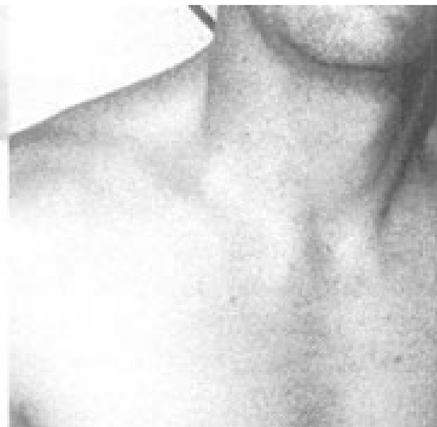
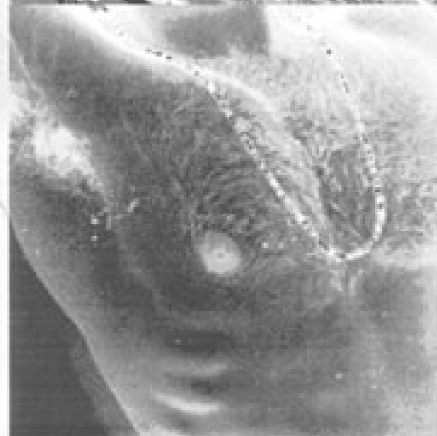
THE SOCIAL CONSTRUCTION OF A GAY DRUG:

METHAMPHETAMINE USE AMONG GAY AND BISEXUAL MALES IN LOS ANGELES





Cathy J. Reback, Ph.D.

1997

Funded by contract #93427 from the
City of Los Angeles, AIDS Coordinator

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To Ferd Eggan

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For further information regarding this research or copies of this report, please contact Dr. Cathy J. Reback, 1136 N. La Brea Avenue, West Hollywood, California 90038; (323) 463-1601; E-mail: RebackCJ@aol.com

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FOREWORD

The research study presented here was commissioned by the AIDS Coordinator for the City of Los Angeles (contract #93427), to examine sexual and drug-related behaviors of gay/bisexual men who use methamphetamine ("crystal") as part of their sexual activities. Another, similar study is planned that will explore prevention issues for women, particularly among Latinas and African-American women.

As a city official responsible for AIDS prevention in Los Angeles, I am seriously concerned about reports of increased use of methamphetamines among this population of men. In Los Angeles, more than three-fourths of all new AIDS cases are reported among gay/bisexual/men who have sex with men, in every ethnic group. In a population that has historically placed a high value on sexuality, a drug that can be utilized as a sexual stimulant can have a strong impact on the population most at risk for transmission of HIV. In this 17th year of the AIDS epidemic, after hundreds of deaths and after the news—hopeful, but difficult—that there finally are medications that show promise of extending life, sexual intimacy is seen by many gay men as an unreachable but highly desired fulfillment of their selfhood. As a gay man with AIDS, in daily contact with many groups and individuals in the gay communities of Los Angeles, I have heard many of my own friends report that they have used crystal and found themselves excited and gratified by sex as never before. From some of those with AIDS, I have heard the poignant announcement that using crystal made them able to overcome pain and depression; from young men, I have heard a great deal of resentment about living their entire sexual lives with the idea that having sex is essentially risking death. Using crystal enables these young men to be sexual without feeling the contradiction between social standards and their desires. From men who are HIV-negative, I have heard that many abandon their own standards of safer sexual behaviors while using crystal. From male and transgender hustlers who work the boulevards, I have heard that crystal is a tool to help earn a precarious living while selling sex. Although most research about HIV and drug use has studied injectors of opiates (heroin), the prevalence of HIV among male injectors in Los Angeles is quite low—approximately 7%—as opposed to its prevalence in cities like New York, where half of all drug injectors are thought to be infected with HIV (Los Angeles County Department of Health Services, 1997). One of the important findings of this report is that, contrary to many assumptions about drug use, it is sexual behavior, not needle sharing, that provides the greater likelihood of HIV transmission among crystal users.

Dr. Reback's report examines how a small sample of men and transgender persons in Los Angeles view—and live—their lives through the mediation of various "identities" within the "gay community." They are, in many ways, typical of other men in this city: diverse in their ethnic backgrounds and socioeconomic status, many bearing the psychological and physical burdens of HIV disease, all vocal about needs for many different kinds of attachments to others. It would be a mistake to lump these men, and all of us, into a "gay community." In fact, there are many gay communities that live in proximity to one another and benefit from the aggregation of activities and (some) shared desires. Hence, throughout the report, Dr. Reback uses the plural: "gay communities." The men who responded so forthrightly to the questions asked by these researchers

demonstrate the formation of a peer group, their own community, one that functions within, and under the sign of, the "gay community."

When Dr. Reback talks about methamphetamine use, this must be seen in the context of this socially demarcated "gay community," one where sexuality is made into a shared identity. I hope that someday soon scientists and theorists will abandon the useless debate about biology versus culture; this study helps to show that "identities" like gay or HIV-positive or drug user are never fixed, but instead are the provisional outcomes of a limited set of choices and chances taken and left untaken. Here we have a full-fledged demonstration of the creation of a sub-culture that consciously shares certain values. The phenomenon of gay crystal use is perhaps related to biology; a few men in this study report that their childhood doctors prescribed ritalin for them because they were seen as hyperactive or suffering from attention deficit disorder. But biology is not used as an explanation by most of the men. What is more common in Dr. Reback's findings is a description of homosexual desire, conflicts about acting upon that desire, and a search for some mechanism to cope with those conflicts:

> [W]e must learn to see that sexuality is something which society produces in complex ways. It is a result of diverse social practices that give meaning to human activities, of social definitions and self-definitions, of struggles between those who have power to define and regulate, and those who resist. Sexuality is not given, it is a product of negotiation, struggle and human agency. (Weeks, 1986, p. 25)

Lacan and his feminist commentators read Freud as saying that sexuality is coterminous with the exile of the self out of perfect union with the mother into the state of lack that is society, and that our desires and our behaviors, our "identities," are mechanisms to cope with that lack.

It is still true in 1997 that homosexuality is highly stigmatized, and is still interpreted—both by those who disapprove and by those who live out homosexual desire—as mainly sexual activity, unregulated by family or other social obligations. By and large, gay men think gayness is sex and feel guilt and shame about it. Many lead quite healthy lives and come to reject negative feelings about themselves, but the mythos of gayness being *outlaw* is a persistent theme among the men in this study and in a large portion of the gay/bisexual male population, as reflected in their visual and narrative representations (Waugh, 1996). It is my thought that outlawry is a great big piece of gay male sexuality, and my reading of the narratives provided by the men in this study is that the lives they have constructed and had constructed for them involve internalization of stigma, a sexualized definition of self, and mechanisms to resist the internalized negative feelings. I take my cue from Bersani's brilliant but notorious paper entitled *Is the Rectum a Grave*:

> [I]nternalization of an oppressive mentality . . . is in part constitutive of male homosexual desire, which, like all sexual desire, combines and confuses impulses to appropriate and to identify with the object of desire. An authentic gay male political identity therefore implies a struggle not only against definitions of maleness and of homosexuality as they are reiterated and imposed . . . but also against those very same definitions so seductively and so faithfully reflected by those (in large part

> culturally invented and elaborated) male bodies that we carry within us as permanently renewable sources of excitement. (Bersani, 1989, p. 209).

Dr. Reback finds among gay crystal users a strong impulse toward sexual activity, but her respondents do not give uniform answers to questions about which comes first for them: a desire for sex or a desire to be "high." As I read their narratives, I hear these men conflating the sex and drug experiences. I do not think this "mistake" is unique to these men. Dr. Reback documents the fact that gay culture has evolved institutions that are highly conducive to sex/drug connections. Consistent with Michel Foucault's observation that our entire culture is saturated with sexual discourse, the gay communities of Los Angeles are replete with institutions that facilitate sex/drug fantasies and activities. Among these institutions are gay drug vendors who deliver crystal to individual homes, gay sex clubs where highly stimulated men can find sex at all hours, gay chat lines where men can find partners, and display and print advertisements using the code word for sex on crystal: "partying." Why? Are we looking at a large population of addictive personalities? I find "addiction" inadequate as an explanation. Eve Kosovsky Sedgwick (1993) offers the following critique of the commonly used but facile excuse of addiction. I cite this long quotation because I am convinced it is time for a closer look at the notion of addictive behavior, a notion that, in my opinion, serves to further pathologize sexual and drug behaviors and drive them deeper underground.

> [I]f addiction can include ingestion [pathologized and addressed through Overeaters Anonymous], or refusal [anorexia], or controlled intermittent ingestion of a given substance; and if the concept of "substance" has become too elastic to draw a boundary between the exoticism of the "foreign substance" and the domesticity of, say,: "food"; then the locus of addictiveness cannot be the substance itself and can scarcely even be the body itself, but must be some overarching abstraction. (p. 131)

Sedgwick thinks that the abstraction that underlies the idea of addiction is that tired old moralism, "free will."

> So long as an entity known as "free will" has been . . . charged with ethical value . . . for just so long has an equally [charged] "compulsion" had to be available as a counterstructure always internal to it, always requiring to be ejected from it. . . . Sites of submission to a compulsion figured as absolute include the insistence on a pathologizing model ("alcoholism is an illness") that another kind of group might experience as disempowering or demeaning; the subscription to an anti-existential rhetoric of unchangeable identities ("there are no ex-alcoholics, only recovering alcoholics") . . . and especially through a technique of temporal fragmentation, the highly existential "one day at a time" that dislinks every moment of choice (and of course they are infinite) from both the identity-history and the intention-futurity that might be thought to constrain it. (pp. 133-134)

Sedgwick thinks HIV and AIDS demonstrate some of the same problems as "addiction" and "free will."

> . . . the way it seems "naturally" to ratify and associate—as unnatural, as unsuited for survival, as the appropriate objects of neglect, specularized suffering and premature death—the notionally self-evident "risk group" categories of the gay man and the addict. (p. 136)

It is clear from this report that methamphetamine use can be profoundly destructive, yet to treat it as merely an individual addiction is an unfortunate parallel to right-wing arguments that gay men are seduced by the allure of perversion and that "normal" men must be protected from this seduction. I would argue, as I think some men in this study argue, that their sex and drug activity is a mechanism adopted—sometimes avidly and other times reluctantly—to cope with at least two cultures that oppress them. One is the hierarchical society of Los Angeles, USA, in 1997. The other is the highly illusory gay community in which these men sought support and solace but instead found more personally difficult hierarchies and epidemic disease. After all, even the rudimentary and fragmented gay community we have is only a few decades old, and many younger men have never experienced that community without the specter of illness and death.

> [The] new gay identity was constructed through multiple encounters, shifts of sexual identification, actings out, cultural reinforcements, and a plurality of opportunity (at least in large urban areas) for desublimating the inherited guilt of a grotesquely homophobic society . . . [the AIDS crisis regrettably encouraged] wholesale de-sexualization of gay culture and experience. (Watney, 1987, p. 18)

Working too hard at maintaining selfhood and imposing some measure of control over the chaos of mass extinction among the gay men who were their friends and lovers, men may be using drugs and sex (albeit unconsciously) as a means to lift those burdens.

> [A] gravely dysfunctional aspect of what is, after all, the healthy pleasure we take in the operation of a coordinated and strong physical organism is the temptation to deny the perhaps equally strong appeal of powerlessness, of the loss of control [of self] . . . For there is finally, beyond the fantasies of bodily power and subordination that I have just discussed, a transgressing of that very polarity which, as George Bataille has proposed, may be the profound sense of both certain mystical experiences and of human sexuality . . . I'm also thinking of Freud's somewhat reluctant speculation, especially in the *Three Essays on the Theory of Sexuality*, that sexual pleasure occurs whenever a certain threshold of intensity is reached, when the organization of the self is momentarily disturbed by sensations or affective processes somehow "beyond" those connected with psychic organization. (Bersani, p. 217)

One further contribution from theory needs to be brought to bear in reading Dr. Reback's study: neither sexual desire nor safer sexual behavior nor drug use is an individual choice that can be un-chosen at will. I wish to allude here to the thoughts of Judith Butler (1993) on what she terms "gender performativity," the process of taking on and acting out gender and sexual roles. Here I paraphrase and, unfortunately, simplify a complex set of arguments: (a) gender performativity is bound to and by the repeated force of regulatory sexual regimes; and (b) to say that a person is

"performing" a gender role is not to say that that person is exercising will or individual choice; that is, gender identifications precede and enable the formation of a subject, but are not, strictly speaking, performed by a subject. Almost no act considered sexual is performed by an individual alone; the theorists quoted here all argue that no sexual desire is conjured up by an individual alone either. Sexual desire and sexual acts involve at least two persons, or, as Freud would have it, at least four, counting each person's views of self and other. And in fact, desire and act occur within the context of a social definition of what is available to be desired and what acts are defined as pleasurable, permitted, or prohibited. Those social definitions both precede and are re-constituted and changed by the participation—willing or not—of gay, bisexual, and transgender persons like the ones in this study.

> All sexual spaces and forms have their rules of emergence and practice, whether or not those who enter into them consider themselves to occupy a marked socio-sexual role. . . . The borders of microcultures [like the microculture of gay male crystal users or the microculture of "A-list gays"] are precarious, changing, co-opted by commercialism, and facilitated by the interpenetration of commercial cultures that camouflage minority desires. (Patton, 1996, p. 13)

In the case of the men in this study, who use drugs in their sexual practice, their microculture is necessarily hidden, because to be visible would be to risk legal sanctions and social rejection. But even if this were not the case, people would make their decisions relying on the support of peers within their microculture as well as that of institutions that profit from sex and drugs and from "treatments."

Nowhere is the existence of microcultures so evident as in Los Angeles, a city divided by race and social class. The recent social upheaval and urban rebellion attest to this fact quite clearly, and its relevance to efforts at AIDS prevention is paramount.

> The historical reality is that gay identity, as we know it, formed most visibly around white middle-class forms of same sex relations. . . . People of color and men and women from other cultures and classes in which "bisexuality" is an unspoken norm are in jeopardy if mutual aid through "community" demands narrow identification with the white middle-class coming-out developmentalism that was critical for Western activism of the past two decades. (Patton, p. 143)

Another important finding of Dr. Reback’s study is that methamphetamine, previously most prevalent among white working-class and outlaw cultures, has spread across classes and ethnicities. Although still most popular within the white gay territories of West Hollywood, Silverlake, and Long Beach, sex on crystal is increasingly prevalent among Latinos and Asians and has made strong incursions into the population of African-American gay men. Latino and African-American AIDS prevention workers state that crystal is competing with crack cocaine as a sex drug among those in their communities who are most acculturated and, therefore, have the most frequent and sustained contact with those self-proclaimed gay territories. Lesbians are also making more frequent use of crystal in sexual activities. The voices heard in Dr. Reback's study report that methamphetamine

facilitates the crossing of class, ethnic, and gender boundaries, motored by uninhibited sexual desire. How ironic that those crossings and cruisings, which in other circumstances are highly encouraged as signs of "diversity" (another problematic and often racist/sexist appropriation of cultures into a "community"), are illicit and clandestine.

These theoretical speculations have been fueled by a reading of the study that follows. Methamphetamine use in Los Angeles is growing and threatens to undo much good work that has been done to help gay/bisexual men (still the population with the highest incidence of new HIV infections) enjoy sexual activity safely and responsibly. The agencies or programs that attempt to work with gay methamphetamine users struggle in the absence of scientific data about the effects of the drug or about the psychological and social constructs that drive its use. Their work is made more difficult by the paucity of information and the force of ideas that pathologize and impede the exposure and amelioration of the problems associated with sex/drug activity. It is the intention of this office, through the publication of Dr. Reback's study, to encourage a closer look at the phenomena associated with crystal and sex and thereby to inform the development of more effective strategies to reduce the harm gay crystal users may do to themselves and others.

Ferd Eggan
AIDS Coordinator
City of Los Angeles

March 1997

EXECUTIVE SUMMARY

I. INTRODUCTION

Methamphetamine ("crystal") use among gay and bisexual males has risen considerably over the past decade. During the 1980s, methamphetamine use among gay men was relatively low compared to the use of other drugs. Recently, however, other data indicate that the prevalence of methamphetamine use has increased dramatically in gay communities, specifically in the Western region of the United States. Prevalence rates of methamphetamine use appear to be lower in other regions of the United States. Another indicator of high methamphetamine prevalence rates on the West Coast has been seen among gay and bisexual male injection drug users. Additionally, the reported effects of methamphetamine on increased high-risk sexual activities raises concerns about HIV transmission, given that HIV incidence is already high among this population.

There is evidence that (1) methamphetamine is the most popular drug used in the gay communities on the West Coast of the United States and (2) this drug is more widely used among these communities than elsewhere. These findings suggest the need to understand and address the changing patterns of methamphetamine use among gay and bisexual males. This research ethnography was commissioned by the AIDS Coordinator for the City of Los Angeles to examine sexual and drug-related behaviors among gay and bisexual males who use methamphetamine. (In the context of this report, the phrases "gay community," "gay and bisexual communities," etc., are used to refer to gay and bisexual *males* only.)

Study Design

Methods

- Three research methods were employed:

    • Observational Field Work
    bar, sex clubs, bathhouses, bookstores, circuit parties, street corners, bus stops, fast food stands, cruising areas, abandoned buildings, coffee houses

    • Interviews (n = 25)
    unstructured, in-depth

    • Focus Groups (n = 38)
    five focus groups representative of specific subgroups: former crystal users (n = 9); youth (n = 10); men of color (n = 6); HIV-positive men who were predominately street users (n = 8); and HIV-positive men who were predominately middle- and upper-middle class professional (n = 5)

Eligibility

- The target population for this study encompassed crystal users who self-identify as gay or bisexual as well as transgender (male-to-female) or heterosexually-identified men who have sex with men (MSM).

- All participants had used crystal at least once a month during the previous six months and at least once in the previous 30 days.

- Participants were screened for any involvement with treatment or recovery programs to avoid reconstruction of their drug-using experience in light of a treatment history.

Sample

- Fifty-four current crystal users and nine former users participated in this study. Participants either were members of a focus group or received individual interviews.

- Participants were found through referrals from street outreach workers, service providers, drug dealers, and other participants.

Sample Characteristics

Demographic and social characteristics

- Of the 63 individuals who participated in this study, 49% were Caucasian/white, 22% Hispanic/Latino, 19% African American/black, 7% Native American, and 3% Asian/ Pacific Islander.

- Participant' ages ranged from 17 to 51 years.

- Their education levels indicate a bimodal distribution; 49% of the sample had a high school education or less, and 46% had some college education or a graduate degree.

- Participants clustered around two distinct socioeconomic groups: (1) street users or others who live marginally, and (2) middle- and upper-middle class educated professionals.

HIV status

- Nearly all participants (98%) reported that they had been tested for HIV and knew their sero-status; knowledge of HIV status was normative.

- Slightly more than two-fifths (42%) were HIV-positive.

- Slightly over half (54%) were injectors.

- Injectors were more likely than non-injectors to be HIV-positive.

- Caucasian/white participants were twice as likely to inject; gay and bisexual men of color were more likely to use non-injection methods.

- Caucasian/white participants were significantly more likely than gay and bisexual men of color to be HIV-positive.

II. INTERNAL DYNAMICS ASSOCIATED WITH CRYSTAL USE

The Meaning of Identities: Gay, Crystal, and HIV

- Participants defined themselves in terms of three primary identities: (1) sexuality, (2) crystal user identity, and (3) HIV status.

- All three of these identities contain a social stigma and can be viewed as marginal, either by the participant or by others.

- Participants have constructed crystal as a functional drug that resists the social stigma associated with their sexuality, drug use, and/or HIV status.

Gay identity

- Participants expressed the importance of sex in their lives and the direct relationship between their gay identity and gay sex.

- For many, crystal use is a positive coping mechanism for dealing with negative internal messages, thus permitting gay sexuality without internal disapproval.

- For others, transcending negative emotions is unnecessary; their crystal use is consistent with positive gay sex and sexuality.

Crystal user identity

- Many participants distanced themselves from the self-concept of drug user by defining their use as "functional."

- Almost two-thirds (64%) of the interview participants viewed their crystal use as controlled, yet they often commented that a friend's or colleague's crystal use was unmanageable.

HIV identity

- Many participants also assigned a negative social meaning to their HIV status.

- Crystal is used to cope with the fear of transmitting HIV, to free participants from the responsibility of safer sex and the guilt associated with HIV.

- For some, crystal is a vehicle to overcome negative social meanings attached to their three core identities, for others crystal is used to reinforce and intensify their concepts of themselves as sexual gay males.

- HIV, AIDS, and HIV prevention messages promoting consistent condom use have stripped many gay and bisexual men of their sexuality.

Perceptions of Self as a Crystal User

- Participants adopt various self-perceptions as strategies for rejecting the stereotypical negative connotations associated with drug use.

Illusions of functionality

- Most users presented themselves as "functional" and stated that their drug use did not cause problems.

- Participants often mentioned that they were not like most crystal users, viewing themselves as exceptions to the norm.

User functionality

- Approximately 20% of the participants described their crystal use in a very predictable manner.

- These users predetermined every aspect of their crystal use including the day and time, the amount, the procedures, rituals, and sexual activities.

- Other users described how crystal facilitates their sex work; those who were homeless often stated that crystal freed them from having to find a place to sleep at night.

Acceptance of Societal Drug Norms

- Many participants evaluated their crystal use with harsh self-judgments that appeared to reflect societal drug norms.

- Self-descriptions of drug use included terminology consistent with addiction and treatment models of recovery.

- The participants who internalized societal drug norms accepted the self-image of "addict."

Self-medicating strategies

- Several of the HIV-infected participants discussed the advantages of using crystal to manage certain AIDS-related conditions or effects, both physical and psychological.

- A few participants cited biochemical reasons for their crystal use.

- The participants who stated they use crystal to self-medicate a medical condition prefer injecting.

Coping strategies

- Participants used crystal to reduce emotional and/or physical pain associated with their lives such as boredom, senses of isolation and hopelessness, grief, and mourning.

- Crystal creates a sustained period during which the emotional and/or physical pain is lessened.

The Meaning of the Crystal Sex Experience

- All participants used crystal during their sexual activities.

- All participants discussed the enhancement of their sexual activities while on crystal.

- Many participants described crystal as a vehicle for greater sexual risks, and many stated that they were unable to achieve the sexual extremes they desired without crystal.

- Sex on crystal was described as more intense, heightened, prolonged and uninhibited.

Heightened sensory experiences

- Crystal amplifies the sensory perceptions.

- When crystal is combined with sex, the user is often amazed by the intensity of the sexual experience.

Disinhibiting effects

- Many participants discussed freedom from inhibitions as a positive aspect of using crystal during sexual activities.

- Participants describe sex on crystal as "experimental," "freaky," and "kinky."

- Some participants stated crystal enables them to engage in certain sexual activities, others stated crystal never changed the content of the sexual experience but only served to heighten and intensify the acts.

Duration of sexual arousal (without orgasm)

- Crystal use during sex is associated with prolonged sexual performance; some described ongoing sex for up to several days.

