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Analyzing HIV/AIDS and Alcohol and Other Drug Use as a Social Problem

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Abstract

Most prevention and intervention activities directed toward HIV/AIDS and alcohol and other drug use separately as well as the combining of the two (e.g., those who are both HIV/AIDS and using alcohol and other drugs) comes in the form of specific, individualized therapies without consideration of social influences that may have a greater impact on this population. Approaching this social problem from the narrowed view of individualized, micro solutions disregards the larger social conditions that affect or perhaps even are at the root of the problem. This paper analyzes the social problem of HIV/AIDS and alcohol and other drug abuse using three sociological perspectives—social construction theory, ethnomethodology, and conflict theory—informing the reader of the broader influences accompanying this problem.

Keywords

HIV/AIDS; alcohol and other drug use; social construction theory; ethnomethodology; conflict theory

THE SOCIAL PROBLEM

The HIV/AIDS epidemic continues to be a major problem in the United States. According to the Centers for Disease Control and Prevention's (CDC) Surveillance Report–Volume 13 (2001), AIDS incidence increased throughout the 1980s, and declined from the mid-1990s through 2001, followed by an increase of 2% in 2002 (compared with 2001). AIDS prevalence, or the number of persons living with AIDS, continues to increase and is estimated to have been 384,906 at the end of 2002 (CDC, 2002). HIV has historically been most prevalent among men who have sex with men (MSM) (Catania et al., 2001) while most new HIV infections are reported among MSM and among injection drug users (IDUs). Recent reports indicate the proportion of HIV cases acquired through heterosexual contact has increased equal to the proportion of cases attributed to IDUs (Karon, Fleming, Steketee, & De Cock, 2001; CDC, 2002). Reports of women being infected with HIV have tripled since the mid-1980s, mainly resulting from heterosexual exposure and secondarily through injection drug use (CDC, 2002). Currently, minority groups are the most affected by HIV associated with drug injection and blacks and Hispanics now account for approximately 70% of all new AIDS cases (Karon et al., 2001; CDC, 2002). Most HIV-infected people in North America are between ages 18 and 44.

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Meyerhoff (2001) reported that 29% to 60% of HIV-infected patients develop an alcohol or other drug (AOD) dependency at some point in their lives—a rate that is roughly three times as high as that of the general U.S. population. Petry (1999) concluded that the prevalence of addiction among *current* HIV-infected individuals is nearly 12%—approximately twice the rate of the general population. This would appear to support findings (Windle, 1997; Metzger, Navaline, & Woody, 1998; Stein et al., 2000) that people who abuse AOD are more likely to engage in behaviors that place them at risk for contracting HIV. For instance, alcoholics in treatment have high rates of IDUs (Windle, 1997; Metzger et al., 1998) and drug-related risk behavior (i.e., needle sharing and unprotected sex) increase along with the increase of alcohol ingestion (Stein et al., 2000). In the past, we have seen a correlation between a history of heavy AOD use and tendency toward a lifetime of high-risk sexual behaviors, which include multiple sex partners, unprotected intercourse, sex with high-risk partners (e.g., IDUs, prostitutes), and the exchange of sex for money or drugs (Windle, 1997; Avins et al., 1994; Boscarino, Avins, & Woods, 1995; Malow, Devieux, & Jennings, 2001).

Medical scientists have done an enormous service to persons suffering from HIV/AIDS by studying and understanding what happens when someone acquires HIV. They have recently provided understanding the effects of AOD usage on HIV-infected persons. The primary target of HIV in the body is a type of immune cell called the CD4+, which is an immune cell found in the blood that performs important regulatory immune functions, thereby protecting the organism against infection. This CD4+ cell is also identified as a T-helper cell (Meyerhoff, 2001). The CD4+ cell plays a vital role in the body's defense against disease-causing pathogens. HIV-infected CD4+ cells manufacture new viruses and eventually die, resulting in the infected person's levels of CD4+ cells in the blood slowly declining, leaving him or her increasingly vulnerable to infections that normally are controlled easily by the immune system and to usual cancers (Meyerhoff, 2001). Researchers have conducted studies using immune cells, including CD4+ cells, that were isolated from healthy, non HIV-infected human subjects both before and after the subject ingested 3 to 9 alcoholic drinks over 2 days (Bagasra, Kajdacsy-Balla, Lischner, & Pomerantz, 1993). The study suggested that alcohol consumption damaged the peripheral immune system, because when the isolated cells were infected with HIV in a test tube, the virus multiplied faster in cells taken after alcohol consumption. These findings suggest that alcohol increases the susceptibility of human cells to HIV infection.

