

**An Ethnographic Study of the Relationships  
between Crack Use, Sexuality,  
and Engaging in HIV Risk Behaviors  
among Persons of African Descent**

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## **ABSTRACT**

The continued rise in HIV transmission rates among African Americans living in the Los Angeles area is a concern for local public health and policy officials. Similar to other communities, HIV transmission likely corresponds to drug use, in this instance, crack cocaine. The AIDS Coordinator for the City of Los Angeles commissioned this project to examine how the use of crack cocaine within African American communities contributes to the transmission of HIV disease. To formulate effective HIV prevention in target groups such as persons of African descent, policy makers and health professionals need insights into the behavior patterns and motives that are not apparent in local epidemiological data.

A series of focus groups were conducted using a standardized set of questions derived from prior research related to substance abuse and HIV transmission. Primary analyses of the narrative responses from the focus groups evaluated how crack use impacts sexual decision-making. Secondary analyses compared/contrasted crack cocaine and crystal methamphetamine use patterns across two aggregate communities: African Americans and gay males, respectively.

The effects of crack use on perception affected the participant's sexual decision-making in a variety of ways likely linked to risk behaviors for the transmission of HIV. In addition, the results demonstrated that most of the African American group members used crack as an aphrodisiac in ways that were similar to the use of crystal methamphetamine by members of gay communities. There were also significant differences related to decision making and the exercise of judgment across these aggregate communities associated with drug use which have implications for prevention efforts and future research. In addition, two types of social networks were identified that form focal points for drug use and/or trafficking. Membership in one or the other of these social networks may place crack users at greater risk for (or protect them from) exposure to HIV disease.

**PLEASE NOTE: WE HAVE ATTEMPTED TO EDIT OUT VULGAR LANGUAGE TO MAKE THIS DOCUMENT SUITABLE FOR READING BY THE COMMUNITY AT LARGE. UNSUITABLE LANGUAGE HAS BEEN REPLACED BY \*\*\*.**

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## CHAPTER 1 - INTRODUCTION

There is much ignorance in the Los Angeles scientific community and in our local lay press about how the use of crack among persons of African descent may facilitate commission of behaviors that transmit HIV. Up to now, few have shown sustained interest in the topic, despite fairly well publicized local HIV epidemiology reports documenting disproportionate increases in HIV transmission rates among African American Angelenos. Similar statistics are being reported around the country (Kaiser Family Foundation, 1998). The Congressional Black Caucus finds the increasing transmission rates among persons of African descent so alarming that it asked the Secretary of the Department of Health and Human Services " . . . to declare a public health emergency to eliminate the HIV/AIDS crisis in the African American community . . ." (Congressional Black Caucus, 1998). Elected officials from Los Angeles are also demanding with vigor that scientific resources be devoted towards understanding the unique ways in which crack cocaine impacts individuals from our African American communities.

Given the nature and extent of the HIV/AIDS crisis in African American communities, the initial goal of this report is to underscore the importance of acting now to address the disproportionate growth of HIV disease among African Americans. Improvements in the treatment of HIV/AIDS, particularly with the advent of highly active antiretroviral therapy (HAART), have significantly reduced the number of HIV infected individuals progressing to AIDS. These improvements in treatment are associated with decreasing viral loads, increasing CD4 levels, and, subsequent decreases in the occurrence of opportunistic infections (one of the diagnostic criteria for AIDS). This rise in asymptomatic individuals appears to be transforming HIV infection into a long-term and manageable chronic disease. Despite these successes, few persons of African descent appear to be availing themselves of these advances in treatment and prophylaxis. Surveys conducted of individuals in Los Angeles County whose initial diagnosis of HIV infection resulted from an AIDS-related hospitalization indicate that the bulk of those hospitalized were of Latino or African descent (HIV Epidemiology Program, LAC DHS, 1998). Thus, making available the option for early intervention for these individuals may be one of the most important responses to HIV that the greater community can offer.

Many of the new HIV diagnoses are also occurring among persons of African descent, particularly among substance abusers, women, young men who have sex with men (MSM), and persons infected through heterosexual contact. Epidemiological reports from the County of Los Angeles (HIV Epidemiology Program, LAC DHS, 1998) support this claim. Overall, the prevalence of AIDS by race/ethnicity from the period between 1990 through 1998 indicates consistently higher annual rates per 100,000 for males and females of African descent than other groups including, Latino, Caucasian, and Asian. Among male adolescents and adults of African descent the major exposure category, accounting for 67 percent of all cases, was through male-to-male contact. Exposure through IDU accounted for 12 percent and heterosexual contact accounted for 2 percent of the male cases. A comparison of the data for males and females revealed that a substantially larger percentage of females than males of African descent were exposed through heterosexual contact (44 percent vs. 2 percent). Exposure through IDU accounted for 32 percent of contacts for the female cases.

A second goal of this research report is to present a qualitative examination of persons of African descent living in Los Angeles who regularly use crack cocaine. It is intended to provide recommendations for prevention initiatives and directions for future research to reduce HIV transmission. The design featured ethnographic methods similar to Reback's (1997) work that captured the social construction of a drug (methamphetamine)

and a community (gay/bisexual men living in the Hollywood area of Los Angeles). Qualitative methods were used to gather the main themes underlying crack cocaine use and its connection to sexual behavior. We were concerned that social desirability might influence responses, so questionnaires were used only to record demographic data. This project employed Reback's methods of inquiry into how, when, and for what purposes crack cocaine is used by individuals within African American communities. On first look, it seems as though the technical ways one can contract HIV disease are limited; however, the mechanisms that facilitate transmission of the disease among local African Americans remain poorly articulated.

This report allows the voices of the participants to describe their risk behaviors as influenced by crack cocaine. Behaviors that support HIV transmission, including but not limited to male-to-male sexual behaviors, often challenge predominant ideas about sexual morality. We made every effort not to discount the disclosures presented in these groups. Instead, we tried to stay focused on simply being the scribe for those who daily deal with the problems of crack cocaine use and its associated problems.

## CHAPTER 2 - DESIGN/METHOD

### *Participants*

Data for this study were obtained from 34 males and females of African descent. Participants were recruited to explore diversity of opinion based on personal involvement with crack use, rather than to establish any kind of representativeness which might reflect the distribution of those opinions across the population as a whole. The primary inclusion criteria stipulated that the participant be of African descent and have used crack within the past six months. These criteria were used to select subjects from five secondary categorical groupings: (a) gay and bisexual males; (b) heterosexual men who have sex with men (MSM) but do not identify as gay or bisexual; (c) heterosexual females; (d) male sex workers and (e) female sex workers. The female sex workers were recruited in the field from the area of Figueroa and Manchester in South Central Los Angeles. Participants were recruited by word-of-mouth or through advertisements posted at a variety of community agencies providing substance abuse treatment and/or HIV related services. The community agencies that assisted in the recruitment process included the Palms Residential Care Facility, Minority AIDS Project, Women's Link, Sisterhood Network, and the Substance Abuse Foundation. Ninety percent of the MSM and all of the male sex worker participants responded to the content of the flyers targeting men who have sex with men (e.g., Earn money: participants needed for research study. To participate you must be: a past or present crack user and an African American male who has had sex with other men. For more information call . . .). Their calls were directed to the principal- or CO-investigator, who screened potential subjects for sexual orientation and based on the subject's response the individual was assigned to either the heterosexually identified or gay/bisexual identified MSM group. The female subjects were recruited in a similar manner; however, the flyers targeting these groups specifically requested heterosexual females or sex workers, respectively. Consequently, females were not screened regarding their sexual orientation. As a result, one-third (30%) of these participants indicated bisexuality on the demographic form, while an additional 9% indicated transgenderism.

