Clinical Note

CRACK 'HOS AND SKEEZERS: TRAUMATIC EXPERIENCES OF WOMEN CRACK USERS

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The involvement of women in crack cocaine abuse has had a severe impact on their health, the health of their children and the stability of their communities. Of particular concern has been the development of a system of barter in which crack-for-sex exchanges are the means through which women obtain the drug. Earlier studies have suggested that drug abuse may be related to and exacerbated by trauma. In the project described herein, we interviewed women crack users in Harlem to study the relationship between trauma, crack use, and crack-related sexual behavior. Results suggested the existence of three types of trauma: (1) traumas that predate the respondent's onset of crack use; (2) traumas that were the direct sequelae of crack use; and (3) stigma trauma, that is, trauma that results from membership in a despised or oppressed group. We observed a complex inter-relationship involving crack use, crack-for-sex transactions, and these three types of trauma. Treatment of the eventual co-morbidity of trauma and addiction is an urgent challenge.

KEY WORDS: Crack-cocaine, black women, trauma, posttraumatic stress disorder (PTSD), substance abuse, HIV

Women in the Crack Epidemic

Crack cocaine use has become epidemic in many impoverished inner-city areas in the United States. Crack use and sales have been associated with an increase in homicide, family disruption, and a breakdown in the response capacity of the law enforcement system (Wachtler, 1990). Crack users face risks from a wide variety of side effects of the drug that can, in extreme cases, cause sudden death. Crack can cause serious complications of pregnancy and delivery (Chasnoff, Landress, & Barrett, 1990; Cherukuri, Minkoff, Feldman, Parekh, & Glass, 1988; Neerhof, MacGregor, Retzky, & Sullivan, 1989), and there is evidence that crack use is associated with dramatic increases in the incidence of sexually transmitted diseases among black women nationwide (Fullilove, 1990).

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Fullilove, Bowser, & Gross, 1990; Rolfs, Goldberg, & Sharrar, 1990), including HIV (Sterk, 1988).

The extreme danger of the drug appears to be related to the patterns of drug ingestion. Those addicted to crack, irrespective of gender, consume the drug during periodic binges in which pursuit and use of crack outweigh other concerns. Personal safety, hygiene, nutrition, and family or occupational responsibilities are frequently ignored (Griffin, Weiss, Mirin, & Lange, 1989). Women addicts, however, are particularly vulnerable. Their extreme need for the drug often forces them to perform degrading sexual acts in exchange for crack or money (Fullilove & Fullilove, 1989). In fact, this sex-for-drugs bartering system (sex-drug-exchanges—SDE) is a unique feature of the crack culture that differs from other forms of prostitution since many transactions may involve participation in bizarre sexual practices for very small amounts of money (Fullilove, Fullilove, Haynes, & Gross, 1990).

The degradation of women within the crack culture has led to the development of stereotypes and labels, including such derogatory terms as “crack 'ho” (crack whore) and its equivalent, “skeezer.” This type of stigmatization expresses group disapproval for behavior that fails to meet culturally defined standards for women. The intense stigmatization of women within the crack culture appears to be part of a complex pattern of abuse that may include: a history of sexual or physical abuse during the childhood of the woman user; sexual and physical abuse in the context of current crack use; degradation and victimization through participation in sex-for-drugs exchanges; and public, as well as private, castigation for failure in maternal roles (Griffin et al., 1989; Wachtler, 1990).

Trauma and Trauma Disorders

The current version of the American Psychiatric Association’s Diagnostic and Statistical Manual, the DSM-III-R, defines trauma (i.e., in relation to post traumatic stress disorder) as unusual events that are extraordinarily stressful or disturbing—experiences that do not occur in the lives of most people but, when they do, are frightening, upsetting or distressing to almost everyone. Terr (1991) expands on this definition to include serial traumatic experiences, defined as a series of long-standing and anticipated blows.