It could be easy to suggest that both HIV infection and chronic heavy drinking have similar and very profound effects on the immune system. However, no strong immunological evidence links alcohol consumption at any level to an accelerated course of HIV disease. That argument put aside, what can be stated is that alcohol increases susceptibility to some infections associated with AIDS, such as tuberculosis; pneumonia caused by the bacterium *Streptococcus pneumoniae*; and the viral disease hepatitis C, which is a leading cause of death among persons with HIV (Fauci & Lane, 2001; Cook, 1998). A major influential factor on HIV-infected persons who are AOD dependent is medication compliance. Studies have associated heavy alcohol use with decreased medication compliance along with poorer response to HIV therapy in general (Wagner, Justice, & Chesney, 2001; Lucas, Gebo, Chaisson, & Moore, 2002). Outcomes of HIV-related therapy improved significantly among AOD-dependent persons who stopped drinking alcohol and using other drugs (Lucas et al., 2002).

CONSEQUENCES OF DOING NOTHING

The consequences of continued AOD use for those HIV-infected are many. Without addressing this problem, people who are HIV-infected and addicted to AODs become non-

adherent to prescribed medication and are more likely to have unprotected sex, and new segments of groups who were not originally considered at risk will become infected with HIV.

Oggins (2003) studied the reasons for low medication adherence rates for HIV-infected groups and concluded that infected persons have concerns about the interactions between HIV medication and street drugs. A high number of HIV-infected individuals believe that the HIV medications could be harmful if combined with cocaine or heroin (Oggins, 2003). Chuan (n.d.) discussed how non-adherence to prescribed medications was a major topic discussed at the World AIDS Conference in Geneva. One of the reasons offered by patients was ongoing substance abuse as well as simply forgetting to take the medications (Chuan, n.d.).

Being high on AODs and taking sexual risks has been linked to the continued spread of HIV. A developing literature seems to indicate that abuse of certain drugs is associated with decreased cognitive ability. According to Rosenberger and colleagues (1993) approximately 75% of HIV-infected individuals had a lifetime of drug and/or alcohol abuse. Recently, a resurgence of HIV infection related to the dramatic increase of club-drug usage has become a concern. Investigators discovered high prevalence of such substances as methamphetamine, Ecstasy, GHB, and ketamine in tandem with reported unsafe sex practices (Gorman, Nelson, Applegate, & Scrol, 2004).

The infection rates among new portions of our society are just being documented (Patterson, Cloud, & McKiernan, 2004). As discussed earlier, recent reports indicate the proportion of HIV cases acquired through heterosexual contact has increased equal to the proportion of cases attributed to IDUs (Karon et al., 2001; CDC, 2002). Reports of women being infected with HIV have tripled since the mid-1980s, mainly resulting from heterosexual exposure and secondarily through injection drug use (CDC, 2002). Currently, minority groups are the most affected by HIV associated with drug injection and African Americans and Hispanics now account for approximately 70% of all new AIDS cases (Karon et al., 2001; CDC, 2002). Without appropriately addressing this issue, the consequences will be much more of the same trend we are experiencing now.

ANALYZING THE SOCIAL PROBLEM

The next section will compare and contrast the usefulness of three theories for analyzing the social problem of HIV/AIDS and AOD use. We will review the major principles underlying the theoretical perspectives as well as what is likely to be learned about HIV/AIDS and AOD use from each perspective. While we could analyze a number of theoretical perspectives in an effort to become informed about this social problem, the three perspectives discussed in this section provide a starting point for future investigation. The three perspectives being analyzed are social construction theory, ethnomethodology, and conflict theory.

