E. Constructs of the Theoretical Frameworks</td>
<td>169</td>
</tr>
<tr>
<td>F. Constructs of Black Feminist Theory</td>
<td>170</td>
</tr>
<tr>
<td>G. Participant Survey</td>
<td>171</td>
</tr>
<tr>
<td>H. Interview Questions</td>
<td>173</td>
</tr>
<tr>
<td>I. Focus Group Questions</td>
<td>175</td>
</tr>
<tr>
<td>J. Letters of Request and Approval from the Women for Women Program</td>
<td>177</td>
</tr>
</tbody>
</table>

REFERENCES | 179 |
## LIST OF FIGURES

<table>
<thead>
<tr>
<th>FIGURE</th>
<th>PAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. National Statistics of Incarcerated Women and Services They Received</td>
<td>52</td>
</tr>
<tr>
<td>2. Mixed Method Triangulation Design</td>
<td>77</td>
</tr>
<tr>
<td>3. Intersection between Sexual Activity and Substance Abuse among the Population</td>
<td>102</td>
</tr>
<tr>
<td>4. Substance Abuse Treatment Attempts as well as Relapse Rates among the Sample</td>
<td>104</td>
</tr>
</tbody>
</table>
## LIST OF TABLES

<table>
<thead>
<tr>
<th>TABLE</th>
<th>PAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Categories and Properties Related to Research Questions, Interviews, and Focus Groups</td>
<td>115</td>
</tr>
</tbody>
</table>

vii
CHAPTER I

INTRODUCTION

The goal of this chapter is to explain the influence of gender inequities on substance abuse treatment, service delivery, and recovery among African-American women who are at risk for Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) infection. This chapter introduces and provides information regarding the research problem and identifies the problem statement. The purpose, significance of the study, and nature of the study are also addressed in this chapter. In addition, the research questions, theoretical framework along with the Afrocentric perspective are explored. Finally, the definition of key terms, assumptions, scope, limitations, and delimitations of the data are addressed, along with a chapter summary.

As a Foster Care Social Worker for the State of Georgia, I had the opportunity to assist families in reunification after a child(ren) was removed from their care. Many of the cases were opened due to substance abuse whereby an infant may have tested positive for cocaine at birth or the authorities were alerted to drug activities that were alleged to have been occurring in and/or around the home. It was during the winter of 2006 that I
met Mary. Mary was a 34 year old African-American mother of 5 children and had just been released from jail two weeks after giving birth. She was incarcerated on a parole violation for the Possession of a Controlled Substance. She was an active crack/cocaine user, alcoholic, and engaged in prostitution as a means of maintaining her substance abuse habit as well as an income for her household. She also cleaned houses to obtain money. She dropped out of school in the seventh grade and began using drugs shortly thereafter as an outlet to years of childhood physical and sexual abuse by various members of her family including her step father. Mary had her first child at the age of 14 and continued to have children. She reported that none of her pregnancies were planned and she only knew the fathers of three of her children. The other two were the products of her prostitution. Mary had previously attempted to complete substance abuse treatment to address her addiction eight previous times, however, she informed that she would leave treatment because of issues with getting back and forth (transportation), not having any money, being concerned about the well being of her other children who were staying with relatives, and having to cut off relationships with boyfriends while in treatment. Subsequently to leaving treatment, she informed that she would relapse within hours and would be back to prostitution and using crack.

Mary delivered a baby girl, Isis, that had tested positive for Cocaine December 2006 and was brought into State custody because Mary’s relatives refused to care for any more of her children. At this time, Mary was also positive for Syphilis. During Mary’s

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1 Name/Identity has been altered to maintain client confidentiality

2 Name/identity has been altered to maintain client confidentiality
previous pregnancy in 2002, she was given prescriptions to treat HIV infection. There was a concern as Mary did not seek any prenatal care nor take these prescriptions during the pregnancy and birth of Isis. When asked how long she had been infected with HIV, Mary replied “Ms. Hamilton, I don’t have HIV.” As I sat looking puzzled, I inquired about her taking the AZT medication during the birth of her son in 2002. She then replied “My T-Cell count is high.” I attempted to make the connection for Mary, linking the fact that AZT is prescribed to people that have tested positive for HIV. As Mary continued to inform me that her “T-Cell count is high,” I thought about the foundational skills I learned in an Interviewing and Recording course at Florida A & M University while pursuing my undergraduate degree. I then rephrased the question from, “How long have you been infected with HIV?” to “When were you first exposed to HIV?” removing the word “infection” as it possessed a negative connotation. At that point, Mary eased back in her chair. A more relaxed feel came over the room as she explained to me that she was first exposed to HIV in 1995 when her boyfriend at the time, Charles was positive for HIV as a result of injecting Heroin with needles. She informed that Charles had also “served time” in prison and she suspected him of engaging in homosexual behaviors during his incarceration, which lasted for nine years, although “he beat me up for asking that,” she reported. She informed that her suspicions derived from different sexual requests that he made. I inquired whether or not Mary used condoms with Charles knowing this information and she explained that in order to get her bills “paid,” she would often have to “fuck the way Charles wanted,” which included unprotected sex so that he could “get in my guts.” I attempted to make the connection with Mary again by

3 Name/Identity has been altered to maintain client confidentiality
stating that if Charles was positive for HIV and she had sex with him without a condom, could she possibly have HIV, she replied, “Ms. Hamilton, my T-Cell count is high.”

Mary’s denial about her HIV status and the associated risk factors deeply concerned me. A major factor that contributed to this was her substance abuse addiction as well as the risky sexual behaviors that she engaged in which put her at risk for HIV and AIDS infection. I saw major strengths in Mary in that she attempted to complete treatment eight previous times but factors such as transportation, money, concern about the well being of her children, and severing relationships with her boyfriends, which are determined to be gender inequities, prohibited her successful completion.

The Centers for Disease Control and Prevention (CDC) reports that substance abuse has been one of the leading causes of HIV infection among African American women (CDC, 2008). This fact, along with the limited exploration of research into the effects of gender inequities on substance abuse treatment completion, and the increased rates of incarceration of African American women due to substance abuse, has led me to ask, “How do gender inequities affect the successful completion of substance abuse treatment by incarcerated African American women who are at risk for HIV and AIDS infection?” The following study is an exploration of this phenomenon.

Background

Substance Abuse has had harmful effects on society as a whole. In the United States, there was an estimated 22.6 million people who were classified as having substance use dependence as categorized by the Diagnostic and Statistical Manual of Mental Disorders (Substance Abuse and Mental Health Services Administration
The term, "substance use" encompasses illicit drugs which are characterized as marijuana, cocaine, heroin, hallucinogens, inhalants, and non-medical use of prescription drugs (SAMSHA, 2007). In addition, marijuana was reported as being the most commonly used illicit drug which was estimated at 14.8 million people in 2006. In addition, marijuana was used by 72.8% of the current illicit drug users and was the only drug used by 52.8% of them. Drugs other than marijuana were used by 9.6 million people or 47.2% of illicit drug users (SAMSHA, 2007).

There is a need for the exploration of gender issues within substance abuse treatment which affect service delivery, relapse rates, and recovery among African-American women. The National Institute on Drug Abuse (NIDA) reported that while men were more likely to have opportunities to use drugs than women, women were more likely to become addicted to and dependent on drugs, specifically those designed to treat anxiety and sleeplessness (NIDA, 2001). In addition, there are variations that exist between men and women who seek treatment for substance abuse. Women in treatment programs are less likely than men to have graduated from high school, employed, and have other health problems (NIDA, 2001).

The use and abuse of illegal drugs has had a detrimental affect on the health and overall well being of African-American women in particular. Due to economic disparities, many African-American women who use illegal substances are more likely to engage in risky sexual behavior in exchange for money (Sterk, Elifson, & German, 2000). Crack cocaine use, the primary drug of choice among low income, inner city African-Americans, contributes to their chaotic lifestyle (Lam, Cance, Eke, Fishbein,
Hawkins, & Williams, 2007). Research suggests female drug users are more depressed and isolated, influencing the rates of substance abuse marginalization (NIDA, 2001). These factors reduce their negotiating power and ability to successfully navigate condom usage with sexual partners. Moreover, condom use has been considered a social statement of power and self respect that is challenging for most women drug users to assert. Women who do not assert power in sexual relationships are not able to negotiate safe sex and condom use. This reduced power ultimately puts them at risk for contracting HIV/AIDS.

Problem Statement

There is a significant body of literature on Substance Abuse, African-American Women, and HIV/AIDS Prevention. However, there is limited research on the influence of gender inequities on service delivery and relapse among recovering African-American women who are also at risk for HIV and AIDS infection. A review of the literature reveals the following gaps which have ultimately lead to the interest in exploring this research topic. There is a need to understand the gender and cultural issues that place incarcerated, recovering African-American women at increased risk of relapse and HIV and AIDS infection. There is also limited information on the impact of gender related issues on incarcerated African-American women in recovery, such as removal from family settings, the impact of past stressors that contribute to the use of illegal illicit substances, engaging in risky sexual behavior as a result of economic hardships, and the fact that traditional substance abuse treatment has been designed for men and fails to meet the cultural needs of African-American women.
The implementation of therapeutic communities within prisons has become widely used in addressing substance abuse treatment; yet, there are few studies that exist which indicate the effectiveness of these programs for substance abusing women. Another gap is the limited use of interviews and focus groups when exploring African-American women’s perceptions of risk for HIV and AIDS infection. This is important as previous studies have utilized a quantitative approach to investigating African-American women’s perceptions of risk for HIV infection. This limits what information becomes known to only those constructs/questions that are identified and imposed by the researcher on the quantitative data collection tool. There have also been a limited amount of studies that have in fact, utilized a qualitative research methodology in exploring this research topic.

As a social problem, substance abuse, specifically the use of crack cocaine and marijuana as a drug of choice for African-American women, became widely used beginning in the 1980s and 1990s (Dunlap, 2006). In 2007, the Centers for Disease Control and Prevention (CDC) reported that both casual and chronic substance abusers are more likely to engage in high risk sexual behavior, such as unprotected sex when they are under the influence of drugs (CDC, 2007). In addition, nearly 1 in 4 African-Americans live in poverty and the socioeconomic problems associated with poverty, which included limited access to health care, the exchange of sex for drugs, money, or to meet other needs, coupled with high levels of substance use, have both direct and indirect impacts on the risk of HIV acquisition (CDC, 2007). As a result of these factors, there was a need to explore the problem of substance abuse among the African-American
population in observing how gender inequities posed problems and contributed to continued substance abuse as well as increased the risk for HIV and AIDS infection.

**Purpose of the Study**

The purpose of this study is to explore the gender inequities that influence service delivery, relapse, and recovery among incarcerated African-American women who are at risk for HIV and AIDS infection. A Mixed Method Triangulation research design, which is inclusive of both quantitative and qualitative measures, is used in exploring this study. The Mixed Method Triangulation Design is a well known and most common approach used by researchers mixing qualitative and quantitative data (Creswell & Clark, 2007). In addition, the use of mixed method is appropriate for this exploratory study as they have been used in the past in exploring HIV Prevention among vulnerable populations (Pinto & McKay, 2006; Gentry, Sterk, & Elifson, 2005). The dependent variable for this study is: Gender Inequities in Substance Abuse Treatment. The independent variables are: (a) Incarcerated African-American Women at risk for HIV and AIDS infection, (b) Service delivery in treatment centers, and (c) Relapse among women at risk. As a result of the increasing infection rates of HIV/AIDS among African-American women, specifically those who use drugs, there is a need for a study to explore the issues that disproportionately increase the risk of relapse due to gender inequities such as bias against single female heads of household/with children, women with partners, and women who lack of education/employment. The overarching question to address this problem is the degree to which gender related inequities in substance abuse treatment
influence the recovery process of African-American women and increase the risk of HIV infection.

Significance of the Study

This research study is important in addressing the rising rates of HIV infection among African-American women who are substance abusers. Data from the Centers for Disease Control and Prevention (CDC) inform that substance abuse is one of the leading causes of HIV among African-American women (CDC, 2008). In addition, CDC identified four risk factors that African-Americans are likely to face in HIV in relation to the HIV epidemic. These challenges include:

- **Poverty**—People with a limited source of income cannot always afford healthcare whereby maintaining their households are paramount in comparison to taking care of their health. Survival needs such as food, housing and transportation are more important than paying for medical insurance. As a result, poor access to health care and HIV prevention education are barriers. This challenge relates back to relates to the single head of household factor.

- **Denial**—In the African-American community, HIV has not been seen as an immediate threat because it is perceived as a disease acquired by homosexual Caucasian men. This challenge relates back to the perception of risk of disease infection.

- **Sexually Transmitted Disease**—In 2005, African-Americans were 18 times more likely than Caucasians to become infected with Gonorrhea and 5 times
more likely to have Syphilis. Certain STD’s increase the chances of acquiring HIV. This challenge relates back to perceived high risk sexual behavior among the African-American community.

- **Substance Abuse**—Injection drug use is the second leading cause of HIV infection among both African-American men and women. In addition to injecting drugs, people are more likely to take risks such as unprotected sex when they are under the influence. As a result, whether individually or collectively, these challenges influence the risk factors that should be considered when addressing HIV prevention among the African-American community (CDC, 2007).

The results from the study contributes to the body of literature in the fields of both Social Work and Public Health in determining effective methods of treatment that may be the most beneficial when working with African-American women substance abusers who are at risk for HIV infection. The results will also challenge the lack of cultural sensitivity that exists in substance abuse treatment. Moreover, women of color who abuse substances are further stigmatized from their communities as a result of being seen as women have who have violated their maternal figure role (NIDA, 2001).

This research study will also contribute to the growing body of substance abuse treatment literature in that it informs gender specific treatment/intervention strategies. This occurs in the aspects of policy development, program design, planning, and evaluation of substance abuse treatment programs for the target population. At times, the goals of HIV Prevention and Substance Abuse Treatment are conflicting. Many
treatment programs focus on stopping substance abuse altogether and the traditional 12 step programs regularly advocate abstinence while in recovery (NIDA, 2008). On the other hand, many prevention programs focus on safer sex and harm reduction, acknowledging that relapse can occur (NIDA, 2008). As a result, while they are moving in the same direction, their definition of successful outcomes places them at odds. These two perspectives may be challenging, if not impossible, when attempting to merge HIV Prevention interventions within substance abuse treatment programs. There is a need to understand how gender inequities limit the success of African-American women in treatment in order to make them more effective at meeting the needs of the target population by reducing risk factors and increasing protective factors for HIV and AIDS infection.

Nature of the Study

The research study is an exploratory mixed method study. The utilization of both quantitative and qualitative methods has been implemented in order to understand the research by acquiring the two types of data. The goals of the study are to understand how gender inequities affect service delivery, recovery, and risk of HIV and AIDS among substance abusing African-American women. If only a quantitative method were to be implemented, the researcher is only able to complete statistical tests in detailing significance, validity, and reliability among the findings; however, a shortcoming to this approach is that the respondent is limited to the selection of answers provided. On the other hand, the use of the qualitative research methods allows the researcher to pose open ended questions to the respondents and allows the respondents to candidly respond to the
questions with few limitations. This is an added advantage to the data collection process as the researcher may acquire more illustrative, relevant information from the narrative comments that are essential in understanding the research question but may not have been initially solicited by the researcher. In addition, this research design accomplishes the goals of the study as the researcher is able to conduct statistical tests on the quantitative data in determining reliability and validity to questions as well as actively engage the respondents with the use of qualitative interviews and focus groups in obtaining relevant information to the questions based on their lived experiences whereby the researcher may not have initially asked.

Research Questions

The purpose of this study is to explore the presence of gender inequities in substance abuse treatment and their influence on increased HIV and AIDS infection. The overarching question to address this problem is the degree to which gender related inequities in substance abuse treatment influence the recovery process of incarcerated African-American women and increase the risk of HIV and AIDS infection. The research questions that guide this study are the identification of gender inequities in substance abuse treatment, the influence of the gender inequities in substance abuse treatment outcomes, the influence of substance abuse relapse on HIV risk and whether or not women who do not successfully complete substance abuse treatment at greater risk for HIV and AIDS infection. This study sought to answer the following research questions:
RQ1: What are the gender inequities that exist in substance abuse treatment, whereby the oppressive issues such as race, class, gender, which have also been seen as barriers to substance abuse treatment for African-American women, can be addressed?

RQ2: How does forced recovery (incarceration) influence women’s perceptions of their substance abuse?

RQ3: What is the perceived susceptibility of risk for HIV among African-American women in recovery?

RQ4: Are women who do not successfully complete substance abuse treatment at greater risk for HIV infection?

Theoretical Framework

The Biopsychosocial model and Ecological Perspectives are being used as they view the person in regards to the various systems that impact the lives of the research participants (biological make up, family, education, employment, social, and environment). Essentially, in order to begin to understand the African-American woman in the context of any research study, it is important to understand her in the context of the various systems in her life, cultural norms, values, and beliefs, as well as her environment and the various systems within the environment. The Health Belief Model (Hochman, 1958; Rosenstock, 1966, 1974; Becker & Maiman, 1975; Janz & Becker, 1984; Rosenstock, Strecher, & Becker, 1988) is the theoretical framework that is used to explore the perceived severity, perceived barriers, perceived susceptibility of risk, and perceived benefits among the target population. This is a cognitive based theory that is
focused on the prevention and elimination of negative health behaviors that put people at risk for acquiring diseases.

In addition, the Afrocentric Perspective that is used to explore the research topic is Black Feminist Theory. Black Feminist Theory allows for the black woman to be kept central in the context of the research study (Collins, 1991). A main characteristic of the African-American community is the shared aspect of “community” and “collectivism” among the people. Once this is understood, one can then understand the African-American woman in the context of Black Feminist Thought which empowers her, as an individual in the context of her own community, to voice her realities and lived experiences. It is important to note that the Health Belief Model is limited in addressing cultural and structural facets within at risk populations but effective in educating about prevention and risk reduction techniques. This is why Black Feminist Theory was selected as another model to be used simultaneously in looking at HIV Prevention and substance abusing African-American women. A key advantage in using Black Feminist Theory in understanding effective HIV Prevention is the way in which this theory addresses all of the systems that exist in the lives of African-American women and, as a result of their lived experiences and realities, respond to these systems (Gentry, Sterk, & Elifson, 2005).

Definitions

_African-American/Black_—A person having origins/ancestors in sub-saharan Africa.
Biopsychosocial Model—A model that posits the biological, psychological, and social factors play a role in human functioning in the context of illness and/or disease.

Black Feminist Theory—A theory that emphasizes the power of self definition and speaks to the importance of allowing subordinate groups to voice their own reality.

Ecological Perspective—A term that Addresses the reciprocity between a person and their environment.

Health Belief Model—A psychological model that attempts to explain and predict health behaviors by focusing on the attitudes and beliefs of individuals.

Perceived Susceptibility—One’s belief of the chances of getting a condition.

Recovery (substance abuse)—Abstinence from alcohol and/or drugs.

Relapse (substance abuse)—To fall back or slide into a former state.

Substance Abuse—Over indulgence in and dependence on drugs.

Substance Abuse Treatment—Services that focus on initiating and maintaining an individual’s recovery from alcohol and/or drugs and averting relapse.

Assumptions

The 12 step model was developed for Caucasian men who were alcoholics (Matthews & Lorah, 2005). This model may not incorporate the unique needs of African-American women which are necessary in effective substance abuse treatment. Many treatment centers utilize the 12 step approach of Alcoholics Anonymous coupled with understanding the addiction as a disease, as the model for substance abuse treatment (Matthews & Lorah, 2005).
Scope, Limitations, and Delimitations

The scope of the study is African-American women in recovery. Participants of a therapeutic incarceration program, Women for Women, which is housed at the Atlanta City Detention Center, contributed to this study. There are some limitations to this study. Specifically, this study is limited by the sample population who are participants of a therapeutic incarceration program. Consequently, there is a limitation in generalizing the findings to a larger population due to the use of purposeful sampling of the target population. Another limitation may be the comfort level of the participants in speaking freely about their past substance abuse and risky sexual behavior. There is a concern that participants may not be forthright or could possibly present inaccurate information as a result of speaking with the researcher on an individual basis or in the presence of their peers during the focus group.

The focus of this study is on substance abusing African-American women, in looking at how gender issues affect substance abuse treatment, service delivery, relapse and recovery among this population. A limitation that exists is the fact that the participants are actively engaged in a mandated program through their court ordered incarceration. The findings may differ if queried to women who were not incarcerated and thereby actively engaging in substance abuse in the streets. A delimitation of this study is that the focus is on exploring a population of substance abusing African-American women who are being therapeutically incarcerated in order to address their addiction. The findings of this study cannot be generalized to other populations such as
Caucasian women, men, and people who may be living in rural areas who do not share the same lived experiences as those who reside in metropolitan cities.

Summary

This chapter introduced the Mixed Method Triangulation Research Design for this study which addresses gender inequities and the effects on substance abuse treatment for African-American women. The purpose of this study is to explore the gender issues that influence service delivery, relapse, and recovery among incarcerated African-American women who are at risk for HIV and AIDS infection. The expected contributions to the body of literature along with the research questions were outlined in this chapter. The next chapter is a review of relevant literature that addresses African-American women, substance abuse, incarceration, and the risk for HIV and AIDS infection.
CHAPTER II
LITERATURE REVIEW

The purpose of this chapter is to review the relevant literature pertaining to the need for the exploration of gender issues within substance abuse treatment centers that affect service delivery, relapse rates, and recovery, among incarcerated African-American women who are at risk for HIV. The topics that are covered in this chapter include substance abuse in America, gender issues in substance abuse treatment, African-American women and substance abuse, HIV risk/prevention and substance abuse treatment, and substance abuse challenges. The Health Belief Model and Black Feminist Theory are also covered in this chapter.