Terr’s modified definition of trauma is particularly helpful in understanding the trauma experiences of people subjected to discrimination because of their membership in a group defined by race, ethnicity, religion, gender, or sexual orientation (Fanon, 1968). Racial discrimination, for example, involves the definition of one racial group as inferior to another, that is, as less “human” than the superior group. Such definitions have been used to justify enslavement, genocide, and apartheid. The social interactions of a divided society include many acts, such as residential segregation, public humiliation, and planned extermination, which reinforce the stigmatized status of the subjugated group. Miller (in press) notes that, “When one group controls the economic well-being of another, it is likely that the dependent group will be stigmatized. The controlling group will determine the other group’s access to housing, employment, and basic resources and can therefore determine the arenas in which intergroup contact is appropriate, the nature of acceptable group contacts, and rules and norms governing interaction.”
WOMEN CRACK USERS

The problems associated with being publicly identified as "inferior" or as belonging to a "despised minority" often have daily consequences: homosexuals in Nazi Germany were forced to wear a pink triangle whenever they went out in public, and, as late as 1964, black people in the American South could only use public facilities that were designated "for colored only." The wearing of a triangle or having the "wrong" skin color leaves the individual vulnerable to name calling (e.g., "fag," "nigger," "spic") or to subtle acts of discrimination or harassment, events that take on the character of dreaded or anticipated blows.

Because this subset of traumatic events is not addressed in current definitions of trauma, and because such events happen to people who are members of a stigmatized group, we shall propose the term "stigma trauma" to characterize the social interactions that result from discrimination or oppression. It is important to note that an event involving stigma trauma can appear to be small and seemingly innocuous. However, the event is just one of many in a continuous series of acts that remind the victim of his or her stigmatized status.

Trauma is associated with a wide range of psychological disturbances. The most definitive trauma disorder is posttraumatic stress disorder (PTSD). The required features of PTSD are: 1) the trauma be reexperienced, for example, in dreams or thoughts; 2) there is numbing of general responsiveness; and 3) there are persistent symptoms of increased arousal, such as difficulty falling or staying asleep, irritability or outbursts of anger, or hypervigilance (APA, 1987). Trauma has been implicated in borderline personality disorder (Herman, Perry, & van der Kolk, 1989; Shearer, Peters, Quayman, & Ogden, 1990) and dissociative disorders (Sanders & Giolas, 1991). In fact, many researchers suggest that there is a spectrum of post-trauma disturbances in which anxiety and depression represent the mildest manifestations and PTSD the most severe.

Because trauma has also been associated with the etiology of substance abuse (Brown & Anderson, 1991), we designed this study to examine what role, if any, trauma may play in crack cocaine addiction among black women crack users and in crack-related sexual behavior. We were particularly interested in the stigma associated with being a crack user (or worse, a crack user involved with sex-drug transactions) and the role that stigma trauma might play in the lives of women crack users.

METHOD

Subjects and Data Collection

The objective of this study was to interview female crack users about their experiences of women's sexuality in the crack culture and about the stresses and traumas, if any, associated with their crack use. The process of the study was to employ two qualitative interview techniques: focus groups and individual interviews. The site for this study was a drug treatment center providing outpatient care for women crack users and located in a poor, inner-city neighborhood, characterized by the severe physical, social and economic disintegration that has been termed "urban ecological collapse" (Wallace, 1988). Treatment staff were informed about the goals of the project and requested to invite women clients to meet with the research team.

Fourteen women accepted our invitation to participate in focus groups. Two focus groups were held at this facility. Each group was attended by seven women.
At the beginning of each group, women were introduced to the research team, which included two interviewers and an audio technician. The research team explained that the goal of the session was to learn about the sexual practices of women crack users; that explicit questions about sexual behavior would be asked; that the sessions would be taped; and that participants were not required to respond to questions or to take part in the discussion. The participants were asked to give informed consent and to complete a brief, anonymous demographic questionnaire. The focus group discussion lasted approximately one hour.

