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David Allen Patterson
State University of New York, University at Buffalo

Robert H. Keefe
State University of New York, University at Buffalo

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DAVID ALLEN PATTERSON

ROBERT H. KEEFE

State University of New York
University at Buffalo
School of Social Work

Many professionals working with people living with HIV and alcohol and other drug addictions rely heavily on micro and mezzo-level interventions. The authors argue that although these approaches are effective for helping people living with some social problems they are too narrow for working effectively with HIV-positive and alcohol and other drug-addicted individuals. The authors use social construction theory to analyze the social problems of HIV/AIDS and addictions and make recommendations for macro-level interventions that may help curtail the dual problems of HIV and addictions.

Key words: *HIV/AIDS, Alcohol and Other Drug Addictions, Social Construction Theory, Macro Practice*

The HIV epidemic continues to be a major health and social problem. According to the Centers for Disease Control and Prevention (CDC, 2002) the incidence of HIV increased in the United States throughout the 1980s, declined during the

mid-1990s, then increased again in 2002. The CDC (2002) estimated that there are 385,000 people in the United States living with HIV of whom many have long histories of alcohol and other drug (AOD) use (Rosenberg et al., 1999).

Of the HIV-infected males in North America, most are between the ages of 18 and 44 and contracted the virus by way of same-sex sexual encounters (Catania et al., 2001); however, most of the HIV-positive African Americans and Hispanics contracted the virus through injection drug use (IDU) [CDC, 2002; Karon et al., 2001]. Other reports have indicated the number of HIV cases acquired through heterosexual contact has increased to the point that heterosexually transmitted HIV cases now equal the number of cases attributed to IDU. Additional reports have shown that the transmission of HIV through same-sex sexual encounters, which had formerly been attributed to IDU, may in fact account for a much larger number of cases than had previously been assumed, particularly in the African American community (Lane et al., 2004).

Most of the research on the primary cause of HIV transmission has focused on individual-level risk factors. However, additional research has concluded that individual-level risk factors account for only a small percentage of HIV transmission and that community, or macro-level, risk factors must be considered (Adimora & Newman, 2002; Lane et al., 2004). Moreover, most of the research has been atheoretical and has not advanced any one theory to explain the spread of HIV and AOD addiction, nor has existing research focused on how many Americans view people living with HIV and AOD addictions.

The purpose of this article is to begin filling the gap in the research on the use of Social Construction Theory (Berger & Luckmann, 1966; Blumer, 1969; Goffman, 1959; Schneider & Ingram, 1993) with HIV-positive and AOD-addicted individuals; to explain how people living with HIV and with AOD addictions are discriminated against by various members of American society and how policy makers discriminate against people living with HIV and AOD addictions in determining the distribution of funds for health and social services; to describe the growth of HIV and AOD as social problems; and to clarify how social workers can use social construction theory as a theory base for macro-level interventions in their work

with HIV-positive and AOD-addicted individuals.

Social Construction Theory

Social construction theory is concerned with the processes by which people describe, explain, or account for the world in which they live (Berger & Luckmann, 1966; Blumer, 1969; Goffman, 1959, 1963; Schneider & Ingram, 1993). The theory postulates that a person's beliefs are created within the social context in which he or she lives and as such his or her knowledge, as a social phenomenon, develops within social interaction (Cheung, 1997).

Berger and Luckmann (1966) viewed social construction as comprised of three stages: externalization, objectivation, and internalization. Externalization is described as the process by which people construct a cultural product or outcome (e.g., becoming HIV positive could be caused by being gay). Objectivation occurs when cultural products take on an objective reality of their own, separate from the people who create them, resulting in being viewed as part of objective reality (e.g., because a person is gay he or she will become HIV positive). Internalization occurs by way of socialization when people in a society learn the "objective facts" of a culture and make these facts part of their everyday, or "internal," consciousness (e.g., taking for granted that becoming HIV positive is directly caused by being gay). Consequently, social realities are continuously being constructed and reconstructed in a dialectic process between individuals interacting with each other and with their social world.

