

Triple Jeopardy and Contemporary Feminist Therapy: When clients are Black, Female, and HIV Positive

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This chapter uses a Contemporary Black Feminist lens to accomplish two goals: 1) to examine the unique needs of Black women currently infected with or at-risk of contracting HIV/AIDS, and 2) to suggest ways in which feminist therapists can effectively serve these populations. The chapter will: (a) define the problem of HIV/AIDS among Black women; (b) assess factors that influence their risk of HIV/AIDS infection; and (c) outline therapeutic concerns and suggestions for therapists using a feminist lens

HIV/AIDS among Black women

The HIV/AIDS epidemic has increased most dramatically among non-Hispanic Black women, particularly among those from urban and low-income areas (Owens, 2003). Although Black and Hispanic women represent only 24 percent of all women in the United States (U.S. Census Bureau, 2006), they accounted for 82 percent of all new HIV/AIDS diagnoses among women in 2005 (Centers for Disease Control and Prevention [CDC], 2006) and an alarming 66 percent of these were Black women. As such, it is imperative that factors that increase Black women's risk for HIV infection receive greater attention in psychological research. Further, because the primary mode of acquiring HIV is via heterosexual intercourse, it is necessary to examine relationships among men and women with a focus on gender disparities, such as power and sexual autonomy within male-female intimate relationships that may contribute to Black women's vulnerability to HIV infection. For example, among 25 to 44 year old Black Americans, the ratio of women to men is imbalanced such that women outnumber men by almost 20 percent. Considering that an additional 11 percent of 25-34 year old Black men are incarcerated, the gender gap widens as the number of available Black men narrows. This 31 percent difference in the number of available Black women and men may cause some Black women to consent to unsafe sexual decisions, which raises their risk of infection, in an effort to sustain their partnership (Beard, 2005). Additional contextual factors, such as poverty, environmental stressors, disparate educational and economic opportunities, relationship history, and victimization experiences disproportionately influence Black women's risk of HIV infection and present additional barriers to adequate healthcare (Bowleg, Lucus, & Tschann, 2004; McNair & Prather, 2004). When women face mounting obstacles such as these, the struggle for daily survival and companionship may take precedence over

concerns about HIV infection and/or advocacy for healthcare. Further, because women with HIV infection are often discussed as transmitters of the disease to their children or to partners, they are narrowly conceptualized by their role in the infection process. As a result, their needs are frequently overlooked and the ways in which factors, such as gender, race, and social class, uniquely increase their risk are often misunderstood.

For these reasons, the analysis presented here offers a feminist lens and a theoretical framework that is sensitive to the wider social, environmental, and structural factors that affect Black women, such as the gendered distribution of power in male-female relationships and racialized gender-stereotypes influencing Black women's behavior (Jigpuep, Sanders-Phillips & Cotton, 2004). Bowleg, Belgrave and Reisen (2000) found that ethnicity, income, and education were predictive of women's use of direct power strategies and a relative lack of power may result in decreased use of self-protective sexual behaviors (e.g., inconsistent condom use, unprotected anal sex, multiple sex partners). Given that sexual contact is a primary source of HIV transmission and the predominant exposure risk for Black women, power imbalances in sexual decision-making must be explored because a woman's vulnerability to HIV infection is increased when her sexual autonomy is compromised.

According to dominant female gender roles, particularly in adolescent heterosexual relationships, young women are not supposed to desire sex or be sexually assertive, and are therefore expected to resist young men's sexual advances (Holland & Thomson, 1998). If a woman insists her male partner use a condom, it implies that she is sexually experienced, sexually assertive, and therefore, sexually promiscuous. A young woman can be labeled a "whore" or a "slut" if she is seen as sexually knowledgeable and/or assertive. Thus, an empowered, independent young woman with her own active sexual desires, who seeks sexual pleasure and sexual safety on her own terms, is not a "normal" feminine woman, but often seen as sexually and socially deviant. These distinctions and accompanying judgments serve to disempower young women by limiting their scope of socially acceptable sexual behaviors. Further, faced with the threat of a tarnished reputation or loss of their relationship, many women choose to remain submissive or ignorant with regard to male condom use, which places them at high risk for contracting HIV through unprotected heterosexual intercourse.