A review of the literature reveals that substance abuse has had detrimental affects on society. Specifically to African-American communities, the use and abuse of crack has had negative affects on African-American families. The use of illegal drugs in the inner city grew rapidly in the 1960s and continued to expand even into the new millennium. It was during the 1970s that the use and sale of cocaine grew vastly. Moreover, the free base form of cocaine, which was referred to as “crack” began to dominate the illegal drug market in 1986 and 1987. According the 2007 National Survey on Drug Use Health (NSDUH), there was an estimated 19.9 million (8.3%) Americans aged 12 and older who were current users of illegal drugs.
In addition, in a study posted by the journal, *Nature*, it was revealed that HIV has existed among human populations for almost 100 years (Kaiser, 2008). Researchers found HIV/AIDS was not formally recognized until 1981 and scientists had previously estimated its origin around 1930 based on research from lymph node tissue that came from an HIV positive woman who died in the Democratic Republic of the Congo in 1960, which was also referred to as the Belgian Congo (Kaiser, 2008). During the same time period, it was believed by HIV/AIDS experts that the disease derived from a chimpanzee virus. While it is believed that the chimpanzee virus was transmitted to people in Africa where the animals were killed for bush meat, the amount of people who contracted the virus was small (Kaiser, 2008).

In addition, according to researchers, HIV/AIDS infection spread rapidly during the colonial era. Increased colonization during the colonial era included not only a larger amount of potential hosts for HIV living in closer proximity, but also for commercial sex work and other high risk behaviors (Kaiser, 2008). Moreover, while the knowledge and awareness of HIV/AIDS has existed for over 20 years, and the knowledge regarding the negative impact of substance abuse to African-American families has existed since the 1980’s, there is still a void in the literature related to how gender issues exist for substance abusing African-American women who are also at risk for HIV infection (Blumenthal, 1998; Bride, 2001; Washington & Moxley, 2003, Matthews & Lorah, 2005, CDC, 2007; CDC, 2008).
Current Findings

The extensive search of the literature failed to identify research that has addressed the combined facets of substance abuse treatment for African-American women and HIV prevention efforts in highlighting gender issues that inhibit treatment completion. This gap is noticeable in the literature for the fields of both Social Work and Public Health. The literature presented in this chapter is representative of database searches of various disciplines including Social Work abstracts, Public Health abstracts, and journals, Journal Storage (JSTOR - archive of academic journals, Sage Publications and substance abuse journals. This literature search also included title searches on substance abuse and HIV, epidemiology of HIV infection in relation to substance abuse, community psychology, and gender issues. The literature review is presented in nine sections. The first section includes estimates and impact of substance abuse among the general United States population as well as substance abuse in the State of Georgia where this study is conducted. The second section provides a discussion on gender in today’s society as well as the perception of gender roles in the African-American community.

Moreover, the third section addresses African-American women and substance abuse followed by the fourth section which addresses gender issues that exist in relation to substance abuse treatment. In addition, the fifth section provides a discussion on the intersectionality of women, substance abuse, and HIV rates, followed by the sixth section which addresses substance abuse treatment challenges. The seventh section discusses incarceration and African-American women followed by the eighth section which discusses substance abuse treatment for incarcerated women. In addition, the ninth
details the components for effective substance abuse treatment for African-American women. The tenth section addresses the notion of HIV Prevention and substance abuse treatment and concludes with the final section which details the Health Belief Model and Black Feminist Theory.

Impact of Substance Abuse

Research indicates that offenders have been found to have higher instances of substance abuse usage than the general population (Drug Policy Clearinghouse, 2001). The Substance Abuse and Mental Health Services Administration (SAMHSA) has estimated that between 60% and 80% of the nation’s offender population has used drugs at some point, as compared to 40% of the total United States population. In addition, the National Justice Institute estimates that up to 80% of offenders have some level of substance abuse problem related to their criminality (SAMHSA, 2007). One of the findings from a report completed by the National Justice Institute concluded that about two-thirds of both adult male and female felony arrestees had an illegal drug in their system at the time of their arrest (McBride, Vanderwaal, & Terry-McElrath, 2002).

The Georgia Department of Corrections (GDOC) reports that over 75% of its offender population has been assessed with a substance abuse problem. Forty-five percent of those identified have received some form of substance abuse treatment and only 10% of those identified are currently enrolled in substance abuse treatment programs (GDOC, 2008). In addition, one-third of the adult offender population is on a waiting list and 18% have completed some type of substance abuse treatment program of the current offenders, just about half of those identified as having a substance abuse problem were
convicted of a violent crime (GDOC, 2008). Moreover, the State Board of Pardons and Paroles (SBPP) reports that approximately 80% of the parole population has a history of substance abuse based on file reviews conducted during clemency considerations (GDOC, 2008).

In Fiscal Year (FY) 2007, just about 3,500 parolees completed substance abuse treatment out of a total of 8,028 (GDOC, 2008). As a fact, the majority of substance abusers in America have been found to be Caucasian yet minorities, specifically African-Americans, have been arrested and incarcerated at alarming rates as a result of substance abuse (McNamara, 2000). Moreover, substance abuse has been found to be linked to criminal behavior and variables such as poverty, child abuse, failure in school, lack of employment, and lack of health care, are identified as contributing factors.

In addition, the Department of Health and Human Services reports that almost 54% of substance abusers (alcohol and illegal drugs) can be expected to relapse. The potential for relapse is acknowledged as a part of the chronic disease of a substance abuse addiction. Moreover, it was found that women were less likely to relapse than men because they are more likely to seek treatment and engage in group counseling which further validates the notion that women in substance abuse treatment respond positively to group treatment (Rubin, Stout, & Longabaugh, 1996). Moreover, the triggers for relapse for women have been identified as the presence of a romantic partner and reported interpersonal problems prior to relapse (Green, 2006).
The Concept of Gender in Today's Society

The World Health Organization (WHO) defines gender as the socially constructed roles, behavior, activities, and attributes that a particular society considers appropriate for men and women (WHO, 2008). In this society, there are expectations regarding men and women concerning the roles and the expression of intimacy within the inter-gender relationships (Lawrence-Webb, Littlefield, & Okundaye, 2004). For African-American women, issues around consumer culture and who assumes the role of "bread winner" always garners specific attention when addressing gender relationships (Lawrence-Webb et al., 2004). Today's society can be described as patriarchal whereby men establish or inherit a social order where they dominate positions and authority (Lawrence-Webb et al., 2004). Patriarchy, which lends to the power of fathers within families, is embedded in society and has the greatest effects on women. Walby (1990) states that patriarchy consists of six major structures which are: patriarchal relations in the State, patriarchal relations in cultural institutions, patriarchal relations in work, patriarchal mode of production, male violence, and patriarchal relations in sexuality. The interactions of these structures shed light in understanding how they each develop at various times (Lawrence-Webb et al., 2004).

Within substance abusing populations, women appear to suffer greater negative life events than men due to several gender related factors (Eliason, 2006). Substance abusing women experience higher levels of stress compared to male substance abusers or non substance abusing women due to their responsibility to children, living alone, lack of education, limited financial resources, and partners who are more likely to use drugs
(Gilbert & Wright, 2003). Essentially, the implications of both patriarchy and the use of role theory for African-Americans are centered on the political, economical, and social framework that has large implications for the survival of African-American men and women (Lawrence-Webb et al., 2004). This creates a spirit of frustration, tension, and oppressive conditions that African-American men and women have to deal with in establishing and maintaining their relationships (Lawrence-Webb et al., 2004).

Ultimately, it has been found that the livelihood of African-American men and women is dependent upon the access to resources which are controlled by the dominant group in society that is encapsulated in institutionalized patriarchal systems (Lawrence-Webb et al., 2004). In addition, the historical and oppressive experience of African-Americans has had a large impact on gender roles and gender relations. The historical negotiation around gender roles and relationships has been a source of increased stress on the relationships of African-American men and women whereby both parties struggle with meeting their basic living needs while trying to maintain a measure of dignity, respect, and personal validation (Lawrence-Webb et al., 2004).

From slavery to present, African-American men and women in the United States have been exploited economically and greatly excluded from the mainstream social and political institutions from where they could gain advancement (Lawrence-Webb et al., 2004). The marginalization of African-Americans in the United States has had the effect of withdrawing the provider function from African-American men and raising the provider functions of African-American women. As a result of assuming the role of provider for the family, African-American women have become essential in the viability
of the Black families and communities. However, they also face economic oppression and thus have severe challenges in providing for their families (Lawrence-Webb et al., 2004).

African-American Women and Substance Abuse

The use and abuse of illegal drugs has had a detrimental affect on the health and overall well being of African-American women. Due to economic oppression, many African-American women who use illegal substances engage in risky sexual behavior in exchange for money in order to provide basic living needs for their families (Sterk, Elifson, & German, 2000). Crack cocaine use, which has been found to be most prevalent among low income, inner city, African-Americans, is attributed to a chaotic lifestyle (Lam, Cance, Eke, Fishbein, Hawkins, & Williams, 2007). African-American women whose sexual partners did not use condoms were four times more likely to believe that asking the partner to use a condom would imply that he was unfaithful, were three times more likely to receive welfare benefits, two times more likely to be sexually non-assertive, three times more likely to believe that it was not difficult to find an “eligible” African-American man, and three times as likely to have one sexual partner (Wingood & DiClemente, 1998). In addition, research has shown that even when drug users exchange sex for drugs or money, although surprisingly, they are still willing to maintain monogamous relationships (NIDA, 2001). Historically, women drug users have been identified as being depressed and isolated whereby the rates of substance abuse increases as women are marginalized (NIDA, 2001).
Moreover, condom use and sexual decision making have been found to be challenging for most women drug users to assert. Women who do not assert power in sexual relationships are not able to negotiate safe sex and condom use which further puts them at risk for HIV and AIDS infection.

In addition, the substance abuse social problem, specifically the use of crack cocaine and marijuana as a drug of choice for African-American women, became widely used beginning in the 1980s and 1990s (Dunlap, 2006). In 2007, the Centers for Disease Control and Prevention (CDC) reported that both casual and chronic substance abusers are more likely to engage in high risk sexual behavior, such as unprotected sex, when they are under the influence of drugs (CDC, 2007). In addition, nearly 1 in 4 African-Americans live in poverty and the socioeconomic problems associated with poverty, which included limited access to health care, the exchange of sex for drugs, money, or to meet other needs, coupled with high levels of substance use, have both direct and indirect impacts on the risk of HIV acquisition (CDC, 2007).

Gender Issues and Substance Abuse Treatment

There is a need for the exploration of gender issues within substance abuse treatment centers that affect service delivery, relapse rates, and retention, among African-American women. In addition, the National Institute on Drug Abuse (NIDA) defines drug addiction as a brain disease because the abuse of drugs leads to changes in the structure and function of the brain (NIDA, 2008). These changes in structure and function of the brain are the primary reasons why many people are faced with challenges when attempting to end their addiction. Drug addiction, which is also referred to as
“substance abuse,” has also been defined as *substance dependence* whereby an individual persists in the use of alcohol or other drugs despite problems related to the use of the substance (SAMHSA, 2006). This definition was created by the American Psychiatric Association and is used when diagnosing people with “Substance Dependence.” While the exact cause of substance abuse is unknown, the National Institutes of Health (NIH), report factors such as a person’s genes, peer pressure, emotional distress, anxiety, depression, and environmental stress, as factors which may contribute to the use and abuse of drugs (NIH, 2006).

Moreover, substance abuse can also include smoking cigarettes or drinking excessive amounts of coffee. People that abuse substances, do so partly in attempts of obtaining a temporary feeling to increase self confidence and control; however, it causes harm to a person’s health (SAMHSA, 2006). Often times, substance and alcohol abusing behaviors in men begin early in their lives (SAMHSA, 2006). Men and women tend to react differently to drugs whereby men seem to have more severe reactions in comparison to women, and tend to abuse cocaine. Moreover, more men have alcohol dependence or alcohol problems when compared to women and these rates are the highest among young adults who are between the ages of 18 and 29 (Women’s Health, 2007).

Women have long struggled with substance abuse challenges although society has typically viewed substance abuse as a male problem (Blumenthal, 1998). Increased attention should be focused on the significant gender issues in both the development from substance use to addiction and in the course of relapse (NIDA, 2001). Women are at increased risk in comparison to men for becoming addicted to nicotine, tranquilizers, and
sedatives (NIDA, 2001). Moreover, men are at increased risk for dependency on alcohol and marijuana (Moon, 2001). Both men and women are at equal risk for abusing heroin, hallucinogens, inhalants, and cocaine (Moon, 2001).

Research has found that women who relapse usually use drugs or alcohol to lessen negative emotional feelings, specifically anxiety and depression. Women are also likely to attribute their initial substance use and relapses to bad experiences or stressors in their lives (Moon, 2001). Men have consistently had higher rates of substance abuse than women according to a report by the National Drug Control Strategy (NCDS, 2001). Correlates of substance abuse include age, gender, race/ethnicity, social class, and residential location (Drugs and Drug Policy, 2003). Young adult men who are 26 and older, are considerably more likely to use cocaine than women (Drugs and Drug Policy, 2003).

The notion that a gender gap exists in illegal substance abuse is evident being that the perceived consequences related to substance abuse become more significant for women than men as age increases (Drugs and Drug Policy, 2003). In comparison to their male counterparts, parenting responsibilities are attributed to women (Weschberg, Craddock, & Hubbard, 1998). The most common effects of substance abuse and gender inequities for women are seen as the loss of family and romantic partner as well as decreased completion of substance abuse treatment and maintaining employment. As a result, parental responsibilities and the idea of being removed from their families may cause women substance abusers to be both more unwilling and reluctant than male substance abusers to seek treatment (Weschberg et al., 1998). Women substance abusers
who are also mothers are motivated to seek treatment to protect their children but are also
more reluctant than women who are not mothers to seek treatment, because of the fear of
losing custody of their children and childcare demands (Lex, 1991; Thom, 1987;
Weschberg et al., 1998). Finkelstein (1994) argued:

[M]any mothers do not enter treatment because they do not wish to put their
children in foster care; fear they will lose custody of their children; and
believe, as society does, that they are terrible people and bad mothers. This
extreme guilt and shame keeps them in denial and out of treatment. (p. 9)

Mumm and Allen (1998) highlighted:

[P]hilosophical differences can hinder service delivery. The child welfare
system is mandated to protect children and assure their safety. Substance
abuse treatment providers, on the other hand, must focus on engaging the
parent in the recovery process, a process that is slow and characterized by
relapse . . . parents have increasingly found themselves caught between
these two systems as reports of substance abuse to state child welfare
systems have escalated. (p. 385)

Azzi-Lessing and Olsen (1996) also observed that when mothers are referred to
substance abuse treatment by child welfare officials, they are referred to a system that has
historically focused on treating the “individual’s problems” and that has been dominated
by treatment models favoring the needs of men. In addition, women substance abusers
have higher rates of sexually transmitted diseases which can lead to HIV infection (CDC,
2007). This is due to engaging in risky sexual behaviors while under the influence of
drugs. Also, substance abusing women often trade sex in exchange for drugs or money (CDC, 2007).

In addition, gender specific planning for programs provides women an opportunity to focus on their needs and desires away from their traditional concerns of social approval and the welfare of others (Bride, 2001). Specifically, the basic requirements of specialized treatment for women are a female therapist, availability of individual counseling, and women only groups (Bride, 2001). In a study by Bride (2001), the use of group therapy and individual interview sessions with Addictions Treatment Counselors, who were women, were utilized. This article also highlighted the fact that women-only programming with women-only staff had great implications for women completing substance abuse treatment programs.

In addition, during the interviewing process, demographic information such as client age, ethnicity, education, marital status, drug of choice, polysubstance abuse, and number of previous substance abuse treatment episodes, was collected. This article was helpful in detailing this information as this is information that is collected using the quantitative data collection method in order to conduct statistical analyses of the strengths of relationships among the variables and obtain visual illustrations on the results. For this study, the independent variable was the completion of day treatment. The researchers identified this as the independent variable because previous studies have consistently reported that most attrition occurred early with the majority of drop outs occurring in the first month of treatment (Bride, 2001). Both Day Program and 90 day completion were recorded as dichotomous dependent variables. In addition, length of stay was chosen as
the third dependent variable because a number of studies indicated that longer treatment
duration predicted improved outcomes with the degree of improvement proportional to
the length of time spent in the treatment (Bride, 2001).

Additionally, because individual interviews were the main source of data
collection for this study, the authors were able to obtain a wealth of knowledge from their
open ended questions which indicated implications for gender specific programming in
addressing gender inequities in substance abuse treatment. The authors were also able to
gather in depth information in understanding the answers to the questions that were posed
in acquiring this information from the study participants based on their experiences.

Further, it was not until feminist theory and the woman’s liberation movement
when male dominated societal norms were questioned and women who were addicted to
substances began to receive attention in their own right (Kandall, 1998). Moreover, for
the reason that women have been underrepresented in research studies and treatment
groups, the effects of and treatment for substance abuse among women are often less
understood than for men (Bride, 2001). The acknowledgement of this fact has led to an
increased emphasis on the development of treatment programs that address the unique
needs of women substance abusers. Blumenthal (1998) noted that in order to increase the
retention of women in substance abuse treatment, the treatment approaches utilized must
address gender inequities in the etiology and treatment of addictive disorders in order to
respond to these unique needs.

In addition, ensuring that the data collection approaches (surveys, interviews, and
focus groups) that I intended to employ are effective in the identified population of
research, I examined another empirical article, "An Examination of Addiction Treatment Completion by Gender and Ethnicity," in exploring the data collection approaches to be used in this study. In this study, the authors examined the discharge status of clients that were admitted to an intensive outpatient facility over the course of a year, specifically exploring the differences based on the client gender and ethnicity in addressing gender inequities. This article argued the need for more culturally sensitive addiction treatment and addressed alternative approaches. Alcoholics Anonymous was developed by Caucasian men who were alcoholic, which was based on their realities of addiction (Matthews & Lorah, 2005).

In addition, this use of Alcoholics Anonymous to substance abuse treatment has encountered several criticisms with respect to women and members of ethnic minority groups being that it was developed by Caucasian men based on their addiction reality. This model focuses on individual pathology and fails to take into account the social and political realities that may affect not only patterns of use but also the realities of addiction and recovery (Matthews & Lorah, 2005). This focus fails to address the effects of sexism and racism on those who experience it (Matthews & Lorah, 2005). The traditional model also fails to acknowledge the differences in the life experience that influence the patterns and impact of substance use (Matthews & Lorah, 2005). In terms of data collection, information such as client gender, client ethnicity, number of days in treatment and discharge status, were collected. All of the staff members were Caucasian, two males and two females, and each participant attended therapy as a part of their substance abuse treatment program. The authors in this article failed to mention the effects of sexism and
racism of the traditional model. This model also fails to acknowledge the differences in the life experience that may have influenced the patterns and impact of substance use (Matthews & Lorah, 2005). This information is vital to me in understanding the service delivery, relapse rates, and recovery for African-American women who are enrolled in treatment centers that are based on the traditional Eurocentric model. The authors utilized surveys and observations as data collection methods for this study. Furthermore, the purpose of this study was to compare the treatment completion rates and the discharge status of women with the rates and discharge status of men and to compare the treatment completion rate and the discharge status of African-American clients with those of Caucasian clients (Matthews & Lorah, 2005).

Moreover, women substance abusers differ when compared to men in their usage patterns (Worrell & Goodheart, 2005). For example, among those who are in substance abuse treatment, women were found to be more likely than males to be daily users of cocaine, barbiturates, and heroin, and used larger quantities of cocaine over a period of a week (Worrell & Goodheart, 2005). Women who used illicit drugs were most often between the ages of 18 and 25, with rates decreasing as age increased and African-American women reported more current use of cocaine and marijuana (Worrell & Goodheart, 2005). The growing body of research on the differences between male and female substance abusers strongly indicates the need for gender specific services. This research has identified various previous circumstances and consequences that lead to abuse, different patterns of substance abuse, and different barriers to treatment and relapse triggers. In addition, men tend to have more access to money and crack;
therefore, they dominate in their relationships with women who are substance abusers. Women who tend to smoke crack in crack houses have the understanding that smoking with a man in the crack house often requires a sex act in exchange with no negotiation of price, type of sexual act, or use of protective behaviors during sex (CDC, 2006). In short, the man who possesses the crack will ultimately receive what he desires.

As a result of crack cocaine being identified as the drug of choice for African-American women, it is important to note that not all women who use crack report exchanging sex for drugs or money (Logan, Leukefeld, & Farabee, 1998). Prevention that is tailored towards African-American women should address these partner influences and gender related factors (Wingood & DiClemente, 1998).

Early life trauma and childhood physical and sexual abuse have been linked to substance abuse in adulthood for women as women learn to self medicate as a coping mechanism (Eliason, 2006). These traumatic events are additional gender issues that pose as a challenge to the successful completion of substance abuse treatment. In addition, more women than men in the penal system report substance abuse and dependency, with 80% of women compared to 50% of men reporting recent substance abuse (Eliason, 2006). Women report greater substance abuse usage patterns and experience negative consequences of use whereas men report greater usage of alcohol.

Further, the patterns, consequences, and reasons for substance abuse are different among men and women (Bride, 2001). Previous studies that have compared men and women who are in substance abuse treatment found that women report more psychiatric symptoms than men, more feelings of depression and anxiety, and lower self esteem and
self perception (Bride, 2001). Moreover, the rates of treatment entry, retention, and completion are considerably lower for women than for men (Bride, 2001). Because of these differences, the substance abuse treatment strategies that are designed for men generally fail to adequately address the needs of women substance abusers which can ultimately prevent the entry and retention of women in substance abuse treatment.

Power differentials between men and women have also been referred to as gender inequality, gender inequity, unequal status, and women’s lack of autonomy (Pulerwitz, Gortmaker, & DeJong, 2000). These power differentials are reflected in women’s relationships and sexual behavior. The reality that men have traditionally held larger influence over when, where, and how sex will occur may render some women incapable of successfully initiating discussions about or negotiating safer sex (Pulerwitz et al., 2000). Ultimately, to engage in safe sex practices, male cooperation is required (Pulerwitz et al., 2000). Research studies that have conducted focus groups with women reported that the women felt they would not insist on condom use due to feelings of not possessing enough power in their sexual relationships with men (Pulerwitz et al., 2000). These findings indicate that relationship power is an important component in the safe sex negotiation process which is ultimately a key factor in a woman’s HIV/STD risk (Pulerwitz et al., 2000).