The overall distribution of the participants by anatomical sex was 55% (n = 19) male and 44% (n = 15) female. The average length of crack use for this group was eight years of intermittent or daily use. However, the participants noticed that they perceived a change in the quality of crack that occurred in the late 1980s to early 1990s. This change in drug quality decreased both the intensity and length of the high and instituted the phenomena of running such that users would frequent the dealer periodically during a given day and consume several hits within twenty-four hours. In relation to residence, 54% reported that they live in a house or apartment, 27% were inpatients of a residential substance abuse program, 12% lived in a residential facility for persons infected with HIV, and 6% lived in a homeless shelter.

Slightly less than one-half (42%) of the participants reported they worked full or part-time, while 3% received Supplemental State Disability Income (SSDI), 18% received Social Security Income (SSI), 15% received State Disability Income (SDI) or General Relief (GR), 3% received support from their partner, 3% received food stamps, and 12% were unemployed. Only one-fifth (21%) of the participants reported that they had not been tested for HIV antibodies, while 27% reported they were HIV-negative, 42% said they were HIV-positive, and 9% had received an AIDS diagnosis.

The gay/bisexual MSM group. Among these six men, self-report of sexual orientation were 83% gay and 17% bisexual. Four were high school graduates, one had attended some college, and one had obtained a bachelor degree. All of these individuals were HIV-positive. Eighty-three percent had no history of current or past drug treatment, however 17% had received drug treatment in the past.

The heterosexual MSM group. Among these eight men, all identified as heterosexual. Six had achieved less than a high school education and two were high school graduates. Fifty percent were unaware of their HIV- status, 25% were HIV-negative, 12.5% were HIV-positive, and 12.5% were diagnosed with AIDS. None of these individuals had a history of current or past drug treatment.

The heterosexual female group. Among these five women, self-report of sexual orientation were 60% heterosexual, 20% transgendered/heterosexual, and 20% transgendered/bisexual. One had achieved less than a high school diploma, two were high school graduates, and two had attended some college. Twenty percent did not know their HIV- status, 60% were HIV-positive, and 20% had an AIDS diagnosis. All of these individuals were currently receiving treatment for substance dependence.

The male sex worker group. These four men reported their sexual orientation as heterosexual (25%) and bisexual (75%). Two had achieved less than a high school diploma and two had attended some college. Three of the four were HIV-positive and one had an AIDS diagnosis. None of these individuals had a history of current or past drug treatment.

The female sex worker group. The ten women in this group's self-report of sexual orientation was 50% bisexual female, 40% heterosexual female, and 10% transgendered female, heterosexual. The educational level of this group was the highest: five had achieved less than a high school education, one was a high school graduate, two had attended some college, one had obtained a bachelor's degree, and one had obtained a graduate degree. Twenty percent were unaware of their HIV- status, 70% knew they were HIV-negative, and 10% knew they were HIV-positive. Ninety percent had no history of current or past drug treatment, however 10% had received drug treatment in the past.

## ***Procedures***

An ethnological research design was used in this project to allow descriptions of risk behavior from the subject's point of view (Dooley, 1995). This method has proven successful in investigations of hidden populations such as those characterized by substance abuse (Reback, 1997, p. 3). Prior to the onset of each focus group, the study was explained by one of the investigators, informed consent was obtained, and each participant completed a self-report demographic form. Statistical analyses of the demographic variables and subsequent graphics used to display the results of these analyses were conducted and produced using Microsoft Excel 97.

The bulk of the data was gathered from audio taping a series of five same-gender focus groups. Each subject was paid a total sum of \$20 for completing one of the focus group discussions, which lasted from 1 to 2 hours and was conducted by two same-gender individuals of the research staff. The focus groups were conducted using a standardized set of questions derived from prior research related to substance abuse and HIV transmission (see Appendices A and B). The units of analysis for this research were the nuclear episodes contained within the participant's narratives. Nuclear episodes are the

key events or basic building blocks within the life story of a person. They are an organized whole that includes people, context, and behavior. Moreover, they provided insight into personality characteristics reflected in the intentions, the recurring goals/motives, and repeated themes of an individual's story. These nuclear episodes were subjected to primary and secondary analyses. The primary analysis examined the influence of crack use on motivation and sexual decision-making. The secondary analyses compared crack cocaine and crystal methamphetamine use patterns across two aggregate communities to determine intervention strategies.

The primary analysis focused on the relationship between two domains, the first of which embodied two personality variables. The choice of variables for this domain was predicated on the work of David Balkan (1966) (as cited in macadamias, 1988) which has consistently identified the constructs of agency and communion as key personality variables that allow us to understand why individuals act in certain ways. macadamias and colleague's further research (1988, 1996) led to the development of a narrative approach for assessing personality by translating the elements of people's self-stories into a series of personality variables (Winter, 1996). Their research demonstrated, for example, that agency encompasses a wide range of motivational ideas undergirding concepts such as self-efficacy, self-regulation, achievement, responsibility, and empowerment. Similarly, communion encompasses motivational ideas that instigate the formation of interpersonal connections such as love, friendship, intimacy, sexuality, sharing, belonging, affiliation, and nurturance.

Domain two of the primary analysis embodied two components of sexual decision making: (a) the participant's perception of their risk factors for exposure to HIV disease and (b) the participant's implementation of safer sex practices such as the use of barrier methods or spermicides to minimize the transmission of the virus.

## CHAPTER 3 - RESULTS

These results capture the consensus among the participants across their categorical groupings.

### ***Communion: In Pursuit of Intimacy***

A common theme across each of the groups was that these African American Angelenos were introduced to crack via a friend, parent, lover, or partner. This specific theme emphasizes the social nature of the drug and hints at the ways the drug can be used to transact intimacy.

I could never imagine myself being on drugs. I went through some financial trouble during my younger years and I was sent to this hotel until you get your welfare benefits. I met this young lady there and, you know I'm a gay lesbian woman and she was a gay lesbian woman. So we got together and she was on drugs but I didn't know she was on drugs. She would take me with her to this place to get her methadone and I thought that it was a hospital and that she was sick. Duh, blind as a bat! She was always so sleepy and I was afraid that this stuff was killing her. The next time we went, I ask what kind of medicine was she taking and the nurse explained it all to me. Okay! I made the emotional mistake; I was already in love with her. So a couple of weeks later, I loved her so much, that she asked me to try the heroin and the cocaine together so we could have better sex. Of course I did, I loved her that much. Here we were learning about each other and we trusted each other, I trusted her. She gave me my first shot of dope and she would always shoot me up and it was good sex. I jumped on the opportunity to have more sex with this woman because what she was giving me was so good and I was so in love with her. (Quote from the heterosexual female group).

Well, I got introduced to crack in 1981. I used to snort cocaine, and when it came up with the rocks, my best friend's father had introduced it to them, and that's how I got started with crack. And I've been messing with it ever since. I've used it for my own purposes, for pleasure, I've used it to make money, and then I get high. Yeah, that's how I started. Turned on by somebody else. Somebody else in my life. I just like em. But it's really getting boring now, because cocaine anion cocaine. (Quote from the female sex worker group).

