

Desperately Seeking Skeezers: Downward Comparison Theory and the Implications for STD/HIV Prevention Among African-American Crack Users

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ABSTRACT. HIV infection rates among African-Americans have increased disproportionately when compared to other at-risk groups in the United States. Crack smoking also has been found to increase the risk of infections with HIV, syphilis, and other sexually transmitted diseases. Despite the scientific and citizenly dissemination of this information, infection rates continue to increase among African-American drug users, as traditionally-used prevention curricula apparently have lacked influence among this population. This manuscript demonstrates the utility of Downward Comparison Theory (DCT) to explain how many Afri-

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Support for original data collection was provided by grants from the Community Research Branch, National Institute on Drug Abuse, R. C. Freeman and C. B. McCoy, principal investigators. The study's procedures and questions were reviewed and approved by an NIH-approved Committee for the Protection of Human Subjects. The opinions herein, however, are expressly those of the authors.

Journal of Ethnicity in Substance Abuse, Vol. 2(1) 2003
<http://www.haworthpress.com/store/product.asp?sku=J233>
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10.1300/J233v02n01_02

can-American crack smokers erroneously assess their risks for STD/HIV transmission. More than 200 African-American crack smokers were interviewed in Washington, DC, and Miami, FL using a qualitative interview guide. Briefly stated, African-American crack smokers believe that women who trade sex for crack are the lowest-ranking members of the social hierarchy. Many members of this group also believe that people who rank lower on the social hierarchy cannot transmit disease to higher-ranking members. Examples of this and other DCT principles are provided as well as implications and suggestions for interventions and future research. *[Article copies available for a fee from The Haworth Document Delivery Service: 1-800-HAWORTH. E-mail address: <docdelivery@haworthpress.com> Website: <http://www.HaworthPress.com> © 2003 by The Haworth Press, Inc. All rights reserved.]*

KEYWORDS. African-American, crack, condom use, sex-trading, sexually transmitted diseases (STDs), HIV risk, Downward Comparison Theory

Public health advocates seek ways to understand human behavior in order to promote better public health. When human beings begin to accept prescribed beliefs or behaviors, we frequently attempt to "integrate" the institutional knowledge with individual knowledge and practices (Berger & Luckmann, 1967, p. 92). Prescribed knowledge—including STD/HIV prevention practices and other public health dicta—are conveyed using expressly prescribed techniques (e.g., Berger & Luckmann, 1967, p. 143). Nevertheless, "The individual apprehends himself as being both inside *and* outside society" (p. 134) and, thus, may subscribe to some, but not all, societal teachings.

One group particularly at risk for HIV/STD transmission is people who trade sex for drugs, frequently known in drug parlance as *skeezers* (Bourgeois, 1989; Fullilove, Lown, & Fullilove, 1992; Goldstein, Ouellet, & Fendrich, 1992). In fact, the advent of crack cocaine precipitated a rise in the sex-for-drugs trade. The act of trading sex for drugs, particularly crack, has been found to increase the risk for infection with HIV (the human immunodeficiency virus) and other sexually transmitted diseases (STDs) (e.g., Balshem, Oxman, van Rooyen, & Girod, 1992; Edlin et al., 1992, 1994; Elwood, Williams, Bell, & Richard, 1997; Inciardi, 1989, 1995; Wallace, Porter, Weiner, & Steinberg, 1997; Williams et al., 1996). Many studies have demonstrated a relation between

trading sex for crack and HIV seroprevalence (Edlin et al., 1994, p. 1422; see also Edlin et al., 1992; Cohen, Navaline, & Metzger, 1994; Forbes, 1993; Fullilove, Fullilove, Bowser, & Gross, 1990); such studies also suggest that crack is associated with high-risk sexual practices that accelerate the spread of HIV infection. Those high-risk practices include multiple daily partners, repeated and forceful sexual intercourse, and fellatio performed by individuals whose gums and inner cheeks are compromised from a lack of oral hygiene and damage from the extreme heat of crack pipes.