Social construction theory (Berger & Luckmann, 1966; Blumer, 1969; Goffman, 1959, 1963; and Schneider & Ingram, 1993) is concerned with the processes by which people in society describe, explain, or account for the world in which they live. The theory postulates that individual beliefs are social creations. According to Cheung (1997), social construction theory views the development of someone's knowledge as a social phenomenon evolving only within a cradle of society's interactive communication. Berger and Luckmann (1966) view social construction as a process of three stages: externalization, objectivation, and internalization. Externalization is described as the process by which people construct a cultural product (e.g., the idea that strange behaviors could be caused by mental illnesses). Objectivation happens 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., mental illness causes strange behaviors). Internalization happens when people in a society learn the “objective facts” of a culture through socialization and make them part of their everyday “internal” consciousness (e.g., taking for granted that strange behaviors are directly caused by mental illness) (1966). Social realities are continuously being constructed and reconstructed in a dialectic process between interacting individuals and their social world qua society (Berger & Luckmann, 1966).

These social constructions also influence policy formation due to the ways in which particular social problems are framed and defined. Donovan (1993) reports that identifiable groups in a society are infused with culturally constructed positive or negative images that create pressures on lawmakers to target policy toward a given group. The influence of this socially constructed image on policy options is correlated with the political power within that identified group. The social constructionist believes this theory provides a lens about society’s lens (Hoffman, 1990).

Groups with positive images and some degree of political power are more likely to receive benefits as compared to those groups with a negative image with no political power (Patterson & Keefe, 2008). Groups with negative images, as with the case with HIV/AIDS and AOD users, are mainly considered deviant, thereby being a burden to the larger group. The only advantaged group associated with HIV/AIDS and AOD users, or the one that is viewed as being positive, is the biomedical research establishment (Donovan, 1993). Because it is society’s desire to discover treatments, vaccines, and cures to deal with the HIV/AIDS epidemic as well as the destruction caused by AOD abuse, along with the favorable conception of scientific and medical research, the national research establishment benefits, and they have much control over policy decisions. By using this theory to discuss and inform us about individuals with HIV/AIDS and AOD problems, the determination of how society constructed the image associated with this group would expose the types of policies directed toward it. Using this theoretical framework provides a very powerful lens to witness how public policy comes into play and allows an evaluation and explanation of the unequal distribution of benefits and burdens to different groups within and across issue areas (Donavon, 1993).

While it is important to understand social construction theory and how images are assigned to people and groups, ethnomethodology could also play a significant role in informing us about the identified population (e.g., HIV-infected AOD users). Heritage (1984) defines ethnomethodology as “the body of common-sense knowledge and the range of procedures and considerations by means of which the ordinary members of society make sense of, find their way about in, and act on the circumstances in which they find themselves” (p. 4). Ethnomethodologists do not focus on individual acts but on the larger membership activities within a structure. This approach attempts to break down conversations, which they term as “accounts,” in order to analyze ways in which the accounting process is offered, accepted, and/or rejected by others within a structure. Conversations within society become interactional, resulting in a need to provide a stable, orderly, and commonly understood society so that tasks can be accomplished.

Basically, in order for a society to be stable and orderly, conversations and terms must be a mutually understood, taken-for-granted flow of accounts in order that people within that society can accomplish their tasks. For instance, a society has commonly understood and accepted social behaviors; anyone acting outside of the understood behaviors could be considered deviant. An advantage to using the ethnomethodological approach to designating terms such as sickness, illness, and deviance is that these accounts provide us with a social reality understanding of the world around us. Personal reality, consciously and

unconsciously, is basically shaped through our socialization. Social, physical, and personal reality interacts simultaneously to form one's collective perception of what is real (Huber & Gillaspay, 1998). However, it is also important to understand how these terms came about as well as who was involved in the accounting process of term designation.