The National Institute on Drug Abuse (NIDA) reported that while men were more likely to have opportunities to use drugs than women, women were more likely to become addicted to and dependent on drugs, specifically those designed to treat anxiety and sleeplessness (NIDA, 2001). In addition, there are variations that exist between men
and women who seek treatment for substance abuse. Women in treatment programs are less likely than men to have graduated from high school and to be employed, and are more likely to have other health problems (NIDA, 2001). Moreover, women of color who abuse substances are stigmatized due to the fact that a Substance Abuse Disorder in the African-American community has been considered to be a violation of the cultural patterns for African-American families especially when the woman substance abuser is formally perceived as the maternal figure in the family (NIDA, 2001).

In addition, HIV infection is closely related to the rates of substance abuse and incarceration and the detrimental affects are seen especially among African-American women (SAMHSA, 2008). Ultimately, there is an intrinsic need for HIV Prevention within substance abuse treatment programs due to the increased rates of HIV infection and risk behaviors among substance abusers, specifically African-American women. Further, participants in these types of integrated programs benefit greatly and are equipped with risk reducing knowledge on how to protect them from HIV infection as well as address their substance abuse challenges (SAMHSA, 2008).

Gender related dynamics are relevant to whether women will take an active or passive partner about safer sex practices, deciding whether and when safer sex practices will occur, using strategies to negotiate or assert power to protect their own health or refusing to engage in risky sexual practices (Bowleg, Belgrave, & Riesen, 2000). These dynamics are key in understanding how a woman decides to engage in sexual intercourse with a partner. Another element that is present is the use of illegal drugs. Often times, women who use drugs engage in risky sexual behaviors such as injecting drugs and
having unprotected sex, which puts them at risk for HIV. In addition, women who are involved in relationships with violent male partners are also at risk for HIV infection. This is due to greater STD risk, psychosocial distress, and substance abuse. Traditional gender role beliefs, lower self esteem, and engaging in sex work activities have contributed to this risk factor among this population (Beadnell, Baker, Morrison, & Knox, 2000).

Women, Substance Abuse, and HIV Rates

Substance abuse has been identified as a major risk factor for acquiring HIV because of its direct association through unsafe injection drug use practices and connection to unsafe sexual behaviors (Elifson, Klein, & Sterk, 2006). Additionally, although African-Americans only account for 13% of the United States population, they comprise 49% of the people who acquire HIV/AIDS (CDC, 2008). In essence, HIV/AIDS is the leading cause of death among African-Americans. Among men, 41% that were diagnosed with HIV/AIDS were African-American and among women, 64% that were diagnosed with HIV/AIDS were African-American (CDC, 2008). Thus, African-American women are disproportionately affected by the HIV/AIDS epidemic. In the State of Georgia, African-Americans make up 30% of the population but account for 30% of all people living with AIDS as of December 2006 (Black AIDS, 2008).

According to a report released by the Black AIDS Institute, it detailed that the United States is not doing enough to address the spread of HIV/AIDS among African-Americans (Kaiser, 2008). This report indicated that in some areas of the country, the HIV/AIDS among African-Americans is similar when compared to some countries in
Africa. In addition, this report was funded by the Ford Foundation and the Elton John AIDS Foundation states that almost 600,000 African-Americans in the United States are living with HIV and that almost 30,000 are contracting the virus each year (Kaiser, 2008). In addition, more African-Americans are living with HIV in the United States than people in Botswana, Ethiopia, Guyana, Haiti, Namibia, Rwanda, and Vietnam—7 of the 15 countries targeted in the Presidents Emergency Plan for AIDS Relief (Kaiser, 2008). Moreover, HIV prevalence in rural areas in the United States is just as high as the rates found in the cities.

Research has shown that African-Americans have a higher risk of HIV due to being unaware of their partner’s risk factors, being exposed to other sexually transmitted infections (STI’s), and living in poverty (CDC, 2007). This is a major concern for society on a larger level as well as African-American people as a whole as well. In addition, substance abuse has been linked to a range of HIV related sexual risk practices which includes having multiple sex partners, having sex while under the influence of drugs, bartering sex for drugs or other goods, and failing to use protective barriers to prevent the spread of HIV and other sexually transmitted infections (Elifson, Klein, & Sterk, 2006).

A study conducted by Elifson, Klein, and Sterk (2006) found that African-Americans were engaging in more frequent risky sex than their counterparts. The authors concluded that this finding was consistent with national trends that indicate higher rates of HIV infection. This is one of the critical reasons why it is important that substance abuse interventions address HIV prevention when working with African-Americans.
(Elifson, Klein, & Sterk, 2006). These interventions should be designed to be innovative, creative, and culturally appropriate, and specific for African-American women who suffer the greatest from the effects of substance abuse and HIV prevention when compared to other gender and ethnic groups (Elifson, Klein, & Sterk, 2006). Research has found that women use drugs as a means of escaping emotional problems by self medicating low self esteem, depression, and past traumatic events (Sterk, Elifson, & German, 2000).

Crack cocaine is a drug that has been identified as a drug of choice for African-American women and prostitution was used frequently as a means to support the crack cocaine habit (Sterk, 1999). It was during the mid 1980s that crack cocaine began to dominate the United States street drug market and the extent substance abuse by women was often downplayed because it undermined society’s expectation of how women should behave in relation to perceived social roles (Washington & Moxley, 2003). While drug addiction affects all women who derive from various ethnic, cultural, and socioeconomic backgrounds, women who abuse cocaine and heroin tend to develop dependency sooner when compared to men who abuse the same substances (Washington & Moxley, 2003).

Moreover, most of the prescriptions for amphetamines and anti-depressants in the United States are prescribed to women (Washington & Moxley, 2003). In addition, it has been found that women also tend to use prescription drugs for non-medical reasons subsequently becoming addicted to the narcotics. Also, in addition to heroin and crack cocaine as drugs of choice, women have been found to also abuse alcohol and marijuana.
The use of these substances provide a temporary “high” which attributes to increased energy and mental alertness as well as provide a short term relief from they psychosocial and traumatic experiences that had subsequently led to the use of substances (NIDA, 2008). Moreover, using a drug of choice such as crack is more appealing to women as it’s an inexpensive version of cocaine which it easier to obtain which ultimately makes it more addictive and keeps the women using it. Injecting and smoking crack cocaine produces a quicker, stronger “high” than snorting the substance in that it is quickly absorbed into the blood stream (NIDA, 2008).

Of all the racial and ethnic populations, HIV/AIDS has had detrimental affects on the African-American community. Barriers such as poverty, sexually transmitted diseases, substance abuse and societal stigma are factors that contribute to the disproportionate rates of infection among African-Americans (CDC, 2008). Moreover, the challenges that exist in addressing substance abuse treatment among women are largely due to the fact that substance abuse treatment has historically been developed from a Caucasian male perspective. It was not until the last ten years that the need for culturally specific and gender specific interventions have been identified.

For African-American men, the most common ways of acquiring HIV are having unprotected sex with another man who has HIV, sharing injection drug paraphernalia (needles/syringes) with someone who has HIV, and having unprotected sex with a woman who has HIV (CDC, 2008). For African-American women, the most common ways of acquiring HIV are having unprotected sex with a man who has HIV and sharing injection drug paraphernalia with someone who is HIV positive (CDC, 2008).
Injecting drugs is the second leading cause of HIV infection for African-American men and women (CDC, 2008). In addition, to injection drug use, people who use other drugs are more likely to take risks, such as unprotected sex when they are under the influence (CDC, 2008). Ultimately, along with alcohol, men tend to inject drugs which then put them at greater risk for HIV. Women tend to abuse substances which alter their judgment and put them at risk for engaging in risky sexual behaviors such as unprotected sex while under the influence. The issue of negotiating safer sex behaviors for women who are substance abusers is of concern when interacting with men who also abuse substances. A number of researchers have proposed that women are constrained in negotiating safer sex practices due to gender based imbalances in relationship power (Pulerwitz et al., 2000).

Substance Abuse Treatment Challenges

In addition, in order to combat challenges in substance abuse treatment programs, it is important that programs are linked to primary care, mental health, HIV specific care and related services that address counseling, testing, partner notification, and social services (SAMHSA, 2007). The Substance Abuse and Mental Health Services Administration suggests addressing these challenges by having gender specific substance abuse treatment centers for African-American women who engage in sexual activity for the exchange of drugs and/or money, and having specialized groups that address health and wellness and relapse for homeless or current drug addicts, including injection drug users and men who have been released from prison (SAMHSA, 2007). Substance abuse is linked to HIV and effective substance abuse treatment and prevention is paramount in
HIV prevention. The National Institute on Drug Abuse (NIDA) views substance abuse treatment as a vital part of HIV prevention due to the fact that substance abuse encourages risky behaviors. Moreover, additional challenges to addressing substance abuse and HIV treatment among African-American women are problematic because women that abuse substances have been found to be poorly educated in general and specifically about their sexual and reproductive health (CDC, 2007). As previously mentioned, minority populations, African-American women specifically, are disproportionately affected by the health consequences of substance abuse and HIV. HIV has been found to eventually develop into AIDS and in 2006, African-American women accounted for 36% of all African-Americans diagnosed with AIDS and represented 66% of AIDS cases in women (CDC, 2007). Sixty-eight percent of African-American women living with AIDS at the end of 2006 acquired their infection through heterosexual contact, 30% through injection drug use, and 2% from other undetermined causes (CDC, 2007).

There continues to be a rise in HIV rates among African-American women who are substance abusers. Particularly, substance abusing women tend to trade sex for drugs thereby increasing their HIV infection (CDC, 2007). Another important factor is the impairment of judgment that ensues while under the influence which increases the participation of risky sexual behaviors and injection drug use (Elifson, Klein, & Sterk, 2006). There is an estimated one in five new diagnoses of HIV for women as related to injection drug use (CDC, 2007). In addition, feelings of powerlessness as related to sexual decision making and condom use are also factors that contribute to increased risk
of HIV among substance abusing women. Specifically, sexual inequality in relationships with men is a major issue in women effectively negotiating condom use in efforts of practicing safe sex techniques (CDC, 2007).

In addition, HIV patients who also have a substance abuse disorder, when provided an intravenous line for infusion therapy, can use the equipment to administer heroin, cocaine, or other drugs, which is continued detrimental behavior to their health and the health of the public at large. Also, clients may relapse and become noncompliant with medical orders for HIV/AIDS (SAMHSA, 2007). Street drugs have also been found to interact with and affect medications used to treat HIV/AIDS (SAMHSA, 2007). When considering HIV infection, it is important for substance abuse treatment to engage in HIV prevention efforts as this is key in reducing the transmission rates. Statistics reveal that injection drug users who do not enter treatment are six times more likely to become infected with HIV when compared to those who enter and remain in treatment (CDC, 2002).

In addressing substance abuse treatment challenges for African-American women, a common barrier that plagues many programs is the fact that historically, the programs were developed from a Eurocentric basis, not designed to meet the needs or address the challenges experienced by substance abusing African-American women (Matthews & Lorah, 2005). Traditionally, this was the rationale of many treatment programs. Data has suggested the need for gender specific and culturally specific substance abuse treatment in addressing these challenges. Other challenges that exist which pose as barriers to African-American women entering treatment are programmatic requirements, societal
stigma, and the overall design of the program (Matthews & Lorah, 2005). Programmatic requirements for some treatment programs detail that women who receive Social Security benefits (SSI) or are pregnant are ineligible to receive services although they may have a diagnosed substance abuse disorder. In some cultures, societal stigma can serve as a challenge for completing treatment and in the African-American culture, women are seen as the “home maker” or maternal figure who was supposed to be in the home (Lawrence-Webb et al., 2004). Thus, substance abuse was shunned and African-American women who abused substances were looked down upon. This in turn, presents discomfort for a substance abusing African-American women who seeks to enter treatment but does not want to receive the backlash from her community. In addition, the design of a substance abuse treatment program can also present challenges for an African-American woman seeking treatment services. Some programs are designed whereby women cannot take their children into treatment or can take some of their children but not all of them, with limits of two children per client (G. Monroe, Personal Communication, November 14, 2006). Some women opt not to enroll in and complete treatment if it means they are not able to bring their children (Flavin, 2001). This further adds stigma on this population and serves as an obstacle for entering and completing treatment.

On the other hand, researchers, practitioners, and advocates have proposed new and innovative ways in ensuring success for African-American women completing substance abuse treatment. The use of faith based initiatives, group work, gender specific and culturally specific programs have proven to be groundbreaking methods in addressing challenges that are experienced. Moreover, federal agencies such as the
Substance Abuse and Mental Health Services Administration (SAMHSA) and the Centers for Disease Control and Prevention (CDC) continue to fund faith based organizations such as churches and non profit agencies in their efforts of providing substance abuse treatment services to women of color. Many of these programs are specifically tailored for the African-American community and are equipped to address the cultural needs of the community members. Often times HIV prevention is also addressed from the faith based standpoint due to the virus having a disproportionate adverse affect on the African-American community and the African-American community which traditionally seeks assistance from churches in their communities when facing hardships (Billingsley & Caldwell, 2001). The use of group work in substance abuse treatment also serves as an advantage in addressing treatment challenges (Bride, 2001). The notion of "community" and "collectivism" is characteristic of African-American heritage and research has shown that substance abuse treatment facilities who incorporate group work in their program design with African-American women, receive increased program participation and success rates. The destruction that has occurred in African-American communities by HIV and substance abuse garners a proactive and aggressive public policy response (CDC, 2007).

In addition, in a study by Washington and Moxley (2003), the authors addressed group intervention with low income African-American women who were recovering from substance abuse addiction in a treatment program. Addiction to drugs affects women from diverse cultural, ethnic, and socioeconomic backgrounds (Washington & Moxley, 2003). This study also utilized group therapy and qualitative inquiry in the form
of unstructured in person interviews, as a method of data collection. Substance abusing women experience serious consequences as a result of substance abuse, with treatment complicated by physiological, psychological, and social concerns (Washington & Moxley, 2003). Female cocaine and heroin users appear to develop a dependency to substances much sooner than their male counterparts (Washington & Moxley, 2003). Women are also more likely than men to suffer greater negative consequences, in part, because of their physical reaction to substance use and addiction and greater stigmatization and negative reactions from society (Washington & Moxley, 2003).

In terms of substance abuse treatment, group work has been found to be successful because it can integrate different treatment strategies to achieve social support, skill development, and role change. Group work also establishes the context in which the participants learn new coping skills using didactic techniques, role modeling, and the sharing of information (Washington & Moxley, 2003). Group work is especially relevant to women who cope with addiction because it decreases the feelings of isolation and increases support by fostering interaction, affiliations, and the social involvement among group members (Washington & Moxley, 2003). This also motivates the participants in a substance abuse treatment program in acquiring the skills needed to resolve personal and family issues that can undermine recovery.

Moreover, recovery focused group work should be flexible and vigorous enough in order to assist participants in negotiating distinct phases of recovery to confront and resolve social and legal issues, securing roles and resources that increase the participants functioning, preventing relapses, and assisting them in facilitating their own economic
independence (Washington & Moxley, 2003). Much of this type of group work is based on the use of qualitative inquiry in allowing the participants to share their experiences as each individual has their own plight (Washington & Moxley, 2003). This allows the practitioner to then plan and implement substance abuse treatment programs based on the experiences that have been exposed by women who abuse substances. This ultimately ensures greater service delivery and treatment completion rates as the program is designed and implemented based on the past lived experiences of substance abusing women. This type of planning and implementation of gender specific programming for substance abusing women not only confronts gender inequities but challenges the use of the historical model which was developed based on Caucasian men who were alcoholics.

In all, this study by Washington and Moxley (2003) utilized group work and unstructured in person interviews as a recovery mechanism for women in a substance abuse treatment program. Empowerment Theory and Self Efficacy Theory were also utilized in structuring the group activities. The criteria for inclusion in this study incorporated living in a residential inpatient facility for recovering substance abusing women, speaking and reading English at a sixth grade level, receiving treatment for a minimum of ten days, and have no psychiatric diagnoses. In addition, the demographic information that was collected was marital status, ethnicity, annual income, source of income, educational level, and type of drugs used. The authors reported that this demographic information was obtained for the purposes of determining statistical significance; however, the article failed to mention the use of surveys or the data collection tool utilized in acquiring this information.
Another study that incorporated both surveys and interviews was completed by Theall, Sterk, and Elifson (2004) entitled, “Past and New Victimization Among African-American Female Drug Users who Participated in An HIV Risk Reduction Intervention.” Adverse experiences which are prompted by the ecological combination of social and health problems are commonly found in women of color who reside in inner city communities (Theall, Sterk, & Elifson, 2004). Among the affects to their individual well being are victimization experiences, substance abuse, and the HIV/AIDS epidemic and a lack of community level resources of social capital (Theall, Sterk, & Elifson, 2004). In order for women to enhance their health and welfare, they need to acquire skills that will assist them in reducing their individual threat levels as well as learn strategies to successfully navigate the social infrastructure (Theall, Sterk, & Elifson, 2004). This is the point which leads this researcher to the rationale for the use of qualitative inquiry and specifically, the use of interviews. In order for substance abuse treatment programs to address the victimization of women of color, it is important for a sample of women from the identified population to be given a chance to voice their experiences and the experiences of their friends who live the same lifestyle as this information is key in the development and implementation of programs designed to meet the needs of this population.

In addition, as women continue to be disproportionately affected by the devastation of the HIV/AIDS epidemic, risk reduction prevention interventions have been designed to assist them in reducing their sexual and substance abuse related risks (Theall, Sterk, & Elifson, 2004). These types of interventions have been found to be successful.
Between those that have targeted female drug users, however, substance abuse related risk reduction tends to surpass sexual risk reduction (Theall, Sterk, & Elifson, 2004). The authors employed street outreach techniques such as ethnographic mapping and targeted sampling in acquiring the participants for their study in Atlanta, Georgia. The participant criteria included women who were at least 18 years of age, resided in one of the identified communities, were not presently enrolled in substance abuse treatment, were proficient in English, HIV negative, have had vaginal sex with a man at least once during the month prior to the interview, and were an active substance abuser (measured as having smoked crack cocaine or injected drugs at least three times during the 30 days prior to the baseline interviews).

In addition, the authors utilized various theories in this study which included the Social Cognitive Theory, The Theory of Reasoned Action, The Theory of Planned Behavior, Transtheoretical Model of Change, and the Theory of Gender and Power (Theall, Sterk, & Elifson, 2004). The authors conducted interviews at baseline and post intervention in measuring change as well as acquiring in depth information from the study participants about their ways of living. A survey was also used to acquire demographic information which was analyzed statistically although the authors failed to mention this tool in the article. As a result the researcher was able to ascertain this notion of the use of a quantitative tool such as a survey, as evidenced by the empirical results and tables from the statistical tests that were performed by Theall et al. The results from their interviews informed that culturally appropriate, woman tailored, and theoretically based interventions may be effective at enhancing HIV preventive behavior among
African-American women, who use illegal drugs, thereby decreasing the likelihood of victimization. These findings also suggest the same implications for the implementation of substance abuse treatment programs for the same population of women.

**Incarceration and African-American Women**

Since the 1970s, the jail and prison population in the United States has increased at an extraordinary rate. This more than 500% rise in the number of incarcerated people has resulted in a number of 2.2 million people behind bars. Among this number, African-Americans include 900,000. Data from the Bureau of Justice Statistics state that one in six African-American men had been incarcerated as of 2001 (Bonczar, 2003). The existence of incarceration for women is considerably lower than men yet African-American women are more likely to be incarcerated than Caucasian women (The Sentencing Project, 2008).

In Georgia, there were disproportionate rates of incarceration among races whereby Caucasians accounted for 623 per 100,000, African-Americans were 2,068 per 100,000, and Hispanics accounted for 576 per 100,000 (Bureau of Statistics, 2005). In addition, drug offenses accounted for half (49%) of the rise in the number of women incarcerated in state prisons for 1986-1996, compared to a 32% increase for men (The Sentencing Project, 2008). In highlighting drug offenses that occurred in Metropolitan cities, they accounted for 91% of the increase in the number of women sentenced to prison in New York from 1986 to 1995 and 55% in California (The Sentencing Project, 2008).
Moreover, the amount of women in prison, a third of whom are incarcerated for substance abuse, is increasing at almost double the rate of men. Often times, significant histories of physical and sexual abuse, high rates of HIV infection, and substance abuse, affect women and contribute to their addiction (Bride, 2001; Eliason, 2006; Gentry et al., 2005; Moon, 2001). On a larger level, women's incarceration has resulted in a large number of children who suffer from their mother's imprisonment and the loss of family ties (Lex, 1991; Thom, 1987; Weschberg et al., 1998). More than 1 million women are currently under the supervision of the criminal justice system in the United States and at least 200,000 of these women are confined in State and Federal prisons or local jails (The Sentencing Project, 2009).

In 2003, women in state prisons were more likely than men to be incarcerated for a drug offense (29% v. 19%) and less likely than men to be incarcerated for a violent offense (35% v. 53%). African-American women account for 30% of all Women incarcerated under state or federal jurisdiction (The Sentencing Project, 2007). In 2005, African-American women were more than three times likely as Caucasian women to be incarcerated in prison or jail. Sixty percent of women in state prison with a history of substance abuse and 1 in 8 women in federal prison receive treatment for their addiction (The Sentencing Project, 2008) (see Figure 1).
Figure 1. National Statistics of Incarcerated Women and Services They Received
(Source: Barriers to Reentry, Women’s Prison Association, Focus on Women and Justice, 1997)

Substance Abuse Treatment for Incarcerated Women

Research shows that only a small portion of people who have substance abuse challenges voluntarily seek help (Bamenberg, Raat, & Plomp, 1992; National Survey of Drug Use, 2003; Price, Cotter, & Rubins, 1990). The legal coercion of people with substance abuse challenges to enter treatment as an alternative to coercion has become widespread (Leukefeld & Tims, 1988; Price & DiAunno, 1992; Shottenfield, 1989). The implementation of legally coerced care remains to be controversial and poses various challenges for Social Workers and other behavioral health care workers. At times, this controversy focuses on ethical or due-process issues associated with the use of forced entry into treatment but also often focuses on debate about the effectiveness of coerced care (Fagan, 1999; Marshall & Hser, 2002; O’Hare, 1996).

In essence, court ordered care is an emerging component of current drug policy aimed at closing the “denial gap” by exposing people to treatment who may not otherwise
seek it (National Drug Control Strategy, 2004). While studies of legally coerced
treatment for substance abuse have not been inclusive of other findings, several studies
support the notion that coerced clients do as well or better than clients who enter
treatment voluntarily (Anglin & Hser, 1990; Collins & Allison, 1983; Leukefeld, 1988;

In addition, earlier studies have focused on treatment retention rather than
treatment outcomes such as the reduction or elimination of substance abuse or the
severity of substance abusing behavior challenges. Some of the studies identified that
coerced individuals remained in treatment longer than non coerced individuals (Anglin,
Drecht, & Maddalman, 1989; Collins & Allison, 1983; Deleon, 1988a; Leukefeld, 1988;
Loneck, Garnett, & Banks, 1996). In other studies, there were no significant differences
noted in treatment retention between coerced and voluntary clients (Allan, 1987; Brizer,
Malansky, & Galanter, 1990; Deleon, 1988b; Rosenberg, & Liftek, 1976; Simpson &
Friend, 1988). Unfortunately, legal pressure to attend and complete treatment
expectations may have compelled both those who were initially unmotivated to engage in
the prescribed behavior change and those who were anxious about this treatment option.

The Notion of Forced Recovery

Due to punitive drug policies and enforcement, substance abuse offenses now
account for the rapid growth of women in prison (Messina, Wish, & Nemes, 2000).
There is a growing phenomenon of therapeutic community (TC) programs in prisons
across the United States. Research indicates that the use of therapeutic communities in
prisons has been implemented without consideration to whether or not they are the most
effective for use with women (Eliason, 2006). Moreover, there is a heightened need for gender specific treatment programs for substance abusing women as a result of findings that indicate the differences that exist among male and female substance abusing behaviors (Farrell, 2000). Substance abuse has been found to be the main reason for the initial arrest of women, the increase in incarceration of women, and the major reason for parole violations (DeLeon, Melnick, & Kressel, 1997).

In addition, the evolution of “therapeutic communities” occurred in the 1980s as they emerged in a few prisons. They were common in psychiatric facilities and communities in the 1960s but due to change in payment systems and budget cuts, most communities could no longer sustain the use of therapeutic communities. On the other hand, prisons were principle in implementing a rigorous, long term substance abuse program (Eliason, 2006). In addition to addressing substance abuse, the use of therapeutic communities also foster positive values that reduce criminal thinking and behaviors. Moreover, one of the characteristics of therapeutic communities is the close knit relationship among groups of supportive people. This is attained in a rigid and highly structured environment with consistent procedures that extend for several months to over a year. While prison-based therapeutic communities vary, most have displayed features in that they are rooted primarily on a Social Learning Model, participants are isolated from the influence of the prison’s general population, participants experience a total immersion into treatment where daily activities become a part of the treatment regime and the supports of peer counseling serve as a major component of the therapeutic intervention (Messina et al., 2000).
Ultimately, because of a woman's participation in a substance abuse therapeutic community during incarceration, one can posit that the notion of forced recovery exists. During the participation in this program, the client is addressing their addiction in an intensive program and focusing on ways to improve their outcomes and address substance abusing behavior in efforts of preventing relapse from occurring once they are released. While it is known that illegal drugs are sometimes consumed in prison, the concept of abstinence from substance abuse is implied because the substances are not readily available as they would be given the participant was not incarcerated or in a controlled environment. The U.S. Office of National Drug Control Policy (1999) commissioned standards for prison based therapeutic communities, establishing the core principles and approaches of a therapeutic community, and outlined four major philosophical issues for all prison based therapeutic communities which include:

1. Substance abuse and criminality are symptoms of a disorder of the whole person;
2. The disorder of the person consists of social and psychological characteristics that must be changed;
3. "Right living" refers to the morals and values which sustain recovery, and is the goal of treatment; and
4. Recovery is a developmental learning process.

Outcomes of Therapeutic Communities for Men

Research conducted on men who participated in therapeutic communities revealed positive effects on recidivism rates (Knight, Simpson, & Hiller, 1999). Therapeutic
Community style treatment programs have been associated with reductions in substance abuse, decreased income from crime, fewer hospitalizations, and increased likelihood of having health insurance (Inciardi, Martin, Butzin, Hooper, & Harrison, 1997). In addition, research from the past ten years that explored the outcomes for men up to three years after release from prison have consistently indicated positive effects of therapeutic communities in prison if community after-care programs are included (Eliason, 2006). Yet, there are some limitations to this body of evidence. Many of the studies did not include control groups or compared therapeutic community programs to shorter, less intensive programs that addressed substance abuse treatment with men.

**Outcomes of Therapeutic Communities for Women**

A study completed by Inciardi (1996) revealed that women who completed a therapeutic community program in a Delaware prison were more likely to abstain from drugs (65%) than a control group of women (30%), and were less likely to be re-arrested (18% compared to 38%). Messina, Wish, and Nemes (2000) compared outcomes by gender for women and men assigned to therapeutic communities with an aftercare component. At the time of admission, men were more likely to have a diagnosis of antisocial personality disorder than women, and the women were more likely to have a diagnosis of depression than the men (Messina, Wish, & Nemes, 2000). Moreover, the women were much more likely to report a history of physical and sexual abuse and these experiences consequently affected substance abuse relapses for women, but not for men. Thus, the outcomes indicate that women who participated in therapeutic communities
during their incarceration must address their prior abuse experiences directly as they are a major factor for relapse.

In another study by Schinka, Hughes, Colletti, Hamilton, Renard, et al. (1999), the authors reported that changes occurred in mood and personality characteristics in women one year after their admission to a therapeutic program, indicating that the women reported fewer depressive symptoms and a decrease in avoidant, dependent, self-defeating, and borderline personality characteristics. Men have been found to endorse antisocial personality disorder whereas women are more likely to be diagnosed with mood and anxiety disorders.

Overall, there was a gap in the literature that addressed the effectiveness of therapeutic community programs for women and the outcome studies available reported mixed findings. For instance, women are socialized to communicate indirectly in order not to hurt someone’s feelings and criticism is often taken as attacks on self-worth (Eliason, 2006). Therefore, the direct communication that occurs within therapeutic communities, which is often public in nature) can be devastating for some women (Farrell, 2000). In addition, another gap in addressing the effectiveness of therapeutic communities is the difference in outcome data for men and women are not directly comparable. Along with gender-specific issues, there are philosophical differences as well as variations in treatment approaches that exist in each therapeutic community. Despite the lack of evidence, prisons and community correctional settings continue to introduce new therapeutic communities for women in addressing substance abuse treatment.
Components of Successful Substance Abuse Treatment for Women

It is important for program administrators, policy makers, and practitioners to consider components that have been proven to be effective for women who struggle with substance abuse addiction. Traditional models that are based on the Eurocentric program design of Alcoholics Anonymous, which was developed for Caucasian men who struggled with alcohol addiction, have undertones of powerlessness and marginalized populations such as African-American women should participate in and complete treatment modalities that are based on empowerment (Matthews & Lorah, 2005). In addressing challenges in substance abuse treatment, it is important for practitioners to assist women in treatment in building up their personal power, rather than surrendering it. The use of empowerment requires participants to strengthen and increase their self-efficacy, which would ultimately enable them to take advantage of opportunities, overcome challenges, and barriers, and establish new roles in their new found empowerment (Washington & Moxley, 2003). Sisters Informing Sisters on Topics about AIDS (SISTA) is a group level gender and culturally relevant intervention that is aimed at increasing condom use and safe sex negotiation among African-American women (Effective Interventions, 2008). The foundation of the SISTA intervention is on “empowerment” and the groups are led by African-American women practitioners who teach the participants safe sex negotiation and communication skills, discuss cultural and gender related barriers on an African-American woman risk for HIV, and emphasizes the importance of partner involvement (Effective Interventions, 2008).
Another component of a successful substance abuse treatment program geared towards African-American women who are substance abusers are programs that are gender specific and exclusively for women (Hohman, McGaffigan, & Segars, 2000). Research has strongly indicated that women had higher success rates for treatment completion when they participated in “women-only” programs (Hohman et al., 2000). Gender specific programming gives women the opportunity to concentrate on their needs and desires away from the traditional concerns of social approval and the welfare of others (Bride, 2001).

In addition, the basic components of a program designed to increase the success of women enrolled in substance abuse treatment centers are a female therapist, availability of individual counseling, and women-only groups. Other components can include sexual and physical abuse counseling, child care services, transportation services as well as family counseling, vocational traditional and job seeking support (Bride, 2001). Essentially, women only programs are more likely to provide services to meet the needs of women.

HIV Prevention and Substance Abuse Treatment

At times, the goals of HIV Prevention and Substance Abuse Treatment are conflicting. Many treatment programs focus on stopping substance abuse altogether and the traditional 12 step programs regularly advocate abstinence while in recovery (NIDA, 2008). On the other hand, many prevention programs focus on safer sex and harm reduction, acknowledging that relapse can occur (NIDA, 2008). These two perspectives
are the reason why it may be challenging to incorporate HIV Prevention interventions within substance abuse treatment programs.

In addition, HIV infection is closely related to the rates of substance abuse and incarceration and the detrimental affects are seen especially among African-American women (SAMHSA, 2008). Ultimately, there is an intrinsic need for HIV Prevention within substance abuse treatment programs due to the increased rates of HIV infection and risk behaviors among substance abusers, specifically African-American women. Further, participants in these types of integrated programs benefit greatly and are equipped with risk reducing knowledge on how to protect themselves from HIV infection as well as address their substance abuse challenges (SAMHSA, 2008).

The Health Belief Model and Black Feminist Theory

In addressing the research study, the Health Belief Model and Black Feminist Theory are the two theoretical frameworks used in exploring the research questions. The Social Work profession has been noted for focusing on the interactions between people and their environments and this notion has been identified as one of the distinguishing factors of the profession (Saleebey, 2001). The Ecological Perspective and General Systems Theory are major theories in the field of Social Work that provide the designs for understanding people and how factors in their environments affect their lives (Saleebey, 2001). An underlying theoretical perspective of Social Work in the health field has been that physical, psychological, and social environmental conditions all have influences on each other and must be considered in order to understand and assist clients
and their families (Fort Cowles, 2003). This understanding gives birth to the Biopsychosocial Model.

The Biopsychosocial Model is similar to the Person-In-Environment Perspective in that it states people both affect and reflect their social environment. This also reflects the dual focus of the Social Work profession (Fort Cowles, 2003). The Biopsychosocial Model has been referred to as a “holistic” view because it encompasses the “entire picture” of the person. This model is often contrasted with medical models which focus on the physical aspects of health problems rather than considering other environmental factors which contribute to the health problems (Fort Cowles, 2003). Moreover, the Biopsychosocial Model is also an example of General Systems Theory because it views a person’s health status as reflecting the interdependency of physical, psychological, and social environmental systems (Fort Cowles, 2003).

General Systems Theory holds that all levels of organization in nature are linked so that change in one affects change in the others (Fort Cowles, 2003). Social Systems Theory provides a philosophical viewpoint on the relationship of a person within their social environment (Britannica, 2008). This social environment is related to the social institutions that exist in society with the understanding that a set of things or parts ultimately form a whole. A “social system” is the composition of people who interact and mutually influence each other’s behavior. This coincides with the thought of hegemonic ideals and the influences of these thoughts on society.

The Ecological Perspective incorporates tenets from biology as a way in describing the relationship between a person and their environment (Ungar, 2002). In
Social Work practice, this involves looking at people, families, cultures, communities, and policies in addressing the strengths and weaknesses among these systems (Ungar, 2002). Brofenbrenner (1979) suggests four levels of ecological facets as a useful framework in understanding how individual or family processes are influenced by hierarchical environmental systems in which they function. These levels include:

Microsystem: The most basic system referring to an individual’s most immediate environment (i.e. effects of personality characteristics on family members).

Mesosystem: A more generalized system referring to the interactional processes between multiple Microsystems (i.e. effects of spousal relationship on parent-child relationship).

Exosystem: Settings on a more generalized level which affect indirectly, family interactions on the micro and meso levels (i.e. the effects of a parent’s substance abuse on the family interaction).

Macrosystem: Most generalized forces affecting individuals and family functioning (i.e. Political, Cultural, Economical, Social).

**Black Feminist Theory**

Black Feminism argues that sexism, class oppression, and racism are all intertwined (Collins, 1991). The Combahee River Collective argued that the liberation of Black women would include the liberation of all people because it would involve the end of the oppressive notions of racism, sexism, and class oppression (Harris, 2001). It was developed by a “collective of black feminists” who were engaged in the process of
defining and clarifying politics while conducting political activism within the African-American community and in partnership with other organizational movements (Harris, 2001). In 1973, the National Black Feminist Organization was founded in New York and the essence of Black Feminism emerged. Black Feminism is defined by Patricia Hill Collins as a manner in which women who theorize the experiences and ideas shared by ordinary black women, which provides a unique angle of vision of self, community, and society (Collins, 1991).

In addition, Black Feminist Theory explores the concerns of how race, class, and gender are related to produce an incorporated examination of power and oppression (Burnham, 2001). A distinguishing characteristic of Black Feminist Theory is its insistence that both the changed perception of individuals and the social transformation of political and economic institutions constitute true essential components for social change (Collins, 1991). Historically, African-American women have been objectified and portrayed based on the viewpoints of white men, which ultimately has hindered African-American women and fueled their subordination in society (Collins, 1991).

In addition, Black Feminist Theory allows for the experience of African-American women to be kept central and offers insights of concepts, worldviews, and epistemologies on the basis of an Afrocentric perspective (Collins, 1991). Moreover, it also offers two major strengths towards increasing the understanding of important connections among knowledge, awareness, and the notion of empowerment. Primarily, Black Feminist Theory advances a paradigm shift in the way oppression is conceptualized (Collins, 1991). By understanding the impact of race, class, and gender in
this society, social relations of domination and resistance are then reconceptualized. Secondly, Black Feminist Theory focuses on the ongoing epistemological disputes in feminist theory and the sociology of knowledge surrounding methods of ascertaining truth (Collins, 1991). Collins states that offering subordinate groups new knowledge about their own experiences can be empowering but revealing new ways of knowledge that allows these oppressed groups the opportunity to define their own reality has larger implications.

Additionally, Black Feminist Theory has been widely used as a part of intervention methodologies when working with oppressed African-American women. As an intervention methodology, Black Feminist Theory considers the multiple facets of oppression such as race, class, and gender, which shape the experiences of African-American women in the United States and allows women to share their viewpoint from their own experience/reality, and not that of a hegemonically based ideology in which society has imposed. The intersectionality of these facets must be each considered as separate parts as well as all together in understanding their impact on an African-American woman’s life (West, 2002).

In addition, in a study conducted in Atlanta, Georgia by Gentry, Elifson, and Sterk (2005), 400 substance abusing African-American women were enrolled between 1997 and 2000 in addressing race, class, and gender gaps in HIV Prevention intervention research. This study utilized Black Feminist Theory as an HIV Behavior Change Theory and utilized a five theme approach, which was suggested by Patricia Hill-Collins (2000) in Black Feminist Thought (Gentry et al., 2005). Essentially, this approach can be
applied in understanding the lives of African-American women in regards to HIV interventions. These themes include (a) Self definition and self evaluation, (b) The interconnectedness of race, class, and gender, (c) The unique experiences of African-American women in America, (d) Controlling images as constructed for poor African-American women, and (e) Structure and agency as a platform for social change (Collins, 2000; Gentry et al., 2005).

This study provided that there were social and economic circumstances that place low income African-American women who abuse substances at greater risk for HIV infection (Gentry et al., 2005). Systems that exist in the lives of substance abusing African-American women such as education, family, employment, and maintaining relationships with intimate partners have been identified as pressing issues that affect their basic survival needs (Gentry et al. 2005). The use of Black Feminism as a theory in addressing HIV Prevention among substance abusing African-American women in this study emphasized the importance of identifying the various systems that exist in the lives of African-American women which also contribute to their use and abuse of substances which also causes them to be more susceptible to increased risk for HIV infection (Gentry et al., 2005). Ultimately, this studied also challenged the ways HIV risk knowledge has been gathered and interpreted about African-American women when a theory such as Black Feminist Theory maintains the African-American woman as the focal point, is not used, and may then lead to ineffective HIV prevention strategies (Gentry et al., 2005).
The Health Belief Model

The Health Belief Model has been widely used with an array of health behaviors in preventing the acquisition of diseases. Knowing an individual’s sense of perceived threat in becoming infected with HIV (perceived susceptibility and perceived severity) as well as the benefits of engaging in healthier behaviors in preventing infections provides a better understanding for practitioners and program directors in designing programs targeted at promoting healthier behaviors (Rhodes & Hergenrather, 2003).

In addition, the Health Belief Model has been commonly used in predicting and explaining individual health behaviors. Moreover, the Health Belief Model is a cognitive learning theory that focuses on health related perspectives and motivations and utilizes a cost-benefit perspective in explaining preventive health behaviors (Mantell, DiVittis, & Auerbach, 1997). This model indicates that an individual’s health behavior is a function of the perception and interaction of (a) threat (susceptibility to and severity of illness), (b) outcome expectations (preventive benefits weighed against perceived barriers to behavior change, such as practical and emotional costs of the prescribed behavior), and (c) cue to action in the form of internal (i.e. physical symptoms) or external (social experiences) stimuli (Mantell, DiVittis, & Auerbach, 1997). Thus, the Health Belief Model assumes that individuals will make a change in negative health behaviors such as injection drug use and risky sexual behavior, if they believe this practice will decrease their chances of acquiring HIV if engaged in the healthier behavior.

Because the Health Belief Model focuses on the individual and how that individual perceives their risk for acquiring diseases, the focus is on changing their
behavior. Someone who does not see themselves “at risk” will have a lesser likelihood of changing their behaviors which then puts them at risk. However, if informed of the harmful consequences of acquiring HIV as a result of engaging in behaviors: if a person believes that engaging in healthy behaviors will decrease their chances of acquiring HIV, there is a stronger chance that the individual will engage in healthier behaviors. In considering Black Feminist Theory, the focus is also on the individual, specifically, the African-American woman, but in the context of community, which is one of the defining characteristics of the African-American culture and heritage (Constantine, Gainor, Ahluwalia, & Berkel, 2003). This is the point where these two theories differ. In essence, one theory, the Health Belief Model, perceives the individual and focuses on the individual while Black Feminist Theory perceives the individual while in the context of her community. On the other hand, both theories emphasize empowerment and liberation from oppressive forces.

For years, African-American women have been disproportionately affected by both substance abuse and HIV (CDC, 2008). Substance abusing behaviors such as injection drug use and risky sexual encounters with a person who is HIV positive contribute to the alarming statistics (CDC, 2008). By combining the aspects of Black Feminist Theory, where the African-American woman is kept central and is the focus whereby she is allowed to use her own voice in detailing her reality, and the Health Belief Model, which also focuses on the individual and educating the person on the premise that if they engage in healthy behaviors, they will decrease their chances of acquiring HIV infection, researchers, practitioners, and program directors can address
this social problem of substance abuse and HIV among African-American women. The implementation of centrality with the Black Feminist Theory and the cognitive based theory, Health Belief Model, assists in educating the African-American woman on her perceived susceptibility to acquiring HIV and the severity of having the illness, which currently there is no cure (CDC, 2008).

In addition, the intersection between these two theories also informs the African-American woman of the benefits of engaging in healthier, preventive behaviors such as decreasing substance abuse and using condoms/clean needs, which serve as the preventive benefits. These benefits also decrease the likelihood of acquiring HIV infection and increases the chance of the woman maintaining a healthier lifestyle. Both the Health Belief Model and the Black Feminist Theory emphasize self-awareness of the individual (Hochman, 1958; Rosenstock, 1966, 1974; Becker & Maiman, 1975; Janz & Becker, 1984; Rosenstock, Strecher, & Becker, 1988; Collins, 1991).

**Constructs of the Health Belief Model**

Perceived susceptibility relates to the perception of relative HIV risk (sexual relationships, protective behavior, fear of becoming infected, and risk to self/partner) and perceived severity, which relates to the perception of HIV/AIDS or consequences of delayed diagnosis: Medical (pain, disability, death), Social (sexual/drug partners, family, friends, and community) and financial impact. Moreover, the perceived benefits are considered to be the acceptance of positive impact (social, psychological, or physical) of behavior in reducing the risk of HIV (Mantell, DiVittis, & Auerbach, 1997). This construct infers that individuals who perceive susceptibility to illness and its
consequences will take action only if the healthier behavior appears to be beneficial (Mantell, DiVittis, & Auerbach, 1997). Also, there is a construct, perceived barriers, which identifies those barriers that might impede risk reducing behaviors by weighing the costs and benefits in determining whether or not the beneficial behavior will be adopted. This leads to the use of condoms or the refusal of unsafe sexual practices.

*Constructs of Black Feminist Theory*

The constructs of Black Feminist Theory include the notion of empowerment and the ability of African-American women to be in total control of their lives and control of the positive change which is to occur. This also addresses the notion of oppression by race, class, and gender, and African-American women being empowered in addressing these oppressive ideologies (Collins, 1991). Specifically, in regards to this study, Black Feminist Theory assists in answering the following question:

RQ1: What are the gender inequities that exist in substance abuse treatment, whereby the oppressive issues such as race, class, gender, which have also been seen as barriers to substance abuse treatment for African-American women, can be addressed?

The construct of empowerment, which is embedded in Black Feminist Theory, equips African-American women with the strength to take control over their lives and an implement decisions that will assist in safeguarding their health and wellness.

In addition, the constructs of the Health Belief Model also addresses the following research questions:
RQ2: How does forced recovery (incarceration) influence women's perceptions of their substance abuse?

RQ3: What is the perceived susceptibility of risk for HIV among African-American women in recovery?

RQ4: Are women who do not successfully complete substance abuse treatment at greater risk for HIV infection?

These questions are related to the individual’s perception of risk given the implementation of risk reducing healthy behaviors, in that the person believes using condoms and not sharing needles decreases their chances of acquiring the deadly HIV infection, the more likely that the individual considers the costs and benefits, and ultimately engage in healthier behaviors. Researchers and advocates have indicated a need for substance abuse interventions that build on the cultural resources in the African-American community (Singer, 1991). This is built upon the premise that substance abuse treatment can be more effective if grounded in a manner consistent with health beliefs, worldviews, values, and culture of the individuals, families, and communities they serve (Gilbert & Wright, 2003). The identification of the substance abuse problem, conceptualization of the client, appreciation of the client’s ecological reality, and history are understood from an African cultural reality and worldview (Gilbert & Wright, 2003).