Some people argue that drug of choice, gender, and/or race/ethnicity explain HIV seroprevalence and/or sexual risk behaviors among populations at greater risk for HIV infection. Notwithstanding, a study of six Southern and Southwestern cities in the United States found that trading sex for crack was related to poverty, homelessness, and lack of formal education, not simply drug of choice, gender, or race/ethnicity (Elwood et al., 1997; see also Weatherby et al., 1992). Maher's (1996) ethnographic study of female crack-using sex workers revealed a set of occupational norms that relate to sex trading as a profession and found *discrimination* to be a central organizing principle among these women. Because this ethnographic sample of prostitutes viewed sex trading as their occupation, they developed a social hierarchy related to the prices, sex acts, client types, and other "work"-related characteristics. For example, a woman who trades sex for crack might warrant less respect under this hierarchical scheme than a woman who trades sex for money, so she has the means to purchase her drugs as any other woman or man—and not have to endure the ignominy most dealers lob upon sex-for-crack traders.

CONDOMS AS HIV PREVENTION

HIV infection rates have increased among African-Americans; perhaps accordingly, condom use rates have remained lower among African-Americans than among other ethnic American groups (Monahan et al., 1997). Furthermore, the choice of condom use predominantly rests with those who own the crack—that is, men; these men frequently choose not to use condoms not only for their own pleasure but also to demonstrate their economic power in the relationship.

Condom use continues to remain among the more widely recommended STD/HIV preventive behaviors. [Male] condom use is a visible cooperative behavior, not simply individual, and thus is relational in na-

ture. When condoms are used, they are often seen as means of birth control rather than in terms of STD prevention. Goals in sexual relationships are related to the nature of the sexual relationship (e.g., casual or sex worker) and sexual behavior (Monahan, Miller, & Rothspan, 1997). People in casual relationships are much more likely to use condoms (see, e.g., Metts & Spitzberg, 1996; Monahan et al., 1997).

Many couples avoid discussing safer sex openly because of the stress it creates (e.g., Afifi, 1999; Buyse & Iekes, 1999; Lear, 1995), preferring to remain quiet about sexual issues (Faulkner & Mansfield, 2002). Traditional sexual scripts do not generally include plans for condom use (Metts & Spitzberg, 1996). Perceptions of condom use norms (especially what the sexual partner desires) predict intentions to use condoms (e.g., Sheeran & Taylor, 1999).

Women in particular feel threatened about asking a partner to wear a condom (Metts & Fitzpatrick, 1992; Dutton & Winstead, 1997; Lear, 1995) in part because it conveys lack of trust (e.g., Metts & Fitzpatrick, 1992; Metts & Spitzberg, 1996). Mays and Cochran (1988) argue men with more available partners (e.g., sneezers) have more choice, such as control over condom use. Additionally, women are perceived negatively for initiating condom use (e.g., Dutton & Winstead, 1997; Metts & Fitzpatrick, 1992) and may use indirect messages (Lear, 1995). Asking about condom use is threatening in an interaction (Afifi, 1999; Lear, 1995), as people are reluctant to imply that they or their partners are unsafe (Metts & Spitzberg, 1996).

In this manuscript, we argue that the discrimination involved in the sex-for-drugs transaction facilitates a rationalization for sex without condoms. The negative comparison of self-with-other influences choices of whether one perceives oneself to be at risk for transmission of HIV and other STDs.

DOWNWARD COMPARISON THEORY

Wills (1981) advanced the principles of downward comparison to explain the essence of many social phenomena. His "theory of basic motivational processes" (p. 266) posits that people experiencing negative affect inherently try to make themselves feel better by comparing themselves with people who are as equal or more unfortunate than themselves—even at the expense of the other people (pp. 267-268). According to Wills, "People are often in the market for a little self-enhancement, even at the expense of others, and are not averse to taking advantage of

an available opportunity" (p. 265). Such comparisons allow individuals to improve their self-esteem or physical well-being irrespective of whether they personally deliver harm to the less fortunate individuals (1981, p. 259; 1991, p. 53). Briefly stated, downward comparison theory (DCT) allows us to explain how people enduring similar negative experiences may cope with distress when they are unable to relieve or eliminate that distress through other means.