In addition to misogynist sexual scripts imposed on all women, Black women are also bombarded with “defeminizing and demonizing” media images of their sexuality. Black women are commonly depicted in one of four roles: the asexual and subservient ‘caretaker’ or ‘mammy’, the emasculating and assertive ‘matriarch’, the economically dependent ‘welfare mother’, or the hypersexualized ‘whore’ or ‘jezebel’ (Collins, 2000). This type of socialization can permeate the consciousness and cause some Black women to internalize these oppressive stereotypes that devalue their bodies (West, 2004). As a result, some women remain sexually passive, fostering sexual practices that increase their risk for HIV infection, such as unprotected anal sex and/or inconsistent condom use. Given these pervasive stereotypes, it is no wonder that Black women fall prey to behaviors deemed as submissive, dependent, and “feminine”.

In addition to negative popular images, cultural norms surrounding power within intimate relationships may also shape sexual behaviors. For example, a woman may feel she has limited options to negotiate or assert protective health measures (e.g., insisting on condom use) as a result of an unequal distribution of power in male-female relationships (Bowleg et al., 2000). Disparate distributions of eligible males in her social group and unequal power dynamics between men and women may contribute to fears of emotional, financial, and physical abuse. Even in the absence of overt abuse, the unequal gender ratio for potential dating partners, where in the Black community women greatly outnumber men, may contribute to fears that resistance to her partner’s requests for riskier sexual practices will increase his likelihood of leaving the relationship or finding other sexual partners to fulfill these desires. Therefore, a woman’s willingness to advocate for safe sexual practices may be limited in an effort to please one’s partner and encourage him to remain in the relationship.

Needs of at-risk and infected Black women and their caregivers

HIV exacts a unique psychological toll on those afflicted and on their loved ones. Internalized stigma and the likelihood of dying may cause an HIV-infected woman and her family to experience a wide range of emotions requiring therapeutic intervention. A woman may feel anger at a partner who infected her or guilt concerning risk to a partner to whom she has been unable to disclose her illness. Shock, disbelief, sadness, and even suicidal ideation are often experienced. Many women learn of their HIV-positive status following pregnancy and/or

childbirth and their functioning as a maternal caregiver may become complicated and/or compromised due to feelings of blame, guilt, anger, and shame. Further, conflicted feelings about transmitting the disease to her children or having the children witness her own deteriorating health may cause a mother to relinquish the role of caring for a child to a relative, regardless of whether or not the child has contracted HIV/AIDS.

A woman's psychological reaction to this diagnosis may be further exacerbated by a number of difficult social and contextual factors. Lack of knowledge of available resources, underemployment, and fear of stigmatization are all possible realities she may face (Owens, 2003). If social support is lacking, an HIV diagnosis may lead to isolation and feelings of having been abandoned (McNair & Prather, 2004). Although research conducted by Owens (2003) concluded that the majority of Black women with HIV view family as a source of support – both emotionally by providing affective support and tangibly by supplying a place to live, transportation and parenting support – a small minority of women disagreed and viewed family as a stressor rather than a support, that provided limited emotional or physical resources.

While extended family relationships are significant sources of socioeconomic and emotional support, caregivers in Tolliver's (2001) study defined extensive caregiver needs that affected their well-being and that of their HIV infected loved one. Specifically, the family's denial, attributions of blame, and perceptions of the woman's ability to cope were most challenging. The caregiver may experience strains on living arrangements as the HIV infected person requires extensive care and difficulty maintaining adequate employment given the unpredictable course of the illness; thus, the caregiver may be managing more expenses with less income (Tolliver, 2001). This can contribute to varying emotions of the caregiver, including frustration, anger, resentment, or conflicting feelings – afraid of the family member's death, but also wanting the pain to stop.