For me, it started with some \*\*\*. I was with a pal of mine. I was married living in a good place. My pal and me both had money and cars and jobs. I was working as an engineer. He came over one night and said to me, You got to try this. So we had both just gotten paid and I left the old lady with \$300. I still had \$600 in my pocket and we went to this bar and there were these two \*\*\* sitting there. They were good looking, so we let them pick us up and take us to their apartment. They brought out the pipes and I'm looking at my friend like I don't know what to do, so they put some rock on the end of the pipe and they put some flame on it and they tell me to inhale and I do and I don't feel nothing. So they do it again and I still don't feel nothing. And \$200 later I'm sitting there telling them I still don't feel nothing. So we party and then go home and that's it. I don't do any crack again for the next two weeks. Then, payday comes again and I make a bee-line to those hoes house and I knock on their door and I tell them I want some more of that stuff that I don't feel nothing (Quote from the heterosexually identified, men who have sex with men [MSM] group).

Their introduction to crack cocaine is a significant episode in all the participant's narratives. For 80% of the participants, a lover/partner introduced them to crack use. I hooked up with my daughter's father who exposed me to it. (Quote from the heterosexual female group). It was my lover in '84. (Quote from the gay/bisexual [MSM] group). The remaining 20% of the participants were introduced to crack by a close friend, casual sex partner or relative, almost always in a sexual context. In fact, most of the participants used crack primarily as an aphrodisiac to heighten the sexual experience. It was within the context of these sexual relationships (many of these encounters were predicated upon fluid understandings of sexuality) that HIV-related risk behaviors arose. However, HIV-related risk behaviors are only one aspect of the risks engaged in by African Americans using crack, many reported engaging in acts of antisocial and criminal behavior as well.

### **Agency: Decreased Self-Efficacy**

. . . Sometimes I get high and I find myself giving away most of mine, and after it's gone, I'm mad because I want some more. Everybody else is just smoking, and they looking at me and say \*\*\* you. Who are you? And it's, it's cold. (Quote from the female sex worker group).

Sure. Um . . . letting people use my car, saying they're gone be back in a couple of hours and waiting and waiting around for them. Giving them money to go get dope, dealer didn't even know them. You know as long as I had my dope, my next hit, I didn't care what they were doing to me. You know, until after I came down. But while I was getting high, I was like, oh yeah, take my car, here's the keys, oh yeah, okay?. Go get another five-dollar, you know. (Quote from the gay/bisexual [MSM] group).

It was like when they saw me coming, it was like, my brother, oh here comes my brother. It was a happy thing for them because they knew that I wasn't gone go into the dope house. I wasn't gone follow them to the dope house. And whatever they brought me, I had to be satisfied. I was spending, paying \$400 at a time to get high, and I was getting like maybe a \$100 worth of dope out of that three or four hundred dollars. (Quote from the gay/bisexual [MSM] group).

I was that hopeless, I've \*\*\*, got \*\*\* for a push. (Quote from the female heterosexual group).

One of the most noticeable outcomes of the participant's use of crack cocaine was change in their cognitive processing. Its use severely compromised the self-regulating internal systems of many of the participant's to respond adaptively in context to promote viability. This level of compromise resulted in irresponsible behavior, loss of impulse control and behavioral mastery, and self-degradation or exploitation. The narratives cited above demonstrate how personality is altered by the use of crack such that the behavior exhibited were antithetical to environmental mastery that promotes health. This attenuation in the personality construct of agency compromised many of the participant's ability to accurately access their potential risks of exposure to HIV disease or exploitation.

### **Sexual Decision Making**

Crack is very physical to me. From the first time I used it, it was orgasmic. I feel it in my lungs (reaches down and runs his hands from his waist upward to his shoulders, while taking a deep breath). Sometimes I use it and it gives me an instant \*\*\*. But I

always get a \*\*\* and then have to find someone to have sex with. (Quote from the heterosexually identified, men who have sex with men [MSM] group).

My lover asked me to try crack so we could have better sex. I did because I loved her that much. You talk about good sex, the first time I tried it, it gave me a tingle in my uterus, my \*\*\* down there. (Quote from the heterosexual female group).

See that's where the freak and the cocaine, it's not the normal sex you want. To me, it all depends on how you start smoking cocaine. The way you start smoking cocaine, you with a person, you go into that room or go wherever you go to have sex or freak, whatever, if that's the way you started out doing it, that's the way you going to depend on doing it. (Quote from the female sex worker group).

Two years I got off this habit. What made me start back is that I craved it everyday. I don't care what they say; it's no good. I was getting into it even before using. The visualizations of it, the smoke, the habit, the drinking. (Quote from the male sex worker group).

I was introduced to it by my lover. And I recall the first time that I did it, I thought the sex was actually great. And so I, continually, on from that time, I had that same feeling. As soon as I took a hit, one of the first things I thought of was sex. I connected the two, you know? Good, uh, good rock cocaine means good sex. Okay, so, even when my lover wasn't there, I'm out looking for sex. (Quote from the gay/bisexual [MSM] group).

The preceding excerpts provide compelling descriptions of the crack high and how it is viewed similarly to sexual pleasure. Many of the respondents equated the crack high to the experience of achieving an orgasm, only many times stronger (heightened clitoral sensations, instant erections, and spontaneous ejaculation). These participants spoke as if their bodies remembered the original pleasurable experience, as if they desired to recapture and relive this experience again and again. Drug-seeking behavior and the anticipation of using triggered bodily and emotional memories which included the handling of the paraphernalia, visualizing the fire as it hit the rock, the smell, the hallucinations, etc. These memories initiated an altered state of being high even before the drug was used.

In one context, crack functioned as a link, connecting the present with the past, interpreted by the user as an aphrodisiac to recognize the excitement and pleasure of the sexual experience. In another context, crack distorted cognitive processing such that the user perceived that he or she was not at risk for exposure to HIV disease, rendering safer sex practices as irrelevant. One of the heterosexual females, for example, stated that her partner told her that he was HIV-positive, yet because of her drug use, she stated that "I didn't give a \*\*\*. I felt very sexual. I just wanted to have sex, that's all, that's all that was on my mind." Other bisexual female participants reported that they did not practice safer sex with their primary or long-term female partners because the use of latex caused clitoral pain and prevented achieving an orgasm. you can't \*\*\* with rubber, you know, that rubber cushion hurts.

### **Trust Increases Risk Taking**

Approximately thirty percent of the female sex workers believed their long-term partners had infected them. Based on this perception, they saw no need to practice safer sex with their long-term partners.

Because I did have a main man and we started off in the program, we're just gone stay in the program. Then I finally had it with a rubber man. And sex; sex with a rubber man. Ended up slipping out of his rubber one night. Oh well, from then on, it was sex without the rubber, so that's where you know that he's the one that had to give it to you. Other people has to wear one, right? So he's the only one you're having sex with without the condom, and he's the only one that gave you that disease too (Quote from the female sex worker group).