The phenomenon of downward comparison has been applied in studies with several populations including cancer patients (Hagopian, Lowery, & Jacobsen, 1994; Stanton, Danoff-Burg, Cameron, Smider, & Kirk, 1999; Wood, Taylor, & Lichtman, 1985), chronically ill patients (Hatchett, Friend, Symister, & Wadhwa, 1997), mentally retarded adolescents (Gibbons, 1985; Harter, 1985), fire victims (Thompson, 1985), arthritis patients (Affleck, Tennen, Pfeiffer, Fifield, & Rowe, 1987; Affleck, Tennen, Pfeiffer, & Fifield, 1988; Bialock, DeVellis, & DeVellis, 1989; DeVellis et al., 1990), mothers of premature infants (Affleck et al., 1987), and college professors (Cansler & Stiles, 1981). These studies found that distressed people demonstrated a predilection to compare themselves with people enduring a more severe condition or who do not cope as well with their situations. In each study, these comparisons allowed these individuals to perceive themselves as superior to others with a similar condition.

For example, Wood et al. (1985) examined predictors of downward comparison in breast cancer survivors and found that these women generally applied downward comparisons as preliminary attempts to cope with cancer- and treatment-related and social-situational sources of threat (p. 1179). Although these women had the opportunity to compare themselves to "supercopers," women portrayed through the mass media as having superior coping skills that others could emulate, the participants in this study were more likely to compare themselves to others who were inferior or less fortunate.

More closely related to the present study is a report on the condom use attitudes and behaviors of 457 high school seniors which found that "perceiving oneself as better off than others makes it less likely that people will perceive a need for, or initiate, self-change" (Tigges, Wills, & Link, 1998, p. 862; see also Wills, 1992; Nadler & Fisher, 1992). Tigges and colleagues (1998) found some evidence of downward comparison as a self-defensive behavior. According to the authors:

The more threatened condom users felt, the more downward comparisons they made. In turn, the more adolescents with lower

self-esteem made downward comparison ratings, the more satisfied they were with the frequency of their past condom use. And the more satisfied low condom users were, the less they intended to use condoms in the future. The results of this study thus provide preliminary evidence that, for some people, downward comparison may, indirectly, be detrimental to preventive behavior. (pp. 879-880)

Indeed, Pittam and Gallois (2000) facilitated small group conversations with a total 132 young heterosexual Australians and found that participants who recounted higher levels of social distance between themselves and traditional at-risk groups were less likely to perceive themselves to be at risk for infection and were less likely to take protective measures. In their study, Pittam and Gallois found that participants particularly stigmatized foreigners and other people unlike the study participants; however, the authors also found that the study participants were more likely to see members of groups with less social distance as individuals capable of individual responsibility. Consequently, the authors recommended that HIV prevention programs should refer to all salient "outgroups" to neutralize participants' tropes used to reduce their perceived personal threat for HIV transmission. Devine, Plant, and Harrison (1999) similarly reported, using the outward homogeneity effect framework, that people with HIV were seen as an "outgroup," or us versus them, as a way to bolster people's own social identity.

HIV Stigma and Downward Comparison

The stigma associated with HIV/AIDS and the U.S. groups commonly perceived to be most at-risk for infection provides a strong rationale for downward comparison among people who engage in sex without latex barriers. Goffman (1963) described stigma as a deep discrediting attribute, later a mark, that signifies a rationale to eschew particular individuals. In ancient Greece, *stigma* literally meant a "tattoo mark," a physical indication that someone is to be avoided. Goffman noted that stigma is relational in nature, always viewed in contrast to a non-stigmatized other, as stigma originates in shared reactions of groups of people who are inherently comparative.

The stigma associated with HIV infection and/or AIDS diagnoses is well-documented (e.g., Crawford, 1996; Devine et al., 1999; Herek, Capitano, & Widaman, 2002; Leary & Schreindorfer, 1998; McAllister, 1992; Sontag, 1990). In the United States, HIV/AIDS is socially de-

finied as a "disease of marginalized groups" (Herek & Glunt, 1988, p. 887; see also Slagle, 1999). Crandall and Coleman (1992) posit stigma as the "single, most important psychological phenomenon associated with AIDS" (p. 163). Some of this stigma is due to the epidemic's association with deviant behaviors via early association of HIV/AIDS with injection drug use and gay men (Elwood, 1999; Leary & Schreindorfer, 1998; see also Clark, 1999). Despite the epidemic's progression in many populations, the stigma endures, frequently represented in the classification of "innocent victims" of HIV and AIDS (e.g., German & Courtright, 1999; Leary & Schreindorfer, 1998).