The way that a term is defined has a lot to do with how people respond to it. AIDS was not labeled as a viral disease like hepatitis B, which is transmittable in the same way; 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, along with abusing AODs, as being morally deviant (Brandt, 1985). Whenever treatment issues or any political discussions begin around the venereal disease designation, both medical and moral judgments are debated (Donovan, 1993). Terms that were used during the debate of the first AIDS legislation, the Ryan White Comprehensive AIDS Resources Emergency Act (CARE; passed in 1990), placed people in two groups: those who are deserving of resources and those who are not (Donovan, 1993). Ethno-methodologists would be interested in accounting processes such as the ones during the Ryan White debate. For example, the Ryan White act targeted the populations "women with AIDS" and "children with AIDS," although in 1990 children made up 1.5% of people with AIDS and women 10.9% (Donovan, 1993). Gay men represented 60.7% and ethnic minorities 71.7% during the same year. According to Donovan (1993), women and children, the "deserving" target population, allowed a "shift in public consciousness" (p. 13) and allowed policymakers the opportunity to provide some form of benefits for that designated group. The defining terms used during debates and throughout society offered a common-knowledge understanding of whom does and does not deserve benefits while suffering from AIDS as well as addictions. These terms eventually become part of our everyday dialogue and allow for social stability.

What can be learned from using ethnographic methods and inform us about the problem is that it investigates the "facts" and categories that HIV-infected AOD abusers employ to define, and gives meaning to their social and natural environment (Leach, 1976). According to Sifaneck and Kaplan (1995), illicit drug users along with other "hidden" populations (e.g., HIV/AIDS) occupy specific "microenvironments," and in order to appropriately deal with these populations, social scientists must gain access to these environments and learn the people's "language."

The final theory being examined is conflict theory. This theory was a response to the structural functionalist's perspective of society being held together by norms, values, and a common morality in an effort to contribute to stability (Ritzer, 1996). Conflict theorists see conflict at all points in the system, and whatever order does exist, stems from coercion of some members located at the top of that system. Whereas functionalists see unity in the structure's shared values, conflict theorists postulate that order is maintained by the role of power (Ritzer, 1996). According to Dahrendorf (1968), positions within social structures have different amounts of authority that are not held by individuals but, rather, are housed within specific positions or titles. The first step in conflict analysis is to identify authority roles (positions) within society without focusing on individuals who may hold that role (Dahrendorf, 1968). Because of that authority being attached to the role in society, involving both superordination and subordination, those with authority positions are expected to gain control over subordinates, thereby legitimizing imposed sanctions on subordinates who do not comply.

Understanding this perspective would help inform us about the stated problem by looking at how structural factors in society affect those within disadvantaged areas. For instance, conflict theorists hold that many chronic drug users are found in lower social classes,

disorganized neighborhoods, low-income families, and relatively politically powerless places (Lo, 2003). According to Goode (1997, 1999), every one of these factors indicates why economically marginal inner cities have been at the center of drug dealing and drug use.

Powers that be within a society who are able to designate how an illness occurs as well as categorize who deserves the benefits of any form of treatment are able to withhold or sanction anyone who may fall into the undeserving population category. The conflict theorist would view the positions discussed earlier, pertaining to social construction theory and ethnomethodology, as being able to maintain order by their positions of power and influence. Lawmakers and medical personnel provide social stability resulting from their ability to set forth the taken-for-granted accounts of proper, value-based behaviors along with designating who deserves appropriate health care within society.

EMPIRICAL SUPPORT TO DRAW CONCLUSION

Having reviewed the history, values, causes, and consequences of HIV/AIDS and AOD use as well as analyzed that identified social problem by comparing and contrasting the usefulness of three theoretical perspectives—social construction, ethnomethodology, and conflict theory—the next section evaluates the empirical support, drawing conclusions as to how each perspective informs the view of the original problem, the HIV-infected AOD user.

As stated earlier, using the social construction framework provides a very powerful lens to witness how public policy comes into play and allows an evaluation and explanation of the unequal distribution of benefits and burdens to different groups within and across issue areas (Donovan, 1993). Schroedel and Jordan, in their 1998 study, utilize Schneider and Ingram's (1993) theory of the social construction of target populations to evaluate the U.S. Senate's response to AIDS between 1987 and 1992. Schneider and Ingram contend that the convergence of political power and social construction creates four types of target populations: advantaged, contenders, dependents, and deviants.