The fourteen women who participated in the focus groups ranged in age from 23 to 44. Ten of the fourteen were black. The majority of the group had completed 12th grade. Though 12 of the women were mothers, only one had custody of her minor children. Two women from each focus group, selected by their counselors as representative of women in treatment, were subsequently asked to participate in individual interviews that lasted for approximately one hour.

The individual interviews were converted into transcripts and first examined for content. Of particular interest were the descriptions of events in which traumatic incidents were recounted. Next, a timeline was created depicting substance use, traumatic events and life events for each woman. In developing these timelines, we followed the models proposed by Post and colleagues (Post, Roy-Byrne, & Uhde, 1988) for the simultaneous depiction of mental illness and life events. Focus group transcripts were edited to indicate speech overlap, significant pauses, displays of intense affect, and interactions among participants (Labov, 1972).

Women were reimbursed for the time they spent in focus groups and individual interviews. Where information is presented about an individual woman, it has been carefully edited to preserve the essence of the woman's story without revealing her identity.

The data presented here are qualitative data, collected from a small number of women. The data are also incomplete in that we do not have full histories detailing traumatic events and drug use for all the women we interviewed. Thus, there are obvious limitations in our ability to generalize from these data. Nonetheless, we think that these data are worth reporting because they have immediate implications for future data-gathering activities, as well as for the collection of a pertinent medical history that may shape the planning and delivery of drug abuse treatment.

RESULTS

Experiencing Trauma

All of the women we interviewed confirmed that trauma was a common occurrence in their lives. In Figure 1, we show timelines which demonstrate traumatic and life events in the lives of two individuals interviewed. Stephanie, whose story is depicted on the first timeline, had a particularly stressful and disorganized life. In the ten-year period between 1980 and 1990, she reported eight traumatic events, including placement of her children in foster care, physical abuse, and learning of the death of one of her former lovers due to a drug overdose.
Figure 1

Stephanie

Life Events:
- 2nd & 3rd children born
- 4th child born
- Pregnant with 5th child
- Moved to Queens, 5th child born
- Pregnant with 6th child
- Birth of 6th child
- Became homeless, 5th child given away
- Beaten, life threatened
- Became homeless, 6th child given away
- Abused, she stabs abuser
- 6th child taken
- Living in shelter
- Treatment sought

Traumatic Events:
- 1st child given away
- Child dies
- Children's father dies from OD
- Children's father dies from OD
- Beaten, life threatened
- 6th child taken

Drug use:
- 1980
- 1986
- 1990

Andrea

Life Events:
- Lost job
- Pregnant
- Crack runs for father
- Pregnant
- Lived in hotel
- Earned $ for drugs; was crack "whore", pimp, pickpocket
- Treatment sought

Traumatic Events:
- Mother died
- Apt. burned
- Child taken away
- Became homeless
- 2nd child taken away
- Beaten
- Choke hold victim
- Kidnap near-rape
- Raped

Drug use:
- 1987
- 1990

Symbols:
- Alcohol
- Marijuana
- Heroin
- Crack
- Methadone
Stephanie gave birth to many children. Eventually all of them were placed in other homes. Of her first child, she said,

My oldest daughter, you know, she didn’t come out with the withdrawal, and nothing like that, you know. But they took her away from me, anyway. And plus, I signed papers for—pause—I wanted them to adopt her because further I didn’t know how to take care of no kids, and when I was living with my mother, my brother, he was, you know, he was an addict. My sister was an addict. I was an addict. Mother used to drink a lot. So the house, you know, my place, there was a lot of people in the house shoot up drugs. I would bring people to shoot up, and my sister would bring people to shoot up ... I didn’t want nothing to happen to her, so you know ... The way my brother was carrying on—breaking and screaming, yelling—was no good for my daughter to be there.

Stephanie’s homelife was chaotic and abusive, and her adult relationships followed a similar pattern. For example, the father of her fourth child was a man she met through church. As the relationship progressed, he began to beat her:

Then he started getting viler and started hitting me and stabbing me and he broke my ribs with a pipe, and he broke my jaw ... He used to drink too. He used to be in a methadone program. And after that ... my kids (were) taken away, we had a fight, and drugs and all that.