I think that crack is the key that opens the closet. I think that lots of men find themselves doing things they wouldn't do otherwise because they have some kind of thoughts or curiosity. Under normal circumstances, it's locked deep away. When they aren't using, they're just thoughts or curiosities and nothing much goes on. Then when they use crack and they find themselves places or in situations and then it happens. Then all that stuff locked away in the gray matter gets let out and pretty soon it's in the hard matter. But that don't mean that someone is homosexual (Quote from the heterosexually identified, men who have sex with men [MSM] group).

But I know that when I use I will have sex and I know that now (implication is that he now prepares for having safer sex). I think that's the way I got the virus was that I didn't pay much attention who I had sex with or what I was doing (Quote from the heterosexually identified, men who have sex with men [MSM] group).

If it (a condom) wasn't there, I wouldn't (use it). I really wasn't doing much anyway. I was just giving head. (Quote from the male sex worker group).

When you say, buy first condom first, it's like saying, saying pay your bills first and then get high. Nobody does that. Who has gone buy condoms first? Condoms are expensive. No, they're expensive. \*\*\*. Three or four dollars, or three and seven. Expensive. That's a piece (drugs) right there! (Quote from the male sex worker group).

Other decisions to forego safer sex practices occurred mostly from insufficient planning or acting spontaneously. Few of the heterosexuals from the MSM group planned ahead to practice safer sex with partners outside their stable relationship. For most of these men crack use served to lift constraints such that they inhabited gender spaces where having sex with other men was permissible. Second, condom use for the male sex workers was not consistent. In fact, they were used only if present. These individuals minimized their engagement in risk behavior. The phrase, out of sight, out of mind seems to capture their thought content in relation to practicing safer sex.

### ***Efforts to Minimize Risk***

Of all the respondents, the female sex workers exercised the greatest degree of power in the process of negotiating safer sex with their male clients. As a rule, all forms of penetration for these females involved the use of a condom. Oral sex typically occurred without the use of a condom unless touch and/or visual cues indicated that a patron was infected. These cues included examining the testicles, looking for purplish bumps or rashes on the skin, palpating for sore spots looking at the way the patron was dressed or examining whether the patron was clean. They also related several incidents where their patrons attempted to undermine their practicing safer sex by offering additional money for penetration without a condom or by placing pin holes in the condom.

But \*\*\*, I don't mind not using a condom (Quote from the female sex worker group).

It's just a chance you take. I look for purplish rises and bumps. You know, every time I go to the doctor, I'm gone get, you know, a Pap smear (Quote from the female sex worker group).

You know that lump, I look for all of that. Or the way they dress (Quote from the female sex worker group).

You look at their testicles. If it's too tender, then you know something wrong (Quote from the female sex worker group).

A lot of men . . . okay, they give me the money and use the condom. And then they want to take the condom off and want to offer you some more money. In other words, they're gone offer me forty dollars just to have sex with a condom, then they will pay me sixty, seventy dollars more without (Quote from the female sex worker group).

But now I got to check the rubbers, because they put holes in them! I'm serious. People are really putting holes in rubbers, I mean really. So now, not only do I have to check man, but check the rubber too! (Quote from the female sex workers group).

### **Influence of Social Networks**

We've all been there but the thing is we pull together. Anion nobody could put down nobody in here. All of us basically get high together. We females control the drugs around here. It's the prostitution between the dope man and the money, that's were the most money comes from. If his stuff is good, then it goes fast. If it's nasty, then it's gone stay. We females control it. We are their bread and butter. (Quote from the female sex workers group).

More likely it works like this. See lots of the women they got kids. And all of the women - no 60%, 70% of the women who got kids, don't got no man. So if the woman's not on crack, what a brother will do is buy the woman's kids birthday and Christmas presents. And this makes the woman happy. So if the brother uses some crack and the police come around and start asking questions about the brother, the woman will cover and say she don't know about any problems with crack cocaine. She only knows that the brother buys her kids the presents, which makes her happy, and the brother can be something of a dad for the kids, so she covers for the brother. The police can't do anything. Then as the kid grows up, he sees that the money to be made from crack let kids his own age and from his hood drive Mercedes and BMWs and have cell phones (runners). And that's how it starts with the young ones. Why work so hard when it's all right there for you? (Quote from the heterosexually identified, men who have sex with men [MSM] group).

If a woman identifies one of more sellers to the police she is subsequently intimidated. One night they're sleeping and the brothers come along and fix the house and when she wakes up in the morning, she walks to the front door and she smells gasoline. She fears that her home will subsequently be burned, so she cleans up the mess and keeps her mouth shut. (Quote from the heterosexually identified, men who have sex with men [MSM] group).

The participants discussed two types of networks that form focal points for drug use or trafficking. The first network was composed of the female sex workers who spend time together, purchase and use drugs together, and exchange information around issues of sexuality and risk reduction. The second type was composed of individuals from the heterosexually identified MSM group. Each network appeared to contain longer-term and more stable relationships. Within the female sex worker network, peer influence and pressure served to bolster self-esteem and reduce HIV-risk behavior. The implications of this distinction will be discussed below.

## ***Long-Term Use of Crack***

### **Decreased Sexual Arousal**

Then as I used it more and more, one day I noticed that my \*\*\* went away and I wasn't able to do it while I was using. That's for after the party. I've never had plumbing problems before crack. But I've never had a drug that made me want sex so much (Quotes from the heterosexually identified, men who have sex with men [MSM] group).

When I say I get high, I don't get high. I get high, I lose it. So I love to stay focused, get dazed. That's when I get high, because then the hallucinations come in. It destroyed the sexual drive. When I first got started on these drugs, I could go about twelve, twenty-four hours a day. Now, twelve years later, even if I see a man, and he touches me, he better have my money. Now it's not so funny. It's not to freak no more. (Quote from the female sex worker group).

My thing was, okay, once I got high, I didn't want to be any higher. I wanted to come down. Um, I would use Valium, a lot of benz, or any kind of downers. I always had to have no matter where I am; it would just become a necessity that I had beer. And, uh, I had this thing of, if I desired at all, if I liked the person that I was with enough to wanna have sex, I had to have marijuana because that's the only way that I was gone have sex with anybody high on crack, is that I had marijuana because marijuana, I don't know, it's just my aphrodisiac. It just made me do things I wouldn't normally do. (Quote from the gay/bisexual [MSM] group).

Cause I started in 84, right? But 90 to whenever I'm at now, I became a hustler. You know, as the years progressed, sexual activity could never come around because it was hard to get a hard on while smoking the drugs. So what I would have to do is wait a few hours after smoking and then you know, perform sex. But I would always try to, you know, while I was smoking. But it's very difficult. Never complete sex when smoking. (Quote from the male sex worker group).

The relationship between crack use and sexual arousal for these participants changed as a function of the length of use. Early in their use of crack, the drug heightened the sexual experience and/or prolonged achieving an orgasm. Over time, however, the degree of sexual arousal decreased for the entire number of male participants and some of the female subjects. The design of the study does not allow us to distinguish how much of this decreased arousal is a function of aging. However, for the males of this study, the effect over time was an inability to become sexually aroused while high, something akin to substance-induced impotence occurred (plumbing problems) and the user would have to wait until he was coming down to have sex (after the party). Thus, other drugs such as marijuana or alcohol were used to mellow the effects of the crack and to stimulate sexual arousal/performance.

### **Communion: Breakdown of Affiliative Bonds**

In the beginning, I had to get high with other people. But towards the end of my addiction, I'd rather be alone, more for me. (Quote from the gay/bisexual [MSM] group).