These classifications, including "innocent victims" and "risk groups," can be used to dissociate oneself from the risk of being infected with HIV or other STDs. Consequently, if one perceives oneself not to be a member of a risk group—or not a frequent practitioner of risk behaviors as another—one then can perceive oneself as not at risk for HIV infection. In short, people can make such comparisons to acknowledge the existence of HIV and to absolve oneself of the potential risk for infection and, perhaps, the guilt associated with not conforming with standard health promotion teachings regarding HIV prevention. The stigma associated with HIV/AIDS since the emergence of the epidemic is a tool in this process.

Stigma has been shown to affect social support, decisions to disclose, coping, and identity (e.g., Derlega & Barbee, 1998; Greene, Derlega, Yep, & Petronio, in press). Unfortunately, not many relational theories explicitly incorporate stigma in their models. Leary and Schreindorfer (1998) identified stigma resulting from perceptions of threat to public health, safety or contagion fears, violations of social standards, perception of lack of contribution, and even death. These factors influence extreme reactions that result in intense stigma. Stigma based on assumptions regarding HIV and AIDS is intense, as it involves perceptions of placing other people at risk for a life-threatening infection and related stigma. Downward comparison theory may explain the linguistic re-countals involved with HIV risk perceptions and risk behaviors, thus reflecting individuals' decisions regarding risky and protective behaviors with sexual partners perceived to rank lower socially than they. Consequently, our research question is,

RQ1: Are drug users who engage in downward comparisons more likely to eschew condom use with their sex partners who trade sex for drugs than drug users who do not make downward comparisons?

RQ2: How do drug users describe sexual partners with whom they trade crack for sex?

METHOD

In-depth semi-structured interviews were conducted in 1996 and 2001 with 201 African-American drug users who were not in treatment. Specifically, 70 of these illegal drug-using individuals were interviewed in the District of Columbia in 1996. Fifty-one African-American drug users were interviewed in Miami in 1996. These interviews were extended using the same interview guide with 80 of these individuals in Miami in 2001. All participants were at least 18 years old and reported at least one instance of drug injection or crack use and vaginal sex in the week prior to their interviews. Sampling quotas were used consistently to ensure that one-half of the sample were women, one-third were under 35, and one-third were reporting using a condom at least once during the previous week.

Data were collected using an interview guide that followed the principles of Downward Comparison Theory and included questions concerning sociodemographics and life history. Although the questions served as a prompt and guide for interviewers, participants were encouraged to elaborate on topics that appeared to contain information relevant to the study. Interviews generally lasted two hours (range: 45 minutes to three hours), were (audio) tape recorded and were transcribed verbatim into text files. In turn, text files were content-coded using objective analytical codes derived from DCT. Included were codes for the research subjects' upward and downward comparisons, attitudes toward condom use, intentions to use, and use of condoms during sexual encounters. Other predetermined codes included accurate HIV/AIDS knowledge and incorrect information about HIV and other STDs. Consistent with the principles of grounded theory (Glaser & Strauss, 1967; Strauss & Corbin, 1990), the coding scheme was enhanced by themes that emerged from the participants' discourse. When codes emerged, previously coded interviews were revisited and new codes applied where appropriate.

Interviews were transcribed and then coded by one of the authors or a research assistant. Coders examined 10% in common, with average reliability of .95 across codes. Both coders searched transcripts looking for instances of the four major variables (downward comparisons, upward comparisons, condom use, condom lack). Each coder identified

presence of a variable in a description and also coded for direction (for example, downward comparison was coded as positive or negative regarding condom use, and that was different from intention to prevent HIV/STD or pregnancy). Kappas were calculated for presence/absence and positive/negative, and they ranged from .92 to .97 ($M = .95$). Disagreements were discussed between coders until 100% agreement was reached. Data that best illustrate analytical patterns were excerpted for presentation below.

RESULTS

We found that the principles of Downward Comparison Theory best explained the patterns of both condom use and sexual risk behaviors with men and women who trade sex for drugs. Specifically, three themes that relate to DCT emerged from the data. First, skeezers are the lowest-ranking group of individuals within the social hierarchy of these illegal drug users. Second, condom use for sex with skeezers reflects the social distance between the partners. Third, the absence of condom use for "skeezer sex" reflects the lack of regard men have for women who they perceive to be socially inferior to them. This idea that skeezers are inferior to other drug users, not simply inferior to men who have the crack to trade for sex, reflects the tacit idea that skeezers cannot transmit disease to those who rank higher than skeezers on the social ladder.