Discrimination Against People Living with HIV and AOD Addictions

Social constructions also influence policy formation by the ways in which groups in power define particular social problems. Donovan (1993) reported that identifiable groups in a society are infused with culturally constructed positive or negative images that pressure lawmakers to target policies toward, or away from, a given group. The influence of socially constructed images on policy options are positively correlated

with the political power of an identified group. Thus groups with political power benefit by the development and subsequent passing of social policies that provide health and social services which advance their mission.

Groups that are viewed negatively within their society, such as people living with HIV and addictions, are mainly considered deviant, thereby being a burden to the larger group. Perhaps the only advantaged group associated with HIV and addiction is the biomedical research establishment (Donovan, 1993), which benefits from federal funding to advance society's wish that effective treatments, vaccines, and cures be found to deal with HIV and addictions. Social construction theory therefore provides a vehicle to explain how powerful groups develop public policy that promotes the unequal distribution of benefits to themselves and burdens to groups without power (Hoffman, 1990).

Schneider and Ingram (1993) argued that the convergence of political power and social construction creates four types of target populations: advantaged, contenders, dependents, and deviants. Advantaged populations (e.g., the biomedical establishment) are positively constructed and politically powerful, resulting in the likelihood of receiving policy benefits. Contenders (e.g., people living with HIV and AOD addictions who are mobilized, such as gay men's groups including ACT-UP) are target populations that have some political power, but are negatively constructed by large numbers of people. Dependent target populations (e.g., spouses and young children born to parents with HIV and AOD addictions) enjoy a positive social construction (e.g., being viewed as "the innocent victims") yet lack political power. Although policy makers are sympathetic to the dependent group, due to the latter's positive social construction, directing resources toward them is difficult. Deviants (e.g., HIV-positive and AOD-addicted individuals who are not mobilized) are both politically powerless and negatively constructed and are thus the least likely to receive benefits from policy makers (Schneider & Ingram, 1993).

HIV and Alcohol and Other Drug Abuse

Rosenberger et al. (1993) approximated that 75% of

HIV-infected individuals have abused alcohol and other drugs. Gorman et al. (2004) reported the dramatic increase of "club drug" use such as methamphetamines, Ecstasy, and GHB in tandem with unsafe sex practices as a major concern in the increased incidence of HIV. Meyerhoff (2001) further reported that 29% to 60% of HIV-infected patients develop an AOD addiction at some point during their lives—a rate roughly three times as high as in the general U.S. population. In addition, Petry (1999) concluded that the prevalence of addiction among HIV-infected individuals is nearly 12%—approximately twice the rate of the general population. Others (Windle, 1997; Metzger, Navaline, & Woody, 1998) reported high IDU rates among alcoholics in treatment, which correlate with increased drug-related risk behaviors, such as needle sharing and unprotected sex (Stein et al., 2000). Moreover, others (Boscarino, Avins, & Woods, 1995; Malow, Devieux, & Jennings, 2001; Windle, 1997) concluded that there is a positive correlation between a history of heavy AOD use and a lifetime of high-risk sexual behaviors such as unprotected intercourse, sex with high-risk partners (e.g., IDUs and prostitutes), and the exchange of sex for money or drugs.

Medication compliance is a major concern for HIV-infected AOD-addicted individuals. Researchers (Wagner et al., 2001; Lucas et al., 2002) have found an association between heavy alcohol use, decreased medication compliance, and poorer response to HIV therapy. Lucas et al. (2002) concluded that HIV-related therapy outcomes improved significantly among AOD-dependent persons who stopped using alcohol and other drugs. Consequently, people who are HIV-infected and AOD-addicted often do not adhere to their prescribed medication regimens and are more likely to have unprotected sex unless their alcohol and drug-use problems are addressed.

The effects of HIV and AOD on the body

Medical researchers have long understood the effects of HIV on the body. However, understanding the influence of AOD use on HIV-infected people has only recently been addressed. HIV primarily targets CD4+ cells. CD4+ cells are found in the blood and perform important regulatory immune functions. HIV-infected CD4+ cells replicate the virus and kill

healthy CD4+ cells resulting in a slow decline in the infected person's healthy CD4+ cells, thus leaving the infected person increasingly vulnerable to infections that were formerly controlled by the once healthy immune system (Meyerhoff, 2001).