- The ability to have continuous sexual encounters and partners was seen as a function of the length of time that one can remain sexually aroused.

Intensified orgasms

- Orgasms were described as very intense as a result of one's heightened state of sexual arousal and ability to prolong an orgasm.

Inability to achieve erection or orgasm: "Crystal dick"

- "Crystal dick," i.e., the inability to achieve an erection resulting from ongoing crystal use, was only mentioned occasionally.

- Participants did not view "crystal dick" as a deterrent to their sexual being or their crystal use since it was described as temporary and insignificant.

- The crystal sexual experience is not focused on erection or orgasm but rather sexual extremes.

III. EXTERNAL DYNAMICS ASSOCIATED WITH CRYSTAL USE

Initiation to Crystal

- Nearly half (44%) of the interview participants were introduced to crystal by a male sexual partner or lover.

- 40% of the participants stated that they were first introduced to crystal by a gay male friend in a gay-related social (but not explicitly sexual) situation.

- Only 16% mentioned first using crystal in non-sexual circumstances.

Availability

- Participants stated that they had no difficulty in obtaining crystal for personal use and that it is readily available and accessible through gay institutions for individuals of all socioeconomic levels.

- Participants reported finding crystal at bars, sex clubs, dance clubs, sex dates, sex phone lines, at parties, and on the streets.

- More affluent users were able to have crystal delivered to them by their dealers.

- Nearly all participants relied on gay drug dealers and met sex partners through gay-related institutions.

- Compared to other drugs, crystal is relatively inexpensive and keeps the user high for periods up to several hours.

- Many participants spoke of not being able to find crystal when they travel to the Midwest or the East Coast.

Activities Associated With Crystal Use

- Although sex is the primary activity associated with the use of crystal, participants also spoke of using the drug to enhance other non-sexual activities such as work-related and/or creative tasks or to prolong high-energy activities such as dancing.

- Participants stated that crystal use generally improves their ability to focus on a particular task.

- Crystal use is reported to foster creative insights, increase work time, heighten sensory perception, improve intellectual capabilities, and produce more energy and stamina.

Social Networks Around Crystal Use

- Social networks and subcommunities of crystal users are formed across class and ethnic boundaries.

- The demographic patterns indicate that user groups are formed around socioeconomic rather than racial similarities; however, these socioeconomically based subcommunities are fluid and easily expand to include individuals outside a particular subcommunity when crystal and/or sex is included.

The "equalizer"

- Crystal was described as the "equalizer" in terms of the role it can play in allowing individuals to move across various boundaries such as age, class, race and socioeconomic subgroups.

- Although just over half of the study participants were gay and bisexual men of color, there is a perception, particularly among the men of color, that the gay and bisexual crystal user is primarily Caucasian/white and professional.

- Other participants varied in their view regarding the relationship between drug choice and ethnicity.

- Crystal use in gay communities is intricately linked to sexuality; therefore, the drug is not confined to any specific ethnic or class parameters. Consequently, sexuality is the vehicle by which crystal transcends these boundaries.

The "slammers" network

- Social networks are also formed around method of use, primarily among injection drug users.

- Both injectors and non-injectors described injectors as a distinct group of users.

- Injectors were referred to in more derogatory terms and were afforded less status by the non-injectors.

The "club kids"

- Many younger crystal users form social networks around dancing rather than around sexual encounters.

- The youth who live with a parent or guardian and are employed (not as sex workers) primarily use crystal for dancing.

- The youth who do not live with a parent or guardian, and tend to support themselves through sex work, primarily use crystal for sex.

The Social Construction of a Gay Drug

- Many of the effects associated with crystal use complement those aspects of gay culture that are valued by many gay and bisexual men.

- The creation of social settings where crystal use is common—or expected—serves to normalize crystal in gay culture.

- The use of crystal in gay communities is facilitated through various gay institutions such as phone sex lines, personal ads, computer networks, circuit parties, bars and clubs.

The impact of HIV

- The impact of HIV continues to be a salient factor directly influencing the sexual lives of gay men.

- At this historical moment gay identity is linked to HIV and one's sexual expression becomes infused with death.

- Participants report using crystal to dissociate from fears associated with sex; to cope with grief and loss; and to alleviate physical and psychological HIV-related pain.

Gay-owned/operated institutions

- Gay-owned and/or operated institutions serve to maintain and support the social networking of gay communities.

- Gay-owned and/or operated institutions have opened or modified their business profiles to accommodate the gay crystal user and thus have institutionalized crystal use within gay culture.

Gay identity and crystal use

- The strong association between gay identity and sex serves as an internalized reinforcement for constructing crystal as a gay drug.

- Crystal use has been integrated and adopted as part of a gay subculture.

- Sex is emphasized within gay crystal-using communities whereas within other crystal-using communities, work, weight loss, and mood control are emphasized.

IV. HIV RISKS ASSOCIATED WITH CRYSTAL USE

Sexual Risks Associated With Crystal

Sexual responsibility on partner

- Most HIV-positive participants said that they tend not to disclose their HIV status to casual sexual partners; they operate from the assumption that it is the responsibility of their partner(s) to use condoms and/or define what is "safe."

- Many participants described social norms that allow high-risk activities to occur:

    - HIV status is not talked about. Participants said they assume everyone is HIV-positive.

    - Participants stated that it is up to each individual to determine what is acceptable sexual behavior. Their sexual partner(s) must tell them what is and is not permissible.

    - The responsibility for using a condom is placed on the other.

- The HIV-negative participants who have engaged in unsafe receptive anal sex, their high-risk sexual behaviors cluster around two primary reasons: (1) fatalism regarding the inevitability of becoming HIV-infected and (2) excitement and a calculated desire to take a risk.

- HIV-positive participants mentioned the desire to meet other HIV-positive men for sex, HIV-negative participants did not mention a desire to meet sero-concurrent sex partners.

Crystal-facilitated sexual decision-making

- Sexual decision-making was mediated by the method of crystal administration; participants who inserted crystal anally were less likely to use a condom during receptive anal sex.

- HIV-positive participants were less likely to use condoms.

- More than three-quarters (79%) of the participants who reported receptive anal sex stated only occasional condom use.

Injection Risks Associated With Crystal

- Unlike safer sex messages, which are widely and accurately known, safer injection practices are misconceived and unclear; however, all injectors knew that HIV can be transmitted through unsafe needle use.

- Crystal injectors can be placed in three distinct categories:

    (1) those who are thoroughly informed about safe injections and are always safe;

    (2) those who have accurate knowledge regarding injection practices but do not always follow those protocols; and

    (3) those who are poorly informed and do not practice safer injections.

- All three groups have HIV-positive and HIV-negative users; complacency was more commonly expressed by HIV-positive injectors, particularly younger (under 24) injectors.

Commitment to lover

- Of those injectors who are highly knowledgeable, safer needle practices were relaxed within the context of an intimate or sexual relationship.

- Among these injectors, safer injection techniques were always maintained outside of the intimate or sexual relationship.

- Unsafe injection practices are interpreted as a sign of commitment.

- In these situations the user defined the sex partner as "worth the risk."

Overriding desire to get high

- Much of the HIV risk reported involved an overriding desire to get high.

- Injectors older than 25 reported safe and extremely meticulous injection protocols; these injectors stated that they prefer to be in control of their injection process.

- Safe injectors pre-planned their use.

- Street users discussed the additional difficulties associated with safer injections such as risking arrest for carrying syringes to the needle exchange.

V: RECOMMENDATIONS

- HIV interventions must address the two distinct demographic and social groups of gay and bisexual crystal users separately as behavioral change interventions relevant to one group may not work for the other.

- HIV interventions should address both high-risk sexual and drug behaviors.

- For injectors, the meaning of romantic love, commitment, and the primacy of sex must be addressed in designing drug intervention strategies as many gay and bisexual injectors relax injection protocols when injecting with a sex partner.

- Interventions must address gay identity, the meaning of adopting a gay identity, and the meaning of gay sex. These interventions must be modified, however, for those who place "gay" as a secondary identity.

- HIV interventions should be geared toward increasing consistent condom use among those who engage in anal respective sex in conjunction with their crystal use.

- HIV interventions for gay and bisexual crystal users cannot be understood outside the historical context of AIDS. Interventions must address the impact of AIDS on both the individual user and the gay communities and must acknowledge that, for many, crystal use is historically and socially relevant.

- HIV intervention strategies built around crystal-using norms and a community of users, and designed to promote dialogue among and about gay crystal use before reducing drug use, could encourage social support and behavior change.

- HIV interventions can work simultaneously with the individual and with the gay communities; both behavioral and community interventions are needed.

CHAPTER I

INTRODUCTION

Methamphetamine ("crystal") use among gay and bisexual males has risen considerably over the past decade. During the 1980s, methamphetamine use among gay men was relatively low compared to the use of other drugs. Morales and Graves (1983) note that around a fifth to a quarter of their San Francisco gay male sample reported using methamphetamine, quaaludes, and MDA during the year prior to the survey. Three quarters (76%) of the sample used marijuana, over half (58%) used amyl nitrite, and 53% used cocaine. In Stall and Wiley's (1988) San Francisco Men's Health Study, 28% of the gay men reported using amphetamines (the category of drugs which includes methamphetamine) over the six-month period prior to the survey. Marijuana was used by 78% of the gay men, 58% used amyl nitrite, 25% used barbiturates, followed by psychedelics (18%) and MDA (9%). Recently, however, other data indicate that the prevalence of methamphetamine use has increased dramatically in the gay community, specifically in the Western region of the United States. In California, methamphetamine-related emergency room admissions increased 366% between 1982 and 1993 (Cunningham and Thielemier, 1995). Data gathered for four of the years between 1985 and 1995 indicated that significant methamphetamine use was reported by five of 43 residents (11.6%) in 1985, 10 of 54 residents (18.5%) in 1988, 45 of 117 (38.5%) in 1992, and 72 of 109 residents (66.1%) in 1995 (Reback & Shoptaw, 1997). The Los Angeles County Sheriff's Department noted a substantial increase in methamphetamine lab seizures from 1993 to 1996. There were 102 methamphetamine lab seizures in 1993, 136 in 1994, 169 in 1995, and 267 in the first four months of 1996 (Reback & Shoptaw, 1997). Prevalence rates of methamphetamine use appear to be lower in other regions of the United States. Among 298 gay male clients at a Boston health center who were part of a two-year longitudinal study, lifetime prevalence rates were only 7% for amphetamines (McCusker et al., 1990).

Another indicator of high methamphetamine prevalence rates on the West Coast has been seen among gay and bisexual male injection drug users. A study conducted at drug treatment centers in Seattle, Washington, between 1988 and 1991, found that among injection drug users, the subgroups of most frequent amphetamine injectors included gay and bisexual men who also had the highest prevalence of HIV infection relative to the other populations studied (Harris, Thiede, McGough, & Gordon, 1993).

Additionally, the reported effects of methamphetamine on increased high-risk sexual activities raises concerns about HIV transmission, given that HIV incidence is already high among this population. Other studies have indicated that "amphetamines are widely regarded as having stimulating and disinhibiting effects on sexual activity, leading to hypersexuality, impaired judgment, atypical sexual behavior, prolonged intercourse, enhanced sexual pleasure, and casual sex with nonregular partners" (Gawin & Ellinwood, 1988; Kall, 1992; Klee, 1992, as cited in Harris et al., 1993).

There is evidence that (1) methamphetamines are the most popular drug used in the gay communities on the West Coast of the United States and (2) this drug is more widely used among these

communities than elsewhere. These findings suggest the need to understand and address the changing patterns of methamphetamine use among gay and bisexual males. (In the context of this report, the phrases "gay community," "gay and bisexual communities," etc., are used to refer to gay and bisexual *males* only.)

LITERATURE REVIEW

Historically, very little research has been conducted on drug use among sexual minorities. During the 1980s, the situation improved somewhat, in large part because of advocacy within the gay and lesbian communities concerns over the connection between drug use and HIV infection (Evaluation Management and Training Associates, Inc. [EMT], 1991). While social researchers increased efforts to address drug use and HIV-related issues among sexual minorities, much of the early research was compromised due to methodological problems in sample selection and size (Nardi, 1982; Stall & Wiley, 1988). Furthermore, Watters and Biernacki (1989) point out how the "social science and public health literatures are replete with studies of captive, institutional and clinical populations" (p. 417), particularly when it involves illegal drug use (Watters, Reinarman, & Fagan, 1985). Studying populations outside existing institutions is often difficult and challenging because their activities are "clandestine and therefore concealed from the view of mainstream society and agencies of social control" (Watters & Biernacki, 1989, p. 417).

Addressing populations that are not part of the social services milieu is important in obtaining a more complete and accurate understanding of drug users who are at high risk of HIV infection. Several studies have noted examples where differences between agency and non-agency injection drug users were identified (cited in Klee, 1992; Hartnoll & Power, 1989; Power, 1988; Stimson, Alldritt, Dolan & Donoghoe, 1988). Sharing injection equipment was found to be less common among those in treatment. Klee (1992) goes on to mention how this has "serious implications for predictions concerning HIV transmission and consequent policy decisions" because, since most injectors are not in treatment settings, prevalence rates would have been underestimated (p. 440). Clearly, prevention and interventions efforts need to be informed by research on the specific populations who are being targeted for these services, since efforts designed for the general population have not been found effective when applied to special populations at high risk of drug abuse and HIV infection (EMT, 1991).

This ethnographic research study will contribute data to help understand the epidemiological data related to methamphetamine use among gay and bisexual males in Los Angeles. The findings from this study are based on non-treatment seeking participants who are frequently under-represented in the research literature. Finally, these findings can be used to inform intervention and prevention strategies geared towards high-risk gay and bisexual drug users.

METHODS

Qualitative research methods were considered an ideal methodology for exploring and understanding the experiences and meanings of the gay and bisexual male crystal-using population in Los Angeles.

Qualitative methods are useful for understanding what lies behind phenomena about which little is known, as well as providing intricate details of phenomena that are difficult to convey with quantitative methods (Strauss & Corbin, 1990). Also, qualitative methods are most appropriate for research involving hidden populations (e.g., the homeless) and low-incidence behaviors (e.g., injection drug use) to avoid class and lifestyle biases that can be introduced when probability sampling methods based on published lists or official records are employed (Watters & Biernacki, 1989).

This type of naturalistic inquiry based on ethnographic methods encourages a more democratic pursuit of knowledge, "one that simultaneously deprivileges our academic inquiry while serving to help recover ideas and practices from other points of view" (Rose, 1990, p. 11). Given this methodology, the point of view of individuals who are often marginalized or oppressed becomes privileged. Ethnography has been characterized as the work of describing another culture in an attempt to learn from people rather than studying them (Spradley, 1980). This definition captures the distinction between ethnography and other more classical research methodologies.

In this study, multiple qualitative methods were employed to ensure the validity and reliability of the data. The use of multiple methods (e.g., field observations, interviews, focus groups) addresses the implicit weaknesses of a singular method. When a combination of methods is used, the strengths of one method complement the weaknesses in another.

The purpose of participant observation is to observe the activities, people, and physical aspects of a particular culture and to gain insight about the cultural rules people follow (Spradley, 1980). This methodology addresses the interactions among the elemental components which comprise any culture. Participant observation is useful in the discovery of cultural themes and serves to provide a context within which additional data can be interpreted (e.g., in-depth interviews).

In-depth interviews provide the researcher with personal data about an individual's attitudes, experiences, and behaviors within their natural setting. Babbie (1989) has defined an unstructured interview as an

> . . . interaction between an interviewer and a respondent in which the interviewer has a general plan of inquiry but not a specific set of questions that must be asked in particular words and in a particular order. An unstructured interview is essentially a conversation in which the interviewer establishes a general direction for the conversation and pursues specific topics raised by the respondent (p. 270).

This method of inquiry offers greater flexibility compared to structured interviews and allows the researcher to follow the lead of the respondent and "to make sense out of an ongoing process that cannot be predicted in advance" (Babbie, 1989, p. 261).

The focus group as a qualitative research method makes use of the group interaction process to obtain data and insights that other research methods are unable to capture (Morgan, 1991). The interaction of group members is useful for evoking discussion around a particular topic or focus.

The interplay among all three methodologies enhances the overall richness and comprehensiveness of the data. The interplay between participant observation and in-depth interviewing is a complementary interaction. The researcher can use observational data to help inform interview questions and probes, as well as contextualize what the researcher is learning from the respondents through the interview process. Also, the interview respondents can provide meaning and clarity to the observational data that the researcher has already collected.

Focus groups provide data that are not obtained easily through individual interviews or participant observation. For example, Morgan and Spanish (1984) have discussed the strengths of focus groups coming from a compromise among the strengths found in other qualitative methods.

> Like participant observation, they allow access to a process that qualitative researchers are often centrally interested in: interaction. Like in-depth interviewing, they allow access to the content that we are often interested in: the attitudes and experiences of our informants. As a compromise, focus groups are neither as strong as participant observation on the naturalistic observation of interaction, nor as strong as interviewing on the direct probing of informant knowledge, but they do a better job of combining these two goals than either of the other two techniques. We believe this is a useful combination, and one which, for some types of research questions, may represent the best of both worlds (cited in Krueger, 1988, p. 260).

Focus groups add to, rather than take away from, other qualitative methods (Morgan, 1991). Furthermore, the information gleaned from the in-depth individual interviews will inform the specific questions developed for the focus groups.

The strength of field research is the "comprehensiveness of perspective it gives the researcher" (Babbie, 1989, p. 261). One way to address the reliability and validity issues among qualitative methodologies is to employ multiple methods to check if data collected by the same method and by a distinctly different method are consistent. Qualitative criteria must be used to evaluate the reliability and validity of qualitative measurement (Zeller, 1993). The researcher can be confident that the results obtained are believable and credible when a respondent echoes what other respondents have previously reported when the same method is employed (reliability) and when different methods are employed (validity).

Field observations, unstructured interviews, and focus groups afford the researcher the opportunity to concentrate on both the group level and the one-to-one level of social interactions. Used simultaneously, these research techniques can serve as a reliability check and balance to avoid problems and limitations inherent in each method individually.

STUDY DESIGN

Eligibility

The target population for this study were crystal users who self-identified as gay or bisexual men and transgender (male-to-female) or heterosexually-identified men who have sex with men (MSM). All participants used crystal at least once a month during the previous six months and at least once in the previous 30 days. Participants were screened for any involvement with treatment or recovery programs to avoid reconstructions of their drug-using experiences in light of a treatment history. However, a few participants with experience in treatment programs were intentionally included in a focus group so that comparisons could be made with the target population.

Sample

Naturalistic, purposive sampling techniques were employed in this study (Lincoln & Guba, 1985). Participants were found through referrals from individuals who have an established rapport with potential participants. Referrals were provided by street outreach workers, service providers that work with methamphetamine users, and participants themselves. Fifty-four current crystal users and nine former users participated in this study, either as a member of a focus group or in an individual interview. To avoid any possible duplication of data, no one took part in both methodologies. Sampling was terminated when additional participants were providing redundant information.

Procedure

Three research methods were employed for this qualitative research study: (1) observational field work; (2) unstructured in-depth interviews; and (3) focus groups. Observational field work was conducted with street outreach workers and other crystal users to gain a better understanding of the places and activities associated with the culture of crystal methamphetamine users. The ethnographer became a passive participant by occupying the role of "bystander" or "spectator" (Spradley, 1980). Spradley (1980) has defined passive participation as being present at the various scenes but not participating or interacting with other people to any great extent. Specifically, the ethnographer did not participate in any drug use or drug-related activities or in any sexual activity. In addition to legal and ethical reasons, this level of participation was chosen to maintain a degree of inexperience about the phenomena associated with crystal use as well as to avoid "going native." In this way, the ethnographer can use his or her ignorance about a culture, in combination with an interest in learning about that culture, as an effective interview technique (Spradley, 1979).

Sites that were observed included bars, dance clubs, sex clubs, bathhouses, street corners, bus stops, fast food stands, cruising areas, abandoned buildings, inexpensive hotels, coffee houses, parking lots. Field notes were taken and analyzed for recurrent themes and patterns.

Conducting observational field work with outreach workers and other crystal users assisted researchers in establishing trust and rapport among potential participants, thereby facilitating access to the target population. The importance of establishing trust and rapport with participants is well

documented in the research literature (Lincoln & Guba, 1985; Massarik, 1981) and serves to minimize the effects of social desirability (Zeller, 1993); facilitate access to hard-to-reach populations (Reback, 1995); improve the quality and level of detail of information being provided by participants (Spradley, 1979); and address validity and reliability issues associated with self-reported information that is sensitive in nature (Weatherby, Needle, Cesari, & Booth, 1994).

Individual in-depth interviews were conducted with 25 participants. Participants were located through personal contacts made by street outreach workers, psychologists, counselors, drug dealers, crystal users who were not participants in the study, and research participants. Efforts were made to include a group of participants who were diverse in terms of age, ethnicity, socioeconomic status, and geographic location within Los Angeles County. Potential participants were screened for eligibility before being invited to participate. Eligible participants were given Consent to Participate forms, which they read and thoroughly discussed with researchers before consenting to participate in the study. Each participant agreed to use a pseudonym for purposes of anonymity and signed the consent form using that pseudonym. Interviews were conducted in places chosen by the participant, provided that the chosen site afforded enough privacy to discuss personal experiences openly. Upon completion of the interview participants were paid $30 for their time and effort and were given a list of community services relevant to their possible needs and concerns. Participants were offered free bleach kits, condoms, lubricant, latex dental dams, and gloves; they were informed about safer sex and, when appropriate, safer injection use guidelines. Interviews ranged in length from one to four hours. The interviews were audio-recorded and later transcribed by transcribers who were bound to confidentiality.

In addition to the individual interviews, five focus groups were conducted with a total of 38 participants. Procedures used with the individual interviewees (i.e., informed consent, remuneration, and debriefing) were also used with the focus group participants. The focus groups were representative of five specific subgroups: (1) former crystal users; (2) youth; (3) men of color; (4) HIV-positive men who were predominantly street users; and (5) HIV-positive men who were predominantly middle-class and upper-middle-class professionals. The focus groups were also audio-recorded, transcribed and analyzed.

SAMPLE CHARACTERISTICS

Demographic and Social Characteristics

Of the 63 individuals who participated in this study, 49% are Caucasian/white, 22% Hispanic/Latino, 19% African American/black, 7% Native American, and 3% Asian/Pacific Islander. Ages ranged from 17 to 51 years with the largest age group (30%) between 20 and 24 years. Participants who self-identified as gay comprise 67% of the sample, followed by bisexuals (25%) and heterosexuals (5%), of which two are transgender (male-to-female). One participant stated that he is questioning his sexual identity, and another participant refused to identify with any defined category. The educational level of the participants indicates that 33% of the sample have less than a high-school education, 16% have graduated from high school or received their GED, 34%

have attended either a trade school or some college, and 17% have college or graduate degrees. Slightly over half (54%) of the participants live in a house or an apartment, 13% live in someone else's house or apartment, 9% are living in hotels, and 24% are living on the streets (i.e., in abandoned buildings, vacant lots, car, or park). Half (52%) live with a roommate, almost one-third (29%) live alone, 16% live with a sexual partner or spouse of the same sex, 3% stated they live with any other adult. Participants in this study represented an heterogenous sample of users with demographic and social characteristics reflecting two distinct groups of crystal users: (1) street users or others who lived marginally, and (2) middle- and upper-middle-class educated professionals. (See Tables 1 and 2.)