I changed because I was tired of the sharing. I was tired of the sharing my dope. I want it all to myself what I was going to say was, um, like in the beginning I did have a circle of people that I did want to get high with, or did get high with, and as I met different people in my addiction, the more I found out how scandalous people become and the more I didn't want to be around them. (Quote from the gay/bisexual [MSM] group).

The participants stated that, initially, they would have to get high with someone else illuminating the social value of crack in the initial experience with the drug. For some, the other person served as a sex partner, for others, he or she provided a calming effect to quell paranoia or tweaking. In time, however, many of these subjects reported isolating themselves when high. That is, rather than promoting forms of communion, longer-term use of the drug was associated with mistrust, paranoia, and the severing of affiliative bonds. Despite these decrements in the socially rewarding aspect of drug use, many of the participants noted that they continued to use crack and that over time the members of their social networks did little to stay connected when they are high. Isolated use combined with the use of intermediaries to secure the drug raises concerns about the safety of these drug users and may explain why so many African American crack users come in contact with the criminal justice system over time.

### **Agency: Anti-Social Behavior**

I would sell my body on Santa Monica Boulevard, ten, fifteen, twenty dollars to get a hit. To get some dope and shit. I had to have it. I had to have it and I would do anything for it. . I would steal things, I would steal, I would lie . . . Oh man, I had a friend, and he told me to watch his apartment while he went to the hospital. And I sold everything in his apartment. The ceiling fan even came down. I sold that too. The TV, microwave, his clothes, furniture. It was all gone. (Quote from the heterosexual female group).

So yeah, that was something that I just wouldn't ordinarily do. And um, selling a lot of my possessions. You know, as well as my family member's possessions and um . . . If I wasn't high, I wouldn't touch that boulevard (Quote from the male sex worker group).

It's just like an opiate addiction. Yes. Plenty of things. But I must say, I was a working addict and I worked for several years as an addict. As no one knew anything about my addiction because I had my finances. I made quite a bit of money when I was working. It was easy for me to cover up. You know, and I wasn't like . . . and at that the time that I was working I wasn't . . . uh . . . as strung out as I was after I stopped working. After I stopped working, I started selling off possessions. I'd sell your stuff, his stuff, his stuff, and you know everybody's stuff I got my hands on. (Quote from the gay/bisexual [MSM] group).

All of the respondents discussed how crack use led them to do things they would not normally do. For many of the participants, long-term use was negatively associated

with the ability to maintain employment to support their habit. The design of this research, however, does not allow us to posit a causal relationship between crack use and unemployment. Long-term use also led to episodes of craving in which they engaged in criminal activity to secure the drug. These activities included theft, robbery, selling drugs, embezzlement, prostitution, and selling stolen property. There was a lack of insight among these users into the effect of their behavior on the larger community or themselves.

On Thursday, Friday nights, the kids would come down from the more affluent neighborhoods such as Palos Verdes and Baldwin Hills in their BMWs and Mercedes Benzes looking for crack. They come into the community because the crack is cheap and everywhere. Moreover, they hang with the brothers and get high and the police don't bother them. (Quote from the heterosexually identified [MSM] group).

Unable to maintain gainful employment, many of the participants assumed the role of drug dealers to support their habit.

## **Conclusions**

### **Enhancing the Sexual Experience**

We conclude that the participants of this study used crack primarily as an aphrodisiac to heighten the sexual experience. This interpretation is a significant departure from most, if not all, of the research (e.g., Carlson & Siegal, 1991; Edlin et al., 1994; Wilson & DeHovitz, 1997) on crack. Previous research has concluded that the relationship between crack use and sexuality occurs primarily within the context of exchanging sex for drugs. For our participants, the exchange of sex for drugs or involvement in other criminal activities tended to occur after longer-term use, particularly when the user was not able to maintain employment as a means of supporting her or his addiction.

### **The Influence of Crack Use on Personality Functioning**

Overall, personality functioning remained integrated for most of the female sex workers, despite their crack use, particularly in relation to their vocation and clients. For the remainder of the participants, personality functioning became fragmented and, some cognitive functions crucial to perception, problem solving and decision-making were severely compromised in relation to crack use. For the latter, crack use diminished their ability to respond adaptively in context to promote their present and future survival. The data suggests that there was also a cumulative aspect to this fragmentation and nullification over time and with continued crack use. These varying levels of compromise in personality functioning had an immediate consequence of placing the individual user at high risk for exposure to HIV disease and raise questions about the long-term consequences of crack use.

### **High-Risk Behavior**

Counterintuitively, two rather than five group perspectives characterized these participants. To a high (not complete) degree the perception of being at risk dichotomized the female sex worker group and the remainder of the participants. Among the latter, while high on crack, the associations between engaging in high-risk sexuality and the transmission of the HIV virus were severed. Why, then, should they practice safer sex?

In the absence of a perceived problem, the motive of communion gained ascendance in either casual or long-term relationships.

Over one-half (50%) of the female sex workers engaged in risk-taking and unsafe sexual practices to symbolize trust or commitment to their long-term female partners or to heighten the sexual experience. An additional 30% of these sex workers believed they had been exposed to the HIV virus by their long-term male partners and felt that there was no longer a need to practice safer sex in this context. This difference between the behavior of males and heterosexual females and the female sex workers was a matter of perception. The former perceived that their behavior were not high risk while the latter recognized the potential risks and choose to forego the practice of safer sexuality in the context of trusted relationships.

### **Reducing Risky Behavior**

Unlike the other four groups of participants, the members of the female sex worker group were cognizant of the risks associated with their sexual behavior in relation to client contacts or with their long-term, nonclient partners and they behaved differently according to their relationship with their partner. These participants viewed client sex as work, a vocation and the use or nonuse of safer sex practices delineates work from personal contexts. They executed a high degree of control over sexual decision making and negotiation in relation to their clients; particularly to minimize the risks associated with servicing multiple partners. Safer sex was the norm for client relationships.

In the work context, these participants used crack as an aphrodisiac, as a prelude to or during virtually all of the sexual encounters. Its use in this context did not attenuate their ability to exercise judgment and agency. The potential loss of valued outcomes (i.e., self-esteem, empowerment, resources) associated with the work experience that would result from poor sexual decision making seemed highly relevant for this group and may have served to bolster their exercise of agency to protect a primary source of securing these valued outcomes.

### **Educational Bias**

The educational level of the participants indicated that 44% had less than a high-school education, 26% had graduated from high school, 21% had attended some college, and 9% had college or graduate degrees.

The primary analysis of the data demonstrated a distinctive skew (skewness: 0.891) in educational level such that approximately three-fourths (70%) of the participants had obtained a high-school diploma or less. This skewness or educational bias (see Figure 3.1) indicates that the educational range of the female sex worker group was the highest. Interpreted in light of the concepts of human agency and sexual decision making, this bias suggests that the reasoning skills (elements of self-efficacy) and discipline (self-control) acquired through education allows one access to and the ability to better use the resources in one's environment. Their participation, for example, in a social/drug network provided empowerment, support and information to lower their risks in a manner similar to interventions based on harm reduction. Our interpretation is consistent with the findings of St. Lawrence et al. (1998) that, consistent condom users reported that their peers not only approve of condom use but peers also behave in ways consistent with a concern for AIDS prevention: discussing sex, AIDS, and condoms among themselves; expressing concern for AIDS; and using condoms . . . (p. 24). Moreover, our interpretation is supported by the findings of prevention efforts based on the use of effective communication strategies (Aggleton, 1997) and Diffusion of Innovations theory which suggests that interpersonal

communication is more persuasive than mass media (Miller, Klotz, & Eckholdt, 1998, p. 99).