Skeezers and the Social Hierarchy

Participants provided frank and brief definitions of skeezers. One man was expressly succinct: "A skeezer is a trick bitch." Another male participant was more discreet in his description, saying, "A skeezer is a girl who gives up her body for some crack." Men and women confirmed this definition as they also described the commercial context for sex between these types of partners. According to a man who reported patronizing skeezers, "That skeezer just wants to have sex with me for some crack. If I don't have anything, I can't be with her." Another man said, "I take them into the alley or somewhere, give 'em a dime rock, get my thing off, and that's it."

A self-proclaimed skeezer was blunt about the transaction, as she said, "I want your dick and I want my rock. He knows what it's about." According to another woman, "If he wants sex, it's sex for drugs." A third woman added a more academic perspective regarding the sex-for-drugs

transaction: "It's purely economics." Yet another female trader was forthright in her interview and with her customers. As she put it, "I'm woman enough to let them know that I sell my body for rock." But a fifth woman was brutally frank regarding the transaction: "I fucked about five guys. . . . All I be thinking about is, 'Motherfucker, hurry up and come so I can get my rock, so the next one can come, come, come!'"

In this milieu of illegal drug users, the act of trading sex for drugs warrants disrespect. As a male participant frankly stated, "They're skeezers, that's what they're there for, to get fucked to get that rock. They're selling their bodies, and I don't respect anybody who sells their body for drugs." Another man differentiated between skeezers and prostitutes: "Skeezers do it for crack. Prostitutes do it for money. If a skeezer knows that the crack is gone, she'll leave in two minutes." One theme that emerges, then, is the condemnation of skeezers. What is intriguing is the lack of any parallel stigma associated with descriptions of the men who were trading crack in order to have sex.

Aside from their sex trading, skeezers apparently engage in other behavior and have the appearance of individuals with low social status. According to a male observer, "They [skeezers] look funny, strange—there's something suspicious about them." Another man provided details about "this young lady named Shirley. She's a skeezer and she's a crack addict. She lives in a crack house, and she ain't bathed. She's the last one I had sex with." A 45-year-old woman who reported *not* trading sex believed that crack addiction and extended periods of trading sex for drugs leads skeezers to have poor judgment regarding their choice of customers and condom use: "They're getting in and out of cars, and in and out of guys' faces. They're jumping in and out of bed. They're not using any protection. They're not even thinking of HIV." Thus, there are clear and consistent descriptions in these data of skeezers as low ranking in the social hierarchy.

Condom Use and Social Distance

Some participants reported recognizing that sex in a skeezer context is a high-risk proposition. Occasionally, some participants reported condom use and avoidance of risky sexual behaviors as a method to avoid disease transmission. A male crack smoker reported,

They [skeezers] want me to eat them while we hit the [crack] pipe. I can't do that. They're tricking constantly, fucking guys with and without rubbers. You can't put your mouth on *that*, you know.

They've asked me a lot, but I draw the line somewhere. Now I've gotten so fucked up on coke before that I've almost, and I thought, "Damn! Wait a minute!" My dick would be falling off next week, and 10 years from now I'd drop dead. You gotta think about these things.

HIV/AIDS has increased exponentially among African-Americans and illegal drug users over the past decade. This is a reality that participants in this study readily acknowledge. According to one man, "This girl named Kelly, I've known her for all my life, and she's HIV-positive. She's sick, man. . . . You see her go to the hospital and come back." Participants may acknowledge that sex with skeezers is imbued with the risk for HIV and other STD transmission. The AIDS pandemic notwithstanding, a more frequently and emphatically repeated rationale for using condoms with this type of sexual partner was that condom use with skeezers reflected the disinterested nature of sex in which one partner is associated with a stigmatized social group.

Frankly put, "Skeezers don't mean nothing to me. I'm going to put on a rubber and fuck them, it's a simple as that." This attitude emerged from women as well, as exemplified by this female participant: "It's a real trick thing. Put a condom on him, give him some head and give him some pussy and let him get on down the road." A male participant's story corroborated that woman's statement: "Some skeezers out here prefer condoms, if they have any clout about it—'You ain't got no rubber, you ain't doin' it.' There's a lot of them like that." This explicit discussion of power or "clout" is not often ascribed to women in this situation; note even here it is described with a qualified "if."