Table 1. Demographic Characteristics of Sample

Variable	Category	N	%
Gender identity	Male	61	97
	Transgender (male-to-female)	2	3
Sexual identity	Gay	42	67
	Bisexual	16	25
	Heterosexual	3	5
	Questioning	1	2
	Refused	1	2
Ethnicity	Caucasian/white	31	49
	Hispanic/Latino	14	22
	African American/black	12	19
	Native American	4	7
	Asian/Pacific Islander	2	3
Age	< 20	4	6
	20 - 24	19	30
	25 - 29	9	14
	30 - 34	12	19
	35 - 39	6	10
	40 - 49	11	18
	> 49	2	3

Table 2. Social Characteristics of Sample

Variable	Category	N	%
Educational attainment	< 8th grade	5	8
	< high school	16	25
	GED	2	3
	High school graduate	8	13
	Trade school	3	5
	Some college	18	29
	College graduate	6	9
	Graduate school	5	8
Current living situation	Own house or apartment	34	54
	Someone else's house or apt	8	13
	Hotel	6	9
	Homeless (e.g., street, park, rooftop)	15	24
Lives with	Alone	18	29
	A spouse (same sex)	4	6
	Sexual partner (same sex)	6	10
	Roommate	33	52
	Anyone around	2	3
Profession/work	Student	2	3
	Unemployed (unskilled)	8	12
	Unemployed (professional)	4	7
	Disability	4	7
	Sex worker/sex industry	16	25
	Drug dealer	3	5
	Manual/technical	8	12
	Clerical/administrative	4	7
	Skilled crafts/artist	7	11
	Professional/management	7	11

Categories of employment were further collapsed into a dichotomous variable, "Employment," to indicate employment or "unemployment/illicit employment" (former users were omitted from this category). As can be seen in Table 3, drug injectors in this sample were significantly less likely to be in the legitimate workforce than their peers who used other methods for drug administration.

Table 3. Method of Crystal Use by Employment

	Injectors (n = 29)	Non-injectors (n = 25)
Employment	17%	44%
Unemployed/illicit employment	83%	56%
Totals	100%	100%

*p<.05

Statistic	Value	DF	Significance
Chi-Square	4.61	1	.032*

Similar percentages of Caucasian/ whites (29%) and men of color (30%) reported licit employment and those who held these jobs were equally likely to be HIV-positive (33%) as HIV-negative (28%). One striking finding from this variable is the overall low percentages of male crystal users in this study who reported legitimate employment (56%).

HIV Status

Nearly all participants (98%) reported that they had been tested for HIV and knew their sero-status. Within this sample, gay and bisexual crystal users, regardless of their socioeconomic status, living conditions, or method of drug use (i.e., injection or non-injection), were aware of the risks associated with their drug use and/or sexual activities. Among this sample of gay and bisexual crystal users, knowledge of HIV status is a normative. Slightly more than two-fifths (42%) of the participants were HIV-positive.

Similar to the greater population, HIV transmission likely occurred through two avenues within this sample: sexual activities without a barrier and/or unsafe injection drug use. Consequently, injectors who engage in high-risk sexual activities are at greater risk of becoming HIV-infected that non-injectors. Comparing participants who injected to those who used other methods of ingesting crystal, the non-injectors had a lower incidence of HIV infection.

Among the HIV-positive crystal users, over two-thirds were injectors. By contrast, slightly less than one-half of the HIV-negative crystal users were injectors. Within this sample of users, those who were HIV-positive were twice as likely to be injectors. Although this finding approached statistical significance (χ^2=3.75, p=.053) it demonstrated the additive risks for infection when individuals engage in both

Table 4. HIV Status by Method of Crystal Use

	HIV-positive (n = 26)	HIV-negative (n = 36)
Injectors	69%	44%
Non-injectors	31%	56%
Totals	100%	100%

Statistic	Value	DF	Significance
Chi-Square	3.75	1	.053

sexual and injection risk behaviors. (See Table 4.)

Table 5. Ethnicity by Method of Crystal Use

	Caucasian/white (n = 31)	Men of Color (n = 32)
Injectors	68%	41%
Non-injectors	32%	59%
Totals	100%	100%

*p<.05

Statistic	Value	DF	Significance
Chi-Square	4.66	1	.031*

Table 6. Ethnicity by HIV Status

	Caucasian/white (n = 31)	Men of Color (n = 32)
HIV-positive	60%	25%
HIV-negative	40%	75%
Totals	100%	100%

*p<.05

Statistic	Value	DF	Significance
Chi-Square	7.79	1	.005*

Table 5 illustrates that among this group of gay and bisexual crystal users, Caucasian/white users were twice as likely to inject and men of color were more likely to use non-injection methods, a difference that was statistically significant (χ^2=4.66, p=<.05). Consistent with our findings regarding injection, Table 6 illustrates that Caucasian/white men were also significantly more likely to be HIV-positive, while men of color in this sample were likely to be HIV-negative (χ^2=7.79, p=<.01). This association between ethnicity, drug administration route, and HIV status indicates that in this sample, men who were white were also likely to inject and to have HIV. Conversely, men of color used other drug administration routes and were correspondingly less likely to be HIV-positive.

These data indicate that injection is a powerful variable for predicting HIV status, ethnicity, and employment status in this sample of gay and bisexual male crystal users. The other variables are also correlated (e.g., ethnicity with HIV status), but are weaker and fail to extend their association to the work variable. Although this report did not study the drug use careers of the participants, data do suggest that there are clear differences in the drug use patterns of Caucasian/white men and gay men of color at the time of interview. Further studies could address the following questions: Are there cultural differences in the drug use careers of Caucasian/white and gay and bisexual men of color who are crystal users? Are there protective factors associated with gay men of color that might slow the progression to injection drug use? Given the findings of this study, the above questions deserve further attention in another research project designed to focus on ethnic and cultural differences among gay and bisexual crystal users.

Despite their significantly greater injection use, the Caucasian/white men in this sample were not more socially marginal than the men of color. As these data illustrates, some Caucasian/white and men of color users are both professional and functional and others are socially and economically

marginal. And, although 69% of the injectors are HIV-positive, the qualitative data demonstrates that it is their sexual behavior, not injection behavior, that presents the greatest risk of HIV transmission among this sample of crystal users.

CHAPTER II

INTERNAL DYNAMICS ASSOCIATED WITH CRYSTAL USE

THE MEANING OF IDENTITIES: GAY, CRYSTAL, AND HIV

Participants defined themselves in terms of three primary identities: (1) their sexuality, (2) their crystal user identity, and (3) their HIV status. All three of these identities contain a social stigma and can be viewed as marginal, either by the participants or by others. The adoption of any or all of these identities can reinforce a marginal self-identity. Participants have constructed crystal as a functional drug that resists the social stigma associated with their sexuality, their drug use, and/or their HIV status.

Gay Identity

Participants expressed the importance of sex in their lives and the direct relationship between their gay identity and "gay" sex. However, gay sex is also associated with other internal dynamics, such as internalized homophobia, guilt, and shame. To assert one's gay identity through sexual expression means that one must also confront guilt or shame. For many, crystal use is a positive coping mechanism for dealing with negative internal messages, thus permitting gay sexuality without internal disapproval.

> Focus group participant: [Crystal] completely takes away my inhibitions. It [crystal] removes all old guilt and shame and makes me feel sexy. . . . We were all brought up in an environment where gay sex was bad, wrong, and could do all kinds of horrible things to you. . . . It's [crystal] a way for gay men to have sex with some of that lifted.

> Focus group participant: [Crystal] makes us more able to justify gay sex.

For the above focus group participants, feeling sexy is contingent on the removal, through crystal, of the shame and guilt associated with being gay. Eric also stated that crystal removes guilt and fear, allowing "a sense of grounded sexuality."

> My social life revolves very much around sex. Probably, first of all, because I'm a very sexual person. Sex is important to me. It always has been, but also because living in the plague years, like we've been living in, it's important to me to, I guess, have a sense of grounded sexual reality without any guilt. That there's no guilt involved, that there's no fear involved, that sex is still okay to have. To achieve that I get crystal. [Crystal] is a part of that. My social life revolves around, a lot around, people that use crystal. Myself using crystal. Crystal causes a sense of freedom with me.

Mickey, a 20-year-old bisexual sex worker (i.e., one who exchanges sex for money and/or other material objects such as drugs, food, a place to sleep), explained that crystal helps him increase his self-esteem and self-confidence and allows him to have sex with other men. He reported that he is not comfortable with gay sex, yet "after a while" he has "gotten used to it."

> Mickey: [Crystal] makes you feel good about yourself.
>
> Q: How so?
>
> Mickey: Just gives you a lot of self-esteem and self-confidence.
>
> Q: Every time you use it?
>
> Mickey: Every time.
>
> Q: So it makes you feel good about yourself. What else?
>
> Mickey: That's basically it. . . . It [crystal] makes you do stuff that you normally would not do sober. Um, like when I first started hustling, I never would have let a guy suck my dick, let alone suck a dick, because I didn't think it was right. But the first time I ever did one of those things, I was high on speed. . . . I suck dick. I ain't gonna deny it. In public I'd deny it.

Other participants expressed no emotional discomfort regarding their gay identity, gay sex, and/or HIV. For these participants, using crystal is a way to enhance an already strong identity as a gay man. Gay sexual expression is highly regarded and is not associated with shame or guilt. For these men, crystal is used primarily for heightening their sexual experiences. Ryan explained that being gay has always been a positive experience for him. His parents were very accepting when he came out, and he enjoyed having a handsome boyfriend in college and was proud to be seen as part of a gay couple. Ryan's description of his crystal use is congruent with his meaning of being a gay man.

> I've never indulged in alcohol or drug use when I've been depressed or when I've had problems, like some people do. I don't find it as an escape mechanism for me, I do it just for the fun of it. And I love to have fun. I'm getting to that age where maybe I should consider differently, but it's fun. And sexually speaking, marijuana was never sexual to me. This [crystal] is probably the most closely associated with sex and that's perhaps why I have such a tight hold on it.

Within gay communities, crystal is associated with increased sexual functioning, productivity, and a sense of euphoria. For many of the participants crystal means sex. Jason described his relationship between crystal and sex:

> Q: What things do you associate with crystal use? Are there certain places, people, things, activities?

> Jason: Sex, is that what you mean?
>
> Q: Sex. Anything else?
>
> Jason: It's a sexual drug for me.
>
> Q: It's all about sex?
>
> Jason: On that drug it is. And I enjoy it. Honey, you could get everything, it is the best, it really is.
>
> Q: How is crystal viewed in the gay community? How do you think it's seen in the gay community?
>
> Jason: It's number one.
>
> Q: Why?
>
> Jason: It's the best high, it's the less tweak of a high.
>
> Q: Compared to?
>
> Jason: It's a sexual high. Compared to crack, compared to heroin, you know.

Mark agreed with Jason, poignantly stating "Crystal is synonymous with sex."

The cultural constructs associated with a gay identity are explicitly linked with sex. It is almost impossible to separate the meaning of being gay from gay sex. And, as many of the participants stated, crystal and sex are synonymous. Crystal is often used as a coping mechanism for the uncomfortable emotional aspects associated with a gay identity. Participants report using crystal as a means to transcend their negative emotions; it serves as a vehicle for a positive gay self-image. For others, transcending negative emotions is unnecessary, and, for these men, crystal use is consistent with positive gay sex and sexuality.

Crystal User Identity

The identity of a drug user, or specifically a crystal user, can hold similar marginal and stigmatized social meanings. In the following quote, Jesús explains that he attaches a negative meaning to both his gay and crystal user identities. Yet, through the use of crystal he manages these identities.

> My only three lovers I've ever had, we always fucked like animals and it was never safe and I never used a condom and I never would. Two of them are dead. It's just because I was embarrassed about being gay because gay sterotypically denoted those

fags at the P____ and that whole scene. I'm not proud I'm gay but I like men. . . . All I know is that I love my dick and it is a great looking dick and my body is great looking and everything is great when I do speed. . . . On top of that, I was ashamed of the fact that I was shooting drugs. And if I ever met somebody good looking when I was high, I avoided them. I would never sleep with them. I would only sleep with guys that I felt were not so attractive. That way I could hide all this. I could hide all this from myself and from other people.

Given that "drug user" is a negative social identity, many of the participants distanced themselves from that self-concept by defining themselves as "functional" drug users. Almost two-thirds (64%) of the interview participants viewed their crystal use as controlled, yet commented that a friend's or colleague's crystal use was unmanageable. These participants distanced themselves from other crystal users by stigmatizing their friends' or colleagues' crystal use as "other" and describing themselves as functional. The following are a few examples:

> Blanche: The people. I mean I never met so many morally bankrupt people in my life. . . . Even heroin [addicts], I was a heroin addict, . . . even they had a certain amount of code. . . . These people do stupid things that have no value. . . . They're out for themselves totally. And lie, I mean, grossness you'd never believe. And, anyway, I'm a person that likes to believe, I want to believe, I live in a fool's paradise where I, like Anne Frank, I still believe there's a good . . . I always try to look for the goodness. So, my day-to-day routine is just getting through the day, not getting my head blown off by some psyched out speed freak.
>
> James: I've noticed that a lot of blacks that do crystal, they kind of go crazy, makes them crazy . . . a lot of blacks that do crystal get real crazy, nutty, they turn into someone else. It makes them maybe, maybe schizophrenic, psychotic, and that kind of frightens me. And Latins, too. Whereas with whites it's not like that. It's like it's just pure speed, it's just pure high for them. But for a lot of blacks and Latins, that's the reason why if you talk to a lot of crystal users, you hear them say that blacks and Latins can't handle speed. And that's the reason why, to a large degree, a lot of people feel hesitant about buying crystal from me.
>
> Q: Why?
>
> James: Because I'm black and I handle the speed very well.
>
> Jay: I can see like a million problems with it [crystal]. I just don't see anything wrong with me doing it. If you were to ask me how I felt about somebody else's drug use, I can name off a million problems. But right now if I was to ask myself how I do it, I wouldn't see anything wrong with it. I guess it's the lack of caring for myself. You know because if I had a problem—if a friend had a problem, I'd do anything to help that person out, but if I have a problem I'm not saying a word about it to anybody.

The distinction between "my" controlled use and "their" unmanageable use was made not only by one social group looking at another, but also within social groups. The assertion was made by older and younger men, homeless men and upper-class men, Caucasian/white men and men of color, gay men and bisexual men. The only commonality among these users was the belief that others did not control their use as they did. This psychological distancing is consistent with the adoption of societal values on drug use as negative and thus helps to manage their identity as a controlled user. Defining "their" drug use as controlled allowed the participants to categorize their crystal use as functional and, as discussed later, normative within gay culture.

HIV Identity

In addition to viewing a gay and drug-user identity as marginal, many participants also assigned a negative social meaning to their HIV status. A participant in an HIV-positive focus group provided an example of the internal emotional issues that he grappled with regarding his sexuality and HIV status.

> Let me be blunt about this, I use crystal because I don't want to be reminded that I'm HIV-positive. I just want to go out and get laid like a normal human being, without having to go through all this stuff about being rejected by a lot of people.

Another participant from the same HIV-positive focus group commented that he uses crystal to cope with the fear of transmitting HIV to his HIV-negative sexual partner. Crystal use frees him of the responsibility of safer sex and the guilt he associates with his HIV serostatus:

> When I had to deal with being HIV-positive all the time and my lover was negative, I used more crystal then because it made it easier to have sex and not feel guilty. It [crystal] made it easier to have sex and somehow lift or suspend that responsibility of still having safe sex. But the dread of the possibility of a condom breaking or something like that caused me to use more crystal than I do now.

The desire to integrate all three of his primary identities was described by a focus group participant as a quest to meet other gay, HIV-positive crystal users. In the following quote, he expressed his sense of alienation as he struggles to integrate these three distinct yet overlapping identities.

> I've always had a problem with integrating that part of me that likes to use crystal with the rest of my life. And, as a result, my life is very divided. But, what's happening here [in the focus group] is I'm getting to meet other gay men, who are HIV-positive, who use crystal in a social context, and what I'm discovering is that I'm not as alone in this as I thought I was. Because, I always thought I have my normal friends and then [there's] that thing that I do [use crystal]. But what's happening here is that I feel like I belong to something. . . . I don't know if there's any sort of a social way of meeting men who are HIV-positive and use crystal? Like what is happening in this room. Obviously they are underground sexually, because

> again, that word "underground" puts all the guilt and shame in. It's like, you know, what is this, a secret society? But, this [the focus group] somehow made it okay. And these people [other focus group participants] don't look like, you know, seventy-year-old tweakers in chaps at the coffee shop. These are like normal people. I know what he does for a living, he works, he eats, he sleeps, just like me. And, I mean, that's something that I, personally, would like to see. I know there are social groups for HIV-positive men, but I'm talking about HIV-positive men who do crystal as well.

The above quote describes how the group process produced a desire within this participant to socialize with other HIV-positive, gay crystal users, thereby integrating his three primary identities and thus normalizing his life.

All participants expressed internal struggles associated with their gay identity, their HIV status, and/or their crystal use. The ability to act in accordance with one or more of these identities, without harmful or disparaging emotions, often motivates their crystal use. Brief episodes void of guilt or shame become self-reinforcing. Social deviance, stigma, guilt, and/or shame play a role in the integration of one's core identity. However, not all the participants interpreted these social constructs negatively. Gay and bisexual crystal users, although they use differently and their use serves different functions, can be categorized into two groups. For some, crystal is viewed as a way to overcome the interpretive negative social meanings associated with their core identities. For others, crystal is used to reinforce and intensify their concepts of themselves as sexual gay males.

HIV, AIDS, and HIV prevention messages promoting consistent condom use have stripped many gay and bisexual men of their sexuality. The cultural norms regarding sexual freedom that comprised much of the gay liberation era are gone. In the second decade of AIDS, crystal—with its deeply entrenched associations with heightened sexual experiences—has become a vehicle for older gay and bisexual men to reclaim the lost sexuality of the 1970s and early 1980s. For younger gay and bisexual men, crystal use is a way to capture a part of the romanticized gay sexuality that is now a part of our gay history.

PERCEPTIONS OF SELF AS A CRYSTAL USER

The crystal user identity is integrated into the individual's self perception in ways that appear to elude the stigma and negative connotations usually associated with "drug user." The participants in this study presented themselves in a variety of ways as crystal users. Based on their self-descriptions of how they use crystal and for what purposes, several themes emerged. The descriptive categories that follow are not intended to characterize a particular type of crystal user, but rather to offer examples of the themes mentioned by the participants. These themes are not mutually exclusive. Some participants might have different perceptions of who they are as a crystal user depending on the circumstances, while others present a fairly consistent view of themselves. Participants adopt various self-perceptions as strategies for rejecting the stereotypical negative

connotations associated with drug use. To avoid these negative connotations, participants implement psychological mechanisms to maintain social acceptance and avoid judgment.

Illusions of Functionality

As demonstrated in the discussion of identity, most users presented themselves as functional and stated that their drug use did not cause problems. If crystal use was mentioned as being problematic, it was referred to historically. Participants would often mention that they were not like most crystal users and viewed themselves as the exception to the norm. Maintaining this separation between themselves and the general population of crystal users affirms their belief that they are in control of their drug use.

Timothy is a crystal injector; he is caring for his lover, who is dying of AIDS. Timothy gets his crystal through "kickbacks," i.e., by providing contacts for a dealer. Timothy described his situation in the following way: "I've been unemployed for about 11 months now, which has nothing to do with my drug use. I'm not like the others [crystal users]. Crystal affects me differently."

In the following interview excerpt, Joshua demonstrated how he views his crystal use as different from others:

> Q: How do you feel about your crystal use?
>
> Joshua: I feel that I have it under control, and I don't feel it's a problem.
>
> Q: And why do you say that?
>
> Joshua: Because I don't have to sell anything to get it. If I don't have it, I don't have it, and if I want it, I know where to get it.
>
> Q: Do you know of other people who have a problem with crystal?
>
> Joshua: Yes, but they're not my friends. The reason they're not my friends is because I don't know them, I just met them.
>
> Q: How do you know if they have a problem?
>
> Joshua: They tell me.
>
> Q: They tell you—and what do they tell you?
>
> Joshua: They tell me all the problems when they're on speed. I'm like, I'm sorry, cause I have it under control, okay? They let the drug control them, they don't control the drug. That's when you know, it controls you. You don't let it control you.

> Q: How do you do that?
>
> Joshua: We know what we can take and we know what we can't take with our bodies. And if our bodies say "Hey, you, stop right now," you can tell when your body says stop.
>
> Q: What does your body do or how do you know when your body is telling you to stop?
>
> Joshua: When my gums are bleeding or when I've done too much, I get tired. I get heat flashes. Okay, just stop, just stop; give it a break, give it some time.

User Functionality

Approximately 20% of the participants described their crystal use in a very predictable manner. They predetermine the day and time, the amount, and the procedures, rituals, and sexual activities. These users are prepared for the drug and its effects, including the coming-down phase, and have strategies in place for the entire crystal experience. These participants use the amount they choose and participate in the activities they pre-plan. They finish their use and go on with their lives.

A focus group participant described his crystal use: "I plan my crystal weekends. I prefer to take it [crystal] Saturday morning, just so I can be well-rested, because I know what it will do [to me]."

Ryan is self-employed and works independently and, therefore, has a large degree of control over his work and leisure time. He stated that he prefers to use crystal after his work obligations have been met:

> I normally, most generally or nearly always, like to do it [use crystal] with my obligations of work and social commitments completed. I don't like to play hookey when I'm going to feel guilty afterwards. Guilt is out of the picture completely in both what I do and how long it takes. Basically I like to do it [use crystal] like a holiday, with my conscience clear that I'm not fucking up on anything. I don't think I would enjoy it if I felt that I was failing to meet my obligations.

Mark, in retelling a conversation with his mother, with whom he is very close, explained how he cares for his body to compensate for his crystal use.

> I'm very conscious of my body, very conscious of what my body needs: herbs, vitamins, homeopathy, all these kinds of things. I know a lot about what to do to stay alive. And my mom, she asked me one time, "Why is it that you're a vegetarian, yet you do drugs?" I said "Mom, that's *why* I'm a vegetarian." You know, 'cause if I'm going to do things like that [use crystal], then I need to take extra care of my body.