Other researchers (Bagasra et al., 1993) isolated CD4+ cells from HIV-negative subjects before and after the subject ingested 3 to 9 alcoholic beverages over a two-day period. Isolated HIV-infected cells were found to multiply faster after alcohol consumption, suggesting that alcohol increases the susceptibility of human cells to HIV infection and to damage of the peripheral immune system. It is thus logical that both HIV infection and chronic heavy alcohol consumption have similar and profound effects on the immune system, thus increasing one's susceptibility to some infections associated with HIV, such as tuberculosis, pneumonia, and hepatitis C, which are leading causes of death among HIV-positive people in the United States (Cook, 1998; Fauci & Lane, 2001).

A major concern for people living in low-income neighborhoods who have limited access to health services is that once the HIV virus enters the system and begins to infect CD4+ cells the newly infected HIV individual is highly infective. By having to wait several days for health services at a neighborhood clinic the same individual who also has an AOD addiction may still engage in high-risk sexual behavior, thus possibly infecting others.

Using Social Construction Theory to Understand Macro-level Interventions in Working with People Living with HIV/AIDS and AOD Addictions

The way that a problem is socially constructed affects how people respond to it. Although HIV is a viral disease like hepatitis B, it was categorized as a sexually transmitted disease like syphilis or gonorrhea (Gilman, 1988). The disease designation is significant because society's commonly understood values continue to define any type of venereal disease and addiction as being morally deviant (Brandt, 1985; Donovan, 1993). The terms that were used in 1990 during the development of the Ryan White Comprehensive AIDS Resource Emergency Act

placed people living with HIV into two groups: those who are "non-deserving" of health care resources (e.g., people living with HIV/AIDS and AOD addictions) and those who are "deserving" (e.g., their wives and children). For example, the Ryan White Act targeted "women with AIDS" and "children with AIDS" as groups deserving health care resources even though children made up only 1.5% and women 10.9% of people living with AIDS, while gay men accounted for 60.7% and ethnic minorities accounted for 71.7% (Donovan, 1993). Donovan (1993) reported the deserving target population (i.e., women and children) brought forth a shift in public consciousness and allowed policy makers the opportunity to provide benefits for that specific group (i.e., the "deserving group"). These discussions eventually became part of our everyday dialogue that led to the decision of who gets needed medical care and who does not.

Because medical care and social services are largely dependent on public policies, social workers who work with people living with HIV and AOD addictions must pay particular attention to which policies legislative bodies pass. Because groups that are viewed by society as non-deserving receive few public funds, they become the groups that often require more intense social work intervention compared to their "deserving" group counterparts. Moreover, because there are fewer services available for the non-deserving populations, social workers must often use macro-level interventions to effect change inasmuch as micro-level interventions do not reach a large enough group of individuals to have a positive impact on their well-being.

Likewise, much of the research on HIV and AOD addictions flowed from the policies that benefited the biomedical establishment, which in turn conducted much of the research. Research that focuses on individual-risk variables is comprised largely of subjects from the deserving groups and is thus more sensitive to the deserving groups' needs. However, the individual-risk variables largely ignore the institutional disadvantages that constrain healthy behavior among non-deserving groups, including people of different races and ethnicities (Link & Phelan, 2002). This is not to say that individual-level risk variables do not play a role in the transmission of HIV, just that they explain only a small percentage of the variance

in HIV transmission among the groups that are viewed as non-deserving of medical care and social services (Adler & Newman, 2002; Lane et al., 2004; Pincus et al. 1998).

Social construction theory and macro-level intervention

By explaining which macro-level factors seem to impact both HIV/AIDS and AOD addiction, one must consider the variables known to impact the groups viewed as non-deserving such as people from racial and ethnic minorities who are among the populations most often newly diagnosed with HIV and AOD addictions. Among the most common macro-level variables impacting these groups which require social work intervention are: disproportionate incarceration rates, residential segregation and gang turf, sex ratios that favor men over women, social norms stigmatizing homosexuality, and constraints in access to STD clinic services (Lane et al., 2004).

