Title: Crack-dependent women and sexuality: implications for STD acquisition and transmission
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Crack-cocaine has done much to devastate an inner city community structure which was already fragmented. Its toll includes higher rates of addiction and street crime and the violence and death associated with drug trafficking and black marketeering networks. The most innocent victims are children, who experience neglect, abuse and, sometimes, abandonment by crack-addicted parents and relatives. (1)

It has been argued that in some locales the crack frenzy has begun to subside, having been replaced by a "normalization" process characterized by fewer new users, a diminished number of crack houses and more routinized and less intense use of the drug. (2)

Other evidence suggests that the epidemic has yet to peak and that users are combining heroin snorting with crack smoking. Through this practice, they are becoming the initial recruits for a whole new generation of heroin users and, eventually, heroin injectors. (3)

In either case, the use of crack is likely to remain a problem in inner city neighborhoods for many years to come. Moreover, crack will continue to have a special impact on women.

The discussion here includes a brief description of the addiction potential of crack-cocaine, the impact of crack use on female sexual behavior and the implications of the sex/crack connection for the spread of sexually transmitted diseases (STDs), including HIV and AIDS.

The impressions and conclusions offered are based on numerous observations in crack houses and interviews with more than 100 crack-using women contacted in Miami crack houses and treatment centers from 1989 to 1991.

Crack Addiction

Crack has been called the "fast-food" variety of cocaine. It is cheap, easy to conceal and vaporizes with practically no odor. The gratification is swift: an intense, almost sexual euphoria that lasts less than five minutes.

Smoking cocaines as opposed to snorting it results in more immediate and direct absorption of the drug, producing a quicker and more compelling "high," greatly increasing the dependence potential. Moreover, there is increased risk of acute toxic reactions, including brain seizure, cardiac irregularities, respiratory paralysis, paranoid psychosis and pulmonary dysfunction.

Users typically smoke for as long as they have crack or the means to purchase it - money, personal belongings, sexual services, stolen goods, or other drugs. Smokers rarely have just a single hit. More likely, they spend $50 to $500 during a "mission" - a three- or four-day binge when they smoke almost constantly, using three to 50 rocks per day.

The tendency to binge on crack for days at a time, neglecting food, sleep and basic hygiene, severely compromises physical health; consequently, crack users appear emaciated most of the time. They also lose interest in their physical appearance.

Many have scabs on their faces, arms and legs, the result of burns and picking at the skin (to remove bugs and other insects believed to be crawling under the skin). Crack users tend to burn their facial hair by lighting their smoking paraphernalia carelessly. They also burn their lips and tongues on the hot stems of their pipes. Many seem to cough constantly.

Many crack users engage in sexual behaviors with extremely high frequency. However, to suggest that crack turns

women into "sex-crazed whores" as sensationalized media stories suggest is anything but precise. The situation is far more complex.

Crack and Sexuality

A strong association between crack use and apparent hypersexual behaviors is evident in our observations and interviews in Miami, as well as in other ethnographic analyses of the crack scene. (4) Many crack-addicted women, particularly those who regularly patronize crack houses, engage in any manner of sexual activity. The sex is private or public, with multiple partners of either sex, or both sexes simultaneously.

Indeed, the tendency of crack users to engage in high-frequency sex with numerous anonymous partners is a feature of crack dependence and crack house life in a myriad of locales. Sex-for-drugs exchanges are far more common among female crack addicts now than they ever were among female narcotics addicts, even at the height of the 1967-1974 heroin epidemics.

Moreover, neither the "strawberries," "skeezers," "head hunters" and "toss-ups" (the crack "house girls" who provide oral sex for just a few cents worth of drugs), nor the crack house "freaks" (the "house girls" who have public sex with other women for similarly small amounts of drugs), have any parallel in either the heroin subculture or old-style brothels.

The question is whether the crack-sex association is primarily pharmacological or sociocultural in nature. That is, do crack users exhibit hypersexual behavior because their drug provides hypersexual stimulation and enjoyment? Or is the aphrodisiac effect of crack a mythical explanation for behavior that actually results from economic, and street-subculture factors? The best answer appears to be that both pharmacological and sociocultural factors are involved.

The pharmacological explanation of the crack/sex association begins with psychopharmacology: one effect of all forms of cocaine, including crack, is the release of normal inhibitions on behavior, including sexual behavior.