In addition, equivalence with African-American culture posits implementing an intervention in a manner that affirms the heritage, rights and responsibilities of African-Americans, and uses interaction styles, symbols, and values shared by members of that group (Amuleru-Marshall, 1991; Asante, 1987; Kambon, 1992). Further, the significance
and need for the development and implementation of culturally specific interventions congruent with African-American culture has been described in substance abuse prevention and treatment, HIV preventive education, and Psychotherapy (Jackson, 1983; Jackson, 1995; Grills & Rowe, 1998; Longshore, Grills, & Annon, 1999; Parham, White, & Ajamu, 1999; Phillips, 1990; Rowe & Grills, 1993; Saulnier, 1996).

Effective and successful substance abuse treatment and recovery must emphasize the acquisition of power (spiritual, personal, familial, communal, institutional, and cultural) that derive from an awareness of the essential interrelatedness of humans with the Supreme Being (Nobles, 1984) and with peculiar socioeconomic, historical, and political reality within which they find themselves. To be effective, substance abuse treatment and recovery must adopt African centered precepts that address the totality of life experiences and development of African-Americans in America (Wright & Gilbert, 2003). To the principle of communalism, individual substance abuse treatment and recovery is reframed as a healing of the African-American community. Recovery reflects community healing because of the independent characteristic of African-American communities: I am because we are, since we are, therefore, I am (Asante, 1987). Communalism is one of the central values in African-American culture contributing to a collective identity and ultimately advances an African Centered approach to treatment (Gilbert & Wright, 2003).

Summary

This chapter contained a discussion of the relevant literature related to African-American women, substance abuse, and the risk for HIV and AIDS infection as a result
of gender issues in treatment as well as challenges to effective substance abuse treatment. As previously mentioned, there were several gaps that exist in the current literature. The literature failed to identify research that has addressed the combined facets of substance abuse treatment for African-American women and HIV prevention efforts in highlighting gender inequities that inhibit substance abuse treatment completion. This chapter also included discussions on the Health Belief Model and Black Feminist Theory, and how they relate to the research study. The next chapter is the Methodology chapter and it addresses the characteristics of a Mixed Method Triangulation Research Design and discusses why this is the most appropriate design for the study. Also, the logic of the data collection approach as well as the criteria for sample selection and data collection procedures are addressed. Finally, there is a discussion on human subjects' protection and the completion of University regulated procedures through the Clark Atlanta University Institutional Review Board.
CHAPTER III
METHODOLOGY

The purpose of this study is to explore whether or not gender inequities disproportionately affect substance abuse treatment and increase the risk of HIV and AIDS infection among incarcerated African-American women. A Mixed Method Triangulation Research Design, which is inclusive of both quantitative and qualitative measures, is used to explore the research questions. This chapter addresses the research methods utilized in acquiring data to answer the research questions and discusses the appropriateness of the research design. This chapter also explores the logic of the identified data collection approaches as well as sample selection and presents limitations attributable to the sample selection strategy.

Mixed Method Research Design

The Mixed Method Triangulation Design is a well known and commonly approach of researchers mixing qualitative and quantitative data (Creswell & Clark, 2007). The Triangulation design brings together the two types of data in obtaining a better understanding of a research topic being explored. The notion of a Mixed Method Research Design is to allow the researcher to utilize both quantitative and qualitative methods in collecting and analyzing data which provides a better understanding of the
research problem. In addition, using the two research methods in combination allows the researcher to understand the interaction of the constructs in greater depth rather than using either approach alone (Creswell & Clark, 2007). Quantitative data includes the use and analysis of numerical data in gathering information. More specifically, quantitative data uses closed ended questions in the form of surveys, checklists, and questionnaires and conveys the information into numbers and statistics. Researchers are able to utilize the data in testing hypotheses and drawing conclusions based on the statistical tests that are performed (Creswell & Clark, 2007). The features of a quantitative method to research are that this research design is: objective, deductive in reasoning in that it tests theory, generalizable, utilizes numbers, and is systematic in its approach to data (Smeeton & Goda, 2003).

In addition, qualitative data involves the use of open ended inquiry for the purposes of obtaining information from the research participants. More importantly, qualitative data obtains the information from the use of interviews and focus groups (Johnson, Onwuegbuzie, & Turner, 2007). Qualitative data can also be obtained in the form of observations whereby the researcher documents what is observed. In addition, qualitative data is also systematic in its approach to data and its features include: subjectiveness, the use of inductive reasoning, is not generalizable because it relies on the realities/lived experiences of the research participant, and utilizes words as a means of data collection (Patton, 2002). Analyzing and interpreting qualitative data involves placing words into categories and identifying common themes in presenting the data that has been collected (Creswell & Clark, 2007). One of the main reasons why I chose the
Mixed Method Triangulation Design is because it provides the ability to compare and contrast different forms of data.

Creswell and Clark (2007) provide three ways in which the two research methods, quantitative and qualitative, can be mixed: merging or converging the two data sets bringing them together, connecting the two datasets by having one build upon the other, or embedding one dataset within the other so that one type of data provides a supportive role for the other data set. Some researchers conclude that it is not sufficient to only collect quantitative or qualitative data; they infer that the data needs to be combined together so that a complete picture of the problem being studied is clear, rather than only understanding the problem when utilizing one research method (Creswell & Clark, 2007). A major characteristic of the mixed method approach is that it provides strength that affects the weaknesses of both research designs whereby limitations in the quantitative data collection can be further explained utilizing the qualitative research method.

One of the main reasons why I chose the Mixed Method Triangulation Design is because statistical tests for significance and validity can be performed on the quantitative data. Further, qualitative data collection was selected as it provides the participants with an opportunity to inform the researcher of their lived experiences based on the questions posed. Unlike the use of an instrument such as a survey or questionnaire in quantitative research, the researcher is the tool as they pose the questions being asked. In addition, these research methods are appropriate for this exploratory study as they have been used in the past in exploring HIV Prevention among vulnerable populations. The dependent variables for this study are: Gender inequities and motivation, Recovery, and HIV risk
and the independent variable is: Substance Abuse Treatment. The overall question to this study seeks to ask how do gender inequities impact the delivery of services and recovery in substance abuse treatment programs for African-American women who are at risk for HIV infection. This study commences in Atlanta, Georgia in the Spring of 2009.

**Appropriateness of the Research Design**

In addition, this study employs a Mixed Method Triangulation Design for the study on, “Gender Issues in Substance Abuse Treatment,” where the research topic addresses African-American women who are at risk for HIV infection, the service delivery in substance abuse treatment centers, and recovery for the women who are at risk. One of the main reasons the Mixed Method Triangulation Design was chosen is because it provides the researcher with the ability to compare and contrast the data that is obtained from the surveys that are administered to the participants with the information that is obtained from the individual interviews and focus groups. The research questions seek to understand how gender inequities have contributed to the reduced success rates of substance abuse treatment and increased rates of HIV risk infection among African-American women. The triangulation of the research design affords the researcher the ability to make interpretations of the research questions based on the results of information yield from the surveys, interviews, and focus groups (see Figure 2).
Interpretation Based on Quantitative and Qualitative Results

Figure 2. Mixed Method Triangulation Design

In using the quantitative research design as a part of the mixed method triangulation approach, the researcher is able to acquire demographic information, frequency of substance use, and other quantitative data in the context of the research questions that seek to address gender inequities in substance abuse treatment and the perception of risk for HIV and AIDS infection. This information is useful in displaying trends and conducting analyses on the findings. As a result, descriptive data is acquired based on the survey questions which also provide the opportunity to perform statistical tests on the strengths of relationships among the variables and depict the findings in graphs or other visual illustrations. In addition, qualitative methodology and the use of open ended questions provide the most appropriate design in understanding how incarcerated substance abusing African-American women feel gender inequities have
affected their successful outcomes in substance abuse treatment as well as their perceived susceptibility of risk for HIV and AIDS infection. Utilizing this component of the mixed method triangulation design means that the researcher serves as the data collection tool in that they are asking the questions in gaining insight regarding the lived experiences as related to the research questions.

Moreover, with the use of the qualitative component of the Mixed Methods Research Design, the study participants are given an opportunity to answer the interview questions freely and from their own reality using their voice and not that which may be forced or coerced. This coincides with the rationale for employing Black Feminist Theory as the Afrocentric Perspective in the study in that it keeps the African-American woman, who is the research participant, as the central focus and allow her to express herself and her experiences from a personal perspective. In addition, the qualitative component allows the researcher to obtain information from the study participants which may not have been asked on the survey. In incorporating a qualitative method in this study with African-American women, it is important to approach the research topic from a culturally sensitive perspective because the varied aspects of the African-American culture and historical and contemporary experiences must be acknowledged (Tillman, 2002).

Moreover, emerging paradigms in qualitative research have provided opportunities for insider perspectives, collaboration, reciprocity, and voice. While there appears to be a shift toward culturally engaged approaches within the field of qualitative research, educational research specific to African-Americans only represents a small
segment of the research that appears in mainstream journals (Kershaw, 1992). Research has identified that African-American culture can be described as (a) differing from European-American culture(s) in various ways that include individual and collective value orientations, language patterns, and worldviews (Tillman, 2005), (b) a shared orientation based on similar cultural, historical, and political experiences, (Lee & Slaughter-Defoe, 1995); and (c) “cultural deep structure,” suggesting a complexity of behaviors that under gird cultural distinctiveness (Boykin, 1985, 1994). Based on the survey results, additional in depth questions are formulated for the focus groups that provide an even deeper understanding of the research problem as quantitative data is closed ended and straight to the point whereas the qualitative data is open ended and limitless. As a young African-American woman researcher who grew up in a neighborhood with various women and some family members who were substance abusers and subsequently became infected with HIV, I experienced the tumultuous highs and lows of substance abuse treatment, the many relapses as well as recovery periods, and barriers they faced in even entering treatment. One thing that also stood out was the lack of HIV prevention education that occurred in the facilities.

In addition, my current employment as a Foster Care Social Worker for the State of Georgia has afforded me the opportunity to see first hand that African-American women in substance abuse treatment continue to struggle with entering treatment, sometimes relapsing once completing treatment, and also observe those who remain clean and in recovery. These various experiences have given me the energy to pursue conducting research in this critical area. The HIV rates for African-American women
continue to be on the rise and one of the major modes of transmission is substance abuse. Moreover, research has indicated a critical need for the study of gender specific treatment centers for women who are affected by substance abuse (Bride, 2001). Previous research studies have concluded that African-American women experienced greater outcomes in gender specific treatment that was culturally specific and tailored to meet the unique needs of African-American women in recovery (Bride, 2001).

*Logic of Data Collection*

In conducting a study on the Gender inequities in substance abuse treatment and recovery among African-American women at risk for HIV infection, there were three data collection approaches that were utilized in obtaining data and answering the research questions. These data collection approaches are surveys, interviews, and focus groups, which all constitute a mixed method study design as both quantitative and qualitative research methods are being implemented. The research questions for my study are:

RQ1: What are the gender inequities that exist in substance abuse treatment, whereby the oppressive issues such as race, class, gender, which have also been seen as barriers to substance abuse treatment for African-American women, can be addressed?

RQ2: How does forced recovery (incarceration) influence women’s perceptions of their substance abuse?

RQ3: What is the perceived susceptibility of risk for HIV among African-American women in recovery?
RQ4: Are women who do not successfully complete substance abuse treatment at greater risk for HIV infection?

Quantitative Research Design: Use of Surveys

As a component of the mixed method triangulation study design, surveys are utilized in acquiring quantitative data from the study participants. Quantitative approaches are considered a major form of scientific inquiry (Thyer, 2001). Barker (1999) defines quantitative research as systematic investigations that include descriptive or inferential statistical analysis. Examples are experiments, survey research, and investigations that make use of numerical comparisons. For the purposes of this study, a survey tool has been developed to capture basic information from the study participants. This information includes similar questions that were found in the qualitative sections of the empirical articles that reviewed in preparation for this research study.

In addition, quantitative studies which have also been described as “descriptive studies,” attempt to answer what without trying to provide an answer to why (Thyer, 2001). The why answers are commonly found in qualitative studies. Moreover, quantitative research designs can be used to describe the characteristics and features of clients, of disorders, of social problems—almost any area of distress to social work practice. As a result, social service agencies utilize descriptive studies of their clientele, community organizers use it to address disparities in resources across neighborhoods, and policy makers use it to highlight the prevalence of specific psychosocial problems (Thyer, 2001). Many theories have obtained their origin as a result of well developed
descriptive studies. More specifically, the use of surveys is among the most established forms of empirical research that is found in Social Work journals.

**Similarities and Differences of Research Designs**

An underlying conjecture of the scientific method is that scientific knowledge is not self-evident (Thyer, 2001). The rational basis for knowing, having common sense, and practicing wisdom cannot be relied upon for verifying a social work knowledge base. This is because too many sources for error exist. Consequently, sound awareness about social work practice requires objective procedures for verification (Smeeton & Goda, 2003).

An assumption of quantitative research methods is that there is a shared reality among the relevant individuals/study participants that can be discerned and described. Presently, quantitative researchers are more sophisticated than early logical positivists who believed they would “study society rationally and objectively” (Thyer, 2001). The concept of “logical positivism” implies that research is dependent on logical and rational reasoning as well as objective empirical observation. Hence, this approach is a combination of both rationalist and positivist philosophies. At present, social and behavioral researchers recognize that there is no way of knowing a “true” objective reality as everyone views the world through their own subjective experience (Gilsson & Gillespie, 1993). Qualitative research methods counter this assumption as it acknowledges that all individuals have their own realities and it allows them to voice their reality. A major difference between quantitative and qualitative research deals with the fundamental postulations about the role of the researcher. In quantitative research, the
researcher is an objective observer who does not take part or influence what is being studied. However, in qualitative research, it is known that the researcher can learn the most by participating and/or being immersed in a research environment (Thyer, 2001).

**Advantages of Quantitative Research**

The use of quantitative methodology as a research design has many advantages to the study of a research problem. One main advantage is the ability for the researcher to obtain statistically reliable results in that quantitative research can reliably conclude that one idea is better than another. In addition, another advantage to employing quantitative methodology as a research design is the ability for the findings to be generalized to the larger population whereby the proportion of participants responding a certain way are similar to the proportion of a population that would have answered in the same manner had they been asked the same question (Creswell & Clark, 2007).

**Disadvantages of Quantitative Research**

While there are some advantages in terms of testing hypotheses and obtaining numerical data with quantitative research, there are some disadvantages that exist. Quantitative research often forces responses or participants into categories that may not be necessarily applicable to them, in order to make meaning (Langhout, 2003). Sometimes, participants complete surveys or questionnaires whereby they are unable to choose an answer as none of the options apply, yet, the tool may force them to select an answer, which then cannot be considered valid. In addition, quantitative data collection tools focus too closely on individual results and fail to make connections to larger situations or the possible causes of the results. Also, research problems are only
measured if they are known prior to the beginning of the administration of a quantitative tool such as a survey, and questions are thus incorporated into the tool. Because of this, quantitative data collection is also considered as an evaluative approach because it only tests and measures that which is known to the researcher (Langhout, 2003).

Qualitative Research Design: Use of Interviews and Focus Groups

Interviews

In addition, as the second component of the mixed method triangulation study design, interviews and focus groups are utilized in acquiring qualitative data from the study participants. Qualitative data is in the form of words which contain both rich descriptions of conditions and understanding of their underlying meanings (Patton, 2002). The use of interviewing is a consistently used technique in social work practice (Grinnell, 2005). There are 12 specific components of qualitative interviewing (pp. 30-31). These components include:

- Qualitative interviews seek to discover the everyday lived world of the interviewee;
- Once the interviewee's everyday lived world is understood, the interview proceeds to search for meaningful themes that are a part of the lived world;
- The interview seeks to explore those themes in ordinary, qualitative language;
- Various aspects of the interviewees life are sought and are expressed in careful nuanced descriptions;
- Abstractions are set aside in favor of a search for specific, concrete actions and settings;
• The interviewer cultivates a deliberate openness and if possible, naivety instead of trying to pull everything together too soon;

• The interviewer must balance between a tight structure and a totally non directive line of questioning;

• Ambiguous and contradictions are accepted and duly noted, not brushed away or ignored;

• If the interview itself creates new insights and forms of awareness for the interviewee, those new insights are welcomed as part of the process and are properly documented as such;

• The interviewer must always be aware of the fact that the interview process is sensitive to the interviewer awareness and sensitivity to the issues that arise during the interview;

• An interview is an interpersonal event, and any knowledge generated by the interview is inexorably shaped by these interpersonal dynamics, whether that shaping is apparent or not;

• A good interview can do much good and be the source of much knowledge and insight, not only for the research project, but often for the interviewee, and in some cases, for the interviewer's personal life;

Researchers implementing the use of interviews as a qualitative data collection method can control for these factors in ensuring that the environment is conducive to the collection of data (Grinnell, 2005). In addition, analyzing qualitative data is challenging because words from interviews have many meanings. In qualitative data analysis, it is not
uncommon to conduct further and/or additional interviews from the research participants (Patton, 2002). The researcher must navigate back and forth between primary and additional interviews, identify units of meaning, coding, and interpreting the data through the entire process (Grinnell, 2005). This provides the researcher with the opportunity to continue to interview the participants further until the researcher has acquired the data necessary in answering the questions during the research study (Patton, 2002). This in turn, is my rationale for also implementing the use of focus groups after the interviews have been administered for my research study.

*Focus Groups*

Focus groups are a form of group interviewing that capitalizes on communication and the interaction between research participants in order to generate data (Morgan, 1988). Although group interviews are often used as quick and convenient methods in collecting data from several people at once, focus groups unequivocally use group interaction as a part of the data collection method. This means that instead of the researcher asking each participant to respond to a question, in turn, the participants are encouraged to talk to one another: asking questions, exchanging anecdotes, and commenting on each other's experiences and points of view (Morgan, 1988). The use of focus groups is particularly useful for exploring the knowledge and lived experiences of research participants and can be used to examine not only what people think but also how they think and why they think in that manner (Morgan, 1988).
Advantages of Qualitative Research

Moreover, the use of qualitative methodology as a research design also has many advantages to understanding research problems. This type of research design allows the researcher the opportunity to interact with the respondents whereby the researcher is able to ask questions and probe in depth based on previous responses which would have been elicited by the study participants. Another advantage of qualitative research as a methodology is its ability to allow group members to interact with one another which often times stimulate discussions and uncovers unanticipated concerns by the researcher (Patton, 2002).

Disadvantages of Qualitative Research

While there are various advantages to utilizing qualitative methods in collecting data, it is important to address some disadvantages in order that I am aware of these key points as the research design is implemented. One main disadvantage to the use of qualitative methods is that the researcher can bias the design of the study and researcher bias can enter into the data collection process. In addition, it is important that the researcher select the appropriate sampling method as the sources and/or subjects of the research study may not always be credible in providing the information. Some of the subjects may be previously influenced and affect the outcome of the study. Also, some background information may be missing which also serves as a disadvantage in the data collection of a qualitative research design (Patton, 1990).

In addition, because it takes time to build trust and establish rapport with study participants which can facilitate honest and true self representation, short term qualitative
studies are at a particular disadvantage where building trust may be a concern (Patton, 2002). It is important as a researcher to know and understand that any group of participants that are being studied is altered to some degree by my presence; therefore, the data that is collected may be somewhat skewed. Lastly, another disadvantage to the use of a qualitative research design is that this method can be unreliable in predictors of the population, which is opposite of the quantitative research design whereby the researcher is able to generalize the findings of a study back to the general population.

Criteria of Sample Selection

The National Institute for Drug Abuse (NIDA) reported that while men were more likely to use drugs than women, women were more likely to become addicted to and dependent upon drugs, specifically those designed to treat sleeplessness and anxiety (NIDA, 2001). There are also variations that exist between men and women who seek treatment for substance abuse. In addition to gender differences, women of color also face further stigmatization due to Substance Abuse Disorder as it is considered a violation of the cultural patterns of African-American women (NIDA, 2001). Women who used illicit drugs were most often between the ages of 18 and 25 with rates decreasing as age increased. Also, African-American women reported more current use of cocaine and marijuana (Worrell & Goodheart, 2005). Among people with lifetime substance use dependency, African-Americans were three times more likely to become dependent in comparison to other ethnic groups (Bierut, Strickland, Thompson, Afful, & Cottler, 2008). In addition, a large portion of HIV/AIDS and other chronic and infectious diseases have been both directly and indirectly related to drug use (Sterk, 2002). Sterk
found that risk factors such as injection drug use, unprotected sex with an injection drug user, and unsafe sex to support a substance abuse addiction accounted for over a third of HIV cases in the United States.

Agency Description

The sample of women who participated in this study were clients of the Women for Women Program, which is a mandated intensive inpatient substance abuse treatment program in a therapeutic community environment. This program is housed at the Atlanta Detention Center and operates seven days a week on a highly structured schedule. The participants of this Program are referred from the Fulton County Superior Court as a result of drug offenses. The criteria for sample selection is: Women at least 18 years of age, have used an illicit drug such as marijuana, cocaine/crack, crystal methamphetamines, or abuse of prescription medications at least once in their lifetime, and have had vaginal sex with a man at least once in life. A number of women have participated in the Women for Women Program two times and for some of the women, failure to complete the mandated program results in prison time.

Currently, there is no existing data as related to successful completion rates, attrition, and relapse that it maintained by the program. A program evaluation is currently underway to detail and publish data on this program. The program has been successful in assisting women in combating addiction; however, the successes have not been documented. The researcher selected this sample of women based on the components of the Women for Women Program. The program is comprised of alcohol and drug education meetings, group therapy and community meetings, career and
vocation, parenting skills education, domestic violence education, self-esteem education, individual therapy/case management, and transition to after-care services. The population of women in this program come from various backgrounds (age, socioeconomic status, educational level, history/level of addiction), are a representative sample from the population of women who abused substances as indicated by the Substance Abuse and Mental Health Services Administration (SAMHSA).