Basically, according to Schneider and Ingram, advantaged populations are positively constructed and politically powerful, resulting in the likelihood of receiving policy benefits. Contenders make up those target populations that have power politically, but are negatively constructed. Contenders could receive policy benefits when their aid is concealed from the public's awareness; however, contenders could be inflicted with policy burdens when public interest is high. The dependent target population enjoys a positive social construction yet lacks political power and, much like contenders, impel policymakers in two opposing directions. While policymakers are sympathetic to the dependent group, due to their very limited political power it is difficult to direct resources toward them. The final target population, deviant, is both politically powerless and negatively constructed, resulting in this population being the least likely to receive any benefits from policymakers (Patterson & Keefe, 2008).

Using Schneider and Ingram's 1993 model, Schroedel and Jordan (1998) sampled 30 roll-call votes pertaining to AIDS legislation. Those votes resulted in 11 groups being explicitly targeted by Senate AIDS legislation. The advantaged group was made up of veterans and health care workers; contenders were gay and bisexual men and the general population with AIDS; the dependent population consisted of spouses, patients, and the public; and the deviant population was made up of intravenous drug users, criminals, prisoners, and foreigners.

Analyzing Senate roll-call votes during the years between 1987 and 1992 pertaining to AIDS legislation offers qualified support for Schneider and Ingram's theory. According to

researchers Schroedel and Jordan, advantaged groups were consistently awarded policy benefits while deviant populations provoked senators to cast unfavorable votes more often than any other group (1998). The remaining two populations, contenders and dependents, received symbolic policies (i.e., contenders received symbolic burdens and dependents obtained symbolic benefits) (Patterson & Keefe, 2008).

Because AOD users along with HIV-infected individuals are considered part of a hidden population occupying specific microenvironments, in order to appropriately deal with this population social scientists must gain access to these environments and learn their language. Rhodes and colleagues (1999) have discussed the use of ethnographic methods in research on the relationship of AOD use to the HIV/AIDS epidemic. As the result of their discussions, a debate ensued concerning whether there have been any successful cases where ethnographic methods and survey research methods have been combined. In order to benefit prevention of HIV/AIDS among AOD users, McKeganey (1999) has pushed for a reconciliation and combining of qualitative (participant-observation) and quantitative (survey) methodological studies of HIV-infected addicts. Employing this tandem data-gathering research approach can provide a more multi-faceted and contextual understanding of the topic under study (McKeganey, 1999).

Sifaneck and Neaigus (2001) attempted to conduct a study similar to McKeganey's (1999) recommended design. They discuss various ways ethnographic methods along with survey questionnaires were used to study HIV risk among non-injection heroin users. They review past studies that have benefited this population's risk factors and overall health resulting from ethnographic techniques (e.g., Barnard, 1993; Friedland et al., 1985; Hopkins, 1988; Robertson et al., 1986; Schoenbaum et al., 1989; and Vlahov et al., 1990). Sifaneck and Neaigus's study aim was to investigate behavioral and network factors associated with transitions to drug use with HIV infection, hepatitis B, and hepatitis C rates. They employed a participant-observation and focus group design using an ethnographic session to investigate, among other things, how non-injection heroin use was embedded in the everyday life of the user. The researchers concluded that their ethnographic approach was enhanced when combined with quantitative activities, and those qualitative ethnographic techniques, such as participant observation, focus groups, as well as in-depth interviews, can contribute greatly to the structured interview surveys among drug users. They also discovered that this design could assist with research staff becoming sensitive to the social and cultural specificity of the study population, labeled as "ethnographic charm" (Sifaneck & Neaigus, 2001). This charm helps with building rapport and is essential for obtaining sensitive and/or illegal activity information.

Trussler, Perchal, and Barker's (2000) community-based, participatory investigation used peer ethnographers to observe their own community and conduct focus groups aiming to renew HIV prevention programming for young gay men. While gay men's risk factors have been explored for more two decades, uncovering the importance of cultural knowledge through appropriate forms of research designs creates a problem for the future of HIV prevention (Dowsett, 1996; Flowers, 1996; Kippax et al., 1996; Meyers, Godin, Lambert, Calzavara, & Locker, 1996; Parker, Herdt, & Carballo, 1999). Trussler and colleagues state that their study "...broke new paths by taking on interpretive ethnography and ethnomethodology as a guiding framework for community level participatory research" (p. 296). Their goal was to avoid investigating individual behavioral risks, and instead focus on social and cultural perspectives in the search for embedded HIV vulnerabilities. The cohort being studied was considered the new generation of gay men young enough to have missed the earliest wave of HIV prevention efforts. From anecdotal accounts of outreach workers, the study theorized that unprotected sex could be developing more like a fad and that in

order to develop prevention knowledge, cultural reality-making through everyday taken-for-granted conversations must be investigated.