Clifford told how, over years of crystal use, he has learned how to minimize the negative aspects of the drug:

> I hate hearing people say "Okay, no more for me." You know, ‘cause I've heard it so many times. I think if you can, at least in your own head, keep it under some sort of control and still function in an everyday society and keep your job or whatever it is. I mean, I've heard horror stories, you know, but obviously those people have no self-discipline. I feel as though those people, [drugs] would be a problem whether it was alcohol, cocaine, pot, whatever it may be. I feel that those personalities probably have no self-discipline on anything anyways. I don't know, I don't have a problem with it. I don't have a problem doing it and I probably always will [use crystal] as long as it's available. I think like through the years you find out all the negative things so you learn how to deal with those, cope with those, or eliminate them. So if you can eliminate most of the negative things, you're kind of left with more of the things that it [crystal] enhances for you, which makes it more enjoyable. . . . I feel I have some control on the [crystal]. I feel sorry for those who don't. I mean I questioned it. Like on Mondays when I'm working and I'm sort of tired but I had a good weekend. So you have to say, which one is it? Are you gonna have that weekend that you're gonna remember forever and you're gonna be tired Monday, or . . . but, at least I question it. I'm glad that I'm tired sometimes on Mondays, so I can ask myself, "Whoa, dude, we did too much." Or, "Should we have not done crystal this weekend?" Or whatever. As long as I'm always questioning myself I feel like I'm okay. And I know that my use of it [crystal] is far below some other people that I know.

Other users spoke of how crystal serves as a functional part of their lives. For example, Jason is a sex worker who lives on the streets; he described the function crystal plays in his life as two-fold. First, when he is on crystal he is temporarily relieved of the constant burden of figuring out where he is going to sleep that night, and second, crystal allows him to make extra money through sex work:

> Especially the hustlers. Because when I was hustling we would hustle all night long. . . . You’re up, you don't have to go worry about where you gonna sleep tonight. You ain't got the worry, ain't on your mind, because you're amped up. Your dick is hard so you're going to go out and do whoever pick you up, what they need you to do for them. You don't have to worry about where we gonna' sleep the night. We ain't worried about sleeping, we're too wired up to sleep. And when you're down, shit, all this worry comes back on you then, you want to go sleep at the bank tonight, or where did you put the crackers, or you want to go join them on the roof and sleep over there. All that shit worries you, it does man, that shit worries you.

For many participants, crystal use could be described as either psychologically or socially functional. For users like Jason, crystal is well integrated into their unplanned lives. Although these

users may not know what is in store for them later that night, they are comforted by the knowledge that while they are on crystal they do not have to worry about where they will be sleeping.

ACCEPTANCE OF SOCIETAL DRUG NORMS

Many participants evaluated their crystal use with harsh self-judgments that appeared to reflect societal drug norms. Self-descriptions of drug use, including terminology consistent with addiction and treatment models of recovery, tended to come from individuals who had adopted a self-image of powerlessness over their addiction. These individuals either feel passive over changing their drug use or hostile toward the negative connotations society places on drug use and users. For example, Blanche, who injects crystal daily, accepts society's definition of an addictive personality.

> I'm an addictive personality. I used to drink. I thought I was an alcoholic, but one day I just stopped. I had no craving for it. . . . I'm basically an addictive personality. I will always be addicted to something for sure. . . . I'm considered lower than whale shit. On the scale of human life, middle-class, upper-class, and the other classes . . . like I said, I'm lower than whale shit.

In the following interview excerpt, Eric's use of language demonstrates his acceptance of societal drug norms. Eric is well versed in addiction vernacular and used that paradigm to express his drug experiences.

> Eric: I am a drug addict, but I'm a responsible drug addict. That's how I look at it. I know when I can do something and when I can't. I don't do crystal at the times that I know I have something to do the next day.
>
> Q: But yet you also said that your life is working right now, so I guess I'm curious to know why it's so important that you would want to stop using it?
>
> Eric: Because I don't want to be dependent on anything, except myself and God. That's it. That's all I really want, you know, it's an addiction, it's a disease. You know, addiction is a disease, and it's, I know that's a contradiction to what I just said, but, I, don't know. It's a disease and I know that.
>
> Q: How do you know that?
>
> Eric: Because that's what I've learned. Because if it was a dysfunction, if it wasn't a disease, I could just stop doing it. But I can't just stop doing it. 'Cause I'll stop doing it for a while, but then it's a thing that creeps up in the back of my mind. . . . There is something wrong with that . . . because it's not willpower, it's not a matter of being a strong person, it's not even a matter of being a spiritually strong person. It's something in my head. It's in my mind.

> Q: So how is it then, that in a given month you are able to use on a weekend for three days . . . and then wait, and then do it the following week. How does that work?
>
> Eric: I don't know. Obviously that's a process that I've been able to do with time. That I've been able to say, I'm able to . . . how is it? First of all, I have to live. I have to survive, I have to have food, I have to have money. Well, I have to have a roof over my head . . . and if I do crystal any more than the times that I'm able to do it, which is the three days that I have off out of these two weeks, any more than that and I'm gonna lose my job. 'Cause I'm just gonna forget about everything, and just be fucking my brains out. That's it and I just, I can't. I'm able to . . . that has been the balance I've been able to be strong enough to uphold, for that couple of weeks I just have to say no. I can't do it. You know, I can't do it. And this is obviously a schedule that I have created for myself. I've somehow been able to balance out this schedule for myself. To where this is how it's going to work, so at least, yes, I have this kind of a job and this is what I do, but, but I've worked out to where these three days out of the week, I get to have a good time, and I get to tweak, and have my addiction. You know, and surrender to my addiction on that level. And then I have to get it together again. I'm not able to, I can't, right now I can't do anything different than that, I just can't.

The participants who have internalized societal drug norms have accepted the self-image of "addict." This identity influences their interpretations of their drug-use patterns. For example, they view an unsuccessful attempt to reduce drug use as a personal failure. Consequently, these participants have adopted a defeatist attitude with regard to their ability to change their crystal use.

Self-medicating Strategies

Several of the participants who are HIV-infected discussed the advantages of using crystal to manage certain AIDS-related conditions or effects. For example, John has an AIDS-related cancer and is undergoing chemotherapy. As a result of the chemotherapy, John is in continued discomfort and his energy is depleted. For John, crystal temporarily invigorates him and it is well worth it.

> I'm the one that's sick. The methamphetamine use is insignificant compared to the other problems that I'm dealing with. If it relieves any part of that physical or mental pain, then I will do it [use crystal].

John's crystal use is within the context of self-medication, be that physical or psychological. For the hours and/or days that John uses crystal, his body feels whole, healthy and strong. Similarly, the following HIV-positive focus group participant states he uses crystal to increase his energy level:

> I'm older. I'm HIV-positive, you know, I can't go to the gym and pump 200 pounds like I used to. But if [I] do a couple bumps it's amazing what you can do. And then [I] have all the energy I had ten years ago.

A few participants spoke of being diagnosed as hyperactive when they were children, and they compared their adult crystal use to their childhood Ritalin experiences. These participants described a biochemical reason for the use of stimulants. One participant stated that when he used crystal as an adult it was "like a *deja vu* experience."

The participants who stated they use crystal to self-medicate a medical condition prefer injecting crystal. As Timothy noted, injecting crystal gives the user an intense rush rather than a gradual and sustained high. "When I started slamming, the buzz is completely different, it's much quicker, you go up incredibly fast."

Timothy explained that due to the restrictions of the health-care system he has not been able to see a psychiatrist to help him with hyperactivity and attention deficit disorder. Consequently, Timothy self-medicates through crystal.

> I found the thing that worked best for me was speed. I could regulate it. I knew when I was too far gone. [Crystal] helped and put me into a state of focus. I could function for the first time in my life when I first started snorting it. I could really actually sit down and focus on something and keep my focus for four or five hours, whereas, before I'd lose it after twenty minutes.

Coincidentally, while Timothy may have started using crystal to help him control his hyperactivity, and his hyperactivity is better controlled through snorting, he prefers to inject. He also marks injection as the point when his drug use changed:

> My use of crystal, which has been about three years pretty heavily, or pretty much basically a daily user for three years. I think it's when I started slamming, um, is when my social thing really changed [i.e., when his crystal use increased].

The common purpose presented by the participants who use crystal as a form of self medication is that their crystal use includes an attempt to maintain a sense of physical or psychological normality. Each of these participants chooses to inject crystal.

Coping Strategies

Just as Jason earlier described using crystal to cope with his homelessness, Jay explained that he uses crystal "just to break up the everyday boredom of life." In the following quote, Jay demonstrated how he uses crystal as an emotional coping strategy:

> Sometimes when I'm down and out and I feel like I don't like myself any more, the things I'm doing for hustling and living in the streets, I take drugs and it falsely portrays a new person in myself. It's my moment of time to escape from reality.

Blanche echoes Jay's sentiments. Blanche also uses crystal to cope with isolation and a sense of hopelessness, "I use crystal to escape. I have no dreams. I have no future. I have no hopes and with crystal I have the illusion of [dreams and hopes]."

In the following quote, Eric used the third-person pronoun to describe how he uses crystal to cope with his lover's death:

> I've been exposed just like everybody else. Although my HIV status is negative, it's a numbers game. I know I've been exposed. Like everybody else, I have had sex with people that are dead. So I'm saying that I don't know if I'm going to be around, I just don't know. The chances of me not being around in the next ten years are probably better than me going to be around. Uh, medically speaking. Like I said, I'm not a doctor, I'm not weighing anything toward one side or the other. The glass is still half full to me but, you know, I'm just watching the process happen before my eyes. Crystal helps me not worry about any of these things. It just helps me. . . . I'm not saying that crystal helps me forget, I'm saying it helps me not worry. You know, it helps me to still go out and have a good time and not have to [worry]. . . . Yeah, I see people take a lot of chemical things out there. I have people that say, "Oh, he's such a drug addict or such a tweaker." [I say] just leave him alone. You know, he just buried his lover. Let him tweak. He's afraid. He's scared. Leave him alone. He's scared to death. He's been with this guy for five years, and now the guy is dead. He's thinking about his life now. Cause he knows that this is gonna happen to him, too. He ain't gonna walk away from this. Leave him alone. Don't point the finger of judgment at anybody. That's just how I look at it. You know, I guess, crystal just helps me deal with it.

Crystal use has been readily adopted within gay communities as a means to alleviate emotional and/or physical pain.

THE MEANING OF THE CRYSTAL SEX EXPERIENCE

In gay communities, sex has long been seen as immensely important, and anything that enhances the sexual experience is also highly regarded. Crystal, therefore, has come to be positively associated with sex. Many participants described crystal as a vehicle that enabled them to take greater sexual risks. Many stated that they are unable to achieve the sexual extremes they desired without crystal. In the following quotes, participants discussed sex without crystal.

> Q: What is an orgasm like without crystal? How do they compare?

Jerry: It's almost just like not even worth masturbating or having sex. Like I said, I'm not sexually excited unless I'm under the influence. It's almost personal (laughs). Simply because I mean, like I said earlier, some people don't even want to have sex unless they're high and once you know how it makes your body feel and how it can be an enhancer in a sexual situation. Then you know, you want to do it more because it's something you enjoy.

Q: Would you like having sex without crystal?

Jerry: I *don't* have sex without crystal.

Focus group participant: You don't want to go back. Once you've had sex on crystal you don't want to go back.

Ryan: I suppose I could live without it, but I would miss it terribly and certainly sexually, I would. It has a detrimental effect sexually, at least for me, in the sense that I'm not interested in normal sex. And I can have sex with someone that is not on it, and is not even aware I'm on it, but I prefer the other person knows it and partakes. And conventional sex, you know, twenty minutes or fifteen minutes, it doesn't interest me. I like the long, drawn out, kind of more like an epic process of it.

The crystal sexual experience is held in high regard by most participants. All participants discussed the enhancement of their sexual activities while on crystal. Sex was described as more intense, heightened, prolonged, and uninhibited. Several descriptive categories help highlight the strong linkages between crystal and sex.

Heightened Sensory Experiences

Crystal is a powerful stimulant that amplifies the sensory perceptions. Combined with sex, the user is often amazed by the intensity of the sexual experience. Blanche and others talked very expressively about what sex is like on crystal:

Blanche: All your senses are ascending, suddenly awakened and not dormant. Like being born; really cool, warm, everything is new and exciting, like the first time. It's like every pore is cumming. Unbelievably incredible.

Focus group participant: It's just every nerve in your body is standing at attention.

A focus group discussion:
Participant #1: It's an earth-shattering experience.

Participant #2: Large amounts of semen.

Participant #3: It sprays farther.

The significance of crystal in heightening the senses reportedly works for the psyche as well as the physical senses. Many participants discussed how their heightened sensory perception assists in connecting with potential sex partners. This has been described by many as the ability to detect whether others are on crystal; as one participant stated, as a crystal user you just "know when somebody is tweaking." And according to Ryan, just knowing another man is high on crystal is interpreted as sexual:

> Seeing and knowing that the other guys are using it [crystal] or under the influence of it, creates a sexual situation for me. Crystal has become so tightly bonded with sex for me.

Heightened sensory experiences are clearly part of the sexual encounter. However, this state of sensory arousal has also been described as a precursor to sex. In other words, participants who are high on crystal mentioned how they seem to attract other men who are also high on crystal because of a mutually heightened state of awareness. Participants mentioned that crystal use has granted them the opportunity to meet a group of men they would not ordinarily have access to, i.e., the "party" boys.

Disinhibiting Effects

The freedom from inhibitions was discussed by many participants as a positive aspect of using crystal during sexual activities. Marcus, who is HIV-negative, mentioned that he had unsafe sex on a few occasions while using crystal. He stated "on crystal it [sex] is more experimental; you're willing to try anything on crystal." Ashley describes how her sexual activities differ while on crystal:

> When I'm on speed and I have sex, it's just a freaky sex . . . it's freaky, kinky, wild, just crazy fucking sex. When I'm on marijuana it's passionate, a lot different, you're not moving so fast.

In the following quote, one focus group participant was more descriptive in his portrayal of the disinhibiting effects of crystal:

> If I did not use crystal I would probably say to myself, "What am I doing here, in this dark room with my ass in a sling and all these men having their arms up my butt? Why aren't I married to a nice man with two cats and living in the suburbs?" When I'm on crystal I don't think any of those thoughts, like what am I doing here. I am concentrating on the fantasy of what's happening. This is not me; it's like I'm watching a movie, and I happen to be there.

As this participant has noted, crystal can produce disinhibiting effects. Another focus group participant commented on how crystal use facilitates his sexual activities: "Physically it [crystal] allows me to participate in sexual activities that normally I would not be able to accomplish or

achieve." Through the use of crystal, some participants described engaging in sexual activities that they would be too inhibited to engage in if not for the drug. However, other participants stated that crystal never changes the content of the sexual experience, but only serves to heighten the intensity of the act(s).

Duration of Sexual Arousal (Without Orgasm)

Crystal use during sex is also associated with prolonged sexual performance. Not only is sex more intense and heightened, but it lasts much longer. Participants commonly described sexual marathons lasting six hours, and some referred to having ongoing sex for up to three days. The length of time that one can remain sexually aroused allows one to have continuous sexual encounters and partners.

Alex, who is in the sex industry, described his ability to have sex for extended periods of time as an asset in his business. His sexual stamina allows him to serve his clients better and earn more money. "To be a bottom in this business you're getting fucked over and over and over and over—most guys I know can only take it twice." Ryan stated that crystal allows him to maintain arousal for extended periods of time without orgasms.

> With crystal, I'm able to control an orgasm more or less indefinitely. I have a great deal of control in that way, where I can just come close to cumming about as many times as I want to, basically, and not do it until I decide to do so. And I do believe that crystal does do that.

Alex explained that when having a "bunny hop" night, i.e., going from one client's home to the next, he must be able to continue to be sexual long after ejaculation. Crystal allows him to do this:

> [I]f I know this is gonna be a "bunny hop" night, and "bunny hop" means when you're done with the first client [sex date] you use their phone to call your next client, I'll usually do a small bump [a line of crystal] before each client. I've done eight clients in a night; that's one an hour. If you wanna be the best, you have to be able to get fucked for a long time after you cum. You have to be able to do this over and over and over again.

In a personal lubricant advertisement in *Circuit Noize: A Rag Custom Designed For Crazed Party Boys* (see Chapter III), the key selling point for a lubricant was its average drying time of 149 minutes; the ad compared this lubricant to eight other, inferior lubricants with drying times from 57 to 146 minutes. The lubricant that stays wet longer works best for prolonged sex. These lubricants have been developed and marketed to meet the demands of ongoing and sustained sex, and advertisements for them are targeted to men who are part of the party circuit.

Intensified Orgasms

Although the gay communities have said much about the phenomenon of "crystal dick," i.e., the inability to achieve an erection as a result of ongoing crystal use, this experience was only

mentioned occasionally by the participants in this study. Rather, the participants in this study discussed the intensity of their orgasms while on crystal:

> Focus group participant: When I do crystal, I start having double orgasms.
>
> Olu: When I cum, my body goes off the goddamn bed. If he [sex partner] hadn't of known that I was cumming, he would have thought I was having a damn seizure, that is how fucking intense it was.
>
> Ryan: I was already very well experienced in the sexual practices—I mean, I figured out that I had sex with 2,500 to 3,000 men at that point—but I never had an orgasm like that. And literally, it was a pleasure . . . not only was it pleasurable and intense, and like mental, physical, and everything else . . . but it caused me to—and I'm not saying this to be prurient or anything—but I shot a wad across the room, I couldn't even believe it! You know, just from the excitement of the thing. You know, we're talking about 36, nearly 48 hours after this whole thing started.
>
> Frederico: Imagine all the other like heightened sensations. That means every pore in your body is alive. That's, what do you call that, um, tantric. It's a tantric orgasm.
>
> Q: Tantric?
>
> Frederico: It's a yoga term. There's a lot of yogis, very sexual kind of discipline to yoga where it takes so long to like get there, but the point is to be in a tantric state. When you're having sex with somebody, it's like yoga with another person. You can look at sex that way and you can achieve the whole-body orgasms.

Inability to Achieve Erection or Orgasm: "Crystal Dick"

While most men described their increased sexual activities while on crystal, a few men noted that their crystal use produced an inability to achieve an erection or orgasm. Nevertheless, "crystal dick" was not seen as a deterrent to their sexual being or their crystal use. Ryan stated:

> Oh, sometimes it [crystal] makes my dick stay limp, but it doesn't really matter . . . and most of the time it doesn't. Some guys find that they can't get a hard-on and all that. And, you know, it does occur, but it's not really common with me. Or and when it does, it doesn't bother me. The other experiences are great.
>
> Timothy: Some people can't get a hard-on at all when they're snorting it. It's called "crystal dick" or "teenie weenie," as I call it, and it's just really strange, I don't understand the whole basis for all that. Even the ones that get "teenie weenie" are still very sexual. . . . Some people can't get a hard-on. . . . Your dick is basically a series of capillaries that have collapsed.

From Clifford's perspective, crystal dick should be considered as one aspect of the crystal sexual experience, and a minor aspect. To Clifford, crystal dick is temporary and insignificant.

> Well, crystal dick is something that I think everybody is going to go through. To me that's all a frame of mind thing because crystal dick means that you can't get a hard-on, which is true, but ten minutes later, let's say in a bathhouse situation, you can get a hard-on. . . . Remember how I told you it [crystal] makes you focus? Well, people are so focused on getting a hard-on, they're rubbing their dick raw, you know, like, let go of it, leave it alone, it's numb. Let's go do something else for a while, you know, take your mind off it, go swimming, go work out, go do something else. And people can't take themselves out of that, you know, that thing. It's like I've got to have it, got to get a hard-on, it's like, why do that to yourself? Who cares? Enjoy the other aspects of it. . . . Calm down and relax and let the blood flow.

Generally, the crystal sexual experience is not about having an erection or orgasm. Other sexual and erotic activities, including fantasy, are found to be exciting and pleasurable. Prolonging the sex play becomes the goal. Orgasms can be delayed for hours, and when they do occur, they tend to be explosive. As the following focus group participant stated, "It [an orgasm on crystal] is like cumming gallons." The crystal sex experience is about extremes.

Those focus group members who are former users of crystal were the only participants who referred to sex on crystal as unpleasant. Some members of this focus group used adjectives such as "painful," "depressing," and "guilty," and the phrases "the fun coming to an end," and "frustrated 'cause it took so long to get there" to describe their crystal sexual experiences. This group stated that, in hindsight, prolonged sexual encounters that lasted for several hours were, in fact, physically painful. However, other former users rhapsodized about the crystal sex experience and, admittedly, viewed sex without crystal as qualitatively different:

> A focus group discussion:
> Participant 4: It's short, painful, depressing.
>
> Participant 5: It's a waste of time.
>
> Participant 6: It's not fun.

Although not a former user, and not describing adverse effects of the crystal sexual experience, Olu was nevertheless the only participant who described any unpleasant side effects from heightened sensory experiences, disinhibiting sexual acts, or the duration of sexual arousal. He described the following sexual mishaps:

> Olu: Now, I'll tell you some of the downsides of that, some of the adverse effects of my doing crystal has had on me. I had to have a ball stretcher surgically removed from out of my ass.

Q: A ball stretcher? That got stuck in your ass? How'd that happen?

Olu: Because I was fucking with goddamn balls and it came out. It felt good so I let him keep it up in there. And three days later it didn't feel too good. So they had to surgically remove it. . . . I got a hard-on [another] time and it wouldn't go down.

Q: For how long?

Olu: Well, I had been fucking for damn near six hours straight and it was not painful, for me it wasn't painful. My dick was like the hunchback of fucking Notre Dame because it was all deformed and everything because it was enlarged in one damn section and you could tell the other section was kind of normal. It just looked strange and I didn't have a car at the time and I was living in Hawthorne. I had to go to Centinela hospital and I had to take the bus. And, I got in the goddamn bus, this was about five in the morning and a hot Latino guy got on the bus. I already had a hard-on, and it took all I could do to keep from getting off the goddamn bus and following him home.

Q: So you made it to the hospital and then what happened?

Olu: Oh, they gave me a shot to relax me so I could go back home, and things went back to normal. I went back home and I was fucking again. The other thing was when I had a cyst on the shaft of my dick and they removed that in the doctor's office. Never again.

Q: What did that have to do with crystal, the cyst?

Olu: It was as a result of me doing crystal when the cyst first started, I didn't have it taken care of until it got to the point that it interfered with my sex life. So something had to be done. The other thing was the day after they did the surgery I was speaking at UCLA to residents about drugs and being a male prostitute. And, of course, the hottest fucker in there was the one that, every time you turned around he was standing up asking a goddamn question. I had six stitches from the cyst that was removed, so I knew not to get a hard-on. But what do you do when the hottest, sexiest mother-fucker in the goddamn place is always up in your goddamn face?

Q: So what happened?

Olu: I got a hard-on, and as it started getting hard I felt the stitches ripping.

Q: Ouch. So then what?

> Olu: I said fuck it. After I got finished with my speech I went to the bathroom, took off the bandage, and I put on another dressing and what not and said fuck it. . . . Two years ago I broke my hand fisting some fucking body.
>
> Q: How did that happen?
>
> Olu: Because it was during my annual New Year's Eve crystal orgy. And I was fucking somebody and somebody was fucking me. And I turned around to give somebody some head, while I was fisting [somebody] and they moved and I didn't.