During her fifth pregnancy, she learned of the death by overdose of the father of her first two children. Drug dealers took over her apartment and converted it into a “crack spot” (a place where crack is smoked) with strangers coming and going at all hours of the day and night. Her fifth child, now one-year old, was exhausted and frightened by this chaotic situation. When Stephanie asked the dealers to leave, they beat her:

They started hitting me, punching me in my jaw. The other one would slap me. They had turned the light off, and my son was crying ... After—pause—they kept coming back ... He threatened to kill me and my son. So I left.

Later, while Stephanie and her sixth child were living with her sister, Stephanie noticed bruises on her child and accused her sister of abusing the girl. The sister defended herself by accusing Stephanie of being too high to know what was happening with her child. Stephanie tried to defend herself against these accusations:

I might have smoked crack, but I didn’t let that crack control me, control my mind, you know, so when I find out, one day my daughter had a black and blue mark on her hand ... I stabbed (my sister) in the breast ... My instinct was to easy my daughter and I wasn’t there.

Stephanie told us that, when they took her sixth child away:

I started screaming, and breaking, and that’s when I really started smoking, heroin ... then it was crack ... and then every time I would smoke, I’d think about my daughter, crying, crying.

Andrea, whose story is depicted on the second timeline, reported nine traumatic experiences during the three-year time period, 1987 to 1990. She was
a working woman at the time she started to use crack, but, shortly after starting to use the drug, she lost her job. She became pregnant and, with her mother's support, was able to stop all drug use during the pregnancy and for a while thereafter. Her mother's untimely death was the occasion for a serious relapse. She described, "I went to the bank and took out all my money. I just wanted to get high and stay high." Following closely on the heels of her mother's death, a second trauma occurred: she was burned out of her apartment. An unstable period began in which she moved between homeless shelters, the streets and the homes of relatives. During that time, her son was taken into custody because she left him with a babysitter for more than twenty-four hours.

During a second pregnancy, Andrea was able to stop using drugs "for the sake of the baby's health." After the baby was born, she lived in a welfare hotel and started using crack again. Again, she left her baby with a babysitter and did not return until late the next evening. She described the scene as:

I was coming down the street, coming home, and I seen the ambulance outside and come to find out, she (the babysitter) said the baby couldn't catch her breath and they wanted to know where the mother was and she told them that I had been gone since yesterday, so the police took the baby.

The chaos and uncertainty in Andrea's life continued. She was actively involved in sex-for-drugs exchanges and in that context suffered four traumatic events: a man hit her in an argument over condom use, she was choked by a man who thought she had robbed him, she was raped, and she was kidnapped and almost raped.

The kidnapping incident occurred because she had tried—in the language of women crack users who trade drugs for sex—to "manipulate" a man, that is, to get money from him without giving him sex. He wanted revenge, which she described in the following manner:

It was night time, it was like, just turning dark outside, and they grabbed me in the car, and they threw me in the car, and drove me to Queens and I was—at a beach somewhere, I was screaming, I was crying, I was scared. They got me this far, they must be going to kill me and leave me here. This is what I was thinking. I was so scared I started peeing on myself in their car. That is how I got loose. They said, this bitch is pissing on my car. I laugh about it now, but it was a very scary experience then. They said, "get out of the car." I was crying so much, I was scared. I had never been that scared in my whole life ... they ripped my panties off, so I knew what was coming next. I knew I was going to be raped. There was three guys, but only one of them was the one I was with that night that I manipulated. I was screaming and crying and I was crawling through the sand and somebody else car lights (went) on. Them headlights saved my life.

**Stigma Trauma**

There was universal agreement among the women we interviewed that women who smoke crack are not respected in the community. "Men ... they put crackheads down, I mean, if you smoke crack, you ain't worth ... a damned penny." The contempt for women in the male-oriented drug culture was amplified by women's participation in SDE and by their inability to maintain culturally defined gender roles—for example, functioning as mothers—while
using drugs. Women were treated as sexual objects and were particularly scorned for their failures in mothering their children. One woman described the disrespect to which a "crack 'ho" (crack whore) is constantly subjected. "You can be walking with your husband, you can be helping an old lady across the street ... and they'll say, 'Yo, baby, who's got that thing, yo, baby.'"

