AIDS AND DRUG WORKERS

Facing death and talking in graphic detail about sexuality and sexual practices is hard for most of us — but that's just what AIDS is forcing drugs workers to do. Should they — can they — meet the challenge?

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AIDS IS CLEARLY an issue which drugs agencies must confront, and articles such as Bill Nelles's (***Druglink***, May/June 1987) stand as a clear challenge to do so. Yet there is, still, a detectable reluctance among some agencies to 'do' anything about AIDS (except, that is, to discuss what should be done). In the drug agencies, we need to ask ourselves what, in practical terms, we are doing now, that we weren't doing before we heard of AIDS. Where there has been little change, this may be explained by our own reluctance to face issues which affect us very personally: specifically, those of sexuality and death.

It is, of course, possible to argue that these issues often crop up in the course of a counselling session, so any trained counsellor should be able to deal with them as with any other problem. This argument falls short of the truth for several reasons. For example, counselling about sexual or relationship problems tends to go on in very general terms, rarely turning into a graphic discussion of sexual activities — a very different matter from telling a client how to put a condom on, or how to produce the sensations of penetration without anal or vaginal intercourse. Working with people to change their sexual habits requires that sexuality should no longer be embarrassing: this requires us to be comfortable with our own sexuality, and that of our clients.

Death and bereavement, too, are issues which are shown in a new light as a result of AIDS. For some agencies, the death of clients has always been an occasional reality, but the workers concerned did not necessarily have the individual or agency resources to deal with these events. It may rather have been a case of biting back grief and using emotional detachment to deal with client deaths — the way most people in our culture deal with death. This is not particularly healthy, nor is it appropriate as a 'coping mechanism' for those working with HIV-positive people or those suffering from AIDS. Our own suppressed grief, fear and bitterness at the deaths we have encountered, whether in our private or work lives, have to be dealt with to some degree before we can provide care to those who are dying from AIDS, or those who are infected and fearing death.

The central problem is that most of us did not come into the drugs field to do this type of work. We did not expect sexuality and death to be issues which occupied a large part of our time and attention, or, at least, not in the very personally challenging way outlined above. This fact has many implications for agencies, both in terms of future volunteer and worker selection, and current staffing practicalities. How will we ensure that a client, who has developed full-blown AIDS, receives high standards of care from a staff member who is capable of discussing death and associated issues, if the client wishes to? Have we reached the point in our own personal coming-to-terms with death where we can befriend a client to the point of their death, with the necessary calmness and strength?

The training implications are clear, but are all our staff prepared to undergo that training, to confront the virtually unique juxtaposition which AIDS creates between some common sexual activities on the one hand and illness or death on the other? That training in itself can be painful, striking deeper chords than any general counselling training course and is, understandably, not an experience which everyone can undergo with equanimity.

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What, then, does such training entail? The relevant work on sexuality centres on recognising sexual conditioning (most commonly messages about sex received as a child), and understanding it for what it is: subjective rather than an absolute statement of what is 'right or wrong', 'nice or dirty'. It is necessary to lay aside prejudices arising from this conditioning. Whether we find 'rimming', oral sex during menstruation, or any other activity, distasteful, is not the point. We must be able to accurately assess and communicate the degree of risk of these activities without any bias arising from our own sexual preferences.

Lastly, sexuality work is about losing some of our social inhibitions. We cannot — as the government's leaflet campaign did — 'throw' safer sex information at people in a random way, and hope they will absorb it, in spite of our embarrassment and theirs. Working with people to change their behaviour, as all drugs workers know, needs careful, long-term support and motivation. This educational work cannot take place if we, as workers, feel embarrassed, or, indeed, if our own sexual habits are 'unsafe'— drugs workers are not in some mysterious way immune from HIV infection.

Emotional detachment characterises the most common approach to care of the dying: 'not getting involved'. This is both painful for the client/patient/family member who is dying, and does them a great dis-service. Now many people involved in AIDS work are finding they cannot (and do not wish to), leave their work behind at the end of the day. It is particularly true of our treatment of the dying that our behaviour towards them is inextricably bound up with the ways in which we have dealt with the deaths we have known in the past, or with the fear of our own death. But this close identification puts us at risk of emotional burn-out, and of overwhelming anxiety for the health of those of our clients who are HIV-positive.

The answer to this dilemma lies in spending time in a supportive environment, working on our grief and associated feelings of anger, fear and bitterness. As an initial training requirement, workers must be introduced to the idea that the deaths they have encountered in the past may profoundly influence their current reactions to death and the dying. It is necessary for counsellors to be involved in counselling each other, to express — and so relieve — their emotions within the confines of a counselling group. In their client work, this 'purging' process enables workers to focus as far as possible on the dying person, without being distracted by their own grief. It enables them to become very close to the dying, without fear of permanent emotional damage when death occurs, since an outlet is provided for the thoughts and feelings provoked by that event. Such training and mutual support necessitates an openness and concern for other workers which many projects may not yet have achieved.

The advent of AIDS means we can no longer separate our work and personal lives as sharply as we would probably prefer for our own comfort: not, perhaps, a palatable fact for most of us. But, as Bill Nelles pointed out, even if we mobilise needle exchange and other measures now, many of our clients will already have been infected. We will find it difficult to counsel and advise them with the necessary optimism and hope for their future, if the possibility of their death is a fearsome, lurking spectre, which we as counsellors refuse to confront.

A PROPORTION of our clients will develop full-blown AIDS. For many of them, their drugs worker will be the one worker they have learned to trust and the one who best understands their drug use. While we may prefer to turn these clients over to AIDS projects and medical staff, the fact remains that it may well be to us they turn for befriending towards their death. We all need to make agency decisions as to whether we are ready to undertake work of this type. Where reluctance to confront the AIDS issue remains, we must ask ourselves whether that reluctance can realistically be justified in the face of the likely high levels of HIV infection among injecting drug users. □

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