The meaning and significance afforded the crystal sexual experience is paramount and deeply interwoven into the users' self-constructs. Unlike other sexual identities, e.g., heterosexual or lesbian, a gay identity is explicitly linked to sex. A complex set of internal dynamics is associated with the use of crystal for gay and bisexual men. The most salient factors deal with one's sexual identity, identity as a crystal user, and HIV status. Participants have linked crystal with the aforementioned internal factors and described how crystal facilitates a method of coping with these internal dynamics. In contrast to individuals who embrace societal drug norms, these participants contextualized their crystal use in terms of functionality and manageability. In addition to the internal dynamics associated with the use of crystal, an extensive set of external dynamics directly contributes to the social world of crystal use for gay and bisexual males in Los Angeles.

CHAPTER III

EXTERNAL DYNAMICS ASSOCIATED WITH CRYSTAL USE

INITIATION TO CRYSTAL

Nearly half (44%) of the interview participants were introduced to crystal by a male sexual partner or lover. Many participants commented that their first introduction to crystal was in a sexual context, or with the later expectation of sex. As Eric recounted:

> I remember the first time I did crystal. It was at a bathhouse. I remember there was this older gentleman who said "I want you to try this." . . . All of a sudden I just became much more aware of who I was sexually.

Ryan described his first experience with crystal as follows:

> That [was the] time when I [first] tried crystal, it was a very intense experience. Sex became epic. I found myself with this fellow engaging in a sexual marathon. It [crystal] gave everything that the coke only hinted at.

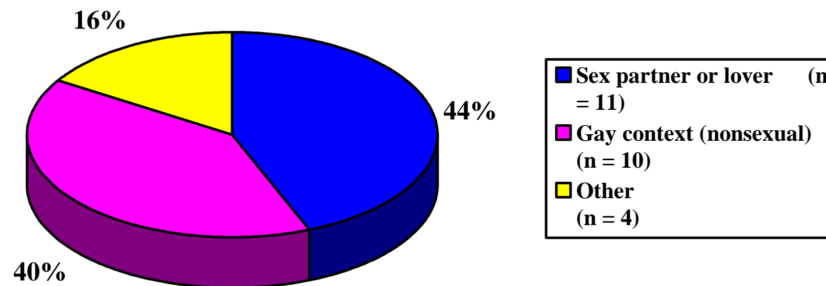
An additional 40% of the participants stated they were first introduced to crystal by a gay male friend in a gay-related social situation, although not explicitly sexual. Although most men were introduced to crystal through sexual partners or boyfriends, 16% mentioned first using crystal in non-sexual circumstances. (See Figure 1.)

Over time, however, all participants reported linking crystal to sex. Mark described how he eventually integrated crystal into his sexual activities and then began to use it more frequently:

> Somewhere along the line, somebody introduced that [crystal] along with sex, and crystal and sex in some ways go together. Not necessarily standard sex, but more like kinky sex. And so then that's when I started using a little bit here, using a little bit there.

In some gay-related social situations, crystal use is viewed as normative and typical. Alex described how crystal is integrated into gay social networks and institutions such as dance clubs and sex phone lines.

Figure 1.
Initiation to Crystal Methamphetamine



> When you snort it you can get yourself into a more sexual kind of high, but it takes at least a day. That's when you go to the P____ and you dance for 12 hours. But by the time you get to the sexual part, it's the next day. That's when the "976" line [sex phone line] is just filled up completely. It's hysterical. That's why I wouldn't do the "976" line on Sundays because they're all like, "I wanna get fucked," so [laughs] that's why I have my little gray book.
>
> Q: What's the gray book for?
>
> Alex: They're tops.

Marcus referred to a specific dance club as a place where the norm is to be high:

> I actually went to the P____ once just to see what it would be like. Me and my friend, not high on nothing. And we had a hideous time (laughs). It was so gross, but you actually feel high being around these people. I don't know, maybe it's mental, but you actually feel high around these people and it's just like, huh, I feel kinda high. I feel kinda wired. 'Cause you know you're around everyone else and they're all fucked up and you want to be on that same level.

Other participants described how their social lives changed once crystal was introduced to them. For older gay men, using crystal reacquaints them with a sexual social environment, as the following focus group participant stated:

> I find that the only time now I really have fun and, I don't even think it should be called a social life, is with the crystal. Because so many of my friends that I was legitimately social with are dead. The professional people that I knew have died of AIDS, and all of that stuff ended. Those dinners and evenings together and things we used to do that were legitimate, you know, they're gone. So the crystal opened new doors and it was, you know, it was clubs and bars and bathhouses and things that I'd really slipped away from.

Given that crystal is often introduced within a sexual context, young gay men who are starting to adopt a gay identity, or others beginning to experience the coming-out process, are vulnerable to attaching crystal use to the formation of a gay identity.

AVAILABILITY

Not one participant mentioned difficulty in obtaining crystal for personal use. Crystal is made readily available and accessible through gay institutions for individuals of all socioeconomic levels.

For participants of lower socioeconomic status, crystal was easily obtained on the streets, through dealers or sex dates, or in gay bars. The following excerpt is from a focus group comprising gay and bisexual homeless street users.

> A focus group discussion:
> Q: Where do you go to get your crystal?
>
> Participant 7: On the boulevard.
>
> Participant 8: You start out on the streets and then you meet, get to know those people, and usually you'll meet someone [who has crystal].
>
> Participant 9: A lot of people that I run into on the street, they got it anyway. A lot of my friends just come and always kick me down [give me free drugs].

More affluent users said they are able to get crystal delivered to them by their dealers. They also obtain crystal in gay bars and sex clubs, along with the sex workers they pick up "for a date."

> A focus group discussion:
> Participant 10: I have a dealer that's also an old friend and she's very accommodating, she delivers. I can run a tab, it's too accessible for me. I mean, I can pick up the phone, and within a half an hour it's there.
>
> Participant 11: Yeah, yeah. If I want to, I can line something up. I can call around to friends.
> Participant 12: It's not hard to find. And there are bars that are known as tweak bars in the neighborhood and not far from here. Like you could walk in there in any length of time and score a baggie.
>
> Q: Other ways of getting crystal?
>
> Participant 12: Night clubs.

Participant 13: Sex clubs.

Participant 12: The baths, for sure.

Participant 14: Any place people are tweaking.

Participant 13: The V_____.

Participant 11: Interestingly enough, on the hard-core line this weekend there was a dealer and he said "Hi, this is so and so, I'm the party favors man. I want all of you to play safe and call me." And he left his pager number.

Participant 12: I've picked up hustlers and had them make the connection for me, sort of do the buying process because they knew where to go.

In addition to its accessibility, crystal is relatively inexpensive and keeps the user high for periods up to several hours. Crystal's cost and duration can be compared to those of the other frequently used drugs in gay and bisexual communities, specifically crack and cocaine (Reback, 1996). Participants stated that a "quarter" of crystal, costing from $20 to $25, is all that is necessary for an average 8- to 12-hour high. Crack—which is reportedly used in the Midwest as a sexual drug and among some African-American/black men who have sex with men in Central and South Central Los Angeles—is sold in Los Angeles for approximately $5 to $10 per rock, lasting only 5-30 minutes. Cocaine is expensive, starting at $125/gram for a 1- to 2-hour high. Ecstasy, which some participants report using to feel emotionally close to a sex partner (but not to induce sexual adventures), costs approximately $25/tab for an average 3- to 4-hour high. It is clear that, in addition to the sexual linkages, both the cost and the duration of crystal add to its appeal.

In the following two quotes, both Blanche and Ashley compared the advantages of the price of crystal and the duration of the high.

Blanche: Because every penny went to buy that crack. You never got the high you were looking for. Never. Chasing a glass dick, never. You spend 200, 400, or 600 bucks a day and never get . . .

Q: A glass dick meaning pipe?
Blanche: Pipe. And then I found someone who sold speed [crystal] and I got some speed and the first shot, I got the high I wanted, it cost me a lot less money and I was high for three days on it. So it seemed like a better idea to me.

Ashley: Coke is too much, you know, it's too expensive, it's much more expensive than gold, I can say that. At least when you're on speed [crystal] you know you're high for about five or six hours. You do coke, you're high for about, what, an hour, an hour and a half. Then you come down. . . . I would buy speed before I would buy coke.

> Q: How does it compare . . . compare it to some other drugs?
>
> Ashley: Rock?
>
> Q: Yeah. Rock.
>
> Ashley: Uh, all I have to say is rock is worser, it's the most worstest drug there is. In my opinion. It's the most worstest drug there ever is.
>
> Q: What's it like?
>
> Ashley: That's the rich man's habit. You heard that saying? The rich man's habit. That is very true. . . . We went, me and my roommate went through—we turned a date was $990 on rock. Ten more dollars would have been $1,000. And see, I can buy, I can buy about, what, two quarter bags, what's that $50, and that'll last me what, two days? Two or three days? That much rock only lasted, what? That night, that night it was all gone.

Marcus compared the sexual high of crystal with the emotional intensity of an ecstasy high:

> Marcus: On crystal, it's like it's more experimental, you're just willing to do anything on crystal.
>
> Q: For example.
>
> Marcus: Oh, you can easily be tied up or you want to tie someone up. You want to fuck someone with a dildo or you want to just, you know, piss on someone if that's what you feel at the moment. Or you can just totally get into like watching the videos and jacking off. But actually it's [ecstasy] just more like a loving thing. You just love the person you're with, you want to please that person, you just want to make out, touch, rub, and just shit like that. I mean it's perfectly intense just hugging someone on ecstasy. But with crystal you just wanna like fuck, suck, tie, or you know, something more hard-core. Crystal is definitely a more sexual hard-core drug. Ecstasy is like just be with someone, just looking for someone.

Many of the participants demonstrated their knowledge about the manufacturing of crystal and provided insight into other aspects of the drug's availability. For example, the ingredients needed to manufacture crystal are easily available in Mexico, a two-and-a-half-hour drive south from Los Angeles. However, given that the manufacturing of crystal produces volatile fumes and foul odors that are easily detectable, "crystal labs" tend to be located in remote and rural areas. There are several suitable areas just one hour east of Los Angeles. Given these two factors, it is not surprising that there are a number of crystal labs just outside of Los Angeles. The economics of supply and demand are directly relevant to availability.

Many participants spoke of the unavailability of crystal away from the West Coast. Ryan reverted to cocaine use while he was in Miami, he said, due to his inability to find crystal on the East Coast:

> I've ended up getting some cocaine because I couldn't get any crystal . . . mostly when I've been in Miami, because on the East Coast crystal doesn't really exist.

Other participants alluded to the regional popularity and availability that they encounter with respect to crystal.

> Marcus: I'm originally from the East Coast and I've been here [Los Angeles] for like six years now and I've never been on crystal until I came here.
>
> Q: Why is that?
>
> Marcus: It was just not popular on the East Coast. I was doing coke on the East Coast, but I never did crystal—I never heard of crystal.
>
> Q: Do you have a sense of what the availability is like with crystal in other places?
>
> Alex: Here [Los Angeles] it's like vitamins. With the East Coast some people don't even know what it is. Drugs on the East Coast are very, very expensive. I mean very expensive.
>
> Q: Can you get crystal on the East Coast?
>
> Alex: You can, but it's very hard to find, [even for] $60 a quarter.
>
> Q: Why do you think that is?
>
> Alex: Because I think New York is just more—New York is very expensive, New York is not like L.A.

All participants stated that crystal is very easily obtained. Participants mentioned finding crystal at bars, sex clubs, hotels, on the street. Men who were engaged in sex work noted exchanging sex for crystal, or "dates" giving them the drug as a tip or as a precursor to desired sexual activities. Some establishments are specifically known as places to find crystal or connect with someone who is on it or can get it.

> A focus group discussion:
> Participant 15: Yeah, you find a gay bar and nine times out of ten you'll find crystal.
>
> Participant 16: And some people get it from their tricks.

ACTIVITIES ASSOCIATED WITH CRYSTAL USE

Although the primary activity associated with the use of crystal is sex, crystal users commented that they use the drug to enhance other, non-sexual activities. Crystal is used to facilitate work-related and/or creative tasks, and many participants referred to accomplishing dreaded household chores such as cleaning and house-painting while on crystal. Others use crystal for prolonged high-energy activities such as dancing.

Mark stated that 90% of the time that he uses crystal he has sex. However, the other 10% of the time, he uses crystal to do other activities. "I'd make sure that I'd use part of the energy for productivity. Clean house, plan things, organizing things . . . your papers, going through mail, going through bills, gardening, cleaning the car."

Participants reported that crystal use generally improves their ability to focus directly on a particular task without other mental interferences and also allows them to remain on the task for longer periods of time. Many describe a heightened mental awareness associated with crystal. Participants discussed the detailed progress and number of accomplishments they are able to achieve while on crystal. Crystal use is reported to foster creative insights, increase work time, heighten sensory perception, improve intellectual capabilities, and produce more energy and stamina.

> Ashley: I mean, you just tweak on your face for hours. I mean, mostly every drag queen you ask, what do they do when they slam [inject], about 99% of them will tell you that they sketch on their face. They do their make-up, they tweak on their face.
>
> Q: What do you do?
>
> Ashley: Me? Sometimes I tweak on my face or I walk.
>
> Q: What other things do you do?
>
> Ashley: Clean house. Clean house, and my house gets spotless. I go find something to do, you know, I mean you go crazy when you don't have anything to do. I'm always doing something. Or I'm out here [on the boulevard] and it stays like that for about four, five, maybe six hours, it depends on how good the dope is.
>
> Brenda: If it's good stuff, I kind of get stuck, a feeling of being stuck. Stuck and don't know what to do. Like I could get stuck in my bag, you know, stuck, for hours, in my bag—in my make-up bag. Just sitting, putting my make-up on. For hours. And keep on putting it on. And leaving it on. Taking it off. Putting it back on.

Bill described how crystal affects his energy level and requires that he keep active:

> Just stay busy doing something. It [crystal] drives you to stay busy. Just keep busy. I can't sit around, you know what I mean, I'm just moving. . . . I get a rush of energy. You know, somewhat euphoric. But I'm up, you know what I mean, I'm speeding and I gotta' do something.

Clifford explained how crystal is not just for sex; he uses crystal to enhance his design projects as well.

> Your sense of touch, I would have to say, is more magnified. The stimulation is greater. Whatever your erogenous zones are become more stimulating. . . . I don't limit that to sex. I don't just fuck under the influence. . . . It's career work-related. Like when I was telling you about when I was working on the house. Your imagination is just going so much faster. . . . I use it constructively in my work. I love to see what I can create, and fortunately, so do my clients.

The following focus group participant noted his increased intellectual abilities while on crystal:

> Like a super strength of power goes to my brain. I can remember things, things like when I was in high school. I remember the answers to like all these tests. I get a lot smarter. I can analyze things. The way I perceive things are a lot different.

Other participants alluded to "getting stuck" in their activities while using crystal. Participants described themselves as "getting lost" in intensely focused activities for hours. Jerry talked about a friend who, while high on crystal, gets so "lost" on a particular task that he is oblivious to what is going on around him.

> I used to have a friend that just would get lost in his apartment. He would be so fucking high. He would just get lost and I would like get ready to take a shower and I would be blow drying my hair or something, and would notice that he wasn't talking and that he was like in a closet. I would assume getting something to wear. But you know—he would be in there tweaking—like finding all these things to put together. I used to say that his house was like the tweak museum. You go in and you see tweak projects and tweak towers and tweak jewelry and tweak furniture because it's all this stuff that has nothing in common with anything else that it is connected to, and it would form something that he apparently had a vision of at one time. Or just ended up with. Sometimes tweaking can be good, and sometimes it's not good at all.

John recalled how his use of crystal advanced his career:

> When I first started using, I was a shooting star in my profession. I was just leaps and bounds over my peers as far as getting promotions. It just seemed like I could do no wrong. Every comment I would make people would applaud, as far as "Gee, you have great insights into this," and so on and so forth.

Although John was, at one time, president of his own company, he is no longer employed. He is currently struggling with AIDS and is on disability.

Sex work is another activity participants mentioned that is enhanced by and associated with crystal use. Jason commented that crystal allows him to have more "dates" in a time period:

> You're up and everybody wants to be up, especially the people that have nowhere to go. We would hustle all night long, get a high on, when that was gone, you're still up enough to stand on the boulevard and still go and perform your sexual activity because your dick is still rock hard.

Brenda uses crystal to feel more self-confident when she is working the boulevard.

> Sometimes I think people know you're on drugs and they tend to pick you up faster. You look more in the mood, or whatever. . . . I am more sure of myself, where I don't care. . . . I'll be half naked and in spike heels and in the broad daylight dressed like a porn star and not caring. You know, when people look at me, I wouldn't care.

Participants have referred to both a physical and a psychological power they feel while on crystal, in part because of the enhanced ability to perform and complete specific tasks, reinforcing a sense of accomplishment. At other times, however, activities were defined as repetitive and unproductive. For those who associated crystal with valued activities such as work, art and sex, crystal was characterized as the agent that increased their sensibilities; however, for others crystal magnified a sense of tedium often described as "lost" or "stuck."

SOCIAL NETWORKS AROUND CRYSTAL USE

The "Equalizer"

Social networks and subcommunities of crystal users are formed across class and ethnic differences. The demographic patterns indicate that user groups tend to be formed around socioeconomic similarities rather than racial groups; however, these socioeconomically based subcommunities are fluid and easily expanded to include individuals outside of a particular subcommunity when crystal and/or sex are factored into the equation. Thus "in-group/out- group" distinctions were temporarily redefined around the use of crystal and activities associated with its use (e.g., sex, dancing, sex work). One participant, "M," described crystal as the "equalizer" in terms of the role it can play in allowing individuals to move across various boundaries (e.g., age, class, race, socioeconomic subgroups). According to "M," crystal is a tool for breaking through barriers that ordinarily tend to prevent people from interacting:

> You know, it works both ways. You know, if everyone thinks that you're good looking, that you got everything coming to you. Or, they're afraid to approach you or

> you're unapproachable, or they think you have an attitude. Then, if you're not good looking, no one's going to want to talk to you anyway. So, this [crystal] is kind of like an equalizer, I would say. I've seen lots of guys who normally would never talk to other people.

A focus group participant echoed the idea that crystal can erase the perceived barriers between distinct groups within gay communities.

> I feel very out of touch with twenty-year-olds, you know, and what they do. They go to the R___ and all that, you know, I'm going to be forty years old. I'm not in touch with that. I'm not in touch with the way they dress, their music. But you know, you can do a couple lines of crystal and it's how you pick up on that real quick. You go right in their groove and it makes me feel young again.

As one focus group participant who engages in sex work noted, "I'm willing to be with all nationalities for the financial thing. . . . [I'll] fuck producers down to the lowest street people."

In the gay communities, crystal is used within all ethnic groups. As noted in Chapter I, participants in this study were approximately one-half Caucasian/white, one-fifth Hispanic/Latino, one-fifth African American/black, and less than 10% were Native American and Asian/Pacific Islander. However, some patterns of use emerged within gay communities. For example, as noted in Chapter I, injectors in this study were more likely to be Caucasian/white.

Although this study found crystal users to be from all ethnicities and social classes, there is a perception that the gay and bisexual crystal user is primarily Caucasian/white and professional. Frederico described his observations of the demographic patterns of gay crystal users:

> The middle to upper-middle class users tend to be white, while the men of color users are generally working class . . . mostly Latino, Chicanos, not immigrants. The stereotype of the West Hollywood crystal user is white, middle-class, employed, maybe professionals and range in age from early twenties to mid-thirties. As for the enclaves of crystal users who are men of color, they tend to be younger, late teens, and they dissipate in the late twenties and early thirties. If I were pinned down to give a profile, they would be working class.

Just over half of the study participants were gay and bisexual men of color; however, the majority of the men of color felt crystal to be more prevalent among gay Caucasian/white men than gay men of color. Participants varied in their views regarding the relationship of drug choice and ethnicity:

> A focus group discussion:
> Q: Crystal has a reputation of being a white gay man's drug. Given that you're all gay men of color, what do you think about that stereotype?

> Participant 17: I think it's true to an extent. Like I said, through my personal experiences, I've run into more white gay men that use it than I have men of color.
>
> Participant 18: I think so too.
>
> Participant 19: Yeah.
>
> Q: What do you find to be the case?
>
> Participant 20: Um, I just find that everyone has a drug of preference. I mean, some people like crack, some people like heroin, some people speed. Drugs aren't racist. Drugs will try to take anybody down.
>
> Q: Based on your experiences, who do you see using?
>
> Participant 20: I just see everybody using.

Frederico spoke of the prevalence of crystal in many gay communities, not just Caucasian/white users:

> What I've been reading is that one idea [about crystal] is primarily coming from like this West Hollywood [dance club] experience, and I would have to say that there is some bleeding [ethnic diversity] in. There are still communities and enclaves that are outside of that particular image or stereotype you would have of crystal users. I would say there's a definite scene in the whole gay cosmos which happens in different parts of East L.A., specifically El Monte, Bell Gardens, North Long Beach which is heavily Latino, some blacks, and a smattering of Pacific Islanders and Filipinos and some Asians. In fact one of the bigger dealers out here in L.A. is Japanese, so it's a colored [ethnically diverse] scene.

The men of color who were interviewed also reported that crystal tends to be more commonly used by Caucasian/white men than by men of color. Several men of color told of using crystal with their Caucasian/white friends. However, one participant, James, who is an African-American drug dealer and works with communities both of color and of Caucasian/white users, reported that African-American communities tend to use drugs other than crystal.

> Q: Where do you usually get your crystal?
>
> James: I get my crystal through, like I said earlier, various friends . . . You know, then there are also places where I can't get it myself because there is a large percentage of people who are doing crystal that are like, Aryans, the Aryan brotherhood.
>
> Q: Because you're black?

> James: Yes. And see, that's another realm, too.
>
> Q: Is it a white drug, is it a black drug?
>
> James: It's a white drug.
>
> Q: Why do you say that?
>
> James: Because in the black community crystal is not even thought of. It's a white drug, it's a biker drug. I mean when you think of Hell's Angels, you think of they're doing crank, which is crystal. You see crystal, they have different names for it, crystal, speed, crank, meth, it's all the same thing.

James' experience, which differs from the findings of this study, is that crystal is used only by Caucasian/white gay men. The distinction made by gay men of color who were participants was not that gay men of color do not use crystal, but rather that they prefer to snort or smoke the drug. This is consistent with the data presented in Chapter I.

> Q: Do you think crystal is used differently by gay men of color than white men?
>
> Participant 21: They say a lot more white men shoot than colored [*sic*] guys shoot. I mean, colored [*sic*] guys don't shoot. Most of the ones I know don't. They all snort it.