Another woman described the pressure to maintain maternal roles:

When I used to get my (welfare) check (my boyfriend) used to wait around me until I cashed it so he could go out there and get his drugs. My son—pause—I'm supposed to be strong, to withdraw from the drug and take care of my motherly chores, while still he's taking my money and getting high and in front of my face, knowing that I want some too, because I have a craving for the drug just as much as he does. But I'm supposed to be strong enough to say, "Wait, I have to do this first," and sometimes I couldn't do that.

Some participants carried painful memories of parenting failures. One woman who had lost a child said:

It hurts, it really hurts because you really want to do it. You really want to take care of your children and everything, but the drug is—just constantly—it's like a monkey on your back. I want it, I want it, I want it, I want it.

Women participated in SDE but felt deeply shamed by this. A woman described her own horror at participating in SDE as:

I sucked his dick, right, and he came in my mouth and I was spitting out—and he gave me $4. I was crying and shit because I knew how bad I (had) gotten. I was like, oh my god, $4 and I was out there beggin' for a fucking dollar. Before, I would never do that shit (fellatio), and I was doing it for nothing.

In the second focus group, women candidly described their participation in sex-for-drug exchanges. One woman qualified her involvement in these activities by saying, "I only did it with someone I knew, never with strangers." The other women in the group challenged her position, contending that SDE with a friend was no different from SDE with a stranger. The participants became very tense, women talked simultaneously, and their voices became louder and louder. The six who had acknowledged sex with strangers accused the seventh woman of "being in denial" and of refusing to admit that she, too, had been degraded by her addiction. The seventh woman, who felt increasingly attacked and misunderstood, continued to assert, "I never did that." A short excerpt demonstrating the intensity of the speech, the speech overlap and the content is displayed in Figure 2.

**DISCUSSION**

Perhaps the most disruptive feature of crack use in the inner city has been the development of a barter system in which sex—rather than money—can be exchanged for drugs. Crack 'hos are the creation of this barter economy as are the extreme forms of sexual degradation which are often a part of their lives. Women who are addicted to crack and who are dependent upon SDEs find
Figure 2
themselves trapped in circumstances where rape or other forms of violence are necessary risks that must be endured in order to meet the demands of their addiction. The longer women remain in “The Life”—a term that is used to describe the world that crack users inhabit—the greater the probability that they will experience trauma, and the greater the likelihood that they will subsequently develop PTSD.

Our findings suggest that crack use in some women follows a complex pattern in which users initiate crack use to relieve the symptoms of depression or trauma, become traumatized by their efforts to secure it, and then relieve this new trauma by seeking additional occasions to obtain the drug. Since these efforts all too frequently provide additional opportunities for trauma, the cycle is reinitiated.

Data from the transcripts and from the timelines suggest three types of trauma: (1) a trauma that predated the respondent’s onset of crack use (e.g., being injured in a traffic accident); (2) traumas that were the direct sequela of crack use (e.g., being raped or having one’s children taken); or (3) stigma trauma (being regarded as a crack “ho” or an inadequate mother by members of the community). Our findings further suggest that when a diagnosis of substance abuse is made, a trauma-spectrum disorder must be considered as a second, concurrent diagnosis. Such dual diagnosis will have important implications for the organization of treatment of substance users.

Rates of trauma vary greatly according to the population studied. The data presented here suggest that women crack-users who live in the inner-city are likely to experience at least one traumatic event, and many will experience more than one. Kulk & colleagues (Kulka, Fairbank, Jordan, & Weiss, 1990) studied the prevalence of trauma in a sample of Vietnam Veterans and in a civilian comparison group. They reported that while 43% of male soldiers who served in the Vietnam theater of combat reported at least one traumatic experience, only 5% of their civilian counterparts reported having experienced a trauma. Breslau and colleagues (Breslau, Davis, Andreski, & Peterson, 1991), in a study of young adult members of a health maintenance organization in Detroit, reported that 39% had experienced trauma. In settings hit by a natural disaster, the prevalence of trauma in the population can reach 100% (Maj, Starace, Crepel, Lobrace, Veltro, DeMarco, & Kemali, 1989; Shore, Vollmer, & Tatum, 1989).