## **CHAPTER 4 - DISCUSSION**

Crack use attenuated the personality construct of agency and compromised many of the participant's ability to implement strategies to prevent exposure to HIV disease. Some of the findings of this study converge across our research and that of Reback's (1997) study of methamphetamine users while others do not. Nonetheless, there was sufficient overlap to conclude that crack was used by many of the participants in our project in ways that carried significant risks for exposure to HIV. Further, our work is the first of which we are aware to begin exploring the ways crack cocaine use (in particular) may function to expose communities that have not been considered high risk heretofore (heterosexual males and females of African descent).

### ***The Interaction of Communion and Agency***

Ironically, sexuality and drug use place agency and communion in center stage. For individuals who are disenfranchised and/or marginalized sexuality and drug use can serve as avenues to reinforce or even build feelings of potency and self-efficacy. The search for communion or intimacy emerged as a significant motive underlying the behavior of many of the participants in our study: the motivation to form interpersonal connections such as love, friendship, intimacy, sexuality, sharing, belonging, affiliation, and nurturance. Crack use severely compromised the self-regulating internal systems of many of the participant's to modulate this motive set and respond adaptively in context to protect his or her health and the utility of safer sex practices went unrecognized. This level of compromise resulted in irresponsible behavior, loss of impulse control and behavioral mastery, and self-degradation or exploitation. Moreover, its use blocked many of the user's access to cognitions integral to problem solving such that they exhibited behavior that undermined their personal agency.

Reback's (1997) sample, in contrast, perceived crystal use as a bolster to one's sense of agency:

Although sex is the primary activity associated with the use of crystal, [the gay male] participants also spoke of using the drug to enhance other non-sexual activities such as work-related and/or creative tasks or to prolong high-energy activities such as dancing. Moreover, crystal use [was] reported to foster creative insights, increase work time, heighten sensory perception, improve intellectual capabilities, and produce more energy and stamina. (p. xiii).

### ***Sexual Decision Making***

Crack use among many of the African American participants distorted their thought processes such that potential behaviors of self-preservation were recast as things that counteract or diminish the pleasure enhancing aspects of its use. Health status was jeopardized because the utility of safer sex practices went unrecognized; rather these practices were cast as intruders into sexual space. For many of these participants, the desire for intimacy and belonging and demonstrating trust served as motivation for their

sexual risk taking, particularly in non-casual relationships. Alternatively, peer influence and spontaneity had a significant influence on crack use and sexual risk taking in casual or temporary relationships. Moreover, impaired judgment secondary to crack use and beliefs about one's or one's partner's HIV status influenced sexual behavior as well.

Perceptual distortions in regard to judgment, self-preservation, and trust similar to those described above influenced sexual decision making in Reback's sample as well. Fifty-five percent of the participants inject crystal, and more than half (53%) of these injectors are HIV-positive . . . Of those injectors who were highly knowledgeable about safer injection practices yet reported unsafe injections, all reported their unsafe practices in the context of sharing needles with a lover . . . For these users, safer needle practices are not followed within the context of an intimate relationship. However, safer injection techniques are always maintained outside of the emotional or sexual relationship. Accurate knowledge regarding injection techniques does not guarantee that one will always inject safely. In these situations, the user defines a partner as worth the risk and relinquishes safer injection protocols as a sign of commitment (Reback, 1997, pp. 59-60).

### **Planning to use**

As reported earlier, only one of the heterosexually identified MSM from the African American participants (3% of the total sample) implied that his use of crack was accompanied by planning to minimize the risk of transmitting the HIV virus. In contrast 20% of Reback's (1997) sample planned their use of crystal. These users predetermined every aspect of their crystal use including the day and time, the amount, the procedures, rituals, and sexual activities. (p. x).

### **Sexual/Gender Identity**

Identity was tied to crystal use in Reback's (1997) sample.

Many of the effects associated with crystal use are congruent with what many gay and bisexual men value within gay culture. In the United States, gay identity is both implicitly and explicitly linked to sex. Consequently, communities that place a high priority on sexual functioning are clearly predisposed to embrace a drug that reportedly enhances sex. The identity, social networks, and institutions that mark a gay subculture have easily evolved to maintain and support the use of crystal within gay communities. The creation of social settings where crystal use is common-or, in some social situations, expected-serves to normalize crystal in gay culture (Reback, 1997, p. 48).

This phenomenon was not evident among the African American participants. (There is, however, a commonality in relation to sexual/gender identity between the two samples that will be discussed below).

The identity of most persons of African descent is fundamentally relational anchored by membership in (relationship to) particular social groups, ethnicities, expressions of spirituality, cultural practices, politics, family lineages, historical/political eras, context, etc. These identities are characterized by multiplicity such that they change, overlap, and interact in ways that make them inseparable. In American, capitalistic society, we (broadly speaking) are encouraged to celebrate and expand our multiplicities to increase potential success in our (a) intimate/emotional relationships, (b) market economy, and (c) pluralistic society.

When it comes to sexuality, it is common practice in American society to assume that an individual occupies one of several mutually exclusive categories: gay, lesbian, bisexual, heterosexual, or transgendered. One fallacy of this assumption is that the classification of human sexual identity is based on a single variable, the gender of the individual's preferred sexual partner. What is hidden here (or obscured) is that this simplistic system gives significant power to cultural institutions and individuals to regulate behavior. Based on one's classification, individuals, communities or the larger society provide rewards (resources, support, inclusion, etc.) or sanctions (the ability to label one as deviant and, in consequence, take away his or her civil liberties, rights, and/or freedom).

A significant portion of these African American participants refused to accept the sexualized space created for them through the language and cultural practice of heterosexual and gay communities. They recognized, consciously or nonconsciously, the enslaving properties of such spaces where race, gender, and sexuality are distorted by racial and sexual myths about black sexuality (Collins, 1990). In this refusal, their behavior provides a means of deconstructing this gendered space to reveal how language and culture are used as expressions of power to mold and constrain behavior (Sneed, 1998; West, 1994). For example, the endorsement of gender category by the heterosexual MSM group was 100% heterosexual. However, most of this group asserted that crack use allowed them to inhabit gender spaces where having sex with other men was permissible. Similarly, it was not inconsistent for a female within the heterosexual group to refer to herself as bisexual or lesbian. A similar inconsistency was evident in the female sex worker group. This phenomenon suggests that choosing someone of the same gender category as a sexual partner does not, of necessity, alter one's status as male or female. Viewed through the lens of traditional gender role ideology this refusal to play the game amounts to gender treachery, a subversion of what it means to male or female. In this respect, we witness the confluence of gender, sexual identity, and sexual behavior.

