



Risk and Recovery: AIDS, HIV and Alcohol

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Chapter 1 HIV and Alcohol: What's the Connection?

HIV Disease: An Overview

When AIDS was first described in 1981, little was known about the disease. Scientists were not sure what caused it, what behaviors put one at risk for it, or what steps could prevent it.

Today, knowledge about AIDS has come a long way. It is caused by a virus called HIV, or human immunodeficiency virus. HIV lives in blood, semen, and vaginal secretions. It is passed from person to person through sexual contact when partners share blood, semen or vaginal secretions or through some other exchange of blood or blood products. The best way to prevent the spread of HIV is to follow safer sex guidelines, so that blood, semen or vaginal secretions are

not shared; and to avoid sharing needles or other equipment during injection drug use. (HIV can also live in other internal body fluids, such as those surrounding joints or organs, and in other body tissues, but these fluids are risky only in specific medical situations.)

AIDS prevention and education efforts have focused mainly on three groups:

- Injection drug users, some of whom have become infected with HIV by sharing needles or other paraphernalia (works).
- Sexual partners of injection drug users, some of whom have become infected with HIV through unsafe sexual contact.

- Gay-identified men in urban areas, some of whom have become infected with HIV through unsafe sexual contact.

But information about HIV disease has not reached many people who need it, because education campaigns have either overlooked other populations or have presented information in ways that many people do not find clear or relevant. Overlooked populations have included people living in rural communities, people of color, women, men who have sex with men but who do not consider themselves gay, teenagers, and heterosexuals who have more than one sexual partner.

AIDS prevention programs have not targeted active and recovering alcoholics or others who use alcohol. There are, however, important areas of HIV-related risk for users of alcohol, and it is essential that these individuals receive HIV education and counseling.

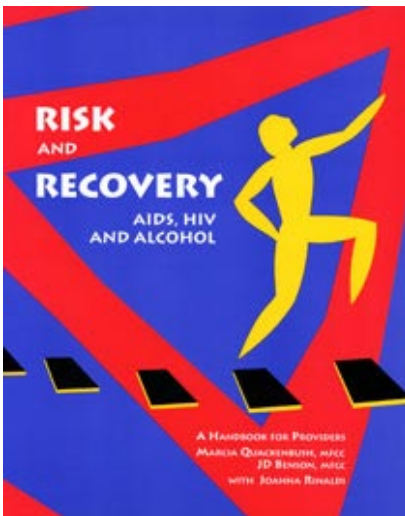
Most providers and program planners who work with active and recovering alcoholics are in an excellent position to see that relevant, effective HIV education and counseling is provided. But without information about the links between alcohol use and the risk of HIV infection, it is impossible to give this issue the attention it requires.

Are There People with HIV Disease in Recovery?

Yes. People with HIV disease are participating in alcohol recovery. While there are few surveys investigating HIV disease in recovery programs, anecdotal reports indicate that alcohol recovery settings include both HIV-infected people and people with HIV-related concerns.

How Do Alcoholics Get HIV Disease?

Alcoholics get HIV disease in the same ways that other people do, but there are some factors specific to alcohol use that



increase the risks for alcoholics to become infected.

Increased HIV-related risk behaviors. When people are mildly drunk, they become disinhibited, and they are less likely to follow some of the rules they normally would. A person who has made a firm commitment never to use injection drugs may change his or her mind when drinking. Someone who has sworn to use condoms and latex barriers during sex may “forget” or find it difficult to use them after a couple of drinks.

In fact, researchers have looked at the reasons why people who have followed safer sex practices for a period of time will slip and have unsafe sex. Alcohol is the single most commonly used substance associated with these slips in sexual behavior.

Blackouts. A common symptom of alcoholism is the “blackout.” An alcoholic can swear to never having used injection drugs in one sentence, and in the next admit to having forgotten half the things he or she has done in the past 10 years. In a community of drinkers and drug users, it would be easy for someone to try injection drugs and share needles while in a blackout, and not to remember the event later. This makes it difficult for alcoholics to assess their risk of HIV infection and to prevent transmission to sexual and needle sharing partners.