In addition, I began establishing a rapport with 14 clients who are currently a part of the Women for Women Program at the Atlanta Detention Center, by attending their therapeutic prevention groups. By establishing this rapport, it contributes to increasing the study participant’s confidence and trust in disclosing sensitive and personal information during the collection of the quantitative and qualitative data collection. A sample size of 14 was purposefully selected as this number is inclusive of the majority of women enrolled in the program. Moreover, the survey is to be administered to the women individually by reading the questions aloud and allowing them to answer them. The questions on the survey address demographic information such as age, race/ethnicity, socioeconomic status as well as level of addiction/addiction history, and sexual history. Once all of the women completed the surveys, each client was interviewed individually in order to acquire in depth information from their personal realities around issues such as service delivery in previous treatment attempts, gender inequities that may exist, prior relapse issues, recovery period, sexual decision making, and overall risk for HIV infection.
Patton (2002) indicates that purposeful sampling is a design approach when using qualitative inquiry which relates to my rational for selecting its use in identifying participants for the interviews. The use of purposeful sample selection ensures that a diverse and representative cohort from the Women for Women Program participants is chosen. Also, this form of sampling of the Women for Women Program can provide the researcher with a deep understanding and awareness into the research problem. Further, this sample of women can provide in depth and real world information regarding the research study as a result of their lived experiences. Once all of the individual interviews have been performed, a focus group inclusive of eight people in the group, two weeks after the interviews have concluded, is scheduled.

Stratified sampling is used in identifying eight people out of the 20 who participated in the survey and interview collection. When using this method of sampling, the population is divided into groups called strata. A sample is drawn from within these strata. This technique is most useful when the stratifying variables are simple to work with easy to observe closely relate to the research topic (Social Research Methods, 2009). Focus group participants are to be separated into two groups (Group 1: 18-35 yrs old and Group 2: 36-65 years old). Four people are selected from each group by picking a card from a basket. Cards with blue dots represent focus group members and cards with red dots represent those who are not participating in the focus group.

Prior to the administration of any of the data collection methods, each participant was provided an Informed Consent form as mandated by the Institutional Review Board at Clark Atlanta University. This Informed Consent provides the participants with
information on the research study, their rights, risks as well as benefits to participating in the study. Participant signatures are also obtained on a copy of the Informed Consent for my records. The participants are with compensated with toiletry items, which were suggested by their Program Administrator. Attrition has been characterized as a reduction in numbers or loss of participants in a research study (Merriam-Webster, 2009). In order to address attrition, the clients who are recent enrollees in the Women for Women Program are inclusive in the study rather than including clients who may be graduating from the study as a result of successful completion. The duration of the program lasts for six months and participants are then released and engage in after-care programs to maintain their recovery. Clients who display serious behavioral/mental health challenges which affect their participation are dismissed from the program and sent back to the general population of the jail thus awaiting possible prison sentences.

Limitations of Sample Selection

In qualitative research, the researcher serves as the “research instrument” given that the data collected through the interview and focus group is done through the researcher. As a result, the researcher’s personal feelings/attitudes about the participants or subject matter can enter into the data collection process and serve as a limitation to this data collection strategy. In addition, another limitation that exists is related to the sampling selection in this study whereby there is a possibility that the research participants may not represent the larger population as a whole because they are African-American women who are incarcerated and participating in an in-custody, therapeutic substance abuse program as well as the possibility of the participants fabricating or
altering the information they report. Moreover, another limitation to the purposeful sampling selection is the fact that the sample population is deliberately chosen by the researcher and thus, researcher/selection bias can occur.

Data Analysis

The demographic information that is collected addresses client age, ethnicity, education, marital status, drug of choice, prior substance abuse treatment and number of children. In a study by Bride (2001) that addressed, “Single Gender Treatment of Substance Abuse and the Effect of Gender on Treatment Retention and Completion,” the same variables were tested. While the author did not include the reliability coefficients for the demographic variables, he indicated the use of ANOVA as a statistical test performed on the continuous variables (age, education, and prior treatment). In addition to these variables, this researcher intends to use ANOVA for the variable, “number of children.” Bride (2001) also used Chi-Square tests of independence on categorical variables such as ethnicity, marital status, drug of choice, and polysubstance abuse. Further, this researcher intends to apply the same tests on the demographic variables for the study.

In addition, the use of constant comparative analysis is used in analyzing the qualitative measures. The constant comparative method (Glauser & Straus, 1967) is a research data analysis method that involves the constant comparison of data obtained. When conducting qualitative data analysis, it is important to understand that the researcher should not wait until the analysis phase to begin reviewing and interpreting the data. The “constant comparison” should ensue and should be ongoing throughout the
study (Charmaz, 2002). This researcher intends to conduct the qualitative data analysis right after the data is obtained in gaining a deeper understanding of the information obtained. If further clarification is needed after the individual interview or focus group, this researcher is able to obtain additional clarification from the participants of the research study.

Validity and Reliability

Validity and reliability are important to address in a research study. This provides readers with the insight on how the results can be generalized or validated if retested. Validity refers to the strength of conclusions obtained from a research study and whether or not the research achieved its goal. Moreover, a key component of reliability is the ability for the findings to be replicated. When conducting a qualitative inquiry, the use of reliability relates to whether or not the study findings are consistent with the data collected. The measure of reliability is more closely related to whether other researchers viewed the same data and would agree with the results (Rossman & Rallis, 2003).

Construct Validity

In quantitative research, construct validity determines whether the instrumentation (survey/questionnaire, rating scale) truly addresses what the research questions seek to answer. Construct validity is evaluated by statistical methods in order to determine if a common trait can be found to occur in several methods using different indicators (Cronbach & Meehl, 1955). Threats to construct validity of the survey include the environment of the survey administration, the administration procedures, the study participants themselves, as well as the construction of the survey.
Internal Validity

Internal validity threats to the study is addressed through the triangulation of the research design, the acknowledgement and control for researcher bias, as well as a review process by the dissertation chairwoman of this study. A common threat to internal validity is reliability. The triangulation design of this study increases the validity of the data as the constant comparing from different data sources (surveys, interviews/focus group) is implemented. It is important for the researcher to present their biases prior to a study being completed (Patton, 2002). In addition, the review process by the dissertation chairwoman of this study provides oversight and assistance in conducting the statistical analyses in the quantitative data as well as identifying themes and properties in the qualitative data analysis.

External Validity

External validity (generalizability) is the degree to which the findings of this study can be generalized to other populations. The findings of this study can be generalized to women who are active in therapeutic communities that are addressing substance abuse in metropolitan cities. The findings of this study cannot be generalized to other populations such as Caucasian women, men, and people who may be living in rural areas who do not share the same lived experiences as those who reside in metropolitan cities.

Summary

This chapter included a discussion on the components of the exploratory research design which was used to conduct this research. A description of the Mixed Method Triangulation Research Design along with advantages and disadvantages of each method
were included in this section. The logic of data collection, criteria for sample selection and target population were also discussed in this chapter along with validity and reliability. The next chapter provides a detailed description of the participant demographics as well as the data collection process and findings.
CHAPTER IV

PRESENTATION AND ANALYSIS OF DATA

The purpose of this exploratory study was to explore the gender inequities that influence service delivery and recovery among incarcerated African-American women who are at risk for HIV and AIDS infection. A Mixed Method Triangulation Research Design, which was inclusive of both quantitative and qualitative measures, was used in this study. Surveys, individual interviews, and a focus group were conducted with 14 inmates who were participants of the Women for Women Program at the Atlanta City Detention Center, Atlanta, Georgia. The ultimate goal of this study was to understand how gender inequities affect substance abuse treatment, recovery, and HIV risk among incarcerated African-American women.

Chapter IV presents a detailed analysis of 14 surveys and 10 individual interviews with female inmates who were participating in a therapeutic community, a type of substance abuse treatment program within a jail or prison, at the Atlanta City Detention Center, in Atlanta, Georgia. The data were analyzed to identify themes and properties centered around substance abuse and incarcerated African-American women in relation to constructs such as gender, power, and perceived susceptibility of risk, among others. The presentation and analysis in Chapter IV includes a rationalization of the
method of data analysis used to identify the common themes revealed from the individual interviews. The results which derive from the analysis are related directly to the research questions that were developed to guide this study. The research questions which guided this study are:

RQ1: What are the gender inequities that exist in substance abuse treatment, whereby the oppressive issues such as race, class, gender, which have also been seen as barriers to substance abuse treatment for African-American women, can be addressed?

RQ2: How does forced recovery (incarceration) influence women’s perceptions of their substance abuse?

RQ3: What is the perceived susceptibility of risk for HIV among African-American women in recovery?

RQ4: Are women who do not successfully complete substance abuse treatment at greater risk for HIV infection?

In addition, from July 2008 to December 2008, the researcher began attending groups at the Women for Women Program, Atlanta City Detention Center, in order to obtain a better sense of understanding of the program process as well as the dynamics of the group. The groups were run by two facilitators based on various topics from Addiction to “Keep it Simple” and “Truths about Me,” where the participants face their past behaviors and process maladaptive decision making in the presence of the Women for Women group. In addition, another purpose for attending the groups prior to the onset of data collection was to establish a rapport with the participants in creating an
environment for them to be forthright in their surveys, interviews, and focus groups. This allowed the researcher to engage in communication with the participant during their therapeutic groups fostering open communication with them. Belcher (1988) stated that the process of observation, negotiation with the respondents, and continuing evaluation of discovered information gradually develops into a research instrument producing consistent data. This further supports the guise that in qualitative research, the researcher is the "instrument." As the outsider coming into the Women for Women Program to conduct interviews, carrying a clear binder consisting of papers, pens, and highlighters, as well as carrying the notes from the surveys, can typically create a feeling of anxiety among the participants. This researcher was careful in utilizing a reflexive approach in being able to adapt my interviewing skills and techniques to the needs of the individual participant being interviewed. If the respondents presented as if they did not understand a question, the researcher rephrased the question posed to ensure that they understood what was being queried. Moreover, this researcher also acknowledges threats to reliability in that the established rapport with the participants could cause them to not answer questions truthfully in efforts of presenting their lives and substance abusing/risky sexual behaviors, in a favorable light for the researcher.

Moreover, data collection ensued from February 2009 to March 2009. Prior to data being collected, approval by the Clark Atlanta University Institutional Review Board was obtained. After IRB approval was obtained (Appendix A), the researcher had to obtain a letter of approval from the Deputy Chief at the Atlanta City Detention Center (Appendix B) in order to bring the digital recorder into the jail as this is otherwise not
allowed. After drafting and submitting the letter, the researcher was provided with the approval letter in which the researcher had to maintain at all times while inside of the jail facility. Prior to the administration of any of the data collection tools (survey, interview and focus group), the researcher read the informed consent (Appendix C) aloud to the each participant and obtained their signatures on each of the informed consent forms (survey and interview informed consent were combined and the focus group informed consent). After informed consent was read and obtained, data collection ensued with each participant individually. The researcher collected the data within the 3-South West Pod at the Atlanta City Detention Center in Cell number 112. Two chairs were placed in the small Cell and the Pod Officer instructed the researcher to sit nearest to the door of the Cell, for safety precautions. The individual interviews were recorded with a digital recorder and later transcribed by an online transcription service.

Population Demographics

A total of 14 participants were recruited for this study from the Women for Women Program. All 14 completed the surveys, however, only 10 completed the individual interviews as the other 4 had graduated and transitioned to Aftercare prior to the implementation of the interviews. Out of the total amount of 14 incarcerated African-American women, in terms of marital status, 8 women identified as single, 4 were divorced, 1 person was involved in a heterosexual relationship, and 1 person identified as being a widow. All of the participants had engaged in sexual intercourse with a man, which was a requirement of eligibility for participation in the study, while 5 also had sex
with both women and men. In addition, all of the participants were over the age of 18 with the youngest being 19 and the oldest being 53 (see Appendix D).

The majority of the incarcerated African-American women had not completed high school. Two of the participants had completed at least eighth grade, 10 had completed some high school, and two were actual high school graduates. Weschberg, Craddock, and Hubbard (1998) highlight that lack of education contributes to gender inequities that exist among African-American women which contribute to decreased rates of successful substance abuse treatment completion. The lack of education contributes to lack of employment and job skills which puts African-American women, especially those who are mothers, in complex situations for obtaining financial resources to care for their family. As a result, some women turned to abusing substances in order to medicate depression and temporarily alleviate the feelings of poverty and despair (Moon, 2001). This temporary fix translates to a lifetime of addiction and pain.

Thirteen of the participants were raised in metropolitan cities while one person was raised in rural area. In terms of criminal histories, all of the participants had been arrested, hence partially their involvement in the Women for Women Program. Four of the participants had been arrested at least 10 times, 5 had been arrested at least 20 times, 3 had been arrested at least 30 times, 1 person had been arrested at least 40 times, and 1 person had been arrested at least 50 times. The average number of arrests for the participants of the study was 14. Moreover, in relation to arrests regarding substance abuse, 10 participants reported being arrested for substance abuse at least 10 times, 1 person reported being arrested at least 20 times, and 1 person reported being arrested for
substance abuse at least 40 times. Two of the participants indicated no arrests specific to substance abuse. Figure 3 illustrates the intersection between sexual activity and substance abuse among the population.

![Graph showing intersections between different activities and arrests](image)

**Figure 3.** Intersection between Sexual Activity and Substance Abuse among the Population

In total, the participants combined were arrested for substance abuse 40 times, for prostitution 65 times, and for both substance abuse and prostitution, 105 times. All of the participants indicated that they would engage in prostitution in order to obtain drugs and/or money to buy drugs and cited a cyclical relationship between substance abuse, prostitution, and class/money.

Self-reported arrests indicated that 8 women had been arrested at least 10 times and 2 had been arrested at least 30 times for prostitution/soliciting sex. Four of the participants indicated no prior arrests for prostitution/soliciting for sex. Those who had been arrested for prostitution reported that their prostitution was a direct result of their substance abuse. One participant described her prostitution/substance abuse addiction as a cyclical type interaction, stating that she would prostitute to get “high” or obtain drugs
and/or money. Eleven of the 14 participants indicated that they were under the influence of drugs when they engaged in prostitution. One participant disclosed that she would never prostitute while she was high, and another participant indicated that she never prostituted at all, although she had a major addiction to ecstasy pills (Methamphetamines), mainly for the reason that it increased her sexual performance.

Additionally, seven of the participants had completed substance abuse treatment in the past while the other seven were in the program for the first time. Three of the participants reported prior participation in the Women for Women Program, with 1 person attending the program for the second time, while the other 11 participants reported as being first time participants. A majority of the current Women for Women Program participants had been in the program less than two months, while four had been in the program at least five months. Eleven of the participants reported previous recovery periods of three years or less while three of the participants had a previous recovery period of at least four years in their lifetime. All of the participants except one person were mothers; two had children that were adults. Figure 4 illustrates substance abuse treatment attempts as well as relapse rates among the sample.

Ultimately, out of the 14 participants, there were 24 combined treatment attempts which were all failed as a result of subsequent relapse. There were seven participants who reported this treatment episode as their first time in treatment.
Further, “crack” was identified as the primary drug of choice for the majority of participants, while two identified cocaine, one identified Methamphetamines and one identified marijuana, as their drugs of choice. All of the participants had been tested for HIV after they were accepted into the Women for Women program. Twelve were negative, one person self disclosed as being HIV positive, and one person self identified as having “full blown AIDS.”

Below is a detailed description of each participant of the study. Their own words have been utilized in order to provide a better sense of their individual personalities.

Individual Participant Profiles

Michelle was a 34 year old African-American woman who has completed six months in the Women for Women Program. As a result, she only participated in the individual survey and was not able to be interviewed because she transitioned to after care. Michelle is a single mother whose 19 year old daughter is being reared by her mother. She completed the seventh grade and worked as a landscaper. She reported that she “never had a job” and it was “easy to prostitute” as she always had someone to take
care of her. Michelle also reported that initially, she turned tricks for $60 to $70 and as her drug habit got worse, she had engaged in risky sexual behaviors for as little as $3 as her focus was on acquiring more crack.

_Sunshine_ was a 36 year old African-American woman who also completed six months in the Women for Women Program. She progressed on to After Care and thus, wasn’t interviewed individually. This was her third time in substance abuse treatment and her drug of choice was Crack. She reported birthing four children and acknowledged that she did not raise any of her children although they are aware that she is their mother. Her absence from their lives was a result of her substance abuse addiction. She completed the ninth grade and maintained employment in fast food industries.

_Ann_ was the oldest participant of the study. She was 53 years old and had graduated from high school. She previously completed and graduated from the Women for Women Program in 2001. She reported maintaining employment at Walmart as a meat slicer in the Deli and stated that her relapse was due to her gaining weight from consuming the meat. She reported that she began drinking at 5 years of age as a result of growing up in an alcoholic family. Ann completed six months in the program and did not complete and individual interview.

_Jamesha_ was the youngest participant of the study. She was 19 years old and had completed the tenth grade. She reported that she began prostituting to acquire money to buy clothing due to her mother, who was single, not being able to provide it for her and her three other siblings. She stated that her drug of choice was Marijuana and that she began engaging in prostitution at the age of 16. She reported that she had 3 children, all
of who were in the custody of the State Child Welfare Agency. This was Jamesha’s first time in substance abuse treatment and she was ordered into the program due to three arrests for Prostitution. Jamesha transitioned to after care and did not complete an individual interview.

*Flower Child* was a 43 year old African-American woman who previously attempted to complete substance abuse treatment on two occasions. She reported completing the tenth grade and had three adult children, all of whom resided on their own. Her main drug of choice was cocaine and she reported having engaged in Prostitution as a means of income. Prior to her substance abuse addiction, she reported she was a licensed cosmetologist as well as a cook. She also stated that while she has had sex with a man, which was a requirement of the study, she reported that she preferred having relationships with women and reported as being a “lesbian.” She further stated that “all men were dogs” and that she struggles with intimate relationships with men as a result of their “lying and cheating.”

*Beautiful* was a 29 year old African-American woman who was completing substance abuse treatment for the first time. When asked if she would have chosen substance abuse treatment if she had not gotten arrested, she reported that she would have as she was tired of getting into trouble. Beautiful perceived her addiction as “cool” and stated that she enjoyed smoking her “geek joints,” which she reported that it was her drug of choice, which she described as “crack and the weed together.” She was most recently arrested for public intoxication. She thought it was fun to get “high” until she found herself “turning tricks to get money.” She also reported stealing from her family to
obtain money to feed her substance abuse habit. She began using drugs at 17 and began prostituting at 19 years old. She stated that it was easy for her to get drugs because she was dating a man that supplied it to her. In addition, Beautiful stated that she desires to go back to school to become a nurse as she desires to help people. She also stated that her aunt, who is a nurse, was also influential in this decision. She added that this will assist her in maintaining a source of income.

_Sabriah_ was a 44 year old HIV positive African-American female. Sabriah was very forthcoming and candid regarding her substance abuse and risky sexual behaviors. Sabriah stated that she was raped, stabbed, and left for dead one evening as she engaged in prostitution for more crack. It was during this episode in which she believes she contracted HIV from her attacker. She disclosed that she completed the eleventh grade and maintained employment as a waitress, cashier, and janitorial services. She reported having attempted to complete substance abuse treatment 15 times and stated that she was determined to successfully complete this program. She was most recently arrested for Prostitution which caused her enrollment in the Women for Women Program. Further, she inferred that she chose the program as she wanted “to do something different with my life today.”

_Rene_ was a 33 year old African-American woman who was participating in the Women for Women Program for the second time. She previously completed the program in 2007. Rene came across as the most candid in both her survey and individual interview in disclosing her past substance abusing and sexual behaviors. Her main drug of choice was crack and she engaged in prostitution to support her drug habit. She
reported that "prostitutes are mostly attracted to tricks" in justifying why prostitutes continually engage in the risky sexual behaviors. Rene completed the tenth grade and had six children, all of whom were either residing with other relatives or when in state custody. While Rene was negative for HIV, she did indicate having Herpes and stated that she acquired this illness as a result of her risky sexual practices.

Ayanna was a 32 year old African-American woman who was enrolled in the Women for Women Program for the first time. Ayanna was also mentally retarded and reported that she engaged in prostitution as a means of income. She had previously received an SSI check for her disability whereas her mother was her payee; however, after her mother’s death, her maternal aunt acquired the check and began using it to furnish her home, thus withholding the check from Ayanna. Ayanna reported that she began using crack shortly after her mother’s death, nine years ago.

Janice was a 28 year old African-American woman who was also completing substance abuse treatment for the first time. Her main drug of choice was also crack and she reported having four children, all of whom were in state custody. She stated that she had been incarcerated seven times for substance abuse and five times for soliciting sex.

Marley was a 22 year old African-American lesbian and self identified as a “Stud.” While the other participants in the program were incarcerated as a result of substance use, Marley was incarcerated as a result of selling the drugs, ecstasy pills and crack, specifically. I observed her appearance to be masculine and during the course of the individual interview, she grabbed the crotch area of her pants, spoke with a deeper voice, and her posture was that of her leaning towards one side with her legs apart, which
can be related to the mannerisms associated with male characteristics. She stated that the
Women for Women Program was a last chance program as she faced a prison sentence as
a result of failing to comply with the Fulton County Superior Court Drug Court Program.
Marley reported ecstasy pills as being her drug of choice and reported that she used the
 pills to increase her sexual prowess.

*Nicho* was a 47 year old African-American woman. She is one of the oldest
participants in the program and reported having obtained her high school diploma. She
had been arrested for prostitution eight times and reported that crack was her drug of
choice. This was Nicho’s first time in substance abuse treatment and she reported being
in her addiction since she was 19 years of age. She openly admitted that she engaged in
prostitution to acquire crack. Nicho also stated in her individual interview that she
always used condoms when she engaged in prostitution. She also stated that she felt in
control of her sexual decision making and power in terms of intimate relationships. She
also did not consider herself at risk for HIV infection as she was “careful” due to using
condoms “all the time.”