Not all of those who experience trauma will develop PTSD. Researchers have examined several factors which help to explain the intermediary links between the experience of trauma and the development of later illness. Individual factors, including gender, age, race, and psychological vulnerability (as suggested by childhood behavior disorders) appear to increase risk for later PTSD (Breslau et al., 1991; Davidson & Smith, 1990; Hough, Vega, Valle, Kolody, Griswold del Castillo, & Tarke, 1990; Shore et al., 1989; Smith, North, McCool, & Shea, 1990).

Some factors that are specific to certain kinds of trauma affect the prevalence of PTSD in a traumatized group. Breslau (Breslau et al., 1991; Breslau & Davis, 1987), in the study of young adults in Detroit noted above, found that 80% of those experiencing rape were diagnosed with PTSD, as compared to 12% of those experiencing a physical assault in which no rape occurred. Among Vietnam
Veterans (Breslau & Davis, 1987) examined in a separate study, the rate of PTSD in those who had witnessed atrocities (56%) did not differ significantly from the rates for those who neither witnessed nor participated in atrocities (53%). By contrast, among those veterans who had participated in atrocities, 100% had a diagnosis of PTSD.

An association between PTSD and substance abuse has also been established. In Kulka's (Kulka et al., 1990) study, 75% of veterans with PTSD had a diagnosis of drug or alcohol abuse. Breslau and colleagues (Breslau et al., 1991) reports a prevalence of drug or alcohol abuse of 43% among those with a diagnosis of PTSD. This co-morbidity of trauma and addiction has important implications for treatment. Treatment services, struggling to understand how to treat crack addiction and how to care for women addicts, face yet another new task in program development: care for those who suffer from trauma-spectrum disorders.

The development of trauma treatment for such women must build on both the experience of treating posttraumatic stress disorder in veterans (Haley, 1985; Scurfield, Corker, Gongla, & Hough, 1984) and the growing experience of treating sexual abuse (Rose, 1986). That body of work would suggest that peer support will be a critical element in recovery. Bollerud (1990), describing a treatment service for women recovering from alcoholism, found that the development of a group for women who had been sexually abused as children created a significant improvement in the treatment setting.

An additional element in treatment must be an affirmation of the self-worth of the woman. Women crack users suffer shame and grief as a result of the loss of culturally defined gender roles. Their shame parallels that of torture victims who are forced to betray friends or loved ones (Alloudi, 1991), or of rape victims who believe “I brought it on myself.” In each instance, the individual is compelled by circumstances that are beyond human control to commit acts that are otherwise unthinkable. The “act” has been committed, but, in a very real sense, the victim (or addict) was not the responsible “actor.” The horror and shame associated with the act must be balanced by the recognition that coercion (or addiction) can overcome human will.

It is interesting, therefore, that in the focus group described earlier, participants insisted that the most important characteristic of a sex-drug exchange was that it occurred, “... when we wanted crack.” The processing of the act in the group permits participants to reframe it from a shameful failure to an unavoidable part of “The Life.” When women have integrated this new understanding, they are sometimes able to use it to strengthen their resolve to have a life free of crack. This approach to drug treatment—one founded on acceptance and tolerance—represents a dramatic break with the shaming and confrontational therapies espoused by many drug treatment centers a decade ago (McLellan, 1986).

We are in the early stages of understanding trauma and its impact on the human mind (Terr, 1991). In treating women who are victims of the crack epidemic, we face both an opportunity and an urgent need to extend our expertise to confront the destruction that has followed the introduction of this drug into the lives of so many women users.
References:


