Although most Americans with AIDS are men, the number of women with AIDS is increasing. AIDS currently is the fourth leading cause of death among women between 25 and 44 in the United States (Centers for Disease Control and Prevention [CDC], 1995).

Only 21% of all U.S. women are African American or Latina, yet these minority groups constitute 75% of U.S. women diagnosed with AIDS since 1981 (CDC, 1996). The overwhelming number of these women have been infected with HIV directly or indirectly as a result of injection drug use with contaminated needles, crack use, and unprotected sexual activity (Khalsa, Kowalewski, Anglin, & Wang, 1992).

Research has demonstrated that for homeless African-American and Latina women to engage in high-risk behaviors as a way of coping is not uncommon (Nyamathi, Stein, & Brecht, 1995; Nyamathi, Wayment, & Dunkel-Schetter, 1993).

Among homeless women, drug and alcohol use in particular often is seen as a coping mechanism to deal with stress, and has been associated with depression and a low sense of positive well being (Malow, West, Corrigan, Pena, & Cunningham, 1994; Nyamathi, Wayment, et al., 1993).

Currently, a paucity of tested strategies that provide culturally sensitive information on coping behaviors of impoverished women at risk for AIDS exists.

The purpose of this study was to explore the usefulness of a visual coping scenario in enabling homeless and drug-addicted minority women to discuss effective and ineffective coping.

Specific questions this study sought to answer were: What were the emotion-focused coping responses identified in the scenarios? Based on the theoretical perspective, what are the factors presented that affect coping (i.e., social support barriers and enhancers to effective coping)? These questions are critical to assess in a population at great risk for ineffective coping.

Theoretical Framework

The Comprehensive Health Seeking and Coping Paradigm (CHSCP) (Nyamathi, 1989) provides the framework used here to guide the assessment of coping of impoverished women of color at risk for AIDS by means of visual coping scenarios.

The CHSCP, developed from Lazarus and Folkman's (1984) "Theoretical Schema of Coping and Adaptation" and Schlotfeldt's (1981) "Paradigm of Health Seeking Behaviors," illustrates major factors that affect coping, a dynamic process that is constantly changing. Coping responses are
defined as cognitive and behavioral efforts to manage internal or external demands seen as taxing or exceeding the resources of the person (Lazarus & Folkman).

**Problem- vs. emotion-focused coping**

Lazarus and Folkman (1984) contend that two forms of coping exist: problem-focused coping and emotion-focused coping. Problem-focused coping strategies are similar to problem-solving strategies. That is, problem-focused coping efforts are directed at changing the environment or actual problem; for example, by seeking information or turning to others for assistance with chores, financial or emotional support, or entry into drug recovery. Research has outlined the relationship between adaptive coping and lower levels of risky behavior (Nyamathi, Leake, Flaskerud, Lewis, & Bennett, 1993). Problem-focused coping reflects the nature of effective coping in this study. Emotion-focused coping efforts are directed at reducing emotional distress. Strategies used are avoidance, minimization, distancing, and self-punishment (Lazarus & Folkman).

**Components of CHSCP**

As depicted in Figure 1, the first five components of the CHSCP—situational and personal factors, cognitive appraisal, social resources, and sociodemographic characteristics—along with nursing goals and strategies directly influence coping responses of the individual, as well as immediate and long-term health outcome. Although all components influence coping, social responses will be the main component explored in this study. The associations among several CHSCP components and coping responses will be summarized.

The situational environment of impoverished women, often characterized by homelessness and drug addiction, can cause great emotional stress, particularly when the future is uncertain. These situational factors are likely to lead to an appraisal of challenge or threat, which in turn can influence coping strategies negatively (Lazarus & Folkman, 1984).

Self-esteem, or one’s regard for oneself, is a personal factor affecting cognitive appraisal of threat and coping strate-
gies. Although homeless and drug-addicted women typically report low self-esteem (Mondanaro, 1987; Nyamathi, Wayment, et al., 1993; Wofsy, 1987), research has shown that homeless and drug-addicted minority women with higher self-esteem and a stronger sense of coherence reported less emotional distress and fewer somatic complaints than women who were lower in these personal factors (Nyamathi, Wayment, et al., 1993).

Social resources, namely social support, influence an individual’s behavior, particularly with respect to drug use and needle-cleaning behavior (Zapka, Stoddard, & McCusker, 1993) and unprotected sexual behavior (Schilling, El-Bassel, Schinke, Gordon, & Nichol, 1991).

Certain sociodemographic factors, especially low income, are associated with less control over the personal aspects of one’s life (Mirowsky & Ross, 1992); ethnicity and acculturation have predicted greater sexual risk and drug use behaviors (Nyamathi et al., 1995).

Method

Sample

The subjects were recruited via a convenience sample from homeless shelters (n=11) and drug recovery programs (n=9). Ages ranged from 24 to 60, with a mean age of 35. The sample consisted of African-American (n=15) and Latina (n=11) women at risk for AIDS.

Of the African-American subjects, 60% (n=9) were Protestant, all were unemployed with a mean education level of 10 years. Sixty percent had never married; 80% (n=12) had children. The majority (73%) of these women were in drug recovery; 66% (n=10) had traded sex for drugs or money. All of these subjects were born in the United States.

In contrast, all 11 Latina women were Catholic, and had a mean education level of 11 years. Similar to their African-American counterparts, all were unemployed, and 55% (n=6) had never been married; 82% (n=9) had children. Of these women, 73% (n=8) were in drug recovery and 27% (n=3) were in homeless shelters. More than one third (37%) had traded sex for drugs or money. All were born in the United States.

Description of the Visual Coping Scenario

Based on extensive involvement in both the African-American and Latina communities, previous focus groups, and intensive one-on-one interviews conducted by ethnic nurses and outreach workers with minority women in homeless shelters and drug recovery programs (Nyamathi & Lewis, 1991; Nyamathi & Vasquez, 1989), the visual coping scenario, “First Step to Drug Recovery,” was developed. A visual coping scenario is defined as a brief (two-page) written document with a picture and brief narrative of a woman coping with a situation in an emotion-focused manner on the first page, followed by a picture and narrative of a woman coping with the same situation in a problem-focused way.

The first half of “First Step to Drug Recovery” introduces an African-American woman, Mary, who is living in a homeless shelter (Figure 2, top). She has two children who have been taken away by the courts and placed in foster homes. The children were taken away because Mary tested positive for drugs. She is angry and depressed and continues to use drugs as a way of emotion-focused coping, or avoiding her problems. The continued drug use exacerbates her problem and makes her unlikely to get her children back. Mary is giving up, and thus, feels more depressed.

The second half of the scenario depicts Mary talking with a health professional (Figure 2, bottom). By talking about her problem over, Mary feels less depressed knowing that she is not alone. Mary makes an appointment with her social worker to discuss drug treatment programs. By talking about her problem, Mary has begun to feel less isolated and depressed. She realizes that she eventually will get her children back by seeking help in a drug recovery program. Mary is beginning to have a feeling of hope and self-worth. As a result, she feels able to reach out to her family for support.

Measures and Procedures

Semi-structured interview guide

A semi-structured interview guide (SSIG) was developed for the purpose of exploring the usefulness of the visual coping scenarios. The interview guide assessed the sociodemographic characteristics of the women, how useful and realistic the women perceived the visual scenarios to be in discussing ways of coping, and the usefulness of the scenarios in helping the women identify barriers and facilitators to effective coping.

Sample questions from the interview guide include “Is this a realistic scene and experience?” and “How many of you have had a similar experience?” With reference to coping responses, the women were asked: “What are the barriers to effective coping?” and “How can effective coping be enhanced?”

Demographic characteristics

Demographic information was collected by a 17-item questionnaire that elicited information about ethnicity, state or country of origin, religious affiliation, education, employment status,
marital status, living situation, and number of children.

**Content validity**

Content validity of the interview guide was assessed to ensure that the items were representative of the domain of coping. Content validity of the interview guide was established by a judge panel of five researchers and clinicians experienced in the area of AIDS and minority populations.

Each judge panel member was given a packet that included the specific aims of the study, the conceptual framework and segments of the literature review, a description of the research design, and the SSIG. The members were also given a description of the purpose of the judge panel review and instructions on how to establish content validity of the interview guide.

The content of each item of the interview guide was evaluated by the judge panel members for comprehensiveness of content and for clarity and appropriateness. Each member indicated "Agree," "Disagree," or "Provisional agreement" as to the validity of the items. Content validity was established at 100% agreement for all items on the interview guide.

**Procedure**

Upon women's arrival at the homeless shelters and drug recovery programs, trained nurses explained the study and sought women interested in participating. Women were eligible to participate if they were between 18 and 69, African American or Latina, and self-identified as a drug user, sexual partner of an injection drug user, prostitute, or homeless individual housed in a shelter or a one-room occupancy building. None of the 26 women contacted refused to participate in the study.

Three focus groups, with 11 women in the Latina group and seven and eight women comprising two African-American groups, were conducted with impoverished women of color. Each focus group, which lasted 2 hours, was conducted in a private room at each of the research sites. The three focus groups were conducted by one Latina nurse and two African-American nurses who were trained and experienced in the focus group approach.

Informed consent was obtained from the women prior to commencement of the focus groups. All women were paid nominaly at the completion of the session. The focus groups were audiotaped with the permission of the subjects and later transcribed. Subsequent to the focus groups, each woman completed the demographic measure.

The visual coping scenario was reviewed by the subjects in all three focus groups. The group facilitator, a trained
nurse, handed the subjects the paired scenario, reading aloud the adaptive and maladaptive sections of the scenario. Using the SSIG, the nurse then asked the group the questions outlined earlier.

**Data analysis**

Content analysis, a method for the objective systematic and quantitative description of communications, was used to identify major themes and various factors that affect coping based on the CHSCP. Focus group transcripts were reviewed thoroughly and systematically and various themes were identified and described based on the CHSCP. Besides race, no differences were found between groups. The qualitative data analysis process involves data reduction using content analysis in the following steps:

**Step 1:** Preview of the audiotapes with subsequent transcripts being identified and clustered (Zemke & Kramling, 1985). The themes developed for each category are numbered so that quantitative data analysis can be performed. The themes are counted under each category and frequency distributions and percentages are calculated. This process of data reduction refers to selecting, focusing, simplifying, abstracting, and transforming the “raw” data that appear in the handwritten notes. This process is not separate from the analysis, but is part of the analysis (Miles & Huberman, 1994).

**Step 2:** Reliability of the content analysis of the SSIG responses was established by the expert judge panel with 100% agreement. Interrater reliability in content analysis was established by computing the percentage of time three independent raters agreed when they coded the transcripts of the focus group interviews (Fox, 1982).

**Results**

Based on the CHSCP, three major themes were identified in both African-American and Latina groups: namely, identification of emotion-focused coping experiences portrayed in the scenario, barriers to effective coping, and strategies that promote effective coping.

**Identification of emotion-focused coping responses**

The women overwhelmingly recognized that drug use is a commonly used coping strategy that helps women forget pain experienced. Many women recounted experiences similar to those depicted in the scenario where children were taken away as a result of addiction to drugs. Such feelings encompassed an emptiness and a longing to forget the pain and resultant continued use of drugs to deal with the negative feelings experienced. As one woman stated:

> You know, since they took her away from me, there wasn’t no reason for me to hold myself together.

“They snatched my child because of what some next-door neighbor said. So after they took her away, you know, it was devastating to me to the point to where, hell, you know, where the only thing that was holding me together anyway, unfortunately, was her. You know, since they took her away from me, there wasn’t no reason for me to hold myself together. All my purpose of being together was wrapped up in her. I couldn’t handle it, so I’d take another hit and push that to the back burner. As long as I could keep it to the back burner, I’m all right. I could keep going.”

The women agreed a better way to cope would be to try to get help: “[She should] try to figure out a way to get off of the drugs and alcohol and to get her child back.”

**Barriers to effective coping**

Many women recognized the difficulty of finding someone who would be helpful. As one woman said, “When you’re out there tripping, the only other people you have to talk to are addicts.”

Another woman revealed the problem of keeping drug-addicted friends.

> “Because everybody that you associate with for so many years, the reality of it is you’ve gotta kinda let them go or associate with them at a distance, like through the phone, until you can build yourself up to where you’re strong enough to face them again or hang around them again, or have a really, really, really, strong spiritual foundation so that it doesn’t affect you too bad.”

Several women were saddened by the fact that nurses and doctors were unavailable as providers of support and that they frequently treated drug-addicted women ready to give birth in an insensitive manner. As one woman stated:

> “... And these doctors, they really didn’t understand, you know, even though a woman knows she’s hurting her child, it is so hard to stop with all this other stuff because it’s a disease, you know, once your head starts playing that song, you know, it’s like labor. You just can’t stop. You can’t stop until you’re either turning insane or you die.”

**Strategies that promote effective coping**

Nonetheless, the women were clear about what help they needed from health care professionals:

> “The way I feel that the nurses can help us with the situation is to give us education on how the drugs are affecting our bodies as a whole. You know, what a toll it takes over us. Not only us, but our children while we’re using those drugs with those babies in our bodies. You know it’s pretty hard to get off drugs while you’re pregnant. Now if they make centers available for women.
who really want to help themselves, you know, because you get a lot of people in here that just want three hots and a cot. This is really serious, you have to save yourself and if you're not serious then I wouldn't even suggest that you come because there are women out there who are really serious and really need help."

Once the women were able to get into drug recovery, they recognized the support available to them in drug treatment.

"The difference I think in coming into a program is you get people who've physically taken steps to get help and you can sit down and you can relate past experiences with that individual. They may have some sort of spiritual foundation for you or there may be people who've got more sobriety than you do and more recovery time than you and their positive outlook may be better, and just speaking with them and wanting to have what it is that they've got will reinvigorate some sort of . . . self-esteem or self confidence in you . . ." 

Even more important for one woman was that advice most accepted came from one who had walked in her shoes.

"You know, so it really helped me to be able to talk to somebody who went through the same thing that I went through, who did the same things that I did. You know, I couldn't turn a deaf ear to that person because I had to, you know, I realized that person went through the same exact thing that [I did]."

The women all reported that the scenario was very useful as it created an atmosphere that encouraged everyone to think and relate. Everyone reported similar experiences that related to the stories. The women felt the stories were good as a starting point for discussing the issues. The scenario helped the women understand that there are places where they can go to get help. The depiction of the health care professional in the scenario helped the women to feel that social workers, nurses, and physicians were reaching out to help them and that there was hope for a brighter future.

Discussion

The use of a visual coping scenario to encourage discussion of effective coping responses is promising as noted by the comments provided by homeless and drug-addicted women participating in this study. Although homeless and drug-addicted women generally have little trouble verbalizing concerns and fears related to risky sexual behavior (Nyamathi & Lewis, 1991) and to drug treatment (Davis, Watts, Farrow, Krohn, & LaFazia, 1994), a visual coping scenario redirects attention from a negative emotional event, such as having a child (Davis et al., 1994; Kingree, 1995). Further, lack of stable residence, the overextended use of resources provided by family and friends, and a history of disruptive social relationships may affect the social resources of these women (Rossi, Wright, Fisher, & Willis, 1987).

As is evident in this research and that of others (Tucker, 1982), social support among drug-addicted people often comes from other drug-addicted persons who are the only friends available.

Women felt criticized by nurses

The fact that drug-addicted women felt criticized by nurses and doctors involved in prenatal and maternity care is of great concern. Health professionals in this specialty may be among the few that can interact with these vulnerable women, and a potentially positive interaction that may have lasting effects in turning the lives of these women around can be wasted. Attention to the concerns and feelings of the women in this study may help educate staff members on the important role they can play in initiating the road to drug recovery.

Impoverished women's concerns about the well-being of their children is a powerful motivator for behavior change (Koniak-Griffin, Nyamathi, Vasquez, & Russo, 1994), and elicited clear interest in this study. Thus, designing visual coping scenarios using strategies that incorporate this and other lived experiences of homeless and drug-addicted women while providing skills in problem-focused coping is important. Development of additional visual coping scenarios is in process. These scenarios capture the experiences of homeless and drug-addicted women related to dealing with a partner's drug use, survival sex, grieving death of a significant other, and gaining access to community agencies.

Conclusion

In summary, this article presents an appropriate strategy rooted in the lived experiences of impoverished minority women that is effective in enhancing dis-
cussion of effective coping responses. As limitations of this study include small sample size and inability to generalize beyond sheltered homeless women in the West Coast area, future research is needed to assess effectiveness of visual coping scenarios with a larger sample composed of ethnic subgroups.

Effectiveness of visual coping scenarios should be evaluated in intervention studies in terms of reduction of avoidant coping and enhancement of problem-focused coping scores as measured by a reliable and valid coping instrument. Changes in drug and risky sexual behavior both by objective and subjective measures would be optimal. Finally, continued development of an array of visual coping scenarios, each focusing on a specific area of need, may help individualize enhancement of coping among homeless and drug-addicted women.

References