The language categories used by the dominant culture such as gay, lesbian, bisexual, heterosexual, or transgendered heterosexual, bisexual, or homosexual are inadequate to capture the realities of the sexual experience. Such labels constrain sexual behavior and fail to acknowledge that sexuality like gender identity is not a discreet category but one of many possible social constructions that lie on a continuum. There are men and women of African descent who choose same-gender sexual partners but for whom this choice has no implications whatsoever for self-identity (Flannigan-Saint-Aubin, 1993, p. 391). A single sexual episode cannot contain the totality of his or her sexuality and gender identity. Moreover, men and women of African descent who have sex with same-gender partners may interpret these behaviors in different ways. For some, sexual orientation is circumscribed completely by genital acts; to others, it includes these acts in an ill-defined way or is completely independent of them (Flannigan-Saint-Aubin, 1993, p. 391). So, unlike the gay males of Reback's (1997) study, men and women of African descent who choose same gender sexual partners do not necessarily experience sexuality as intimately wedded to identity or gender.

### **Implications for Outreach to Hidden Communities**

The presentation of AIDS as a disease resulting from enacting high-risk behavior has been successful to some degree (to emphasize that it is the high risk behavior across sexual orientations, rather than sexual categories, that must be avoided. When applied to many persons of African descent, however, this approach has left little room for a discourse about the appropriateness of attempts to make distinctions among sexual behavior, gender identity, and sexual orientation. A large proportion of our participants,

for example, engaged in bisexual behavior and yet self-identified as heterosexual. This suggests that we have inaccurate information about what behaviors fall within the category of heterosexuality. In order to understand the meaning of HIV among persons of African descent, we must understand their construction of sexual identity and sexual behavior, risk and relationships. Thus, we must examine the range of behavior that fall within the rubric of heterosexuality. This level of examination may threaten personal and socially-defined categories of acceptable sexual behavior and challenge predominant ideas about sexual morality. However, it is only by exploring the dialectic of sexual identity and practice that progress can be made in AIDS prevention. We have based much of our prevention efforts on assumptions about how people behave and with whom they identify that have too often proved incorrect (Lear, 1995, p. 1312).

It is now widely accepted that there are categories of men who have sex with men (MSM) and who do not self-identify as gay or bisexual. We were careful to include this category into this research design to better understand the transmission of HIV disease. However, as indicated in this project, there are similar groups of women who have sex with women and who self-identify as bisexual or lesbian in limited contexts. There appears to be a fair amount of heterosexual behavior among women who have sex with women. For example, a factor often ignored in studies of lesbians (and evident in this project) is their involvement in the sex industry. With women who have sex with women, the widely held assumption that lesbians are not at risk for HIV exposure continues to be a major obstacle to effective intervention (Hunter & Alexander, 1996, p. 51).

Our prevention efforts must focus on both risk behavior and sexual identity. That is, prevention efforts must simultaneously target groups by sexual orientation/category and focus on risk behaviors within the larger concept of sexuality.

## **CHAPTER 5 - RECOMMENDATIONS**

We conclude that crack was used by many of the participants in our project in ways that would support transmission of HIV. Further, these private behaviors are conducted in ways that present challenges to those interested in prevention initiatives with just these types of individuals. This conclusion suggests the need to design community, as well as individual interventions. In this way, the burden (process) of change becomes the community's and the individual's responsibility. Individuals and communities are empowered through the contextual accrual of knowledge, expertise, skills, resources, and support, but most importantly, through their involvement in decision-making and interventions for promoting health (Cole, 1996). To address the needs of both the individual and community, our recommendations focus on the broader perspective and on specific areas.

### ***Broader Initiatives***

The analysis of the data indicated a relationship between self-perceptions of being at risk for exposure to HIV disease and the subsequent engagement in safer sex practices. That is, perceptions of being at risk (HIV represented as a problem) or external pressures must occur prior to the initiation of behavior (thought) to minimize the same. The ability to minimize participation in risky behavior and plan ahead are intimately related and represent steps to follow in reducing the transmission of HIV disease. These steps may be addressed most effectively through the use of harm reduction strategies. Harm reduction interventions are based on the belief that it is possible to modify the behavior of drug users, and the conditions in which they use, in order to reduce many of the most serious risks that drugs pose to public health and safety (MacCoun, 1998, p. 1199). This set of strategies assist users, particularly those who do not view their behavior as problematic, to prepare ahead to use crack and safer sex practices in concerted ways that minimize the transmission of the HIV virus and create space to work on decreasing or eliminating drug use. This philosophy is the backbone of needle exchange programs and similar efforts to teach injecting drug users (IUDs) how to use bleach. It does not advocate drug use rather it recognizes that abstinence may not be a feasible goal for a large group of individuals until other conditions in their life are altered through vocational rehabilitation, psychotherapy, and/or improving quality of life.

The harm reduction interventions that we recommend emphasize the direct modification of individual's risk behaviors through mechanisms such as enhancing perception of personal risk, [increasing the practice of safer sex behaviors], providing behavioral skills training, and changing attitudes and beliefs. They may also be characterized as influencing risk behaviors indirectly through modifying one or more elements of the physical or social environment such as encouraging participation in social networks that support the practice of safer sex (Rhodes & Malotte, 1996, pp. 217-218).

### ***Social Influence Interventions***

Many planners in the field of public health assert that the HIV prevention campaigns designed for the gay community have not worked for persons of African descent. There is irony and arrogance embedded in espousing such a perspective. The irony is that the

political tactics (e.g., the demonstrations, boycotts, marches, negotiation strategies, etc.) used by the aggregate gay community to garner resources and support and influence policy in combating HIV disease were modeled on the aggregate strategies used by persons of African descent in their struggles to obtain civil rights. The arrogance associated with this perspective is that there is no evidence to support its assertion. That is, a comprehensive educational, intensely political, and community focused set of interventions on the scale that occurred within the gay community has never been attempted with African Americans. Thus, we are left with an empirical (research) question of whether selectively emulating some of the strategies that have worked within the gay community will assist African Americans to deal more effectively with HIV disease?

Our findings support previous research that has demonstrated how communication between peers in social relationships promote risk reduction (i.e., Miller, Klotz, & Eckholdt, 1998). The most successful prevention efforts that draw upon peers in social contexts have been founded on Diffusion of Innovations Theory (Rogers, 1995). This theory holds promise for increasing our understanding of how and why certain strategies adopted by the gay community, early in the epidemic, were so successful in affecting behavior change. Diffusion is a form of interpersonal communication used by participants within a specific context and/or community to create and share information with one another about a new idea in order to reach a mutual understanding. The innovations or set of new ideas represent problem solving strategies for generating attitudinal and behavioral change through alteration of the structure and function of the social system or community (Rogers, 1995, pp. 5-6).

Three assumptions underlie interventions based on the theory and are consistent with those identified as efficacious by outcome research (e.g., St. Lawrence et al. 1998). These interventions assume that community-wide change comes about through informal conversations among peers, conversations that are triggered by opinion leaders. They also assume that the distinctive nature of social networks in urban areas provide particularly powerful spaces for diffusion interventions to occur. Lastly, they assume that this strategy will prove most effective in networks with fairly stable populations. That is, the more attached an individual is to the network, the more important it may be to him or her what others in it do and the more he or she may be influenced by what others in it advise him to do (Miller, Klotz, & Eckholdt, 1998).

Integral to this approach is the use of peers within specific contexts as trend setters or opinion leaders to model new behavior to others and to alter the perception of what is normative. These peers promote cultural adaptation such that others within their context or social network will begin to adopt the new behavior (Rogers, 1995). Ultimately, the entire set of members of this particular community, regardless of whether they have had contact with the original trendsetters, are expected to adopt the new behavior as it diffuses (filters) throughout its various social networks. Thus, at both the contextual and community level, peers and perceived peer norms become discriminative stimuli to mediate behavioral and attitudinal change.