The disinhibiting effect of cocaine is markedly stronger than that of depressants such as alcohol, Valium, or heroin. While the latter drugs typically cause a release from worry and an accompanying increase in self-confidence, cocaine typically causes elation and an accompanying gross overestimate of one's capabilities. In addition, the release of inhibitions is rapid.

Medical authorities generally concede that because of the disinhibiting effects of cocaine, its use among new users does indeed enhance sexual enjoyment. There is improved sexual functioning, including more intense orgasms. (5) These same reports maintain, however, that among long-term addicts, cocaine decreases both sexual desire and performance.

The Economics

Going further, the crack/sex association involves the need of female crack addicts to pay for their drug. Even this connection has a pharmacological component. The rapid onset of crack's effects, extremely short duration of effects and high addiction liability combine to result in compulsive use and a willingness to obtain the drug through any means.

Although overdose is a constant threat, crack use does not pose the kind of physiological limit on the maximum needed (or possible) daily dosage typical of many drugs. The heroin addict commonly needs four doses a day, for example, and an alcoholic often passes out after reaching a certain stage of intoxication. The heavy crack user, however, typically uses until the supply is gone - whether that takes minutes, hours, or days. The financial burden can be staggering.

Other parts of the economic crack/sex relationship, however, are strictly sociocultural. The access of women to illegal income is typically more limited than that of men. Prostitution has long been the easiest, most lucrative and most reliable way for women to finance drug use. (6)

The combined pharmacological and sociocultural effects of crack use can put female users in severe jeopardy. Because crack makes its users ecstatic and yet is so short-acting, it has an extremely high addiction potential. Use rapidly becomes compulsive use.

Crack acquisition becomes enormously more important than family, work, health, values, morality, or self-respect. This makes sex-for-crack exchanges psychologically tolerable as an economic necessity. Further, the disinhibiting effects of crack enable users to engage in sexual acts they might not otherwise even consider.

For the female crack addict, the consequences may be extreme sexual behavior, but the term "hypersexuality" is deceptive. Rather, as a 22-year-old Miami woman reported in early 1991:

There been days when I sexed 20, 30, 40 different men. . . But I ain't no superwoman, no superwhore, no supernympho. It's the cracks. I done so, as many things. But it's the cracks. I done things, sex things, an' other things too, that I wouldn't have done but for the cracks. An' it's so degrading. . . It's got so that I hate the cracks now, an' I hate sex, an' men, an' myself too. But I need the cracks. I'm caught by the drug, an' I got to do it.

Crack, Sex and STD Infections

During the second half of the 1980s, reported rates of sexually transmitted diseases increased dramatically, particularly for syphilis. In the one-year period from 1986 to 1987, reported syphilis cases increased by 25 percent in the United States.

Rates per 100,000 expanded for all groups of women. There were increases of 22 percent among whites, 24 percent among Hispanics and 43 percent among blacks. Among men, while rates decreased among whites and only slightly increased among Hispanics, significant increases were observed among blacks. (7) In New York City, congenital syphilis increased by more than 500 percent between 1986 and 1988. (8)

These increases have been reported in numerous locales. Accumulating evidence links these sexually transmitted diseases (STD) increases to the crack epidemic, in that crack users have significantly higher rates of STD than nonusers. (9) Even more importantly, it would appear that crack use is contributing to the spread of HIV and AIDS.

For example, a study in Florida reported relationships between number of sex partners, condom use and HIV seropositivity. (10). Among the 50 drug users in this study, only one was currently using intravenous drugs; however, 97 percent were current users of crack. For the group as a whole, some 20 percent had either HIV or AIDS.

Interestingly, there was a time when crack users were not considered to be at particularly high risk for HIV acquisition and transmission. As recently as 1988 researchers in New York Ctiy suggested the adoption of crack smoking, in lieu of intravenous cocaine use, to reduce the risk of AIDS. (11)

However, recent studies indicate that crack smokers are at equal or greater risk for HIV and other STD infections when compared with intravenous drug users. In one study of East Coast prostitutes, for example, rates of HIV seropositivity were higher among the crack users than among the drug injectors. (12) Similarly, data from a San Francisco study suggested that women addicts who traded sex for crack were more likely to spread HIV infection than women who injected heroin or cocaine. (13)

Comment

These studies, combined with our data, suggest that at least some of the increases in STD rates are associated with crack use. Sexual activity is the greatest risk factor associated with sexually transmitted diseases, including HIV/AIDS, among cocaine and crack users.