Incarceration. The disparate rates of incarceration are among the more pressing issues for racial and ethnic minorities (Lane et al. 2004). Complicating this problem is that HIV has become the second leading cause of death in U.S. prisons (Berkman, 1995). Maruschak (2001) reported that the inmate population is at least five times more likely to be infected with HIV than the general population. Hammett, Harmon, and Rhodes (2002) estimated that 20% to 26% of all people living with HIV in 1997 spent time as inmates that year. Brewer et al. (1988) calculated a rate of 4.15 HIV infections per 1,000 person years in prison whereas Polonsky et al. (1994) concluded that in Illinois the rate was 25 per 1000 person years in prison.

Roughly 25% of all inmates entering U.S. prisons have injected drugs, which put them at risk for HIV as well as hepatitis B and C (Hammett & Maruschak, 1999). Some of these inmates continue to inject drugs while in prison and share syringes and drugs purchased on the underground prison market (Reingold, Lurie, & Bower, 1993), thus compounding the dual problem of HIV and AOD addictions. Many other inmates across studies report being raped while incarcerated. Robertson (2003) concluded that prisoners are raped an average of nine times during their incarceration. Moreover, prisoners have been found to trade sex for drugs or other items, or to engage in consensual or companionship sexual behavior, which is more often than not unprotected (Hammett, Harmon, & Maruschak,

1999). Wohl et al. (2000) estimated that 90% of the sex in correctional facilities occurs without the use of condoms and that 20% of the males with HIV and 9% of the males without HIV claimed to have had anal sex while incarcerated.

Residential segregation. Like incarceration, residential segregation can result in the maintenance of elevated rates of HIV and other sexually transmitted infections. Socially isolated individuals choose partners from within their social context and thus transmit infections among fellow members (Friedman & Aral, 2001; Rosenberg, Moseley, & Kissinger, 1999; Youm & Laumann, 2002). Racial prejudice severely limits upward mobility, thus promoting residential segregation, which in turn limits mate selection. Moreover, the prevalence of gangs, which threaten harm to people who enter a turf in which they do not reside, further limits the ability of people to initiate relationships outside of a few narrowly defined neighborhoods (Lane et al., 2004).

Sex ratios. Sex ratios have been shown to impact the prevalence and incidence of HIV. Laumann et al. (2004) found that there are fewer males than females among African Americans in Chicago, and Lane et al. (2004) found the same in Syracuse. The uneven sex ratios were associated with males maintaining sexual partnerships with two or more females. Guttentag and Secord (1983) argued that the low male-to-female sex ratio robs women of their bargaining power in relationships. As the number of available men becomes scarcer, each relationship becomes more difficult to secure. Consequently, a woman in such a macro-level context may accept conditions she would not agree to if her bargaining power were greater. In fact, Adimora et al. (2002) found that among over 10,000 women nationally, 21% of African Americans, 11% of Whites, 8% of Hispanics, and 6% of Asian Americans and Pacific Islanders were in partnerships in which one of the partners was concurrently in another partnership.

Sex ratio issues within a community could also relate back to the disproportionate incarceration of African American men, as men are more likely to be incarcerated than women, thus skewing the sex ratio. A low male-to-female sex ratio leads to a smaller pool of potential partners from whom to choose and has been found to be associated with the presence of

concurrent partnerships (White & Burton, 1988). There are often significantly more African American women than men of marrying age in many urban areas (Lane et al., 2004). Consequently, that pool consists of a larger number of potentially HIV-infected individuals.

Homophobic social norms. Additionally, hidden same-sex encounters (referred to as *Down Low, DL,* or *sneaking*) are often found among men of color. These men may not self-identify as gay, homosexual, or bi-sexual and therefore miss being reached by safer sex messages (Lane et al., 2004). Lehner and Chiasson (1998) found that 87% of the men who have sex with men (MSM) also report having sex with women. Due to the twin discriminations of homophobia and racism, African American MSMs in Chicago and Atlanta reported that they feel marginalized by both the African American and the gay white communities (Kraft, Beker, & Stokes, 2000). Churches in the African American and Latino communities, a great source of support for many people, may lead some men to sexual secrecy because of the disapproval these men perceive from clergy and other congregants (Woodyard, Peterson, & Stokes, 2000).