Many participants reported that the impersonal nature of skeezer sex accounted for "using condoms is the first thing that comes into my mind when I'm gonna go with a skeezer." According to a man who patronizes skeezers, "I always use a condom with them. But that's [HIV/STD prevention] only part of it, really. I don't want to be having a baby with no skeezer." Other men reported this attitude, for example:

I don't want to get none of these skeezers pregnant, either. They don't give a fuck about me as long as they get some rock or some blow out of me. Yeah, there's AIDS out there, too, and I don't want to get no AIDS. But I don't want to give no skeezer my baby. So I got to protect myself and put on a rubber and take it from there.

In summary, HIV/AIDS is an implicit component to the social fabric of this sample of African-American drug users. Condom use is cited as a way to "prevent AIDS," because someone "don't want no HIV," and because, "I don't want to catch anything." Equally, if not more important among this population, is the perception that condom use exemplifies the social distance between skeezer and male partner and prevents a man from impregnating a woman and having his baby endure the ignominy of being the child of a skeezer.

Condom Lack and Social Distance

Some participants reported using condoms not simply to prevent disease transmission and pregnancy but also to create a physical barrier between partners. This physical barrier represented the social barrier in which skeezers are perceived as the lowest-ranking group of drug users. In comparison, some men reported *not* using condoms with skeezers because they perceived skeezers as being unable to transmit disease to someone who ranked above them within the social hierarchy. Briefly and candidly, one man stated, "Hell, no, I don't wear no condom. She's only a skeezer—she can't give me nothing."

Participants who reported not using condoms with skeezers also acknowledged that women who trade sex for crack were more likely to be infected with HIV than other types of sexual partners. According to the non-trading female participant, "Nine out of ten skeezers are already infected with HIV, so most of them just don't give a damn, condom or no condom." According to a (male) customer, "If the girl says, 'I don't care if you use a condom,' we go ahead without one. I've done seen skeezers get banged by three or four men in a row, man, and no condoms."

Despite the perception that skeezers have lots of unprotected intercourse and are likely to have HIV, the perception that disease cannot be transmitted upwards endures. Another man reported not using condoms with skeezers and described how his belief in downward comparison HIV prevention is verified by regular HIV-negative test results. In his words, "We smoked the rock, we had the sex. [Did you use a condom?] No, I didn't use a condom with that skeezer. I go up to the clinic every two or three months and get an AIDS test. I don't have AIDS." Thus, reports of non-condom use often reflect biased perceptions of means of transmission.

DISCUSSION

The purpose of this study was to provide a description of the ways in which downward comparisons both facilitate and impede condom use

among this sample of African-American drug users who engage in heterosexual sex-for-crack exchanges. Toward that end, we found that the sexual partners in sex-for-crack exchanges have little personal regard for one another in the setting of this commercial transaction. Within the drug-using social milieu for this sample of illegal drug users, the commercial sex-for-drugs exchange is a high-risk proposition. It is how these individuals define the risk that predicts whether and for what reason they will use condoms.

One research question was: Are drug users who engage in downward comparisons more likely to eschew condom use with their sex partners who trade sex for drugs than drug users who do not make downward comparisons? The women in this sample appear to understand the disease-related risks associated with exchanging sex for drugs. Notwithstanding, they are individuals who desire the scarcer commodity of crack; the commodity they have to exchange—fellatio and/or intercourse—is much more readily available. Consequently, they have little bargaining power for condom use, indeed for anything else, in this commercial setting (cf. Lear, 1995; Metts & Spitzberg, 1996). It is unknown from this study whether powerlessness exists when men exchange sex for drugs. Although five participants reported knowing of men who performed sex for drugs, they did not report having sex with such men—nor did these men participate in this study which required participants to have had recent vaginal intercourse. A study of a similar population that did not have such stringent recruitment requirements, however, found a significant percentage of men who traded sex for drugs under similar powerless circumstances (Elwood et al., 1997). If this is the case, then, it may be that sexual role, not simply gender, predicts difficulty in initiating condom use.