Unlike drug-use patterns evident in heterosexual populations, the use of crystal within gay communities crosses both ethnic and class boundaries. Within African-American communities in Central and South Central Los Angeles, crack has been reported as a sexual drug among some African-American/black men who have sex with men (S. Shoptaw, personal communication, March 1997). Within these communities, if one's primary identification is based on ethnicity (i.e., black gay man) then he may be more likely to use crack as a sexual drug. Whereas if one's primary identity is based on sexuality (i.e., gay black man) and his primary affiliation is within gay communities, then he is more likely to use crystal as a sexual drug. Because crystal use in the gay communities is so intricately linked to sexuality, the drug is not confined to any specific ethnic or class parameters. Among gay communities, sexuality is the vehicle by which crystal transcends these boundaries.

The "Slammers" Network

Social networks are also formed around method of use, primarily among injection drug users. Timothy, who injects crystal, described the unity he experiences as part of the "slammers" (i.e., injectors) subculture:

> A lot of people in the crystal meth community are totally against slamming, and they won't allow you to do it in their house. . . . Slammers pretty much look out for each other. It's really strange, it's kind of like, I don't know, if you ever saw *Paris Is Burning*, and that whole subculture and how they kind of watch out for each other and they take care of each other, and when somebody's down they try and help them out, slammers are the same way. . . . People that do drugs, especially crystal meth, and specifically people that slam know that you've had a hard time. Even if you don't have any money and you've helped them out in the past, they will give you a quarter of their dope. They will help you out.

Injectors were described as a distinct group of users by both injectors and non-injectors. Injectors were referred to in more derogatory terms and were afforded less status by the non-injectors. Consequently, injectors have more of a tendency to bond together around the marginality of their injection status than non-injectors. As noted in the following quote, Ryan had a disparaging tone when speaking of injectors.

> I hate being around tweak pigs, you know, the drugs are what they are seeking, more than anything. And there's people like that, that it's not the sex. It's not the fun, and whatever, it's the drug. And that is more so with slammers, I mean, just from my observation. . . . They [slammers] think they're having as much fun, but I don't think they are.

To Ryan, crystal is about sex. He shows disdain for those who use the drug only to get high.

The "Club Kids"

Social networks are also formed among crystal users based on varying social activities. Many of the younger crystal users form social networks around dance (e.g., "club kids") rather than around sex encounters. The youth focus group revealed that those who live at home and are employed (not as sex workers) primarily use crystal for dancing. The youth who do not live with their parents or guardians, and tend to support themselves through sex work, primarily use crystal for sex.

> A focus group participant:
> Q: Who do you hang out with when you use crystal?
>
> Participant 22: Oh, club kids, you know, with club kids.
>
> Q: What's a club kid?
>
> Participant 22: People who go around the club circuit.
>
> Participant 23: I get tingly when I take it [crystal].
>
> Participant 24: I dance better.

> Participant 22: Yeah, you dance better, 'cause you're tweaking.

Joshua described his typical crystal weekend:

> Joshua: Okay. My social life is like basically clubbing. Some of the time I'll go out weekends, just go out, tweak, just go out and have fun; the kind of people I go out with all are tweakers.
>
> Q: So what are the things that you like to do socially—you said clubbing . . . ?
>
> Joshua: Clubbing.
>
> Q: What does that involve?
>
> Joshua: Like going club-hopping, going to different clubs . . . it's just like meeting new people. Most people I meet are tweakers, and they do like bumps here, bumps there, lines here, lines there.
>
> Q: What's a typical weekend like for you?
>
> Joshua: A typical weekend is going to West Hollywood. Tweaking and stay there for a couple of hours. I'll do three lines. Then go to the A____ and party there. And like stay up Sunday, stay up Saturday do some lines, and not go to sleep for like five days later. Like stay up for two weeks straight. Get to sleep, Monday through Thursday, Friday, I party.

Although dancing was also mentioned as a chosen activity while on crystal among the older than 25-year-old users, the older users incorporate sex into their dancing. For the older users, dance is a prerequisite to sex or part of a longer "partying" weekend. For the youth users, dance is the activity. The identity of the youth "club kids" is integrated into the dance scene rather than sexual activities.

THE SOCIAL CONSTRUCTION OF A GAY DRUG

As discussed earlier, the meaning of crystal use in gay communities is associated with three primary identities: (1) the user's sexual identity, i.e., gay or bisexual; (2) the user's identity as a drug user, i.e., a user of crystal methamphetamine; and (3) the user's HIV status. The internally defined meanings attached to gay and bisexual crystal users help to explain how crystal use has come to be integrated and supported within many gay communities.

As Frederico noted, because crystal is directly associated with sexuality, as is gay male identity, the drug fits neatly into the social world of gay communities:

> The other thing too is it's like, crystal has a special purpose for gay men because so much of the way we use it is based on our sexuality or the kind of sex we have. Or, a particular reputation for, you know, being like hunters and collectors, male. I think also it's such a big deal in the gay men's community. And again there is a talent there.

Many of the effects associated with crystal use are congruent with what many gay and bisexual men value within gay culture. In the United States, gay identity is both implicitly and explicitly linked to sex. Consequently, communities that place a high priority on sexual functioning are clearly predisposed to embrace a drug that reportedly enhances sex. The identity, social networks, and institutions that mark a gay subculture have easily evolved to maintain and support the use of crystal within gay communities. The creation of social settings where crystal use is common—or, in some social situations, expected—serves to normalize crystal in gay culture. An examination of the context in which crystal is used by gay and bisexual men reveals how the drug has come to be constructed as gay.

> Marcus: You know crystal picks you up for quite some time, and therefore we have to leave the underground clubs which [are] known here in Los Angeles and everyone parties there. Everyone has done some type of drug, mostly crystal, mainly crystal. . . . We would go out to a dance club like and just dance all night and basically everyone in those types of clubs are usually tweaked out.

> Eric: Friday night or Saturday, depending on what my work schedule calls for, that's when I start. I do a nice big line. I go out. Within a couple of hours I end up at the V_____. [I] find someone that I think is real hot, ask them if they party, would you like to get high. If they say yes, I drag them into the bathroom and get them high, and then we proceed to be nasty little oinky pigs all night. The next thing you know the sun's coming up, the V_____ is now closing, it's six in the morning and we either go back to my place, or back to their place.

> Focus group participant (discussing where to buy crystal): The P____, the other was a bar, it was 7___. That was an all night bar so it was kinda like any hour of the night you can go there and score.

The Impact of HIV

Over the past decade-and-a-half, gay communities have been decimated by HIV/AIDS. The impact of HIV continues to be a salient factor, directly influencing the sexual lives of gay men in particular. Crystal use has been described as a way to dissociate from the fear and responsibility associated with sex within the era of HIV/AIDS.

> Eric: I think a lot of people that use crystal, including myself, it's because a lot of my dreams and a lot of my aspirations as to how things were going to be 10 years ago—how I was going to pursue a certain thing and be with a certain kind of person—that's

> gone. You know, that's because I don't know if I'm going to be around in the next, whew, I don't know if I'm going to be around in the next 10 years.

The presence of a virulent virus has contributed to the escalated use, acceptance, and integration of crystal in gay male communities. For some, crystal use is viewed as a plausible way to cope with the ravaging effects of HIV.

> Focus group participant: In the eighties when all my friends were alive it was always, you know, the gang getting together for dinner, the gang doing this or that. But, they all died. I'm a long-term survivor with HIV. I'm like here and they're not. So my weekends can be very, very lonely. And, as a result of that, my drug usage increased.

For some, the timing of crystal is perfect. The drug quells feelings of hopelessness and fits neatly into devastated gay communities. In this historical moment, when a gay identity is either directly or indirectly linked to HIV, one's sexual expression becomes infused with death. HIV has impacted crystal use in several areas: participants report using crystal to overcome fears associated with sex; to cope with their experience of grief and loss; and to alleviate physical and psychological HIV-related pain.

Gay-Owned/Operated Institutions

Gay-owned and/or gay-operated institutions serve to maintain and support the social networking of gay communities which, at this point in time, include the gay crystal user. Befittingly, gay-owned and/or gay-operated institutions have either opened or modified their business profiles to accommodate these consumers. For example, the sex phone line industry helps men to connect with other men who are seeking sex or sexual service. These lines are busiest during weekends; voice ads are commonly used to find men who "like to party and play," i.e., use crystal and have sex. The sex phone lines also have voice ads by men who are in search of "party favors," which is the coded reference for crystal. During 1995, *Frontiers Newsmagazine* (a popular gay magazine) reported that revenues generated by advertisements for phone sex lines were second only to advertisements for HIV doctors and medical care. As stated in *Circuit Noize: A Rag Custom Designed For Crazed Party Boys* (a national 'zine that announces circuit party advertisements and updates), Los Angeles exceeds other cities in "976" lines:

> Just a few blocks south of Santa Monica on Highland resides the Probe. L.A.'s Saturday circuit circus. Although most clubs close at 2:00 AM, Probe pounds 'til the PM on special Saturdays. . . . The city is also the "976" capital of the world, especially in the post bar hours. (*Circuit Noize*, 1996, Spring)

In addition to the sex phone lines, there are the circuit parties. These parties cater to the more affluent gay men who can afford to travel from party to party across the nation. The circuit parties usually last the weekend and revolve around a continuous celebration of gay sexuality, primarily

involving dancing and sex. The need to meet the weekend-long demands of these major party events makes crystal the perfect drug for the occasion. As *Circuit Noize* has pointed out:

> When the crowd is packed in like eels in a barrel and one's dancing is limited by space to a repetitive swaying shuffle, it's almost impossible not to brush against one's neighbors. Since it's impossible to gain any perspective of the boys that engulf and surround, many find it sensible to feel one's way through the crowd, looking for just the right space to park in the swirling sweating mass. All this touching and the close proximity of the aromatic studs that are in such abundance, often leads to the sleaze that can be found at the parties where the boys get nasty. (*Circuit Noize*, 1996, Summer)
>
> The Circuit is a series of queer parties that are held in North America. A circuit party gives us the chance to escape the pressures of our day-to-day existence and to enter the altered world where man-to-man sex is not only accepted, but is celebrated. When The Circuit comes to town, that town becomes an instant gay ghetto full of hot men behaving as queer as they care to be. (*Circuit Noize*, 1996, Summer)

Alex described the circuit parties:

> You see it's all body, body, body. They're all burning off water retention [dancing while on crystal]. And what's underneath is muscle, muscle, muscle. You know, so they look good and then they get horny and then it all ties into sex.

The crystal users' experience has become institutionalized within gay culture through gay-owned and/or gay-operated businesses such as magazines, phone lines, bars and clubs, which serve to normalize the crystal user experience.

Gay Identity and Crystal Use

The strong association between gay identity and sex serves as an internalized reinforcement for constructing crystal as a gay drug. For a gay man—where sexuality informs identity—the functional reasons for using crystal are apparent, as the following focus group participant noted:

> We all want to be eternally young and you do crystal and you've got the energy to prove it to yourself, that I can do this, you feel great.

In the following quote, Jesús talked about when he first made a direct association between his sexuality and his crystal use:

> When I was a teenager, like seventeen and eighteen, I still felt like a feminine fag, and when I started doing speed, I noticed that there was a male side to me that seemed to be like, you know, when I go out in bars and stuff. I was always being cruised everywhere, but I didn't understand it. After I did speed for the first few

> times, I was running [injecting] it, I noticed like, wow, there is this side to me. . . . There is this masculine lustful side. This side that was really an important feature to my life. And, um, it was an important feature in the sense that it was, there is something there that had to be addressed and had to be, I had to court this thing . . . this thing that I felt when I did speed.

Crystal use has been integrated and adopted as part of a gay subculture. The participants in this study discussed how they are able to fit into gay communities through the use of crystal. Crystal allows them to feel self-assured rather than self-conscious. The mere use of crystal facilitates social interactions and sexual encounters. Eric characterized crystal as an integral part of gay life:

> The gay community that I know, that I've seen around, I mean, all the way from being a bartender here to just living in West Hollywood and San Francisco and New York. The gay community, what they think about crystal, they think it's very necessary. As far as I know, they like it. They're into it. It's part of who we are.

Michael, who identifies as bisexual, uses crystal with both his gay and heterosexual friends. In the following interview excerpt, Michael recounted his experiences of using crystal within the context of different sexual communities. According to Michael, crystal use in gay social settings is always sexual; however, in a heterosexual milieu, crystal is used to listen to music, "kick back," or go find something to steal or someone to fight.

> Michael: It seems like the gay community does it [crystal] for sex, uses it for sex a lot, uses it to party a lot. The straight community, they don't use it so much for sex.
>
> Q: What do you notice in the straight community?
>
> Michael: [T]hey just do it and do it and do it and do it, you know. And in the gay community they do it. . . . They know what they're doing when they're on it. They do it when they're sexually active or they're going underground. Straight people, it's hard to explain. It's really hard to explain. I mean, I've partied with straight people before, but then it's a lot different than partying with gay people.
>
> Q: Tell me about what's it's like partying with straight people, doing crystal, what goes on, what happens?
>
> Michael: They want to go do things, they want to kick it, or, I mean, they don't want to—when I'm with gay people they want to fuck. That's all they want to do, is fuck. Straight people want to kick back and not really think about sex, I guess, you know, lounge or go kick it with people.
>
> Q: Is this a bunch of men and women, guys and girls?
>
> Michael: Yeah, whatever.

Q: And they don't want to have sex?

Michael: No, they don't think about sex. I mean they probably do, but we just kick it, you know. But if I'm with gay people . . .

Q: When you kick it what do you do?

Michael: Laying back, listening to music, bull shitting, whatever. But if I'm with gay people all they want to do is fuck, that's all they talk about is fucking.

Q: So for you, what do you, where are you with that?

Michael: Sometimes I don't mind it if the circumstance is good and I'm with an individual. But most of time I just like to kick back, I don't like mind games or whatever like that. I just like to kick back with some music. I don't really like talking that much, you know, I love music.

Q: So do you feel the same when you are tweaking with some gay friends than when you're with straight friends?

Michael: No.

Q: How do you feel when you're tweaking with gay friends?

Michael: I'll tell you, I feel more comfortable with gay people. There's none of the violence and most of them, they don't really want to go out starting shit with people, you know. You know, all they want to do is fuck. I mean, they're funny, but they make me laugh and they kick back and . . .

Q: And you're comfortable with that?

Michael: Yeah.

Q: And all the sexual stuff?

Michael: I mean, they just say it, that's all they do and I mean, I sometimes get annoyed by it or enjoy, or whatever. But I feel more comfortable around them, you know, and the straight people, they always want to go start shit. They get really anxious, all hyper, whatever.

Q: What do you mean, start shit?

> Michael: Go fight somebody or go fuck with somebody or go steal something, or some shit like to that extent. And I'm not like that. . . . Like with gay people they clean their house or whatever, you know, instead of going out and starting shit with people.

Another participant, Marcus, had the opportunity to compare crystal use in gay and heterosexual circumstances. Marcus was interviewed the week after four college friends from the East Coast came to visit. Marcus came out as a gay man after moving to Los Angeles; he remains "closeted" with his straight college friends. During their four-day visit, they decided to use crystal. While Marcus and his friends were high, they played cards, went to clubs (to listen to the bands, not to dance or cruise), and watched TV. About 12 hours into their crystal high, and after playing cards for most of the night, Marcus excused himself by stating that he had to take a friend to work. He then went to a gay bookstore known for heavy cruising. When he returned to his apartment, about four hours later, his friends were relaxing by the pool.

> It was around like 11:30 or 12 o'clock so then I get back home, these guys are laying out at the pool—wrong thing to do. In the sun, tweaked out. So, I'm like, "How long have you guys been laying out?" And they're like, "Ah, for a couple of hours," and I'm like, oh God. I said "You guys need to come in and drink some water. Lots of water." So I get 'em out of the sun and say "Come in and drink the water and take your vitamins and lay out," and they're all burnt. They were all fucking burnt, and Max's like full of sun 'cause he was out there for like three hours. And, um, so we hang around here, and this is like Friday. Friday night and so we hang around and we order us some pizza and we try to like nibble on that and no one has an appetite. And so time rolls around, and it's like about 8 o'clock and we decide we want to go out. So we started getting dressed, and as we are getting dressed, Max's like, kinda of like feeling sick. Oh, come to find out, he has sun poisoning. He started shaking, you know, he's just like totally out of it.

As Marcus recounted, sexual activity or sexual seeking was not a part of his friends' four-day visit. The absence of sex in conjunction with crystal was also noted in a *Los Angeles Times* (March, 1996) article on methamphetamine, which focused exclusively on productivity in the workplace. Demographic data under the heading "Who's Using Meth" reported ethnicity, gender, and age. Sexual identity was omitted as a demographic variable. Although a few interviewees mentioned using methamphetamine outside the workplace, only one alluded to the connection between methamphetamine and sex; he referred to the effects of methamphetamine on sex, his ability to concentrate, his sense of smell, and his enjoyment of food. The lack of connection between methamphetamine and sex in this article stands in contrast to their linkage within gay communities. Similarly, a recent *New York Times* (Goldberg, 1997) article, which focused on women and methamphetamine, stated that women primarily use the drug for weight loss and, consistent with previous studies on women and drugs, to alleviate anxiety and depression. Again, there were no associations made between methamphetamine and sex among this population.

CHAPTER IV

HIV RISKS ASSOCIATED WITH CRYSTAL USE

SEXUAL RISKS ASSOCIATED WITH CRYSTAL USE

Sexual Responsibility on Partner

Although participants are aware of their HIV status and the high risk of further HIV transmission, most HIV-positive participants said they tend not to disclose their status to casual sexual partners; they operate from the assumption that it is the responsibility of their partner(s) to use condoms and/or define what is "safe." Jerry, who was infected through shared needle use when a sex partner injected him for the first time, described that experience and denounced the man who infected him. Nevertheless, Jerry stated that it was his responsibility to protect himself in that situation. Consequently, Jerry now feels it is the obligation of everyone else to protect themselves:

> For a period of time it [HIV-positive status] made me question whether I should inform my partner of my sexual [*sic*] status; but then I rationalized in my mind that if they cared they would ask me to slip on a condom. And if they don't ask, then they don't care. Because that was my attitude about it before I was HIV-positive.

Jerry continued to explain that he negotiates safer sex, be it anal or oral, by alerting his sexual partner when he is about to ejaculate by announcing, "I'm close." At that time it is the responsibility of his partner to interpret the clue (i.e., "I'm close") and make his safe sex decisions accordingly.

> Jerry: And anytime that I am able to achieve an orgasm and, you know, I am having sex, and on the verge of it, they pretty much indicate at that time what they want me to do . . . I'll say, “I'm close.”
>
> Q: If you're fucking them, they'll say "Don't cum in me."
>
> Jerry: Well, if you're giving them head too . . . and if I say "I'm close," they either then start using their hand and mouth or they'll just say, “Go for it.” You know because I've gotten all the way up to the point of danger, "I'm close." All right, I'm in the danger zone, I'm in the danger zone, warning, warning.
>
> Q: So if they say "go for it," you will cum in their mouth or up their butt or whatever.
>
> Jerry: Yeah. I mean if I had verification that I'm going to be able to satisfy my sexual [potency] to its fullest extent then that's even better. . . . But it does have an influence on your judgment and your sexual habits because you want sex more and sometimes you're not in the position to give or have sex with someone that is terribly

> attractive. I mean you rationalize, you find that you can place yourself in any position that you want to, given the right circumstances and amount of people. I mean if you just want head and you don't want to involve yourself to having any other sex with them, you can pretty much find facilities in the places to provide that.
>
> Q: You mean, like the right sex clubs?
>
> Jerry: Yeah, yeah. Some of them have glory holes, so you just go there and do it.

Olu, who supports himself through sex work and describes himself as a "sex addict," stated that he uses crystal in every sexual transaction. His comments regarding safer sex responsibility were similar to Jerry's:

> And the sad part about it is, unfortunately, that 90% of my dates are married men sleeping with their wives, and 80% of them do not practice safe sex. They're doing drugs. I am only responsible for myself. I am not responsible for what anybody else does. If you choose to have sex, not knowing my HIV status when I'm out on the goddamn street, and unless I'm asked, I don't tell them. Because you know the risk that you are taking when you bring your ass out there in the first place. If you don't, just too fucking bad. That's not my problem.

Although Olu's statement regarding the number of heterosexually identified men purchasing gay sex cannot be verified, his comments, nevertheless, serve to punctuate the degree of unsafe sex work engaged in between men (regardless of their sexual identity).

Another focus group participant expressed his attitude about crystal, sexual activities, and safer sex:

> When I'm on crystal, it should be up to them if they want to use a condom. I'm not going to use one. If you want to be safe, you go ahead and be safe, but I'm not going to bring it up. He's got just as much responsibility as I do.

The transference of responsibility from self to sex partner could be used as a psychological tool to reduce the discomfort or guilt associated with their own sero-conversion. Implicit in their comments is the sense that these individuals are angry at themselves for becoming infected. Given that gay communities have been inundated with messages that HIV is preventable, these men feel manipulated by these prevention messages into feeling guilty for not "caring enough about themselves" to avoid becoming infected. All participants who expressed a sense of guilt regarding their sero-conversion were infected after the mid-1980s and, therefore, after HIV prevention messages stressing safer sex permeated gay communities. As explained by the following focus group participant, crystal serves to alleviate many of the feelings associated with HIV infection:

> I think the HIV issue conjures up a lot of loneliness and fear, whether or not we want to admit it. And then the crystal steps right in and eliminates all that, just like that [snaps fingers]. Forget you've got it [HIV].

One appeal of crystal is that it relieves the fear of sex and HIV. Introducing condoms during a sexual encounter signals that HIV is present; therefore, condoms serve as a reminder of all the emotional issues associated with being HIV-positive. By placing the responsibility for having safer sex on the sex partner, one can be free of the burdens and avoid directly addressing the topic of HIV.

> It's too painful to deal with sex and death at the same time . . . they don't mix. It's very difficult to feel that "Hey, I'm turned on to you, now give me an answer to a question that will tell me if I'm still going to be turned on to you." In a lot of ways [I'm] humiliated and alone.

Sexual risks associated with crystal use were reported by several participants. Many participants described social norms that have evolved around sexual interactions that allow for high-risk activities to occur without question. One focus group participant stated:

> . . . in other people it [crystal] brings out really scary things. I have seen really dark sides of people who were just not good. People into things like water sports and scat, or unsafe sex. You know, it's like, people don't care when they are on drugs. It's like, "I'll go ahead anyway."

However, a small subset of HIV-positive men believe that, although HIV status is not discussed, they always use condoms unless given permission not to. As a focus group participant stated, "If I'm in a situation and it's [HIV] not being discussed, but somebody wants the condom used, fine. . . . I mean, I have some responsibility if I know somebody is HIV-negative."

Several social norms have developed around sexual risk taking for crystal users. First, HIV status is not talked about. Participants said they assume everyone is HIV-positive. Second, many participants stated that it is up to each individual to determine what is acceptable sexual behavior, and that their sex partner(s) must tell them what is and is not permissible in their sexual interaction. Third, the responsibility for using a condom is placed on the other. Given that all sexual partners are operating from the assumption that the other is HIV-positive, and neither partner is taking ultimate responsibility for initiating condom use, these sexual norms construct a large terrain for HIV transmission.