Constraints in STD clinic services. Limited STD clinic service hours also serve to increase the rates of HIV in communities. Lane et al. (2004) reported that limited STD clinic hours were associated with long wait periods between the time an individual makes an appointment at an STD clinic and the time he or she is seen at the clinic for services. Because the viral load in the blood of a person recently infected with HIV or another STD is higher immediately post infection, the wait period between making an appointment, being seen at the clinic, and then obtaining appropriate medication puts individuals within the community at greater risk of infection than individuals living in areas with adequate STD clinic services.

Recommendations and Conclusions

To be effective in their work with people living with HIV and AOD addictions, social workers would be wise to consider macro-level interventions that address problems

known to impact populations at risk of contracting HIV and developing AOD addictions. Among these pressing problems that have not been a focus of macro-level intervention are the disproportionate rates of incarceration, in which African Americans are sentenced to prison more than whites, residential segregation and gang turf that limit upward mobility and permeability of community boundaries, sex ratios that promote concurrent partnerships, social norms that stigmatize homosexuality creating down low activity, and inadequate STD clinic services and hours of operation in various cities.

Social construction theory offers a broad lens through which HIV and AOD addictions can be viewed. By focusing on the variables impacting groups that are viewed as non-deserving, various recommendations for sociologists and social work researchers and practitioners can be made. First, the health care in U.S. prisons has been described as poor (Berkman, 1995). It is therefore important to examine services that could help to curtail the spread of HIV in prisons. One method would be to allow condom distribution. Currently, only six prisons nationwide allow prisoners to have access to condoms. Condom distribution would provide inmates with greater protection from sexually transmitted diseases. Another recommendation would be to allow staff from health care agencies, including STD clinics, access to inmates so as to provide education on sexually transmitted disease prevention and to screen for HIV.

Second, racial segregation has been an ongoing problem in the United States for decades and must continue to be addressed. Proposals for how to eliminate racial segregation have been made by others (see Goetz, 2000). The urban renewal efforts of the 1960s served to isolate many urban neighborhoods, which in turn creates gangs which inhibit the flow of people between and among neighborhoods. Offering decentralized or mobile STD and free clinic services will help to address the problem of neighborhood permeability and its affects on health care access, while allowing residents to address many of the health-related concerns within urban areas.

Third, lawmakers must deal with the criminal adjudication process if the disproportionate rates of incarceration between whites and people of color are to be addressed. All too

frequently racial and ethnic minority groups receive tougher prison sentences than do whites for the same crimes (Rosenthal, 2001). Reducing the disproportionate rates of incarceration will likewise help to reduce the disproportion in sex ratios and increase women's bargaining power in relationships.

Fourth, social norms that perpetuate the negative stereotypes of homosexuality in racial minority communities need to be addressed so as to reduce the down low problem. Churches, synagogues, mosques, and other religious and civic centers are macro-level support systems that can be called upon to encourage their members to use services and to be more cognizant of their healthcare needs (Rosen et al., 2004; Okwumabua, Glover, & Bolden, 2001).

Finally, the lack of access to STD services disproportionately affects disadvantaged groups because many individuals within these groups do not have adequate health insurance or health care providers whom they see for ongoing care (Link & Phelan, 2002; Fleming & Wasserheit, 1999). Decentralized public health clinics and mobile screening teams may increase access to care for people in low-income, high-risk neighborhoods where limited transportation and the presence of gangs are problems.

Individual-level risk factors explain only a small percentage of the incidence in HIV and AOD-addictions. By focusing on macro-level interventions that address neighborhood characteristics such as residential segregation and gang turf, the disproportionate rates of incarceration, norms that stigmatize homosexuality, and the limited access to STD clinic services, social workers will help to reduce the incidence of HIV and AOD addictions, thus removing the stigma associated with non-deserving group status. Sociologists and social work researchers can then evaluate the impact of these interventions and societal views of people affected by HIV and AOD addictions.

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