It is important to understand the negative images of skeezers and how this might affect sexual decision-making and negotiation. Skeezers—all women in the present study—were described as having little input in condom decisions, not unlike previous research describing the difficulty of women in initiating condom use (see Dutton & Winstead, 1997; Lear, 1995). The current findings are much more explicit about the power of the person with the reward (crack in this case). Further complicating the relationship is the dual illegality of the act, both trading sex and illegal substance use. Other research on condom use would indicate causal relationships would have higher condom use (e.g., Lear, 1995; Metts & Spitzberg, 1996), not always the case in the present study. This should provide an area for further exploration.

The men in this sample who reported using condoms did so because they perceived the sex-traders to rank lower within the social hierarchy than the men who have crack to trade for sexual services. There was little comment among men (or women) about their role in trading crack to obtain sex, rather they were happy to have sexual access. What is intriguing is the absence of stigma ascribed to their own behavior while they attribute many, many negative characteristics to skeezers, their partners in this behavior.

This lack of acknowledging complicity suggests the applicability of the biblical adage that those without sin should cast the first stone. Men who recognized the STD risk associated with sex-trading also reported using condoms to prevent disease transmission. Other men who reported using condoms reported condom use simply because the women were skeezers—and that the men either did not want the women to have contact with their body part and/or did not want any progeny to endure the stigma of having skeezer for a mother. Some of the men in this sample, however, reported not using condoms or avoiding STD transmission with sex-traders. These men reported the belief that people who rank lower on the social hierarchy (skeezers) cannot transmit diseases to those who rank higher within the hierarchy.

Limitations

The limitations of the present study rest primarily from the sample, also one of the strengths. The participants were sampled from two cities in the southeast and were African-American. Sampling quotas required all participants to have had recent heterosexual intercourse, which resulted in data only from female skeezers. Other studies that included interviews with male skeezers, or with women who trade crack for sex with women or men, may provide different patterns. Additionally, there were two waves of data collection, though only the second wave in one city.

Implications

Although the limitations associated with any qualitative research with hidden populations apply to this research project, HIV/STD program planners and researchers should be aware of downward comparison relationships that emerge through STD/HIV prevention folklore in their target populations. For example, some men reported the belief that they were not at risk for HIV/STD infection through unprotected vagi-

nal intercourse with skeezers because women who rank lower on the social hierarchy cannot transmit HIV/STDs to men who give them drugs for sex.

Implications for health campaign designers. Condom use with skeezers appears to occur among this population not simply to prevent disease but also to increase or demonstrate the social distance between the male drug user and the woman trading sex for drugs. Curriculum designers might seek to add to this perception by encouraging condom use specifically in commercial sex transactions. Such an informational approach would address the setting of the commercial transaction and thus eschew any references to partner type and associated stigma that could promote rationalizations for avoiding condom use based on downward comparison. In contrast, designers could capitalize on this downward comparison phenomenon by rhetorically connecting condom use with avoidance of skeezers and their stigma. This latter type of campaign would need to avoid promoting any ideas capitalizing on this stigma that could lead to violence and other abuse against women who trade sex for drugs. Clearly, this is a difficult line to walk.

Implications for health care workers and counselors. Regardless of whether downward comparison is used as a future intervention strategy, interventions should expressly address condom use and non-insertive sexual behaviors to reduce risk of infection/transmission and maintain strategic differences between self and other. Additionally, campaign curricula should address the erroneous belief that HIV/STDs recognize social distinctions and do not climb the social ladder. Those in direct contact with drug users may increase efforts to distribute condoms.

Future Research

This study has demonstrated that downward comparison beliefs exist among a sample of heterosexually-oriented African-American illegal drug users in Washington, DC, and Miami, FL. Because these sentiments exist among the population, they constitute a strong reservoir of rationales on which to construct intervention curricula that promote condom use. It is important to continue to explore the role of stigma in understanding decision-making. Downward comparison theory has been shown to be an effective theoretical model in other medical/behavioral contexts. Its utility remains to be seen for future intervention research to change perceptions of others and personal risk for infection with HIV and other STDs. Other areas for exploration include gender effects and the role of power in initiating condom use. At present, how-

ever, some of the participants in this study have demonstrated a belief system that they believe protects them from disease—but it is a belief system that the HIV virus does not share. It remains for scientists and practitioners to help this target population abandon their comfortable belief and to practice safer behaviors.

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SUBMITTED: 06/04/02

ACCEPTED: 08/18/02