Although many family members will try to conceal their grief denial, anger, fear, or shame initially, psychological symptoms of distress are likely. Not having access to, or not feeling safe to use, therapeutic services may contribute to caregiver distress and heighten feelings of isolation. Further, agency approaches to intervention typically do not include cross-cultural knowledge of gender and ethnicity. For example, support groups and individual psychotherapy are recommended for single mothers with HIV or women isolated from

available supports (Cargill, Robinson & Stone, 2004). However, seeking these services may become complicated because, similar to the person diagnosed with HIV, the caregiver may also mistrust support agencies as a result of past racism and/or discrimination. The cumulative effect of these multiple factors can extract a high price from caregivers, (Tolliver, 2001). Despite limitations to utilizing community resources due to personal mistrust, cultural insensitivity within the agencies that provide care, and insufficient HIV/AIDS prevention programs in communities of color, caregivers of family members living with HIV/AIDS often coped by adopting a positive attitude, using distractions (positive and negative), and joining support groups. Strong spiritual beliefs, prayer, and involvement in a church were also found to provide strength and comfort in the face of despair and frustration. Whether at-risk, infected, or caregivers, Black women's unique lived experiences from intersecting culture and gender perspectives are central and should be appropriately integrated in a therapy setting. Feminist therapy lends itself well to serving this population.

Tenets of feminist therapy

Basic tenets of feminism include a belief in the equal worth of all human beings, recognition that each individual's personal experiences and situations are reflective of society's attitudes, and a commitment to political and social change that equalizes power among people. Feminists recognize and attempt to reduce the influences of oppressive societal attitudes through understanding the use of power and its connection to gender, race, culture, class, physical ability, sexual orientation, age, and any forms of oppression based on religion, ethnicity, and heritage. In contrast to feminist thought beginning with gender and then adding other variables such as race and social class, contemporary Black feminist thought sees these distinct elements as part of an interlocking matrix with a focus on the effects of the interconnection of these forces of oppression (Collins, 2000). As such, a feminist therapist also strives to be aware of the meaning and impact of her own ethnic and cultural background, gender, class, age, and sexual orientation, while examining her own biases and evaluating interactions with clients for evidence of bias or discriminatory attitudes or practices.

In addition to the oppressive societal attitudes, a feminist therapist acknowledges the inherent power differentials within the therapeutic setting between client and therapist and uses this power wisely. In using the

power differential to the benefit of the client, the therapist does not take control or assume power that rightfully belongs to clients and she educates them on such power relationships, their rights as consumers of therapy, and their responsibility for the therapeutic process (Hughes, 2002). The development of such a collaborative relationship presents a model for women to take personal responsibility to develop egalitarian relationships with others. While it is accepted that the therapist knows more in terms of psychology, the client knows more about herself. The client is the expert on her own life and that knowledge is as critical as the therapist's skills in developing a successful therapeutic relationship. Assuming control of the therapeutic process may appear threatening to some clients, though others may welcome this. The therapist should honor the client's process and allow therapy to progress at the client's own pace. However, this does not mean the therapist is non-directive; instead, therapists serve as guides and facilitators, remaining active and providing direction when needed. As with any journey, it is the role of the traveler, in this case a client, to determine the destination, the limits of the distance to be traveled, the stops along the way, and the overall pace (Hughes, 2002). It is the guide's responsibility to meet the objectives of the guided.

Addressing therapeutic concerns and suggestions for therapists using a contemporary feminist lens.

Since many authors have concluded that gender-based factors such as socialized gender roles, power in relationships and society, value attributed to sex, and socioeconomic vulnerability may affect a woman's HIV-related risk behaviors, it seems natural to apply a feminist theoretical lens when examining therapeutic interventions with this population (Cargill et al., 2004; Jigpuep et al., 2004; McNair & Prather, 2004; Owens, 2003). There are three main feminist theory interventions that are particularly useful for feminist therapists working with Black HIV-infected or affected population: creating a collaborative environment, helping to empower clients, and bringing oppressions to the forefront.