Among the HIV-negative participants, several perspectives were expressed. In general, HIV-negative participants stated that HIV status is rarely discussed; however, they assume their partner(s) are HIV-infected. While HIV-positive participants mentioned the desire to meet other HIV-positive men for sex, no mention was made among the HIV-negative participants to seek other sero-concurrent sex partners. However, the few HIV-negative participants who were in intimate relationships with HIV-negative men did report having sex without condoms.

Thirty-nine percent (n = 7) of the HIV-negative interview participants stated they engage in receptive anal intercourse. For those within this group who have been unsafe, their high-risk sexual behaviors clustered around two primary reasons: (1) fatalism regarding the inevitability of

becoming HIV-infected; and (2) the excitement and calculated desire to take a risk. Unlike HIV-positive men, HIV-negative men did not state that they prefer to have intimate or sexual relationships with only sero-concurrent partners. The desire to be with HIV-similar partners was absent from all sexual discussions with the HIV-negative participants. This could be due to the assumption that everyone is HIV-positive, which was made by the HIV-positive participants.

Ryan and Alex, among other participants, discussed using crystal specifically to add to their sexual experiences. Ryan stated that he uses crystal to add "perversity" to his sex. For Ryan, risk-taking is a function of sexual fantasy rather than unsafe sex. Ryan always has safer sex. By contrast, Alex stated that while on crystal he desires to engage in what is considered the sexually taboo (i.e., unprotected anal sex). Both Ryan and Alex expressed their desire for sexual excitement and risk-taking; however, one of them is always safe and the other chooses to be unsafe.

Crystal-facilitated Sexual Decision-making

Ryan's decision to always use condoms stems from losing several friends to AIDS. While recently visiting a popular Hollywood hotel where crystal users have sexual encounters, Ryan recalled his surprise at others' lack of responsibility while on crystal:

> I met a young guy not so long ago at the C____ S____ on one of these tweak-a-zoid weekends . . . a hot and beautiful guy and everything. . . . I mean the guy wanted me . . . he didn't know me from Adam, and he wanted to be fucked without a rubber. They have no responsibility.

HIV status and preferred method of crystal use are often predictors of condom-use practices. Both HIV-positive and HIV-negative participants stated that HIV status is rarely discussed before or during a sexual encounter. However, those who are HIV-positive are more likely not to use condoms during any sexual act. Additionally, sexual decision-making is facilitated by the method of crystal administration; participants who insert crystal anally were more likely to mention impaired judgment related to high-risk sexual activities. These participants were also less likely to use a condom during receptive anal sex. Participants reported a fast and intense rush when anally injecting crystal; as Mark reported, crystal turns one into a "voracious bottom."

John described his experience of injecting crystal anally, emphasizing the influence crystal has on his sexual decision-making:

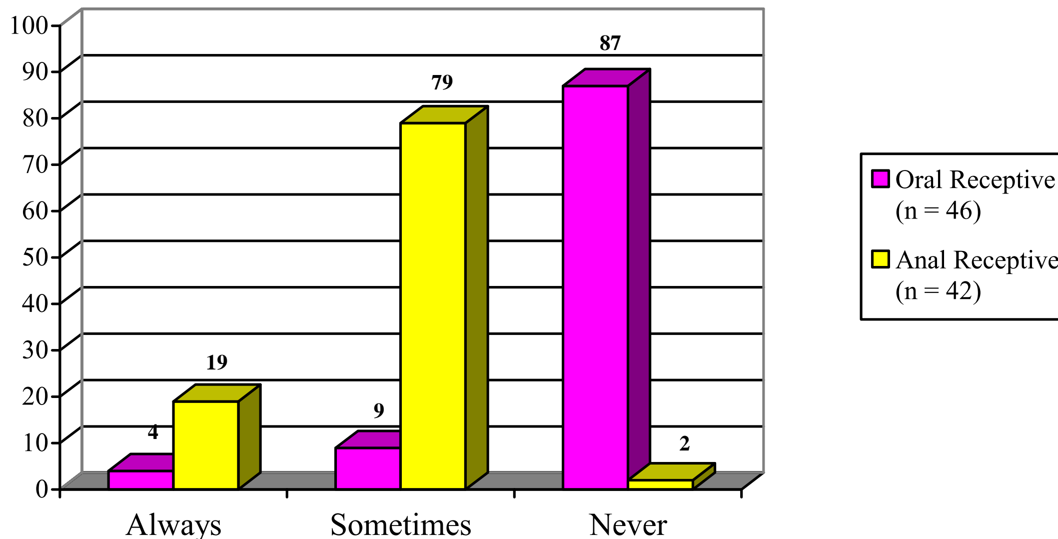
> It makes it very pleasurable to be a bottom at that point. And it then becomes definitely the method of choice. "Tooting" [snorting] is okay, but when it's time to play, that's [anal insertion] the way you want to do it. . . . Now there are dangers associated with that. If you have done it that way [anally] and you want to do a little bit more, one tends to lose sensitivity, and then you end up tearing yourself, or you end up poking a hole in your colon. Some people forget to take the point out of the needle, and this is obviously not good. I have grabbed the needle out of a person's hand who was going to give himself a lot of problems because the desire is so great.

> It's a different kind of desire than just doing a "toot." . . . The intensity of the rush is so quick and so hard, then the precautions are thrown away. Your perception is lost. The sensitivity to size [referring to dildos], you lose your judgment on trusting people, and people do shift personality-wise on the drug, and there are those who just don't care. They're going to fuck you and that's it. I've found that people are very excessively aggressive, and they aren't going to take "no" for an answer, and they literally get raped.

The interaction between high-risk sexual activities and crystal use is often mediated by method of administration. Compared with other drug-use methods, anal crystal use involves unique risks. Unprotected receptive anal sex is considered to be at highest risk for sexually transmitting HIV. Several participants reported that crystal injected anally serves to escalate risk-taking behavior involving anal sex.

The relationship between crystal and sex was discussed by all (100%) of the participants; however, not all participants discussed all aspects of their HIV risk behaviors. As shown in Figure 2, the majority of the participants (87%) never use a barrier when engaging in receptive oral sex, which is perceived by this population as "low-risk." However, during receptive anal sex, which is known to be the highest sexual risk, only 19% of the participants always use a latex barrier. More than three-quarters (79%) of the participants who engage in receptive anal sex reported that they sometimes use a latex barrier. Condom use among this group ranged from usually to rarely; therefore, it is these participants—since they have some experience with and acceptance of condom use—who would be most receptive to behavioral change interventions.

Figure 2.
Condom Use of Participants



INJECTION RISKS ASSOCIATED WITH CRYSTAL

Fifty-five percent of the participants inject crystal, and more than half (53%) of these injectors are HIV-positive. Only 11 of the interview participants discussed their injection practices. However, unlike safer sex messages, which are widely and accurately known, safer injection practices are misconceived and unclear. Although participants expressed uncertainty regarding safer injection procedures, all of the injectors knew that HIV can be transmitted through unsafe needle use. As with many subgroups of users, crystal injectors fell into three distinct categories: (1) those who are thoroughly informed about safe injections and are always safe; (2) those who have accurate knowledge regarding injection practices but do not always follow those protocols; and (3) those who are poorly informed and do not practice safer injections. All three groups have HIV-positive and HIV-negative users; complacency was more commonly expressed by HIV-positive injectors.

Commitment to Lover

Of those injectors who were highly knowledgeable about safer injection practices yet reported unsafe injections, all reported their unsafe practices in the context of sharing needles with a lover:

> Q: Why were you willing to share needles with David? You said you always used a clean needle with everyone else.
> Blanche: Because I loved him. I figured if he got it, we're together. And I don't feel that way anymore. If he gets it, he's on his own.

> Robert: One day I said, “I don't care,” and he shot me up. And right after he poked me in the arm, the first time that we shared the needle, I walked in the bathroom and almost started crying; because I knew what I had just done. But at the same time I didn't care because I was high.
>
> Q: This was a boyfriend of yours?
>
> Robert: He was my lover.

For these users, safer needle practices are not followed within the context of an intimate relationship. However, safer injection techniques are always maintained outside of the emotional or sexual relationship. Accurate knowledge regarding injection techniques does not guarantee that one will always inject safely. In these situations, the user defines a partner as "worth the risk" and relinquishes safer injection protocols as a sign of commitment.

In addition to the influence of an intimate relationships, the effects of the drug itself and the anticipation of getting high have been described as interfering with safer injection practices.

Overriding Desire to Get High

Within the group of users who do not adhere to safe injection practices, much of the HIV risk involves an overriding desire to get high and, therefore, a disregard for safe needle practices.

As this focus group participant (an HIV-positive youth) expressed, "Sometimes you just don't have the patience to wait [to get a clean needle]; you know you should but you don't. [I'm] too tweaked out to care."

Brenda described an indifferent attitude about sharing needles. Brenda often injects with her boyfriend and his older lover, who is dying of AIDS (all three are HIV-positive). She depicted a typical injection:

> Brenda: Well, I went back into the kitchen and my boyfriend was mixing the dope in the bag. He drew I think 30 units and gave Sonny [his lover] his hit . . . rinsed the needle with water. And then drew out 20 more . . . and hit himself . . . and then he put some more speed in the bag, and then drew up like 10 units for me . . . then hit me.
>
> Q: How many syringes were used?
>
> Brenda: Just one.
>
> Q: And in between each use . . .
>
> Brenda: Just rinsed.

Q: And what do you use to rinse it?

Brenda: We just used water.

Q: Is that how it usually works when you shoot up?

Brenda: Yeah. More or less. Yeah, or then I do myself if I can, if the needle is sharp or new, I can do myself. But I'd rather have people do it for me 'cause it's faster. 'Cause when I do it myself I tend to take longer, even if it is sharp, because I don't want to feel it. But, it's better when somebody does it 'cause they just kind of do it and get it over with.

Q: Where do you get your water?

Brenda: The sink. Or sometimes the needle exchange, you can get water, you know, purified water. It's better to shoot purified water than tap water, tap water got parasites and things up in there.

HIV-positive youths (under 24) who inject were more likely to express complacency about safe injection practices. Another HIV-positive youth who participated in a focus group echoed this sentiment when he proclaimed himself a "sloppy junkie":

Q: Do you have a bleach kit?

Focus group participant: I always have bleach, but I don't always use it.

Q: Why don't you always use it?

Focus group participant: Because I'm a sloppy junkie.

In contrast to these younger injectors, injectors older than 25 were more likely to be not only safer but also extremely meticulous about their injections. For example, Olu stated:

> I've never shared needles. It [safe injection techniques] is inbred in me as far as when I fix my hit, anybody in here could tell you that I go through a routine. I will not be rushed, I will not be rushed. My routine is that I use sterile water. I put it [crystal] in a bottle, not in a spoon or in one of the bags that it comes in. I put the cap back on it and I let it dissolve by itself because I'm not in that big of a goddamn rush. While this is dissolving, I go in the bathroom, I take my douche and what have you and so, by the time I'm finished doing my routine in the goddamn bathroom, this is ready. Then I have one needle that I measure the water. Then I have my tourniquet that I use. Then I get my Kleenex so that when after I do my hit and I put pressure on it. . . . I always shower before I take my hit, before I do drugs, I always

> shower before I have sex any goddamn way. Then I inject and then when I take the needle out, I put the cap back on. I make sure it registers and blood comes in, and then I push it a little to make sure that it hasn't slipped out or it's not in the damn wall of the damn vein. And, if everything is all right, then I go ahead and I inject. Then after I inject, I put the cap on and it goes into the sharpie.

Mark also maintains a very exacting injection technique:

> When you're running it [injecting crystal], there's a whole process to it. . . . I'm very, very particular about it, I don't let anybody mix it up for me. And I don't let anybody do it to me. I do it myself, and what you do is you take a spoon, and you take the amount, how much you are going to do, put it in the spoon, then you need hydrostatic water or sterilized water, and you take about 20 to 30 ccs of it, and you put it in with your crystal. . . . You use the other end of the syringe and you kind of crunch it and do it until it turns into a liquid. Then sometimes you can heat it if it won't completely melt. Then you take a cotton swab, take a piece of that off and roll it into a ball, put it into the spoon and you draw through that, so that any impurities are caught in that. Then once you've gotten it all out, then you tie off, wherever you need to tie off to make your vein pop up. Then you use alcohol to clean the area, and to clean the tip of the point, and then with the sliced edge facing up, you tap it in until you get it in the vein, then you draw back a little bit just to make sure that you are in the vein . . . blood comes back up into the syringe. Then you release the tie, sometimes you check again to make sure you are still in the vein.

The injectors who reported always practicing safe injections also stated that they prefer to be in control of their injection process. They inject themselves, either alone or, if in a social setting, in a private space. Additionally, they described detailed structure and ritual as an integral part of their injection process. Clean needles, sterilized water, alcohol, cotton swabs, and bleach are always part of their injection routines.

The safe injectors' practices go beyond injection techniques. They exhibit a degree of pre-planning in conjunction with their injection protocols. Without exception, everything that is required for a safe injection is in place and available at the time of their injection. They exercise strict control over all aspects of their injection process. The safe injectors in this study reflect all socioeconomic groups, including professional injectors who are safe and unsafe, as well as street injectors who are safe and unsafe. However, older professional men are more likely to be safe than street youth. The street users discussed the additional difficulties associated with safer injections, such as risking arrest for carrying syringes to the needle exchange. The one commonality found in the study was that injectors who are consistently safe in their injection practices always maintain control over the process, i.e., they inject themselves and they obtain their own injection paraphernalia.

CHAPTER V

CONCLUSIONS AND RECOMMENDATIONS

CONCLUSIONS

The use of crystal methamphetamine has risen dramatically in the western United States, most specifically in gay communities. This study has shown that there is no consistent profile of a gay crystal user. Rather, among gay and bisexual males, crystal users include both older and younger men, both homeless and affluent men, men of color and Caucasian/white men. Crystal users in this study clustered around two distinct socioeconomic groups: (1) street users or others who live marginally and (2) middle- to upper-middle-class educated professionals. Crystal users are of all ethnicities; however, the Caucasian/white users are more likely to be injectors. Of this study's sample of gay and bisexual crystal users over half (54%) were injectors. The large proportion of injectors among this population related their choice of injection to sexual enhancement rather than to drug intensity (the "rush" from injecting crystal increases sexual arousal).

Almost half (41%) of the gay and bisexual crystal methamphetamine users in this study were HIV-positive. This figure is significantly higher than the sero-prevalence rate of either gay and bisexual men in Los Angeles (estimated at 20-30%) or the injector population (estimated at 8-10%) in Los Angeles (HIV Epidemiology Program, Los Angeles County Department of Health Services, March 1997). Ninety-eight percent of the participants knew their sero-status. In this ethnographic research project, all interviews were unstructured and open-ended. Participants volunteered their sero-status and were not tested. Therefore, the fact that nearly all of the participants had been tested *and* returned for their test results is extremely unusual. (Only one participant did not know his sero-status; however, he stated that he believed he was HIV-positive.) This fact speaks to the reality that gay and bisexual males using crystal are aware of their high-risk activities. It is also significant to note that, even among the injectors in this study, it is sexual behavior *not* drug-related behavior that presents the greatest risk of HIV transmission. It was not uncommon to hear HIV-positive injectors recount very precise injection protocols that protect them against other blood-borne pathogens; however, these men did not discuss safer sex techniques with their prospective sex partner(s).

A complex set of internal and external dynamics associated with the use of crystal have been presented here to delineate the context of crystal use for individuals within gay communities. Among the internal dynamics addressed in this report are the meanings attached to three primary identities: (1) sexuality; (2) crystal use; and (3) HIV status. Participants have constructed their crystal use to counteract the social stigma attached to any or all of these identities.

All participants in this study discussed the importance of sex in their lives and the relationship between their sexual identity and gay sex. Participants comprised two dichotomous groups: those who use crystal to neutralize negative internal dynamics associated with gay sexuality (such as internalized homophobia, guilt, and shame) and those who use crystal—given its reputation for increased sexual functioning—in concert with an already strong gay male identity. Participants from

both groups commented that using crystal increased their status as gay men and provided them access to a group of men with whom they would otherwise not come in contact (e.g., the "party" boys).

The identity of "drug user" can hold a similarly marginal social meaning. Nearly two-thirds (64%) of the interview participants viewed themselves as functional users, often labeling others as dysfunctional. These crystal users distanced themselves from a negative self-concept by defining themselves as "functional" drug users. Descriptions of "my" *controlled* drug use and "their" *unmanageable* use were given by participants from all demographic and social groups. More financially stable users tended to describe planning and limiting their drug use in relation to their work responsibilities.

A parallel meaning is attached to an HIV identity. Many participants who are HIV-negative accepted the inevitability of their sero-conversion. Consequently, it was not uncommon to hear statements such as the following made by Eric, an HIV-negative participant, "So I'm saying that I don't know if I'm going to be around, I just don't know. The chances of me not being around in the next ten years are probably better than me going to be around." Many men referred to the "numbers game;" they have had unprotected sex with men who are now dead. The HIV-positive participants who sero-converted after the mid-1980s expressed anger toward moralistic HIV prevention messages implying that they do not care enough about themselves to practice safer sex. Both HIV-negative and HIV-positive participants stated that they do not discuss sero-status with potential sex partners. Both groups assume that their sexual partners are HIV-positive.

Over the past 15 years, gay communities have been devastated by AIDS. HIV/AIDS directly impacts the sexual lives of gay men, stripping them of their earlier, freer sexuality. The gay liberation movement of the 1970s sent messages to gay men to be "free." The AIDS crisis of the 1980s and 1990s sent messages to the same gay men to be "safe." Gay sexuality has become infused with the spectre of death. Crystal began permeating gay communities (particularly those on the West Coast) in the early 1990s, replacing much of the guilt, fear, and shame connected with gay sex in the 1980s. All participants in this study reported using crystal during their sexual activities. With the use of crystal, men can have sex without the agonizing fear of a condom breaking: "I just want to go out and get laid like a normal human being. . . ." For gay men who remember the 1970s and early 1980s, crystal is a vehicle by which their stolen sexuality can be reclaimed. Many participants have reported that their lives changed after they were introduced to crystal. For the older men, men who had experienced gay culture prior to AIDS, crystal has reacquainted them with a social/sexual environment. For younger gay men, the crystal sexual experience hints of an earlier era of gay sexuality, now romanticized as gay history.

"Gay" is the only sexual identity that is explicitly linked with sex. Certainly this is not true for a heterosexual or lesbian identity. Sex is held at an elevated status in many gay communities. Virtually every participant in this study discussed the importance of being a sexual gay man. Many participants described crystal as the drug that allows sex to be more intense, heightened, prolonged, and uninhibited. The crystal sex experience is less about an erection or orgasm and more about erotic activities, risk-taking, and sexual extremes. Given the significance of sex, anything that

reportedly enhances sexual functioning is also highly regarded. The positive effects associated with crystal are congruent with the place of sex and sexual enhancement in gay culture. For the participants in this report, gay identity is inextricably linked with gay sex.

These data do not suggest that there is a chemical component to crystal methamphetamine that translates to an immediate sexual response. Rather, what occurs is a heightened sensory experience that allows one to focus on whatever activity is chosen, be it having sex or paying bills. Participants reported an intensity associated with crystal use; many described a heightened mental awareness that enables them to focus directly on a task. Crystal users report increased creativity, stamina, and energy, as well as the ability to work longer, have deeper sensory perceptions, and experience an acute intellectual aptitude. Ashley, a transgender participant, stated that she spends hours cleaning out her purse after using crystal, and Mark commented that crystal affords him the concentration necessary to sort through a month's worth of mail in one evening.

Two participants, Michael and Marcus, described using crystal outside of a gay setting. Although they recounted completely different stories, both noted that crystal is not used within a sexual context among their heterosexual friends. Therefore, it is not the drug that is inherently (or pharmacologically) sexual, but rather the meaning attached to the drug. Historically, methamphetamine has had a long association with other populations such as biker communities and suburban housewives; however, these groups have not linked crystal directly to increased sexual functioning as do gay communities, in which crystal is defined as a sex drug. Gay and bisexual users construct the drug as sexual.

Social networks and subcommunities of crystal users form across class and ethnic differences. Group distinctions are temporarily redefined and replaced with activities associated with crystal use, such as sex or dancing. Participants in this study considered crystal as an "equalizer" in terms of the role it can play in allowing users to cross socioeconomic, cultural, and age boundaries. Subgroups form around method of use (i.e., injectors are likely to use together) and crystal-related activities (i.e., younger users discussed dancing and going to clubs while on crystal).

Drug-use patterns can be observed in other communities. African-American communities report the prevalence of crack, while Caucasian/white communities, particularly those in a higher socioeconomic range, report greater use of cocaine. However, crystal is used in many economically and ethnically diverse gay communities. Among users who adopt "gay or bisexual" as their primary identity, the construction of crystal as a gay drug allows sexuality to transcend class and ethnic boundaries.

Crystal is readily available and accessible through gay institutions at all socioeconomic levels. Most study participants (84%) were introduced to crystal within a gay-related context; within that group, slightly over half (44%) were introduced to crystal by a sexual partner. Nearly all participants relied on gay drug dealers and met sex partners through gay-related institutions. The external social world of gay-owned and/or gay-operated institutions works in conjunction with the internal meaning individuals attach to their gay identity. Gay institutions maintain and support the social networking of gay communities; currently, these include gay crystal users. Gay businesses have modified their

operations to accommodate gay and bisexual crystal users. The use of crystal in gay communities is facilitated through various gay institutions such as telephone sex lines, personal advertising, computer networks, circuit parties, bars, and clubs.

Participants described evolving social norms that allow for high-risk sexual activities. Both HIV-positive and HIV-negative participants reported that HIV is not discussed before a sexual interaction. Both HIV-positive and HIV-negative participants noted that they place the responsibility of using a barrier on their sexual partner. Participants in this study did not discuss safer-sex options; rather, each placed sexual responsibility on the other. As Jerry noted, "If they cared, they would ask me to slip on a condom." Both HIV-positive and HIV-negative participants stated the assumption that everyone is HIV-positive. Increased sexual risk-taking is associated with using crystal, regardless of the user's socioeconomic status, ethnicity, or age.

The vast majority (87%) of the participants never use a condom during receptive oral sex, which is perceived as "low-risk" and worth the risk. However, during receptive anal sex, which is known to involve the highest sexual risk for HIV transmission, 79% of the participants reported using a condom only occasionally. These participants would be most likely to benefit from behavioral change interventions, given that they have some experience with and acceptance of condom use.

HIV risks associated with crystal use are more directly related to sexual behaviors than to drug use. Those participants who attributed their HIV infection to unsafe injections combined sex with their drug use. For example, Jerry told of sero-converting when a sex partner injected him, and Brenda stated that her boyfriend, with whom she shares both injection equipment and sex, infected her. For these users, safer injection practices were relaxed in the context of an intimate or sexual relationship. For gay and bisexual injectors, definitions of romantic love, commitment, and the primacy of sex must be part of any intervention strategy. In this population, HIV transmission is most likely to occur in the sexual arena, and HIV intervention strategies that are geared toward injectors must also address sexual dynamics.