Frequency of high-risk sexual ventures, multiple sex partners and unprotected sex have been linked to the increased chance of STD acquisition and transmission. The crack subculture exacerbates the risks associated with these behaviors, putting women at special risk.

Women's dependency on crack typically results in bartering sex for crack. This exchange system involves numerous sex partners who are at high risk for STD and HIV infection. There is little risk reduction through condom use, because condoms are strongly disapproved in all street drug subcultures.

The high-frequency/multiple-partner sexual activities associated with crack result not from hypersexuality, but from the psychopharmacology of crack combined with the economic demands of addiction. As a consequence, women who exchange sex for crack experience a level of human suffering previously unknown in the street drug scene.

Intervention for this population requires vigorous outreach into crack-using communities, with recruitment directly from local crack houses, followed by intensive drug abuse treatment with case management in aftercare.

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Notes

(1) See, Ron Rosenbaum, "Crack Murder. A Detective Story," New York Times Sunday Magazine, 15 February 1987, p.29-33, 57, 60; Newsweek, 22 February 1988, 24-25; Time, 7 March 1988, 24; Newsweek, 28 March 1988, 20-29; Newsweek, 27 April 1988, 35-36; Time, 9 May 1988, 20-33; New York Times, 23 June 1988, sec. A, p. 1, sec. B, p. 4; Time, 5 December 1988, 32; New York Doctor, 10 April 1989, 1,22; U.S. News & World Report, 10 April 1989, 20-32.

(2) New York Times, 6 April 1991, p. 1, 10.

(3) Drug Enforcement Report, 23 February 1989, 7; U.S. New & World Report, 14 August 1989, 31-32; Stephen Brooks, "The Perilous Swim in Heroin's Stream," Insight, 5 February 1990: 8-17; Newsweek, 19 February 1990, 8-17; Newsweek, 19 February 1990, 74, 77; New York Times, 21 July 1990, 1, 26.

(4) For example, see Phillipe Bourgois and Eloise Dunlap, "Sex-for-Crack in Harlem, New York" (Paper presented at the Annual Meeting of the Society for Applied Anthropology. Charleston, South Carolina, 13-17 March 1991); Stephen Koester and Judith Swartz, "Crack Cocaine and Sex" (Paper presented at the Annual Meeting of the Society for Applied Anthropology, Charleston, South Carolina, 13-17 March 1991).

(5) Roger D. Weiss and Steven M. Mirin, Cocaine (Washington, D.C.: American Psychiatric Press, 1987); Lester Grinspoon and James B. Bakalar, Cocaine: A Drug and Its Social Evolution (New York: Basic Books, 1985).

(6) See Paul J. Goldstein, Prostitution and Drugs (Lexington, MA: D.C. Health, 1979).

(7) Mary E. Guinan, "Women and Crack Addiction," Journal of American Medical Women's Association, 44 (1989): 129.

(8) S. Schultz, M. Zweig, T. Sing, and M. Htoo, "Congenital Syphilis: New York City, 1986-1988," American Journal of Diseases of Children, 144 (1990): 279.

(9) R. E. Fullilove, M. T. Fullilove, B. P. Bowser, S. A. Gross, "Risk of Sexually Transmitted Disease Among Black Adolescent Crack Users in Oakland and San Francisco, California," Journal of the American Medical Association, 263 (1990): 851-55; Robert T. Rolfs, Martin Goldberg, and Robert G. Sharrar, "Risk Factors for Syphilis: Cocaine Use and Prostitution," American Journal of Public Health, 80 (1990): 853-57.

(10) Edward J. Trapido, Nancy Lewis, and Mary Comerford, "HIV-1 and AIDS in Belle Glade, Florida: A Reexamination of the Issues," American Behavioral Scientist, 33 (1990): 451-64.

(11) Don C. Des Jarlias and Samuel R. Friedman, "Intravenous Cocaine, Crack and HIV Infection," Journal of the

American Medical Association 259 (1988): 1945-46.

(12) Claire Sterk, "Cocaine and HIV Seropositivity," The Lancet, 7 May (1988): 1052-53.

(13) Benjamin P. Bowser, "Crack and AIDS: An Ethnographic Impression," Journal of the National Medical Association, 81 (1989): 538-40.