First, feminist therapy supports creating a collaborative environment that recognizes and minimizes power differences. Black Americans have long suffered from blatant and subtle forms of institutional racism, discrimination, and oppression. A feminist perspective views the 'personal as political', meaning the concerns of a woman are not separate from the social and political constructs within which she is socialized. Therefore,

women's symptoms of distress are not pathological; instead they act as protective mechanisms permitting survival within oppressive conditions (Nabors & Pettee, 2003). It is also important to remember that therapeutic interventions may be seen as another institution to be met with suspicion and that regardless of the race of the therapist, resistance to therapy may be normative. As such, recognizing and addressing the inherent power of the therapist and the possible client mistrust is imperative and every effort should be made in initial sessions to make therapy a collaborative process. For similar reasons, a Black feminist therapist may choose to also incorporate self-disclosure, with discretion, as an attempt to balance other unequal power relationships in Black women's lives.

A therapist with a Black feminist lens recognizes that a Black female client's voice may be marginalized in a White patriarchal society and consciously integrates this awareness into the therapy process. This leads to the second feminist tenet of empowerment. The HIV-infected Black female population may feel marginalized, disempowered, and silenced. Specifically, within the medical community, Black women report feeling invisible, patronized or unimportant (Nabors & Pettee, 2003). Further, by virtue of their illness, medical doctors come to dictate much of their lives. To counter these feelings of disempowerment in multiple areas of her life and by multiple people and/or institutions, it is imperative that the therapeutic environment is a safe place where the client determines the direction and pace of therapy. These historically oppressed minority clients facing HIV/AIDS need to be empowered to act in their own best interests, to make their own decisions, and communicate their needs effectively. Attempting to acquire these abilities in the presence of a controlling "expert" is hardly conducive to producing results.

Empowered clients tend to break from patterns of decision-making that increase HIV/AIDS risk. Many Black women feel disempowered and as such, have trouble negotiating safe sexual practices with their partners. Empowerment may increase the skills necessary for women's increased comfort in sexual communications. Empowering female clients decreases their likelihood of maintaining passive sexual roles and increases self preserving decision-making. In essence, the client has to value herself enough to want safety at the risk of being rejected by a partner. For Black women, the imbalance in the male-female sex ratio (McNair & Prather, 1994)

results in fewer available male partners and less interpersonal power in relationships, this is a factor that should be discussed within therapy.

Additionally, feminist therapists make visible socialized gender expectations and help clients to actualize their true needs and wants. This feminist principle is particularly applicable to family members and caregivers of the Black women infected with HIV. Feminist therapists acknowledge the societal gender expectation that females act as relationship tenders and nurturers. Within the Black community, the value of responsibility requires members of a family to be their brothers' and sisters' keepers. A Black feminist therapist acknowledges such cultural obligations and makes room for these when planning interventions. Therapists can help in preventing role overload and burnout among caregivers while acknowledging the desire among Blacks to hold together the extended family.

Finally, a feminist therapist recognizes that the dominant culture determines perceptions of what is normal and consequently, such a therapist has a goal of uncovering and respecting cultural differences. By considering the impact of traditional gender roles on health and well being, therapists make invisible inequalities visible. This feminist tenet encourages clients to recognize differences between their individual needs and societal expectations and pressures. Most importantly, clients come to understand their physical and emotional limitations and determine how to balance their caretaking with their need for self care. Table 1 provides suggestions for initial sessions with such clients.

Conclusions

Black women living with HIV/AIDS are often challenged by social isolation, poverty, discrimination, and lack of access to quality health care. Those individuals who are at-risk for HIV infection or who are caregivers for the infected population also have special needs of therapeutic concern. Feminist therapists, as professionals whose training is devoted to clinical interventions and acknowledgement of societal oppressions, play a key role in designing strategies and in framing public health responses to the HIV/AIDS epidemic. The epidemic, in turn, provides an opportunity to expand research on the needs of people and families who are coping with a chronic and debilitating health condition and on multicultural approaches to addressing the AIDS epidemic.