Injection risks unrelated to an intimate or sexual relationship were reported primarily among poor and homeless users who have difficulty gaining access to clean injection equipment. Additionally, HIV-positive youth who inject are more likely to be negligent regarding safer injection practices than are older injectors.

This ethnography illustrates a complex matrix of internal and external factors involved with the use of crystal in gay communities. The relationship between crystal use, sexual identity and behaviors, and gay cultures is interactive; consequently, HIV prevention interventions must be multi-tiered to address both the internal and external dynamics of crystal use.

RECOMMENDATIONS

- This report identifies two distinct demographic and social groups of crystal users. Educational attainment and socioeconomic status reflect a bimodal distribution. One group

could buy sex, whereas the other sells sex. HIV interventions must address these two groups separately, as behavioral change interventions relevant to one group may not work for the other.

- Interventions for gay and bisexual crystal users (injectors and non-injectors) should address both high-risk sexual and drug behaviors. Because the primary route of infection for this population is risky sexual behaviors, sexual activities and sexual motivations must be considered even when drug use is the focus of the intervention.

- For gay and bisexual injectors, the meaning of romantic love, commitment, and the primacy of sex must be addressed in designing drug intervention strategies. Many gay and bisexual crystal injectors relax their injection protocols when injecting with a sex partner. Among this population, HIV transmission can occur through both drug-related and sexual behaviors.

- All the participants in this study discussed their lives as gay or bisexual men and the roles crystal plays in their social/sexual lives. Crystal use is embedded in their identities as sexual gay men, or men having gay sex. Interventions must address gay identity, the meaning of adopting a gay identity, and the meaning of gay sex. These interventions must be modified, however, to accommodate those who place "gay" as a secondary identity. For example, many men of color define their ethnicity as their primary identity and their sexuality as secondary (e.g., black gay man versus gay black man).

- This study found that only 19% of the participants "always" use a condom during receptive anal sex. Seventy-nine percent of the participants "sometimes" use a condom, and 2% "never" use a condom during receptive anal sex. Therefore, more than three-quarters of the participants have had some experience with and acceptance of condom use. HIV intervention should be geared toward increasing consistent condom use among this population.

- HIV interventions for gay and bisexual crystal users cannot be understood outside the historical context of AIDS. For older gay men, sex on crystal is reminiscent of sex during the gay liberation era of the 1970s. AIDS has robbed gay men of a form of sexual expression. Young gay men live in the shadow of death, with only history to teach them that gay life was ever different. The transmission of a lethal virus through sexual activity has inextricably linked sex with death for gay males at this historical moment. The use of crystal methamphetamine, a drug that reportedly enhances sexual functioning, has escalated in the midst of this epidemic. Consequently, HIV interventions must address the impact of AIDS on both the individual user and the gay communities and must acknowledge that, for some, crystal use is historically and socially relevant.

- All participants discussed internalizing their sexual identity, crystal-user identity, and HIV identity. For some, the adoption of these three primary identities was alienating and led to internalized homophobia, guilt, shame, and isolation. Others discussed the desire to integrate their three primary identities without negative social consequences. HIV

intervention strategies built around crystal-using norms and a community of users, and designed to promote dialogue among and about gay crystal use before reducing drug use, could encourage social support and behavior change.

- HIV interventions can work simultaneously with the individual and with the gay communities; both behavioral and community interventions are needed. Crystal has a very particular meaning for gay communities, and institutions have been structured to accommodate crystal use. There have been sex drugs in the past and will be in the future; however, given the prevalence of HIV in the gay communities, there has never before been a sex drug so clearly and directly connected to death.

REFERENCES

Babbie, E. (1989). *The practice of social research*. Belmont, CA: Wadsworth.

Bersani, L. (1989). Is the rectum a grave? In D. Crimp (Ed.), *AIDS: Cultural analysis, cultural activism* (pp. 197-222). Cambridge, MA: MIT Press.

Butler, J. (1993). *Bodies that matter.* New York: Routledge.

Cunningham, J. K., & Thielemier, M. A. (1995). *Trends and regional variations in mephetamine-related emergency admissions: California, 1984-1993*. Irvine, CA: Public Statistics Institute.

EMT Associates, Inc. (1991). *Gay men, lesbians, and their alcohol and other drug use: A review of the literature* (Report for the Lesbian and Gay Substance Abuse Planning Group). San Francisco: Author.

Goldberg, C. (1997, March 16). Way out west and under the influence. *New York Times,* p. E16.

Harris, N. V., Thiede, H., McGough, J. P., & Gordon, D. (1993). Risk factors for HIV infection among injection drug users: Results of blinded surveys in drug treatment centers, King County, Washington 1988-1991. *Journal of Acquired Immune Deficiency Syndromes, 6*, 1275-1282.

Kammon, S. (Ed.). (1996, Spring). *Circuit Noize, 7.*

Kammon, S. (Ed.). (1996, Summer). *Circuit Noize, 8*.

Klee, H. (1992). A new target for behavioural research—amphetamine misuse. *British Journal of Addiction, 87*, 439-446.

Krueger, R. (1988). *Focus groups: A practical guide for applied research*. Newbury Park, CA: Sage.

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry.* Newbury Park, CA: Sage.

Los Angeles County Department of Health Services, HIV Epidemiology Program. (1997, January 15). *Advanced HIV disease (AIDS) surveillance summary*. Los Angeles: Author.

Marsh, B. (1996, July 7). Meth at work: In virtually every industry, use among employees is on the rise. *Los Angeles Times,* pp. D1, D4.

Massarik, F. (1981). The interviewing process re-examined. In P. Reason, & J. Rowan (Eds.), *Human inquiry: A sourcebook of new paradigm research* (pp. 201-206). New York: John Wiley & Sons.

McCusker, J., Westenhouse, J., Stoddard, A. M., Zapka, J. G., Zorn, M. W., & Mayer, K. H. (1990). Use of drugs and alcohol by homosexually active men in relation to sexual practices. *Journal of Acquired Immune Deficiency Syndromes, 3*, 729-736.

Morales, E. S., & Graves, M. A. (1983). *Substance abuse: Patterns and barriers to treatment for gay men and lesbians in San Francisco* (Report to Community Substance Abuse Services, Department of Public Health, City and County of San Francisco). San Francisco: Author.

Morgan, D. (1991). *Focus groups as qualitative research*. Newbury Park, CA: Sage.

Nardi, P. M. (1982). Alcoholism and homosexuality: A theoretical perspective. *Journal of Homosexuality, 7*, 9-26.

Patton, C. (1996). *Fatal advice: How safe-sex education went wrong*. Durham, NC: Duke University Press.

Reback, C. J. (1995). Constructing the outreach moment: Street interventions to women at risk. In B. E. Schneider, & N. E. Stoller (Eds.), *Women resisting AIDS: Feminist strategies of empowerment* (pp. 170-191). Philadelphia: Temple University Press.

Reback, C. J. (1996, June). *HIV risk factors among gay, bisexual, lesbian, and transgender street users.* Poster session presented at the 58th Annual Scientific Meeting, The College on Problems of Drug Dependence, Inc., San Juan, Puerto Rico.

Reback, C. J., & Shoptaw, S. (1977). Methamphetamine use and HIV-related sexual behaviors among gay and bisexual males in Los Angeles. Unpublished manuscript.

Rose, D. (1990). *Living the ethnographic life.* Newbury Park, CA: Sage.

Sedgwick, E. K. (1993). *Tendencies.* Durham, NC: Duke University Press.

Spradley, J. P. (1979). *The ethnographic interview.* New York: Holt, Rinehart & Winston.

Spradley, J. P. (1980). *Participant observation.* Orlando, FL: Harcourt Brace Jovanovich.

Stall, R., & Wiley, J. (1988). A comparison of alcohol and drug use patterns of homosexual and heterosexual men: The San Francisco men's health study. *Drug and Alcohol Dependence, 22*, 63-73.

Strauss, A., & Corbin, J. (1990). *Basics of qualitative research: Grounded theory procedures and techniques*. Newbury Park, CA: Sage.

Watney, S. (1987). *Policing desire: Pornography, AIDS and the media.* Minneapolis, MN: University of Minnesota Press.

Watters, J. K., & Biernacki, P. (1989). Targeted sampling: Options for the study of hidden populations. *Social Problems, 36*, 416-430.

Watters, J. K., Reinarman, C., & Fagan, J. (1985). Causality, context, and contingency: Relationships between drug abuse and delinquency. *Contemporary Drug Problems, 12*, 351-373.

Waugh, T. (1996). *Hard to imagine: Gay male eroticism in photography and film from their beginnings to Stonewall*. New York: Columbia University Press.

Weatherby, N. L., Needle, R., Cesari, H., & Booth, R. E. (1994). Validity of self-reported drug use among injection drug users and crack cocaine users recruited through street outreach. *Evaluation and Program Planning, 17*, 347-355.

Weeks, J. (1986). *Sexuality*. London: Tavistock Publications.

Zeller, R. A. (1993). Combining qualitative and quantitative techniques to develop culturally sensitive measures. In D. G. Ostrow, & R. C. Kessler (Eds.), *Methodological issues in AIDS behavioral research* (pp. 95-116). New York: Plenum Press.

APPENDIX A

THE INTERVIEW PARTICIPANTS

Alex is a 27-year-old white gay man who is HIV-negative. Alex is an entertainer in the sex industry. He is an actor in porn films, a go-go boy (i.e., dancer), and a personal escort. Alex describes himself as a therapist, stating he is in the business of making people feel good through his sex work.

Ashley is a 17-year-old Native American transgender who is HIV-negative. Ashley moved, on her own, from Oklahoma to Los Angeles about four years ago. She said she never expected to be in a gang or sell dope; she now does both. However, sex work is her primary source of income. Ashley describes her life as, "A hectic, hectic, hectic road to go down."

Bill is a 44-year-old African-American bisexual man who is HIV-positive. Bill currently lives with friends in a small, bare apartment. As a result of AIDS, he is on disability. Bill first started using heroin and marijuana in 1969; he uses crystal because he doesn't want to "face life on life's terms." Bill doesn't sell drugs but serves as a "helping hand" by telling others where and how to find drugs. Bill makes enough money as a helper to score his drugs and claims that the more money he has, the more he uses. When asked if he has any words to pass on to others about crystal, he simply said, "Don't."

Blanche is a 51-year-old white gay male who is HIV-negative. Blanche recalls his days as a glamorous drag queen. He was in the Stonewall bar on the evening of the riots, and is very proud of the fact that drag queens launched an international social movement. Blanche has used drugs for over thirty-five years. He switched from heroin to crystal four years ago because it is cheaper. He lives alone in a studio apartment and says his only friend is his cat.

Brenda is a 24-year-old Pacific Islander transgender who is HIV-positive. She lives with her boyfriend and his older lover who supports them. She has been doing sex work for about seven years. Brenda tested HIV-positive last summer and is sure she was infected by her current boyfriend. Brenda states, "I gave up my life for my boyfriend." When discussing crystal, Brenda says she "just wants to flirt, have sex, make money, and prostitute."

Clifford is a 35-year-old white gay man who is HIV-negative. He is a self-employed professional and uses crystal for both work and recreation. He states that he has created some of his best work on crystal. Clifford does not identify as a drug addict and is critical of those who demonstrate no self-control. According to Clifford, crystal definitely raises his sexual awareness.

Eric is a 32-year-old Latino gay man who is HIV-negative. Eric is employed as a studio sound technician and picks up extra money working construction. After his lover died from AIDS, Eric significantly increased his crystal use. He defines his crystal use immediately after his lover's death as "out of control." However, he now calls himself a "responsible drug addict." Crystal allows Eric to be "open sexually in the midst of this horrible thing [AIDS]." Eric has a strong commitment to his gay community and believes we are all in this together. He does volunteer work at an AIDS service organization.

Frederico is a 29-year-old Pacific Islander bisexual man who is HIV-negative. Frederico works in a community-based social service organization. He describes how he uses crystal to gain self-knowledge and introspection. Frederico believes the entire crystal experience is important for personal insight and can be used for self-improvement. Both the "highs" and "lows" of a crystal run offer insights into issues that can be addressed in one’s life. Frederico uses a very exact formula in calculating his drug use. For every day of use he allows two days to come down. He incorporates classical music, meditation, and masturbation into the coming down process.

James is a 45-year-old African-American gay man who is HIV-negative. Although trained as a electrician, James now works as a drug dealer. He calls himself a "commodities broker." James describes his life as risky and dangerous; he moves from motel to hotel so people can't find him. James prides himself on his street expertise and business savvy. He enjoys crystal for dancing and meeting men. James' hope is to regain the lifestyle he lost due to his drug use.

Jason is a 23-year-old African-American gay man who is HIV-negative. Jason lives in an inexpensive hotel with a reverend who is HIV-positive. Jason is a sex worker on the streets, and he appreciates the fact that crystal can enhance his capacity for work. Jason talks a great deal about his hope to live a different life and to make changes in his life. He would like to find a job and get off the streets. He states that he uses crystal to "forget about missed opportunities."

Jay is a 22-year-old white man who is HIV-negative. Jay is questioning his sexual identity. To Jay, hustling is a business. He enjoys being paid to have sex, and he prefers not to repeat his clients. Contrary to the practice of many HIV-negative men who believe sero-conversion is inevitable, Jay is extremely conscientious about his condom use and is determined to stay HIV-negative.

Jerry is a 29-year-old white man who is HIV-positive. He is a personal assistant for a drug dealer. Jerry states he can't enjoy sex without crystal and always has sex when high. Jerry sero-converted when he shared a needle with an HIV-positive sex partner. He is very bitter about that experience. When asked about his crystal use Jerry states, "It

hasn't caused me any problem." Jerry would like to use more and have sex more often, but his job interferes with his ongoing use.

Jesús is a 34-year-old Native American gay man who is HIV-negative. Jesús is an artist; he works in mixed-media and assembles sculptures that express social statements. He is homeless and moves from friend to friend. When he discovered crystal, Jesús discovered his masculine sexuality.

John is a 43-year-old white gay man who is HIV-positive. Prior to receiving disability due to HIV, John worked as an engineer and was president of a company. John spoke of how crystal enhances his intellectual abilities; he was viewed by his colleagues as a "rising star." He referred to crystal as "lady meth" who brought "gifts" such as increased productivity and sexual pleasure. John states that he is "addicted to being productive and the implement is crystal." However, now that the gifts of lady meth have become elusive and replaced by "meth monsters," he is contending with a different side of crystal use.

Joshua is a 20-year-old African-American gay man who is HIV-negative. Joshua left home after coming out to his family at the age of 14; he describes the pain of being called a faggot by his mother. Joshua likes to go dancing and "party" with his friends. He gets his crystal from his lover, who deals drugs. Joshua listens to his body to regulate his drug use, which is under control because, unlike many of his friends, he doesn't have to sell anything to get it.

"M" is a 30-year-old African-American bisexual man who is HIV-negative. "M" describes himself as a loner and computer nerd. At one time "M" was a go-go dancer and part of the active L.A. party circuit. "M," who has a background in nursing, views drugs as any substances that are ingested, from vitamins to crystal. His personal guidelines to drug use include knowledge of the body and the substance, and an awareness of his limits. After using crystal, he stresses the importance of taking vitamins, getting rest, and drinking plenty of fluids to cleanse his liver and kidneys. According to "M," getting crystal is easy: "pretty face, pretty boy, everyone offers it to you. . . . It's like a calling card."

Marcus is a 25-year-old African-American gay man who is HIV-negative. Marcus started using drugs around the age of 17. His father was a coke dealer and, therefore, drugs were easily available. After college, Marcus moved from the East Coast to California, where he was first introduced to crystal. Marcus refers to a period of unemployment when his drug use was "out of control." Marcus is now working and he limits his crystal use to weekends. His weekends are commonly spent partying either in L.A., San Francisco, or other cities to participate in circuit parties.

Mark is a 36-year-old white gay man who is HIV-positive. Mark is very knowledgeable about HIV health issues, homeopathic healing, and nutrition. He has been HIV-

asymptomatic for over 10 years. Mark states that he would like to reduce his crystal use and is looking for a nonjudgmental program that views the individual drug user with respect and dignity. Mark primarily uses crystal for sexual reasons, although he explains that at this point in his life, "sport sex" (sex on crystal) is not fulfilling and he is more interested in pursuing "affectionate sex" (sex off crystal).

Michael is a 21-year-old Latino bisexual man who is HIV-negative. Michael shares an apartment with a close friend and works as a firefighter. He hangs out with "underground people, club kids, and everyone from gang members to prostitutes." Michael enjoys doing crystal when he goes to clubs, and he usually buys his drugs at the clubs. There was a time in his life when he used crystal daily. He says of that period, "Speed was my life, I wasn't doing nothing for myself." At another time, Michael left L.A. and went home to try to stop using. After awhile, he said he got bored and returned to L.A. and started using again. Now he uses crystal primarily on the weekends.

Mickey is a 20-year-old white bisexual man who is HIV-negative. When Mickey was nine years old, he and a friend ran away from home to escape his father's abuse. Mickey lives with his transgender girlfriend and works the boulevard because the money is good. He makes as much as $800 in a night. Mickey has done "normal work" and enjoyed it, but he can make much more money on the boulevard. Mickey injects and says he always uses clean equipment, he always uses condoms, and doesn't get fucked. Mickey speaks fondly of his one-year-old daughter who lives in Florida. Mickey identifies as a white supremacist. He hasn't told his gay friends that he is a white supremacist, and he hasn't told his white supremacist friends that he is bisexual and has many gay friends.

Olu is a 48-year-old African-American gay man who is HIV-positive. Olu refers to himself as a sex addict and engages in sex work as a way to increase his number of sexual encounters. He states that he is "always cruising for men." He has also been a spokesperson for needle exchange, and he is an ardent proponent of safe injections, always following a strict injection protocol. Although trained in nursing, Olu no longer works—due to HIV—and is currently on disability. Olu is open with his doctors regarding his crystal use, and he will not take any HIV medications that could interfere with his drug use. Olu verifies possible complications by using a PDR software program on his computer.

Robert is a 24-year-old Native American gay man who is HIV-negative. Robert originally started doing crystal as a way to lose weight and is pleased that crystal allows him to maintain his weight loss. He began doing sex work as a way to get money to help a roommate pay for his HIV medications. Robert is currently homeless and describes his relationship with other homeless people as family.

Ryan is a 50-year-old Latino gay man who is HIV-negative. Ryan is a successful businessman who pre-plans his crystal use and sexual activities. Ryan likes sex on crystal because it prolongs the experience and enhances his ability to act out his sexual fantasies. He prefers his sexual partners to be on crystal too and will buy enough to share with others. Ryan lives with his lover of 15 years, who is HIV-positive. He talked a great deal about how HIV has radically changed his world. He recalls a time when getting together with friends for dinner was common. Now, most of his close friends are dead.

Scott is a 32-year-old white bisexual man who is HIV-negative. Scott discovered crystal when he moved in with a friend who manufactured the drug. When Scott tried crystal for the first time, he noted that the effects were similar to that of Ritalin which he was prescribed as a child. Scott is a sex worker and states that he refuses to "date" a client who doesn't treat him with respect. He says that, although he is not one to express a great deal of affection, several people pay him to be held and touched. He interprets this as a reflection of their loneliness. Scott lives in his car which is parked at a friend's apartment.

Timothy is a 31-year-old white gay man who is HIV-positive. Timothy lives with his lover, who has AIDS, and helps him with his health care. Timothy is a freelance designer. He also makes drug connections for a friend who is a dealer, thereby getting free crystal. Timothy describes a strong sense of community with other crystal injectors. Timothy explains that he has attention deficit disorder and uses crystal to help him focus.

APPENDIX B

THE FOCUS GROUPS

Former Crystal Users (n = 9)
Approximately halfway through the data collection process, it was decided to conduct a focus group made up of former crystal users to see whether these former users would describe their crystal-using experiences in different terms than currently active users did. Focus group participants were recruited by the staff of a treatment facility as well as by other former crystal users. The group met in the meeting room of a recovery house—a site that was familiar to most of the participants. The participants were screened to verify that they had been crystal-free for at least six months and that when they were using, they had used crystal at least once a month for at least six months. The duration of their abstinence from crystal use ranges from seven months to 14 years. Their ages range from 27 to 44 years, with a mean age of 34 years; 78% are Caucasian/white, and 22% are Hispanic/Latino. These former users have a high level of educational attainment, with all but one having attended college.

Youth (n = 10)
Obtaining a youth perspective was important in order to understand developmental differences among crystal users, particularly since gay and bisexual youth have only experienced their gay identity and communities in the context of HIV/AIDS. Youth participants were recruited by street outreach workers, the staff of a needle exchange program, and a local youth drop-in center. The youth focus group was held in the meeting room of the drop-in center because the participants were comfortable in this setting. The ages of these participants range from 17 to 23 years, with a mean age of 21 years; 60% are Hispanic/Latino, and 40% are Caucasian/white. Only one participant (10%) currently attends high school, 50% have dropped out of school, and 40% have graduated from high school.

Gay and Bisexual Men of Color (n = 6)
Interviews with both Caucasian/white participants and men of color suggested a general perception that crystal is predominantly used by Caucasian/white, professional men. The purpose of a focus group consisting of gay and bisexual men of color was to better understand this impression and to further examine the role ethnicity plays in the gay crystal-using communities. Participants were recruited by street outreach workers as well as by other users who were men of color. The group met in the back room of a storefront needle exchange program after exchange hours. The ages of the participants range from 19 to 45 years, with a mean age of 29 years; 17% of the men are Native American, 33% are Hispanic/Latino, and 50% are African American/black. None of the participants are high-school graduates.

HIV-positive Street Users (n = 8)

Conducting a focus group comprising only HIV-positive crystal users provided the opportunity to gain a more complete understanding of crystal use in direct relation to HIV. Participants were recruited by street outreach workers as well as by other HIV-positive users. The group met in the back room of a storefront needle exchange program after exchange hours. The participants range in age from 24 to 47 years, with a mean age of 33 years. Three-quarters (75%) of the participants are Caucasian/white, and one-quarter are African American/black. Half of the participants have less than a high-school education, one-quarter are high-school graduates or have a GED, and the other 25% have some college education.

HIV-positive Professionals (n = 5)

A second focus group was conducted with HIV-positive participants. Participants in the first HIV-positive focus group had inadvertently been recruited from similar socioeconomic environments (i.e., they were predominantly street users). Therefore, for reasons of comparison, a second focus group was organized with HIV-positive professionals. Data from both groups were analyzed to help determine the role socioeconomics can play in HIV-positive crystal users' experience. For this second focus group, participants were recruited by social service providers who work with middle-class and upper middle-class HIV-positive men and who could identify which of these men were actively using crystal. The focus group met in the meeting room of a youth drop-in center chosen for its central location and availability. These participants' ages range from 24 to 44 years, with a mean age of 35 years; 80% of the participants are Caucasian/white, and 20% are Hispanic/Latino. One-fifth (20%) of the participants have a GED, 60% have attended or graduated from college, and 20% have a graduate degree.