Biological susceptibility. Laboratory studies have suggested a variety of possible effects which might increase susceptibility to HIV infection. In one study, alcohol impaired the responses of white blood cells to HIV. These important disease-fighting cells of the immune system help prevent or fight infection. In another study, a single episode of drinking limited the immune response of white blood cells, making these cells more susceptible to HIV infection.¹ A person using alcohol may actually facilitate the process of HIV infection by making it easier for the virus to establish itself during an unsafe encounter.

Polydrug use. Many alcoholics are polydrug users. While alcohol may be their drug of choice, many users have tried other substances including heroin, cocaine, or speed, all of which can be injected. People who have used injection drugs have usually shared needles at some point in time and this puts them at especially high risk of HIV infection.

Prevalence of HIV disease among gay-identified men. A large number of gay-identi-

fied men have become HIV-infected through unsafe sexual contact. It appears that gay men also have a higher rate of alcoholism than of most other segments of society. The result is that gay men, some of whom are HIV-infected, are participating in recovery programs.

HIV can infect anyone. HIV infection is caused by a virus. The virus does not care if a person is gay, bisexual or heterosexual; male or female; old or young; Black, White, Latino, or Asian. Anyone who has unsafe sex or who shares injection equipment can become infected with HIV if his or her partners are HIV-infected. (See also Appendix D: Participant Training Tools for a list of safe and unsafe sexual activities and instructions for proper cleaning of injection drug works.) People in recovery can be infected with HIV if they have been sexually active in relationships with men or women, one person or many, or because they have shared needles or injection equipment, one time or many times.

What are the Future Risks for People in Recovery?

There are also potential risks for people who are currently in recovery and who are not infected with HIV.

Relapse. Not all participants will succeed in a given effort to achieve sobriety. While this does not mean they cannot succeed in a future effort, it does mean that many people “go out” and start drinking again. Among participants who have used drugs, some will also begin to inject drugs and share needles again upon alcohol relapse.

New sexual relationships. Most programs advise participants in early recovery to avoid new romantic or sexual relationships. Nonetheless, some participants do become sexually involved with someone in the recovery community, someone who is still using, or someone—gay or heterosexual—who has had sexual partners in the past. Any of these individuals could be HIV-infected. Many people in recovery have not yet developed the self-esteem necessary to attend to their own needs or assert their desires. It can be difficult for a newly sober person to set forth his or her wishes, take steps to care for him or herself, and follow safer sex guidelines.

People who have been in recovery for a longer period of time also enter into new sexual relationships. The desire to be sexu-

ally close to another human being is a natural one, and it is something that many people anticipate as they grow in their recovery.

Involvement in already-established sexual relationships. Some participants come into recovery already involved in sexual relationships. Their partners may also be in the recovery community, may still be using alcohol or drugs, or may have had past sexual partners.

What Issues Arise When Providers or Participants Have HIV Disease?

In established recovery programs, such as recovery homes or outpatient clinics, there are some common issues that arise when providers or participants are known to have HIV disease.

Fear of infection. Some participants and providers are afraid of “catching” HIV disease from an individual who has the infection. HIV, however, is not transmitted through casual contact. The virus cannot pass from one person to another unless there is an exchange of blood, semen or vaginal secretions. Such exchanges can easily be avoided in day-to-day contact between recovery providers and participants.

Discrimination. Participants and providers may discriminate against people with HIV disease. They may believe that HIV-infected people will not benefit from a recovery program or that people with this life-threatening illness should not take up space in programs with limited resources.

Additionally, a disproportionate number of people with HIV disease are gay men, people of color, or poor people. When participants and providers interact with HIV-infected people, they may come face to face with old feelings of homophobia, racism, and classism. At a more subtle level, they may simply feel uncomfortable with someone they perceive as different from themselves. In the past, recovery programs and providers have not limited care for people facing life-threatening illnesses. Individuals with cancer, liver disease, or heart trouble have not been excluded from services. People of many different backgrounds and experience have joined in and contributed to the recovery community. Similarly, people with HIV disease deserve to be welcomed and supported in the process of recovery.

Infection control. Participants and providers may not be familiar with proper infection control procedures. In residential, inpa-

tient, or day-treatment programs, outpatient clinics, and private households, however, certain guidelines should be followed for the protection of all participants. People with HIV disease are susceptible to a variety of infections that would not affect someone with a healthy immune system. It is also possible, though much less likely, that a person who is not HIV-infected could be exposed to HIV if he or she handles blood improperly during a first aid situation.

Finally, there are infections other than HIV—such as hepatitis B—that can pose a danger or cause inconvenience to anyone, and the transmission of many of these can also be prevented by proper infection control. Extensive “household studies” have found no instances of HIV transmission among people with family or housemates with HIV disease, except where specific risk behaviors, such as unprotected sexual intercourse or needle sharing, have occurred. (See also Chapter 4: Facts about HIV Disease.)

Recovery programs generally have legal obligations to follow infection control guidelines, and could be liable if participants become ill because the program has not taken proper precautions. (See also Appendix C: Infection Control.) **Physical abilities.** Some people with HIV disease have medical conditions that limit their level of physical activity. A participant may have difficulty, for example, doing housecleaning chores shared by members of a residential community or waking up in time for an early morning group. Providers will need to know how to properly assess such a situation. Is a participant’s behavior a sign of physical illness, a symptom of resistance, or a form of acting out?

Each possibility must be carefully considered. Discussions with co-workers, a more experienced colleague, or the participant’s medical providers can offer further insight in such a situation. (There are laws concerning the confidentiality of medical information and HIV-related information. Prior to discussions with others, providers will have to obtain HIV-specific releases signed by the participants in question. See also Chapter 7: Legal Issues for Providers.)

Alienation. Ignorance about the causes, course, and treatment of HIV disease can lead to suffering among HIV-infected people. For example, characterizing HIV disease as a death sentence, a hopeless situation,

or something a person brought upon him or herself can contribute to a sense of alienation, despair, or hopelessness for a person with HIV infection. Providers and participants who are educated about the cause and course of HIV disease are less likely to have these beliefs or to make such statements.

Processing Feelings about AIDS. Programs, providers, and participants will need to deal with the feelings raised by serious illness, loss, and death. While this has not been a traditional feature of recovery programs, when providers or participants have HIV disease (or cancer, liver disease, or other life-threatening conditions), it is necessary to discuss such matters. Programs can implement activities that encourage the open expression and exploration of such feelings. Providers will benefit from trainings or consultations that help them improve their skills for facilitating such discussions in both group and one-to-one sessions. (See also Appendix D: Participant Training Tools for training information regarding grief and loss.)

What Should Recovery Providers Do?

When they were drinking, most participants did not make the best choices for themselves, their families, or their communities. In sobriety, particularly during early recovery, any kind of decision-making process is often difficult and confusing. People need help learning how to gather information, judge its reliability, and make healthy and positive choices. Many participants will look to providers to learn these skills.

To support these needs, recovery providers are encouraged to take three important steps:

Educate yourself, colleagues, and participants. All providers and participants need to be educated about HIV disease—what HIV is, how to prevent its transmission, and why people who use or have used alcohol have special risks for contracting it. This means that providers need to be able to talk comfortably about HIV infection, health, and sexuality with program participants.

Know about the HIV antibody test. Some participants will be interested in taking the HIV antibody test to find out if they are infected with HIV. Providers can help participants think about the decision to test or not to test. To do this effectively, providers must understand what the HIV antibody test is, what it does and does not tell people,

and how people react to taking the test and hearing test results, especially during early sobriety.

Support people with HIV disease in the recovery community. People who have HIV infection will continue to seek recovery services and be active in the recovery community. Providers and administrators need to understand how the presence of HIV-infected people will affect program planning. Providers will want to know how other participants will react to the knowledge that there are HIV-positive people in their programs, support groups, or other activities.

To offer the best possible support, providers must also be familiar with the special issues facing HIV-infected people in early recovery. Common issues are likely to include concerns about inclusion or exclusion within the program or community—"Do I belong to this group? Do I want to? Do they want me?"; apprehensions about changes in appearance, physical disability, or death; questions about whether recovery efforts are worthwhile in the face of another life-threatening disease; and confusion about just where to focus when dealing with the dual diseases of alcoholism and HIV infection. Administrators should establish policies concerning medical treatment of people with HIV disease, and consider what their program's response will be if an HIV-infected participant becomes seriously ill.

What about the Alcoholic Who is Still Using?

Active alcoholics also need information about their risks for HIV infection and how to protect themselves from HIV transmission. The presence of HIV infection, or the fear of becoming infected, often inspires a person to evaluate his or her life. The fear that one's life span might be shortened by HIV infection can create a tremendous crisis. In many cases, a positive HIV antibody test result or an AIDS diagnosis is the crisis—the bottom—that motivates a person to enter recovery.

While users may deny HIV-related risks associated with alcohol, it is important for providers to acknowledge that simply seeking information about HIV disease is an active step in self care and a positive and healthy choice. Providers can help alcohol users understand this and encourage them to continue making healthy choices in the future. These choices include decreasing

or eliminating risks for HIV infection, and seeking further assessment or treatment for alcohol-related problems.

Wherever possible, providers should keep the door open for further contact with alcohol users. In the future, an active alcoholic may want more information about HIV disease, the relationship between HIV infection and alcohol, or his or her own drinking behaviors. Each contact can be another opportunity to educate a person about HIV prevention and another opportunity to urge the person to get help for alcoholism.

In terms of HIV prevention, providers can encourage active users to protect themselves from HIV disease, even if drinking and other drug use continue. Recovery is always a possibility, even for alcoholics far progressed in their disease. But once a person is HIV-infected, alcohol recovery will not save him or her from the progression of HIV disease.

What about the “Social” Drinker?

There are some people who are able to drink socially and who are not alcoholics. But the disinhibiting effects of alcohol may be present even for a person who has had only one or two drinks. People unaccustomed to drinking may find these effects even more powerful. Add this to a situation where a person is feeling a strong sexual attraction, and the result may be unsafe sexual contact. Providers offering HIV prevention education can discuss the association between drinking and HIV transmission risks with all participants and clients, no matter how often they currently drink.

While the quantity of alcohol a person drinks is important in assessing alcoholic behavior, their pattern of drinking and the reasons for and consequences of their drinking is also relevant. If occasional drinking is associated with life-threatening behaviors—such as having unprotected sexual intercourse with a person who may be HIV-infected—it may be considered addic-

tive drinking and, therefore, may require recovery intervention.

What’s the Connection?

The connection between HIV disease and alcohol is not as straightforward as that between HIV disease and injection drug use or unprotected sexual intercourse. No unsafe “body fluids” are exchanged during drinking, so many people assume alcohol has no connection to HIV disease. It usually takes repeated education to convince drinkers and recovering alcoholics that they may face genuine HIV-related risks and that HIV infection is an issue of concern to them.

But the connection is clear. Alcohol can weaken the immune system’s ability to fight infection. Alcohol disinhibits people and makes it more likely that they will participate in risky behaviors even if they have resolved to avoid unsafe sex and needle sharing.

Providers can help people see the important relationships between drinking behaviors and HIV risk behaviors. They can encourage participants to explore their own feelings about the epidemic, to consider their own past or present risks for HIV infection, and to evaluate their response to the presence of people with HIV disease in a recovery program. Providers can welcome participants with HIV infection and take steps to make the recovery setting a supportive and safe place for them.

Open and direct information about HIV disease and alcohol, paired with a foundation of compassion and understanding for all participants, will strengthen the ability of individuals to achieve and maintain sobriety. The HIV prevention message has the potential to save lives. By making this important effort to educate participants and colleagues about the connections between HIV infection and alcohol, providers offer an essential contribution to their programs and to the larger recovery community. ■