We recommend the implementation of HIV prevention interventions based on this model. We believe this strategy can be tailored to work within the social networks that make up urban communities of African descendants such as its faith communities, social and bar networks, educational associations, and cruising spots. These are ideal and powerful spaces where diffusion can promote problem solving to minimize and/or eliminate the transmission of HIV disease.

## **Decision Making and Support Networks**

For many of the participants of this research, peer influence was associated with their introduction to crack and its continued use. These individuals pursued communion through exclusive relationships marked by the absence of peers to serve as standards by which to gauge their behavior or who would support condom use and express concern about HIV/AIDS. To counter this type of isolated sexual decision making, we offer two additional recommendations. While we anticipate that the peer-mediated social interventions discussed above will be very successful in initiating change, we also recognize that these changes in behavior and attitudes must be sustained over time. Change is sustained when the innovations (i.e., the new problem solving behaviors and attitudes) are consistently reinforced over time as well. Peer networks are required to provide reinforcement that supports and promotes the continuation of change. As evident in the social network of the female sex workers, peers are needed who both advocate practicing safer sex and who behave in ways consistent with a concern for HIV prevention: discussing sex and sexually transmitted diseases (STDs), and who also practice safer sex. Collectively, these interpersonal interactions bolster the exercise of agency and are central to promoting psychological well being.

## **Brief Interventions**

To promote outreach and address secondary levels of prevention, we recommend emulating a set of brief interventions to reduce HIV drug-related and sexual risk behaviors among crack users that have been evaluated in several large-scale collaborative efforts. We propose working with community and clinical organizations to create models based on the Cooperative Agreement for AIDS Community-Based Outreach/Intervention Research Program (Rhodes & Malotte, 1996). These studies compared standard and enhanced interventions that were evaluated with regard to efficacy in reducing HIV risk behaviors. The standard intervention often augmented HIV testing and counseling and focused on HIV/AIDS education with referrals to community services as needed. At a maximum, this set of standard interventions comprised two sessions and emphasized communication of HIV/AIDS information with consideration of methods for reducing personal HIV risk and demonstration of correct techniques for needle cleaning and condom use (Rhodes & Malotte, 1996, pp. 211-212). The enhanced intervention, as exemplified by the Long Beach facility, consisted of two individual sessions and viewing a videotape of drug users discussing high-risk sexual behavior and the consequences of HIV infection. This was followed by two sessions of structured behavioral counseling focused on identifying personal HIV risks, committing to change for a specific risk, and developing and implementing a plan for achieving the risk-reduction objective (Rhodes & Malotte, 1996, pp. 213-214). Preliminary outcome data from these studies indicate that both the standard and enhanced interventions lead to substantial changes in drug-related HIV risk behaviors and reductions in frequency of drug use for both drug injectors and crack cocaine users. The standard and enhanced interventions have specific strengths and weaknesses, however the preliminary data led to us to conclude that neither should be used in isolation.

## ***Specific Initiatives***

### **Treatment on demand.**

Given the intertwined nature of HIV-risk behaviors and crack cocaine use in this population, one common sense approach would be to increase access to drug treatment for those seeking treatment. Though there may not be sufficient resource for treatment on demand, certainly reducing barriers to treatment would seem reasonable. This may be achieved by applying for grant funding to add treatment slots to the areas populated by African American drug users.

### **Outreach/Prevention Initiatives**

This could be accomplished by having outreach workers getting accurate information about risk behaviors associated with crack cocaine use to the community. Allocating money for outreach workers would allow them to go to crack houses and other distribution points for crack. At these places, outreach workers could distribute condoms, lube, and information packets. They could also engage individuals in prevention points (contacts) about staying safe when under the influence of crack cocaine. The efforts of the outreach workers could be augmented by sending specially prepared prevention information about risk behaviors associated with crack use to service delivery and primary care providers in the community. This information could also be distributed by working with the faith communities.

### **Community Involvement**

This initiative would focus on educating the police and schools about HIV-related risk behaviors that correspond to crack cocaine use. A special initiative might be helpful by sending emissaries to gangs to let people know about the size and scope of the public health problem in African American communities. The point here is to get the word out to those at greatest risk, in the contexts where these risks are common, that crack cocaine use leads upstanding African Americans adults (and more recently eighth graders) to engage in types of behaviors that transmit HIV. Further, these behaviors may not be typical of these individuals when they are not high on crack. Thus, the prevention word needs to be available as close to the point at which it is needed as possible.

### **Limitations**

Focus groups facilitate the collection of data on group norms, priorities and shared experiences. Focus groups, then, tend to capture the groups consensus and thus represent more of a collective rather than an individual voice. This perspective is both a strength and weakness of the data collection. Overall, this format generated a wealth of data. The addition of one-on-one interviews may have minimized the influence of issues such as shame, embarrassment, or homophobia on divulging personal data. The second limitation centers on the fact that all of the respondents were adults. In consequence, the perspectives of youths are not included. Lastly, the small number of participants in this study may not fully reflect the totality or diversity of opinions in the larger population of African American crack users living in Los Angeles.

### **Future Directions**

Despite its limitations, the data from the project raises several issues (questions) that may be addressed through future research. Consider the following.

Our findings support previous research that has demonstrated the effectiveness and feasibility of peer-led interventions to promote risk reduction. Implementing an intervention of this type as an applied research project within one of the various communities of African descent in Los Angeles would be an appropriate next step as a follow-up to this study. Such a project, in collaboration with one or more community agencies, would send a powerful message to the affected communities that the sponsor of this research is committed to addressing their needs. The lay public frequently does not understand the utility of research; rather it appears to them as an endless process of speculation (or avoidance) that rarely leads to practical outcomes. Moreover, a study of this type could be designed to gather additional data for constructing additional interventions as suggested by the questions that follow.

Our findings also provide insight into the interactions between crack use, behavior patterns, and motives that have the potential to increase the transmission of HIV disease within African American communities. Despite fairly well publicized local HIV epidemiology reports documenting disproportionate increases in HIV disease among African American Angelenos, comparable data on the incidence and prevalence of crack use within these communities is lacking. We do not know the magnitude of crack use or whether its use is increasing or declining. Moreover, crack use is associated with an inability to assimilate information about the harmfulness of its use and difficulty assessing/recognizing high-risk sexual behaviors. This compromise in cognitive processing suggests a potential increased mortality rate for this population and the need to conduct survival analyses for this population. Other questions that beg for answers include, To what extent does the relationship between crack use and engaging in high-risk sexual behavior contribute to the incidence and prevalence of HIV disease? And, How do other forms of substance abuse contribute to the incidence and prevalence of HIV disease in communities of African descent?

Additional research focusing on needs assessment, epidemiology, and applied outcomes of service delivery are required to provide answers to the questions posed above. Policy makers and health professionals will require these answers to develop and evaluate alternate HIV prevention strategies for persons and communities of African descent.

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Consensus does not require 100% endorsement; thus, the percentage of participants who responded in a particular way is indicated in the text as follows. Where percentages are not reported, the term most refers to 75% or more of the participants, many indicates 50% to 74% of the participants, and assume covers a range from 20% to 49% of the participants.