Trussler and colleagues' (2000) study concluded that "the development of collaborative inquiry using ethnography in the field and ethnomethodology in analysis to uncover the HIV vulnerabilities of a local sexual culture has shown itself worthy of pursuit elsewhere" (p. 304). They discovered an epistemological divide between individual and cultural interpretation of HIV risks. The isolated learning that gay men proceed through in serial relationships and the everyday conversations within gay life affect interpersonal communication in gay relationships, thereby contributing to risk factors (Trussler et al., 2000). Gay cultural practices set up HIV vulnerabilities occasionally and coincidentally due to the unspoken and spoken negotiation practices stemming from the desire of monogamy and casual sex at the same time. This study enabled prevention outreach workers to better understand and communicate risk factors associated with the new gay generation by utilizing findings from this ethnomethodological research.

Conflict theorists who have focused their attention toward AOD use and problems that accompany that activity, such as HIV/AIDS, hold that we find increased numbers of chronic drug users in lower social classes, disorganized neighborhoods, low-income families, and relatively politically powerless places.

Lo (2003) employs a social conflict theory to link macro-social-context factors to the use of illegal drugs by arrestees. Her study uses 1990 census data and 1991 and 1992 Drug Use Forecasting (DUF) projects that collect data on AOD use among arrestees in more than 20 large U.S. urban cities. She hypothesizes that certain structural disadvantage factors targeted by social conflict theory contribute to explaining arrestees' use of AODs. Lo goes beyond the individual phenomenon of AOD usage, focusing also on the social context factors. The study explores interactions between both the macro-level structural-disadvantage factors and micro level in an attempt to gain insight into how individuals are conditioned by the structural-disadvantage factors. According to Goode (1997, 1999), conflict theory would postulate that arrestees would come from places where structural disadvantage exists, such as high poverty rates, limited legitimate opportunities, and high levels of social disorganization.

Although drug use in the middle 1980s and early 1990s was declining in the general population, the highly publicized crack cocaine phenomenon during this time contributed to the drug scare (Lo, 2003). While drug use is defined as a crime, criminals were easily found after government officials' response to this "crime," with strengthened policing and increased arrests (Liska & Chamlin, 1984; Belenko, Fagan, & Chin, 1991; Liska, 1992). Due to these drug-using persons being economically marginal and alienated, social conflict theorists would conclude that this specific population would be arrested for their drug use.

The study resulted in supporting the social conflict theory's view that structural-disadvantaged individuals were more likely to use drugs and become arrested as the result of that crime. While individual factors are associated with drug use, hailing from cities or counties with numerous structural disadvantages puts individuals at risk of serious drug use, indicating that individual behavior is embedded in a much broader social environment and behavior(s) should be taken into account when evaluated (Rountree, Land, & Miethe, 1994; Wallace, 1999).

CONCLUSION

As the result of reviewing the history, values, causes, and consequences of HIV/AIDS and AOD use, as well as analyzing that social problem by comparing and contrasting the

usefulness of three theoretical perspectives—social construction, ethnomethodology, and conflict theory—a much broader perspective when discussing and appropriately addressing the problem must be considered. Particularly, it seems that most of the research on the primary cause of HIV transmission has focused on individual-level risk factors. More recent research has concluded that individual-level risk factors account for a small percentage of HIV transmission and that macro-level risk factors must be taken into account (Adimora et al., 2002; Lane et al., 2004). Oftentimes research has been atheoretical and thus not served to advance any one theory to explain the spread of HIV and AOD. Approaching this social problem from the narrowed view of individualized, micro solutions disregards the larger social conditions that affect or even are at the root of the problem. Because this social problem and these three perspectives are connected, having some type of effect on everyone within our society, without an understanding of the macro level, any efforts at dealing with this problem may be limited.

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