*Barbara* was a 48 year old African-American woman who was new to the
Women for Women Program. She stated that she completed the eleventh grade and had
four adult children. Barbara said that even though she engages in prostitution as a means
to support her 17 year long cocaine habit, she has never completed a substance abuse
treatment program. Her longest length of recovery was one week. When asked if she
would have entered substance abuse treatment if she had not been arrested, Barbara
reported that she would not have chosen the program; however, she was glad to be in the
Summary

This chapter presented a detailed analysis of 14 surveys and 10 individual interviews with female inmates who were participating in a therapeutic community, a type of substance abuse treatment program within a jail or prison, Atlanta City Detention Center, in Atlanta, Georgia. The data were analyzed to identify themes and properties centered around substance abuse and incarcerated African-American women in relation to constructs such as gender, power, and perceived susceptibility of risk.
CHAPTER V

CONCLUSIONS, IMPLICATIONS, AND RECOMMENDATIONS

The purpose of this exploratory study was to examine the gender inequities that influence service delivery and recovery among incarcerated African-American women who are at risk for HIV and AIDS infection. The research questions that guided this study were:

RQ1: What are the gender inequities that exist in substance abuse treatment, whereby the oppressive issues such as race, class, gender, which have also been seen as barriers to substance abuse treatment for African-American women, can be addressed?

RQ2: How does forced recovery (incarceration) influence women’s perceptions of their substance abuse?

RQ3: What is the perceived susceptibility of risk for HIV among African-American women in recovery?

RQ4: Are women who do not successfully complete substance abuse treatment at greater risk for HIV infection?

Fourteen African-American women who were incarcerated at the Atlanta City Detention Center were purposefully recruited and participated in the study. While all 14 women completed surveys, 10 women completed individual interviews as the other 4 had
graduated and transitioned to Aftercare at Mary Hall Freedom House, a substance abuse treatment facility located in Atlanta, Georgia, prior to the initiation of the qualitative data collection. Eight women were selected to participate in one focus group.

Although both quantitative and qualitative data collection methods were used, the qualitative interviews and focus group served as the main source of data collection. The participants were specifically recruited from the Women for Women Program, a therapeutic community within the Atlanta City Detention Center that serves as a substance abuse treatment program for substance abusing women who have also been arrested for prostitution/soliciting sex.

An analysis of the qualitative data revealed two categories in regards to how forced recovery influences a women’s perception of their substance abuse, which were relationships with their family (support) and chaotic lifestyles. Regarding the influence of gender inequities on the successful treatment completion rates, three categories emerged from the data. The participants identified power, relationships with men, and childhood abuse and neglect (feelings of depression). The participants indicated two categories in relation to their perceived susceptibility of risk. There was a contrast in viewpoints between the younger participants and the older participants and risky unprotected sex. When looking at the notion of unsuccessful treatment completion, the category that emerged from the analysis was prevention education. This chapter includes a detailed discussion regarding the general conclusions of the study, limitations of the study, and implications for theory and practice in the field of social work policy, planning, and administration.
Conclusions and Discussion

After analyzing the data, there were conclusions that were drawn from the analysis which included:

1. Relationships maintained with both family as well as with significant others have typically affected the successful treatment completion rates of African-American women who are substance abusers.

2. Women between the ages of 18 and 34 in the study perceived themselves to be at collective risk for HIV as well as individually. However, women over the age of 35 acknowledged that collectively, African-American women were at risk for HIV, however, did not acknowledge their own individual risk.

3. Power, the ability to earn money, as well as the perceptions of intimate relationships affect sexual decision making of substance abusing African-American women.

4. All of the women in the study indicated that HIV Prevention education was key in substance abuse treatment and decreasing the rates of HIV and AIDS infection among substance abusing women

Appendix E is an illustration of how the constructs of the theoretical frameworks, Health Belief Model and Black Feminist Theory, were revealed and contributed to the conclusions of the study. The constructs of the Health Belief Model include: Perceived Susceptibility of Risk, Perceived Barriers, Perceived Benefits, and Perceived Severity. The constructs of Black Feminist Theory (Appendix F) include: Race, Class, and Gender, in relationship to the African-American Woman.
Relationships maintained with both family as well as with significant others have typically affected the successful treatment completion rates of African-American women who are substance abusers.

A review of the literature revealed that parental incarceration and the absence of the African-American mother from the home has affected treatment completion. At the end of 2004, there were 249,400 inmates who were serving time for drug offenses of this population, 112,500 (45.1%) were African-American, 51,800 (20.8%) were Hispanic, and 65,900 (26.4%) were Caucasian (Sabol, Couture, & Harrison, 2006). Seven of the 10 participants who completed individual interviews reported the affects of being away from their children and families. Sabriah, who is completing treatment for the 15th time, informed that many of the previous failed attempts were due to her desires to return home to raise her children as she did not want her family raising them.

Rene, whose children are in foster care, reported that being separated from them affected her ability to concentrate on her recovery during previous treatment attempts. Now that all of her children, with the exception of her oldest son, are with family, she indicated that she is able to concentrate and successfully complete treatment. According to the National Household Survey on Drug Abuse, while most illicit substance abusers were Caucasian, African-Americans constituted 36.8% of those arrested for drug violations and over 42% of those in federal prison (Sabol et al., 2006). Moreover, substance abuse has been found to be the primary reason why women enter prison and is the main health problem for women in prison (Henderson, 2003).
In addition, the impact of incarceration on children has had effects on the family unit as a whole where separation and attachment issues arise as well as the trauma of the family unit breaking apart for the duration of the incarceration period. The effects are also seen as behavioral problems in boys while girls tend to internalize the stress of the maternal incarceration. On a larger scale, women’s incarceration has resulted in an increased number of children who suffer from their mother’s imprisonment and the loss of family ties (Lex, 1991; Thom, 1987; Weschberg, et al., 1998).

Many of the participants who were mothers from the Women for Women Program reported behavioral challenges as well as attachment issues that occurred with their children as a result of the maternal incarceration. Most interesting is that all of the participants reported experiencing childhood abuse and neglect which they included as triggers for their initial substance abuse. The determinants of how children and the family unit as a whole adjust to the incarcerated parent, are the nature and quality of the alternative living arrangements as well as the opportunities used to maintain contact with the incarcerated parent (Parke & Clarke-Stewart, 2001). Also, families where a parent has been incarcerated also face marital hardship and instability as a stressor on the family unit (Miller, 2006). In 2007, the American Civil Liberties Union (ACLU) reported that Black women represented 30% of all incarcerated women in the U.S. although they represent 13% of the female population (ACLU, 2007). Among female prisoners, two-thirds are mothers and over 1.5 million children have a parent in prison (Department of Justice, 2007).
In addition, women who abused drugs who are also mothers experienced increased challenges because of the societal perceptions of mothering and the notion of that behavior (Baker & Carson, 1999). In the United States, these notions are based on a Caucasian, middle class, heterosexual norm, which places the biological mother as the sole parent to deliver constant care and attention to the family (Baker & Carson, 1999). The people that do not fit this model have ultimately been deemed as “unfit” mothers. African-American women are more likely to be single heads of household and are less likely to have someone with whom to share the child related responsibilities (Flavin, 2001).

Moreover, there are both risk and protective factors that exist in relation to intimate relationships for African-American mothers who are substance abusers. From a protective factor, Barbara and Tasha specifically, were maintaining relationships with men who discouraged their substance abuse. Barbara, who was extremely guarded about divulging any information about her boyfriend, Willie, reported that he was opposed to her substance abuse and prostitution, and had tried on several occasions to assist her in completing substance abuse treatment. Also, Willie was not a substance abuser. She reported that Willie was always concerned about her health and safety in leading such a chaotic lifestyle and even with Barbara engaging in prostitution, Willie still wanted to maintain their relationship.

For Tasha, her main concern for entering treatment was because her boyfriend “don’t love no ‘hoes,” meaning that her risky sexual behaviors/prostitution, were not supported or accepted. While her boyfriend discouraged her substance abuse, Tasha
informed that he was an active substance abuser. Tasha’s focus appears to be on maintaining an accepting relationship with her boyfriend and not necessarily focusing on her recovery which is considered as a risk factor. This risk ultimately increases the likelihood of a failed treatment completion attempt or relapse if Tasha does not take an active and personal role in her own recovery.

Mothers who were substance abusers have often been stigmatized and served as targets for disapproval by society, as a result of their failure to meet societal standards of mothering (Baker & Carson, 1999). This has been especially challenging for African-American women who abused drugs. Since the early 1980s, substance abuse has posed a significant challenge to the African-American community (IDVAAC, 2007). Substance abuse among African-American women has also affected the family unit as a result of children being removed and placed in foster care due to the mother’s substance abusing behaviors. Research has shown that many times addicted mothers devote the majority of their time to obtaining money and using drugs, therefore, neglecting their families (Harrington, Dubowitz, Black, & Binder, 1995). This was proven to be true based on the information revealed by the participants of this study. Nine of the participants reported in their individual interviews that a lot of time was spent “in the street” using drugs and engaging in prostitution to feed their substance abuse addiction. This is essential because in the African-American community, the family is crucial in serving as the client’s primary support system and ultimately has a great affect on the person’s recovery (Freeman, 2001). The inability to maintain the relationships and support from family members has ultimately had an adverse affect on treatment completion.
In identifying substance abuse treatment centers that utilize Black Feminist Theory as an intervention methodology, one key characteristic which is present is the fact that this theory allows for the participant to remain as the central focus of the intervention. This methodology ultimately taps into the strengths of African-American women during the process of the intervention (CSAT, 2000). Research has defined some of these strengths as the social support networks from peers and family, faith based networks, and extended family networks (SAMSHA, 2008). In addition, the relationships maintained with significant others was also identified as a barrier to successful treatment completion based on data revealed from the participants of this study. Further, in implementing Black Feminist Theory as an intervention methodology, African-American women who are enrolled in substance abuse treatment and rehabilitation are given the opportunity to disclose the lived experiences from their own lens, rather than forcing the alignment of their realities to that of a Eurocentric viewpoint.

In addition, as an intervention methodology for substance abuse treatment, Black Feminist Theory uncovers oppression and empowers the African-American women to affect change for their lives and the lives of those around them (Collins, 1990). The participants of this study were empowered to speak candidly during their individual interviews about their substance abuse and risky sexual behaviors. Despite any of the negative situations they were confronted with while active in their addiction, this research study allowed them to voice their reality from their own individual and unique experiences. As mentioned in the introduction, there have been limited studies which addressed how gender issues affect the successful completion of substance abuse
treatment for incarcerated African-American women who are at risk for HIV and AIDS infection. This research study is giving voice to the thousands of African-American women who are confronted with trying to maintain recovery in a society which has been oppressive and unfair towards them.

Joseph Spillane’s book, *Cocaine*, gives a historical account on the use of the drug, cocaine, and how it was placed in the community where it seemingly purposefully destructed the class of women. Dating back to the late 1800s, this book detailed how cocaine was used to control and manipulate a sense of slavery among when as a result of their addiction to the drug (Spillane, 2000). Black Feminist Theory challenges these negative historical images and facets by advocating and giving voice to African-American women as they are empowered to define themselves. As society has often inferred, speaking on behalf of the lived experiences of African-American women gives them a different perspective of the way they see themselves and their worldviews are ultimately tainted from that which is forwarded by hegemonic culture (Roberts, Jackson, & Carlton-Laney, 2000).

By implementing Black Feminist Theory as the Afrocentric Perspective with the study population, it allowed for the researcher to be cognizant of the importance of the protective factor that exists in an African-American woman’s self-image, self-esteem, and centeredness, keeping her central and as the main focal point in allowing her to give voice to her unique experiences as a substance abuser who’s successful treatment completion has been affected by gender issues and societal oppression. In order for an intervention methodology to be effective, the members must feel empowered. While this
is key, the collective action in the larger group will be effective in implementing this transformation of formerly oppressive issues as related to substance abuse. Moreover, it is also important for substance abuse intervention methodologies to build on the cultural resources of the African-American community (Longshore, Grills, Annon, & Grady, 1998). In turn, this is referred to as “culturally congruent” whereby the interventions are tailored to embrace the cultural heritage, rights, and responsibilities of the African-American community (Longshore, et al., 1998).

Women between the ages of 18 and 34 in the study perceived themselves to be at collective risk for HIV as well as individually. However, women over the age of 35 acknowledged that collectively, African-American women were at risk for HIV, however, did not acknowledge their own individual risk.

Moreover, the younger study participants reported having unprotected sex especially while under the influence of drugs. They indicated that they had experiences where they “did more” in regards to sexual encounters when they were offered more money. In many instances during the prostitution, they would get paid more for having sex without a condom. All of the younger participants admitted to engaging in this activity and cited being “high” as a reason for their poor decision making skills. Many of them coined the action as “geekin’ and freakin’” whereby they would be high as they engaged in sexual favors in exchange for money and/or drugs.

Many of the participants reported previously having a sexually transmitted disease due to risky sexual behavior and they all collectively agreed that they have placed themselves at risk for HIV. In a report by CDC in 2007, it was found that both casual
and chronic substance abusers were more likely to engage in high risk sexual behavior, when they were under the influence of drugs (CDC, 2007). In addition, nearly 1 in 4 African-Americans live in poverty and the socioeconomic problems associated with poverty, which included limited access to health care, the exchange of sex for drugs, money, or to meet other needs, coupled with high levels of substance use, have both direct and indirect impacts on the risk of HIV acquisition (CDC, 2007).

In contrast, the older participants of the study acknowledged that African-American women as a whole were at increased risk for HIV and AIDS infection because they perceived African-American women to have the most risky and unprotected sex. Interestingly enough, all of the older women indicated that they used a condom “everytime” and that they were “careful” when they prostituted for money and/or drugs. They also indicated that they were never high when they “turned tricks” or engaged in prostitution and cited making sure they would not be taken advantage of. Specifically, one of the participants stated that she did not want her children to see her acquire HIV and suffer. In regards to the collective perceived risk of HIV and AIDS infection among African-American women, the entire sample related to “down low brothers” or heterosexual men who have sex other men and risky sexual behaviors as leading reasons why African-American women are at increased risk for infection.

*Power, the ability to earn money, as well as the perceptions of intimate relationships affect sexual decision making of substance abusing African-American women.*
In regards to power and sexual decision making, most of the younger study participants perceived their power as the ability to “pussy whoop” their significant other. They felt that women had power in sexual relationships if they were able to thoroughly satisfy their sexual partner and “keep ‘em comin’ back.” They also felt that not using a condom equated to love making and would routinely not use a condom if they were with a significant other they perceived to be in a relationship with.

Three of the participants, Rene, Flower Child, and Beautiful, reported that exerting power in sexual interactions involved aggressive sex for them and admitted to having “sexual addictions” which were also fueled by their substance abuse. Flower Child specifically reported that she had no problem with saying “no” regarding performing sexual acts.

The ability to make money and sustain their chaotic lifestyle of substance abuse affected the decision making of the study participants. Most of the participants reported that they “sold pussy for money” in order to take care of their household, minimizing the influence of their substance abuse addiction. As I probed deeper regarding prostitution and making money for the household in relation to their substance abuse, the participants then rephrased their responses stating that they would “drop money off at the house first” and then proceed on with getting high.

Intimate relationships were perceived as one of the main triggers for relapse by the study participants. It was reported that relationships with men were not healthy or productive especially in cases where the significant others encouraged the substance abuse addiction and prostitution. In contrast, the older participants reported having
difficulty in exerting their power in sexual encounters with men as they perceived them to want to be “too in control.” They felt that men perceived women by this statement: “the only place they [women] should be is in the kitchen and in the bedroom” and “women should be seen…not heard."

From a practice and policy standpoint, intimate relationships are often not accepted in substance abuse treatment. Rene and Sabriah reported that relationships were large triggers for them and stated that they had been told to wait at least a year into their recovery prior to engaging in another relationship. In fact, many treatment centers discourage relationships and often discharge women from programs if they find the woman has engaged in a relationship. The implementation of a policy within a substance abuse treatment program that discourages intimate relationships does not consider facets where the intimate relationships may, in fact, serve as a support to the program participant.

Moreover, most substance abuse treatment centers utilize the Abstinence Model which ultimately infers a “no tolerance” for intimate relationship perspective and teaches that Abstinence is the only method in which recovery can be obtained. The methodological use of the Abstinence Model in substance abuse treatment clearly does not acknowledge HIV Prevention. This is of great importance being that substance abuse is one of the leading causes of HIV infection, especially in African-American women. By advocating the Abstinence Model, practitioners are failing to address how risky sexual behaviors during substance abuse addiction ultimately increase the rates of HIV and AIDS infection among its program participants. Further, the absence of HIV
Prevention does not adequately prepare recovering substance abusers in protecting themselves from infection once they complete the substance abuse treatment programs.

All of the women in the study indicated that HIV Prevention education was key in substance abuse treatment and decreasing the rates of HIV and AIDS infection among substance abusing women.

When queried with the question, “Are women who do not successfully complete substance abuse treatment at increased risk for HIV and AIDS infection,” all of the participants responded “yes,” in their individual interviews. Specifically, they mentioned that the lack of HIV prevention education and not knowing how to protect themselves as risk factors that contribute to increasing rates of HIV infection. Rene stated that women who do not successfully complete substance abuse treatment programs will subsequently return to their “old playgrounds” and have unprotected risky sex for drugs and/or money. “This program saved me,” were Rene’s sentiments during her individual interview as she felt that if she had not entered treatment, she would have continued to live a chaotic lifestyle of risky sexual behaviors and substance abuse addiction. Nicho, who was an older participant in the program stated that “programs [treatment] should talk more about HIV Prevention because black women have AIDS and the prevention classes can help prevent them from catching it.”

Sabriah and Rene, who both described themselves as having a “sexual addiction” reported that an open discussion about risks of sex while “freakin’ in the streets” or “sellin’ pussy for crack” and the proper way to use condoms needs to occur. In addition, all of the participants, in their own individual and private interviews, stated that HIV
Prevention education should be geared towards and tailored to young African-American girls. The participants felt that many young girls are engaging in risky sexual behaviors and not using condoms which ultimately place them at greater risk. They also acknowledged that, in their opinion, African-American men do not like to use condoms and some African-American women are not empowered to enforce condom negotiation within a sexual interaction, thereby placing them at increased risk for HIV and AIDS infection.

Limitations of the Study

There are limitations that exist with this study. The findings of this exploratory study are affected by the purposefully selected sample size of fourteen participants who were inmates at the Atlanta City Detention Center, in the Women for Women Program, which is a therapeutic community for the purposes of substance abuse treatment. Another limitation is the possibility of uncomfortable feelings amongst the participants as issues of substance abusing behaviors and risky sexual behaviors were discussed openly during administration of the surveys, individual interviews, and focus group.

Because of the small sample size and the method of sampling, the findings of this study cannot be generalized to the larger population of substance abusing African-American women. This lack of generalizability can be perceived as another limitation to this study.

The ultimate goal of this study which was to inform how gender issues affected the successful completion of substance abuse treatment by African-American women may have been hindered by the participants inability to speak openly regarding their
unique experiences of substance abuse addiction and risky sexual behaviors. My increased awareness and understanding of this phenomenon rested largely in the participants willingness to detail their lived experiences, both truthfully and efficiently. I attempted to address this issue by establishing a rapport with the participants and attending several group sessions at the jail seven months prior to initial data collection. During the days of actual data collection, I also sat among the group for an hour in order to ease any feelings of anxiety that may have existed surrounding the collection of sensitive information.

Finally, another limitation that existed was that there was no way to determine whether or not a participant was being truthful with the information they reported. If the participants were hesitant to be honest about their substance abusing behaviors and sexual experiences and may have stated what they considered as safe answers, in an attempt to present themselves favorably, may cause the results to be skewed. The use of a pseudonym/unique identifier and the heavy emphasis on confidentiality was an attempt to minimize this limitation. It is important to note that even with the added safeguards in place, there is still a concern that truthful responses may not have been given.

Implications for Theory and Practice in Social Work Policy, Planning, and Administration

This exploratory study explored the effects of gender issues on the successful completion of substance abuse treatment as well as the perceived susceptibility of risk for HIV and AIDS and gave participants the opportunity to discuss their lived experiences from their perspective and in their own words. The focus of this study was ultimately on
understanding what the participants, as African-American women, determined as factors that prohibited their success in treatment completion and further put them at risk for HIV and AIDS infection. Based on this understanding, the participants also detailed what they considered as components necessary and helpful in ensuring that they successfully complete treatment and maintain their recovery.

This study utilized the Health Belief Model as the theoretical framework in that it teaches empowering a person to engage in understanding perceived barriers, risks, severity of behaviors, as well as benefits and teaches healthier behaviors with the overall construct of empowerment from the model. This study also employed Black Feminist Theory, which is also an empowerment based Afrocentric Perspective. By educating a person on their level of risk based on current unhealthy behaviors, they can be empowered to change and lead a healthier life with the newly acquired understanding. Because the participants of this study detailed their unique lived experiences in their own words and gave insight into factors that contributed to their substance abuse addiction and risky sexual behaviors, the findings from this study provides both theoretical and practical implications for practitioners on gender specific and culturally relevant programming. The findings also provides insight for others who are charged with developing policy, implementing, and evaluating substance abuse treatment programs as well as HIV prevention education within these programs.

Moreover, there have been limited programs and studies that have utilized Black Feminist Theory and the Health Belief Model within the context of substance abuse treatment with African-American women. From a programmatic stance, the integration
of the two individualistic and empowerment based theories provides the conjecture that positive effects can be seen in a population of substance abusing African-American women who are also at risk for HIV and AIDS infection, when the two are implemented simultaneously. Also, many substance abuse treatment programs operate from the “Abstinence Model” whereby intimate relationships are discouraged or the client faces expulsion from the respective program. This study revealed that not all intimate relationships are negative as a result of two participants who articulate positive attributes from their intimate partners whereby they were encouraged to discontinue their substance abuse/risky sexual behaviors, and enter treatment.

From a policy standpoint, the findings from this study suggest that substance abuse treatment centers, as well as the Women for Women Program, reconsider their policy on relationships with men when the relationships are actually healthy and in the best interest of the participant, thereby maintaining that specific relationship. Also, often times, treatment centers dissuade visitation with children/other relatives until the participants have reached a certain level in treatment (i.e., 30 days to 3 months). Policies should be developed and implemented to support maintaining the familial relationships as findings from this study indicated that these relationships contribute to the many gender inequities that have historically hindered the successful completion of substance abuse treatment for substance abusing African-American women.