Finally, the examination of Black women’s lives requires that we use an intersectional framework that is sensitive to the many ways in which gender and race intertwine. For Black women with HIV/AIDS, their positive HIV status can result in triple jeopardy, where they are oppressed along a minimum of three dimensions--their race, gender, and HIV status. Black Feminist Thought further implores researchers and therapists to utilize collaborative and participatory processes where individual and collective empowerment is a primary focus. Through empowerment, Black women with HIV/AIDS are able to move beyond the barriers created by their triple jeopardy. Specifically, the application of a Black feminist lens can decipher the challenges and rewards presented by the intersection of race and gender and add greater depth to our understanding of Black women’s lives.

Table 1. Hypothetical Therapy Case: Recently Infected Mother of Two Seeks Therapy

Session 1	Client shares her presenting problem and goals for therapy. Therapist introduces her therapeutic style, emphasizing the collaborative theme and non-expert stance. Client is reminded that she is the expert on her own life and is encouraged to ask questions, change directions, and set the pace of therapy.
Session 2	Therapist begins to work on empowering client. In discussing the source of transmission, client is directed to identify her role, but is also led to acknowledge those contextual factors that contributed to her choices. Client is encouraged to identify those things in her life that give her strength.
Session 3	As client shares her strengths, therapist uses these to continue to work on a theme of empowering client toward future decision-making. Client is encouraged to balance her role as mother and nurturer with her new need to lean on others as a source of social support. Client is to work accepting help from others.

References

Beard, H. (2005). *Getting real: Black women taking charge in the fight against AIDS*. Black AIDS Institute: Los Angeles.

Bowleg, L., Belgrave, F. Z., & Reisen, C. A. (2000). Gender roles, power strategies, and precautionary sexual self-efficacy: Implications for Black and Latina women's HIV/AIDS protective behaviors. *Sex Roles, 42*, 613-635.

- Bowleg, L., Lucas, K. J., & Tschann, J. M. (2004). "The ball was always in his court": An exploratory analysis of relationship scripts, sexual scripts, and condom use among African American women. *Psychology of Women Quarterly, 28*, 70-82.
- Cargill, A., Robinson, M. R., & Stone, V.E. (2004). HIV treatment in African Americans: Challenges and opportunities. *Journal of Black Psychology, 30*(1), 24-39.
- Centers for Disease Control and Prevention. (2006). *HIV/AIDS Surveillance Report, 2005*. Retrieved October 19, 2007 from <http://www.cdc.gov/hiv/topics/surveillance/resources/reports/>.
- Collins, P.H. (2000). *Black feminist thought: Knowledge, consciousness, and the politics of empowerment*. New York; Routledge.
- Holland J., & Thomson, R. (1998). Sexual relationships, negotiation and decision making. In J. Coleman and D. Roker (Eds.), *Teenage sexuality: health, risk and education*. Amsterdam: Harwood Academic Publishers.
- Hughes, C. (2002). *Key concepts in feminist theory and research*. Sage Publications: London.
- Jipguep, M., Sanders-Phillips, K., & Cotton, L. (2004). Another look at HIV in African American women: The impact of psychosocial and contextual factors. *Journal of Black Psychology, 30*, 366-385.
- McNair, L.D. & Prather, C.M. (2004). African American women and AIDS: factors influencing risk and reaction to HIV disease. *Journal of Black Psychology, 30*, 106-123.
- Nabors, N.A. & Pettee, M.F. (2003). Womanist therapy with African American Women with disabilities. *Women & Therapy, 26*, 331-341.
- Owens, S. (2003). African American women living with HIV/AIDS: families as sources of support and of stress. *Social Work, 48*, 163-171.
- Tolliver, D. E. (2001), African-American female caregivers of family members with HIV/AIDS. *Families in Society, 82*(2), 145-156.
- United States Census Bureau. (2006). *Statistical Abstract of the United States*. Retrieved on October 19, 2007 from <http://www.census.gov/prod/2005pubs/06statab/pop.pdf>.

West, C. M. (2004). Mammy, Jezebel, and Sapphire: Developing an "oppositional gaze" toward the images of Black women. In J. Chrisler, C. Golden, & P. Rozee (Eds.), *Lectures on the psychology of women* (3rd Ed, pp. 236-252). New York: McGraw Hill.