In addressing Social Work Administration and the Women for Women Program, it is important to note that the program has never been evaluated since its inception in 1999. Social workers within settings such as substance abuse treatment are charged with
ensuring not only that program participants are equipped with tools to maintain their recovery but are also able to implement these tools outside of the respective substance abuse treatment program and without the assistance of the social worker/treatment facilitator. Evaluating practice and effective social work administration is key in ensuring that the clients being served are assisted efficiently. This is critical in ensuring the viability of programs and services. It is recommended that a program evaluation ensue for the Women for Women Program in identifying additional areas for improvement as well as monitor and track successes and identified challenges of the participants that enter the program. Treatment centers such as the Women for Women Program, which is operated within the context of a jail, provide the opportunity to address and provide preventive services on public health challenges such as HIV and AIDS infection being that there is a direct relationship to substance abuse, therefore, it is important that the administration of such programs are inclusive of evaluative activities and exercises as well as culturally competent, evidence based social work practitioners.

Recommendations

The purpose of this exploratory study was to explore the gender inequities that influence service delivery and recovery among incarcerated African-American women who are at risk for HIV and AIDS infection. A Mixed Method Triangulation Research Design was implemented in gathering data. Based on the findings from this study, the following recommendations are proposed for further exploration:

1. Replicate this study with adolescent African-American girls.
2. Replicate this study with women who are actively abusing substances in order to acquire information from a person pre-recovery.

3. Replicate this study with the same participants post recovery to explore how the Women for Women Program components and curriculum affect their decision making in regards to substance abuse and sexual decision making.

4. Replicate this study with women over the age of 50 regarding their perceptions of risk for HIV and AIDS infection.

5. Explore additional HIV education for the older women in this study in addressing individual and collective risk for HIV and AIDS infection.

6. Women for Women Program staff members and facilitators should incorporate curricula that addresses why older women in the program do not generally consider themselves at risk for HIV and AIDS infection.

7. Conduct a study with African-American men in understanding their perceptions of condom usage and safe sex practices.


9. Home/Community based treatment mandated by the judicial system so that the African-American women does not have to leave her home/community for treatment (where applicable as some clients may need intensive inpatient/detoxification services due to their respective addiction)
Summary

This purpose of this study was to explore the effects of gender issues on the successful completion of substance abuse treatment for incarcerated African-American women who are at risk for HIV and AIDS infection.

This study added to the vast body of knowledge regarding gender issues and substance abuse treatment for African-American women. It explored the affects of gender related issues on a substance abusing African-American women’s treatment success in maintaining her recovery. It also investigated how substance abusing African-American women perceived their susceptibility of HIV and AIDS risk of infection. There were four conclusions that were drawn from the analysis of the findings for this study. These conclusions are that relationships maintained with both family as well as with significant others have typically affected the successful treatment completion rates of African-American women who are substance abusers, that women between the ages of 18 and 34 in the study perceived themselves to be at collective risk for HIV as well as individually, however, women over the age of 35 acknowledged that collectively, African-American women were at risk for HIV, yet, did not acknowledge their own individual risk. Power, the ability to earn money, as well as the perceptions of intimate relationships also affected sexual decision making of substance abusing African-American women, and all of the women in the study indicated that HIV Prevention education was key in substance abuse treatment and decreasing the rates of HIV and AIDS infection among substance abusing women. The limitations and recommendations for future research were also presented in this chapter.
APPENDIX A

Institutional Review Board (IRB) Approval Letter

Yarneccia D. Hamilton <dgervin@yahoo.com>
School of Social Works
Clark Atlanta University
Atlanta, GA 30314

RE: An exploratory Study: Gender Issues in Substance Abuse Treatment and Recovery Among Incarcerated African American Women who are At Risk for HIV and AIDS Infection.

Principal Investigators: Yarneccia D. Hamilton

Dear Ms. Hamilton:

The Human Subjects Committee of the Institutional Review Board (IRB) has approved your protocol under expedited review in accordance with 45 CFR 46.110 but with a provision. Beginning immediately, the IRB insists on a mandatory training for all human study investigators. If you have previously completed the NIH IRB Training, that will suffice for now, and we require a copy of your certification. If that training has not been done, then we require you to complete the new IRB Training offered by CITI Program at the Univ. of Miami. This online training can be found at www.citiprogram.org. Please complete this training in the next couple of weeks and notify our office.

Your Protocol Approval Code is HR2009-01-299-1/A

This permit will expire on January 31, 2010. Thereafter, continued approval is contingent upon the annual submission of a renewal form to this office. If you have any questions, please contact Dr. Georgianna Bolden at the Office of Sponsored Programs (404) 880-6979 or Dr. Paul I. Musey, (404) 880-6829.

Sincerely:

[Signature]

Paul I. Musey, Ph.D.
Chair
IRB: Human Subjects Committee

cc. "Dr. Sarita Davis <sdavis@cau.edu>
Office of Sponsored Programs, “Dr. Georgianna Bolden” <gbolden@cau.edu>
APPENDIX B

Approval Letter from the Deputy Chief, Atlanta Detention Center

CITY OF ATLANTA

MEMORANDUM

To:        Mrs. D. Rasouliyan

From:      Deputy Chief P. Doggett

Date:      February 12, 2009

Subject:   Tape Recorder

This is to certify that I am giving permission for Doctoral Student Y. Hamilton to bring a tape recorder into the facility for the purpose of conducting a research study regarding African-American Women, Treatment and HIV/AIDS. Ms. Hamilton will be allowed to bring the tape recorder into the facility on the following dates: February 17, February 19, February 20, and February 26. The focus group recording is projected for March 5, 2009.

If there are any questions or concerns you can contact Mrs. Moore at 404-865-8063.

PD/am
APPENDIX C

Consent Forms

Survey and Interview Consent Form

I, ________________________________, agree to participate in a research study titled “An Exploratory Study: Gender Inequities in Substance Abuse Treatment and Recovery among Incarcerated African American Women who are At Risk for HIV and AIDS Infection”, conducted by Yarneccia D. Hamilton, a doctoral student from the Whitney M. Young, Jr. School of Social Work at Clark Atlanta University (telephone: 850-321-7664; email: yhamilton97@aol.com), under the direction of Dr. Sarita Davis, School of Social Work, Clark Atlanta University. I understand that my participation is voluntary. I can stop taking part without giving any reason, and without penalty. I can ask to have all of the information about me, to the extent that it can be identified as mine, returned to me, removed from the research records, or destroyed.

I understand that the purpose of this study is to explore how gender inequities affect substance abuse treatment and recovery among African American women who are at risk for HIV and AIDS infection.

If I volunteer to take part in this study I understand that:

• I will participate in a 15-minute survey and 45-minute long interview session.
• The researcher will ask me personal open-ended and close-ended questions regarding my past substance abuse and sexual relationship behaviors, knowledge of and perception of risk regarding HIV/AIDS, and any factors that have affected my successful completion of substance abuse treatment.
• My interviews will be audio taped and pseudonyms will be used in an effort to keep my identity confidential. The audio tapes will be locked in a secure file cabinet located in the researcher’s on campus office, and will be only accessible to the researcher. All audio tapes will be retained only until the completion of the study and will be destroyed immediately following its completion (April 1, 2009).
• I may be contacted by the researcher to participate further in the study by attending a small focus group meeting where I will be asked to discuss many of the point of my interview in a group setting. My decision to participate would be strictly voluntary.

Although there are no tangible benefits associated with my participation in this study, the researcher is hopeful that my participation in the study will in some way empower me through my own retrospective look at my decisions regarding substance abuse treatment and recovery and that my participation could lead to informing the development of new strategies in the development of HIV prevention and substance abuse treatment programs that target African American women. Low risk is expected, however if I experience any discomfort or concern about my participation, I may contact the researcher as well as the Counselors and Therapist at my program, Women for Women Program at the Atlanta Detention Center who are trained to address my concerns.

The investigator will answer any further questions about the research, now or during the course of the project (850-321-7664). No information identifying me will be shared with others without my written permission. All information concerning me will be kept confidential.
Appendix C (continued)

I understand that by signing this consent form, I am agreeing to take part in this research project and understand that I will receive a signed copy for my records. Please sign both copies, keep one and return one to the researcher.

*I understand that I am agreeing by my signature on this form to take part in this research project and understand that I will receive a signed copy of this consent form for my records.*

Signature of Participant  Date

Yarmeccia D. Hamilton (Investigator)  Date
(850-321-7664)
yhamilton97@aol.com
Focus Group Consent Form

I, ____________________________, agree to participate in a research study titled "An Exploratory Study: Gender Inequities in Substance Abuse Treatment and Recovery among Incarcerated African American Women who are At Risk for HIV and AIDS Infection", conducted by Yarneccia D. Hamilton, a doctoral student from the Whitney M. Young, Jr. School of Social Work at Clark Atlanta University (telephone: 850-321-7664; email: yhamilton97@aol.com) under the direction of Dr. Sarita Davis, School of Social Work, Clark Atlanta University. I understand that my participation is voluntary. I can stop taking part without giving any reason, and without penalty. I can ask to have all of the information about me, to the extent that it can be identified as mine, returned to me, removed from the research records, or destroyed.

I understand that the purpose of this study is to explore how gender inequities affect substance abuse treatment and recovery among African American women who are at risk for HIV and AIDS infection.

I understand that the purpose of this study is to explore how gender inequities affect substance abuse treatment and recovery among African American women who are at risk for HIV and AIDS infection.

If I volunteer to take part in this study I understand that:

- I will participate in a 90 to 120 minute long group interview session.
- The researcher will ask me personal open-ended questions regarding my past sexual relationship, knowledge of and perception of risk regarding HIV/AIDS, and any factors I consider in my decision making as it relates to my sexual relationships and I will be expected to talk about them with the group.
- The interview will be audio taped and pseudonyms will be used in an effort to keep my identity confidential. The audio tapes will be locked in a secure file cabinet located in the researcher’s on campus office, and will be only accessible to the researcher. All audio tapes will be retained only until the completion of the study and will be destroyed immediately following its completion (April 1, 2009).
- I will be required to keep both the content of the group discussion as well as the identity of the group members confidential.

Although there are not tangible benefits associated with my participation in this study, the researcher is hopeful that my participation in the study will in some way empower me through my own retrospective look at my decisions regarding substance abuse treatment and recovery and that my participation could lead to informing the development of new strategies in the development of HIV prevention and substance abuse treatment programs that target African American women. Low risk is expected, however if I experience any discomfort or concern about my participation, I may contact the researcher as well as the Counselors and Therapist at my program, Women for Women Program at the Atlanta Detention Center who are trained to address my concerns.

The investigator will answer any further questions about the research, now or during the course of the project (850-321-7664). No information identifying me will be shared with others without my written permission. All information concerning me will be kept confidential.

I understand that by signing this consent form, I am agreeing to take part in this research project and understand that I will receive a signed copy for my records. Please sign both copies, keep one and return one to the researcher.
Appendix C (continued)

I understand that I am agreeing by my signature on this form to take part in this research project and understand that I will receive a signed copy of this consent form for my records.

Signature of Participant ______________________________ ______________________________ Date

Yarneccia D. Hamilton (Investigator) 
(850-321-7664) 
yhamilton97@aol.com 

Date ______________________________
APPENDIX D

Demographics of Participants

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<th>Education</th>
<th>Sexual Orientation</th>
<th>Drug of Choice</th>
<th>Previous Treatment Attempts</th>
<th>Previous Relapse</th>
<th>HIV Status</th>
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</tr>
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<td>Ann</td>
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<td>Crack</td>
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<td>Negative</td>
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<td>Crack</td>
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<td>Lesbian</td>
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<td>No</td>
<td>Negative</td>
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<td>Cocaine</td>
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<td>Crack</td>
<td>Yes</td>
<td>Yes</td>
<td>Positive</td>
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Constructs of the Theoretical Frameworks

**APPENDIX E**

The Health Belief Model is the theoretical framework that will be used in exploring the perceived susceptibility of HIV risk among the target population. This is a cognitive-based theory that is focused on the prevention and elimination of negative health behaviors that put people at risk for acquiring disease (Hochman, 1958; Rosenstock, 1966, 1974; Becker & Maiman, 1975; Juno & Becker, 1984; Black Feminist Theory allows for the Black woman to be kept central in the context of the proposed research study thereby this theory empowers her, as an individual in the context of her own community, to voice her realities and lived experiences (Collins, 1991).
APPENDIX F
Constructs of Black Feminist Theory

Race
"African American women are more promiscuous"

Class
"Sex with no condoms will get you more money"

Gender
"I have said prayer for health and
fucked without rubber for more money..." (same age 33)
"I talk to my friends about getting
their partners to use condoms..." (female age 38)
"I talk to my friends about
using condoms..." (female age 38)

Perceived Susceptibility
Women, 16-24, in the study acknowledged both their
individual risk for HIV, as well as African American
women as a whole, to being at risk. Women, 35-55, in the
study acknowledged collective risk for HIV, but did not see
themselves as being at risk.

Perceived Severity
Power, the ability to earn
money, as well as the
perception of lucrative
relationships affects sexual
decisions, making certain
situations among women
at greater risk of contracting
African American
women.

Perceived Barriers
Relationships maintained with
family and significant others
have typically affected the
successful treatment
compliance rates of African
American women who use
substance abusing.

Perceived Benefits
All of the women in the
study indicated that HIV
prevention education was
key to substance abuse
reduction, as well as
increasing the rates of HIV
and AIDS among substance
abusing African American
women.

Race/Class
"I didn't finish school...no
education...it made me do what I
gotta do..."
"I have no money...no
means for treatment...
nothing...
nothing..."

Race/Gender
"I can't go home anymore
and leave my kids..."
"I can't go home anymore
and leave my kids..."

Class/Gender
"It goes with the
flow."
"I can't go home anymore
and leave my kids..."

Classes on sexual
knowledge and
prevention..."I
learned...it was
something I didn't
know before..."
APPENDIX G

Participant Survey

1. What is your date of birth? __________________ Age: ____________

2. What is your race?
   - African American _____
   - Caucasian _____
   - Hispanic _____
   - Other _____

3. What is your marital status? (1) Single (2) Married (3) Divorced (4) Partnered
   - Single _____
   - Married _____
   - Divorced _____
   - Partnered _____

4. What is the highest level of education completed?
   - A. Elementary School (K-5th grade) _____
   - B. Middle School (6th – 8th grade) _____
   - C. High School (9th – 12th grade) _____
   - D. Obtained High School Diploma/GED _____
   - E. Associates Degree _____
   - F. Bachelors Degree _____
   - G. Masters Degree _____
   - H. Other __________________________________

5. What would you consider the city were you were raised?
   - Urban (City) _____
   - Rural (Country) _____
   - What city/state were you born in: _______________________

6. Have you attempted to complete substance abuse treatment in the past?
   - Yes _____
   - No _____

7. If Yes to the previous question, how many times have you started a substance abuse treatment program? __________ How long ago? _____________________

8. How many times have you been incarcerated for substance abuse? __________

9. Have you participated in the Women for Women Program before? ______
   - If so, how many times? __________

10. How long have you been apart of the Women for Women Program? ______

11. How many live births have you had? __________
Appendix G (continued)

12. Of your living children? 

13. Who do your children reside with while you complete treatment? (Check all that apply)
   - Their father 
   - Other relatives (Grandparents, Aunts, Uncles, God Parents, etc.) 
   - Foster Care/State Custody 
   - Children have been adopted 
   - Friends 
   - Other 

14. What is your primary drug of choice?
   - Marijuana 
   - Cocaine 
   - Crack 
   - Methamphetamines 
   - Heroin 
   - Prescription Drugs 
   - Alcohol 
   - Other 

15. What drugs have you used? 

16. Reason for incarceration? 

Thank you again for your voluntary participation in completing this survey!
APPENDIX H

Interview Questions

1. What are the gender inequities that reduce the successful completion of substance abuse treatment?

   A. How old were you when you first used drugs?
   B. Why do you continue to use drugs?
   C. How does being a mother have an affect on your substance abuse
   D. How has your most (current) significant other encouraged your substance abuse?
   E. How has your most (current) significant other discouraged your substance abuse?
   F. What do you do when you are in need of money?

2. How does forced recovery (incarceration) influence women’s perceptions of their substance abuse?

   A. Do you think you would have chosen substance abuse treatment this time, if you had not been arrested? Why/why not?
   B. How did you perceive your addiction prior to this program?
   C. In your opinion, what things would help you successfully complete this program?
   D. How will you sustain (continue) your recovery once released? What will be your greatest challenge in maintaining your sobriety? What will be the things that help you maintain your sobriety?
   E. What has contributed to past relapse?

3. What is the perceived susceptibility of risk for HIV among African American women in recovery?

   A. Do you consider yourself “at risk” for HIV or AIDS infection? If so/If not, how?
   B. Do you think your substance abuse increases your risk for contracting HIV? If yes, how? If no, why not?
   C. What are some behaviors that occur during active substance abuse that increase the risk of HIV and AIDS infection?
   D. As a woman (mother/girlfriend/partner), are there things that help/hinder your recovery?
4. Are women who do not successfully complete substance abuse treatment at greater risk for HIV infection?

   A. Have you ever failed to complete substance abuse treatment? If so, when? What happened?
   B. How do you think substance abuse treatment helped/hampered you in decreasing these chances?
   C. How do you protect yourself from contracting HIV?
   D. What has your experience with substance abuse taught you about your risk of contracting HIV?
APPENDIX I

Focus Group Questions

1. What are the gender inequities that reduce the successful completion of substance abuse treatment?
   
   A. How old were you when you first used drugs?
   B. Why do you continue to use drugs?
   C. How does being a mother have an affect on your substance abuse?
   D. How has your most (current) significant other encouraged your substance abuse?
   E. How has your most (current) significant other discouraged your substance abuse?
   F. What do you do when you are in need of money?

2. How does forced recovery (incarceration) influence women's perceptions of their substance abuse?
   
   A. Do you think you would have chosen substance abuse treatment this time, if you had not been arrested? Why/why not?
   B. How did you perceive your addiction prior to this program?
   C. In your opinion, what things would help you successfully complete this program?
   D. How will you sustain (continue) your recovery once released? What will be your greatest challenge in maintaining your sobriety? What will be the things that help you maintain your sobriety?
   E. What has contributed to past relapse?

3. What is the perceived susceptibility of risk for HIV among African American women in recovery?
   
   A. Do you consider yourself “at risk” for HIV or AIDS infection? If so/If not, how?
   B. Do you think your substance abuse increases your risk for contracting HIV? If yes, how? If no, why not?
   C. What are some behaviors that occur during active substance abuse that increase the risk of HIV and AIDS infection?
   D. As a woman (mother/girlfriend/partner), are there things that help/hinder your recovery?
Appendix I (continued)

4. Are women who do not successfully complete substance abuse treatment at greater risk for HIV infection?

   A. Have you ever failed to complete substance abuse treatment? If so, when? What happened?
   B. How do you think substance abuse treatment helped/hampered you in decreasing these chances?
   C. How do you protect yourself from contracting HIV?
   D. What has your experience with substance abuse taught you about your risk of contracting HIV?
APPENDIX J

Letters of Request and Approval from the Women for Women Program

CLARK ATLANTA UNIVERSITY

August 25, 2008

Women for Women Program
Atlanta City Detention Center
254 Peachtree Street S.W.
Atlanta, Georgia 30303

To Whom It May Concern:

My name is Yarneccia D. Hamilton and I am a doctoral student in the Whitney M. Young, Jr. School of Social Work at Clark Atlanta University. I am preparing my dissertation entitled, "An Exploratory Study: Gender issues in Substance Abuse Treatment, Service Delivery, Relapse, and Recovery Among African American Women Who Are At Risk for HIV Infection." I am seeking to understand how gender issues affect African American women in substance abuse treatment as well as understand how they, African American women, perceive their own risk of HIV Infection. The results obtained from this study will inform policies, the planning and administration of services geared toward substance abuse/HIV Prevention, educate Social Work Practitioners who are practicing in this target area, and add to the body of knowledge regarding this topic.

I am writing to ask your permission to recruit participants from your agency. I am seeking 20 volunteers to complete surveys and participate in individual interviews that will last approximately 60-90 minutes. To ensure their anonymity each participant will select a unique identifier. The results obtained from the surveys and interviews will be transcribed and the tapes will be stored in a locked cabinet in a secure room in my home/office. Consequently, only the researcher will have access to the data. At the conclusion of the study, the tapes will be destroyed. I will also secure human subjects approval by the Clark Atlanta University Institutional Review Board in providing additional oversight.

In exchange for their participation each volunteer will receive donated toiletry items. In addition, the results from the study will be shared with your agency as well as with the participants of the study. If you have any questions, please do not hesitate to contact me at 850-321-7664 or yhamilton97@aol.com.

Thank you in advance for your willingness to participate in this endeavor that will ultimately have a positive effect to the population that we serve.

Respectfully,

Yarneccia D. Hamilton, MSW
Doctoral Student

Deb Rasouliyan

223 James P. Brawley Drive, S.W. Atlanta, Georgia 30314
October 24, 2008

To Whom It May Concern:

Please let this letter serve as one of confirmation in regard to the research project that Ms. Y. Hamilton will be conducting in the Women for Women Program. I am aware of Ms. Hamilton’s research project (HIV/AIDS and Substance Abuse), and that the content of her research with this population may be considered sensitive.

Major components of our program include: HIV/AIDS education, relapse prevention, parenting, life skills, remedial education, 12-step book study, and very intensive groups, psycho educational classes, and individual counseling. Please be assured that there are two licensed therapists in the facility during the week, along with a lead facilitator with 18 years of recovery.

The topic of research that Ms. Hamilton has chosen, although sensitive in nature and may be conceived as one of risk, is not uncommon due to the nature of our program. We are an in custody segregated therapeutic community with licensed professional therapists who take into account these sensitivities on a daily and ongoing basis. The primary treatment staff is available to process any feelings which may prove to be uncomfortable to the client. Additionally, due to the intensive nature of the program, the primary treatment staff receives continuous training to provide effective services in these sensitive areas. Our community resources serve in the continuum of services in the aftercare component upon release from the jail.

I feel confident that the clients in the Women for Women Program who will be participating in Ms. Hamilton’s research will be emotionally, spiritually, and mentally safe at all times during this process. I am further confident that Ms. Hamilton will provide the very best of information in the “informed consent” portion of her research.

Please let me know if you need any additional information.

Sincerely,

Debra Rasouliyan, Ed.S., LPC, MAC

Debra Rasouliyan, Ed.S., LPC, MAC
Director
Women for Women Program
Atlanta City Detention Center
drasouliyan@atlantaga.gov
404-865-8101
REFERENCES


