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ORIGINAL CONTRIBUTION

Working With Heroin Sniffers: Clinical Issues in Preventing Drug Injection

CATHY CASRIEL,* DON C. DES JARLAIS,† RAY RODRIGUEZ,‡ SAMUEL R. FRIEDMAN,* BRUCE STEPHERSON,* AND ELIZABETH KHURI‡

*Narcotic and Drug Research, Inc., New York City, †Beth Israel Medical Center, New York City, ‡ New York Hospital, Cornell University Medical College, New York City

Abstract—*Preventing illicit drug injection would be the ideal point for preventing HIV infection and AIDS among illicit drug injectors. This paper reports on clinical issues that arose in a program for intranasal ("sniffer") heroin users who were at high risk of injecting drugs. Extensive field notes were kept by the staff of the project. A generalized mistrust of authorities, denial of problems associated with non-injected drug use, and ambivalence about injecting were the major issues that arose during subject recruitment and the group sessions. The staff underwent trial and error learning, both becoming more confident in working with heroin sniffers, and finding better results for later participants in the study.*

Keywords—Heroin, sniffers, AIDS, injection, HIV.

THERE IS GROWING RECOGNITION of the need to prevent AIDS among intravenous drug users. Not only are IV drug users the second largest group of persons to have developed AIDS in the United States and Europe, they are the primary source of heterosexual and perinatal transmission in those areas (Des Jarlais and Friedman, 1987). Both the President's Commission on the Human Immunodeficiency Virus Epidemic (Report of the Presidential Commission, 1988) and the National Academy of Science (National Academy of Science, 1986) have called for massive increases in the effort to prevent AIDS among IV drug users.

The ideal point for preventing AIDS among IV drug users would be to prevent persons from starting to inject illicit drugs. This would not only curb the transmission of HIV through the sharing of injection equipment, it would also prevent the many social, psychological, and other health problems associated with the injection of illicit drugs. Broad based approaches, such as through mass media or school based programs, mostly reach those at little risk of starting to inject. Also, because they are aimed at a great many people, these services are likely to have little depth at the individual level.

Targeting AIDS prevention to persons likely to begin injecting drugs is a more sensible approach, but it is not without problems either. Such persons do not gather in large numbers at easily accessible locations. They have good reasons for hiding their identity as potential drug injectors. In this paper we report our experiences recruiting and working with persons at very high risk for injecting illicit drugs. The purpose of this paper is to provide an experiential report of what it was like to work with this population, rather than a statistical analysis of findings. (A conventional statistical analysis has been reported elsewhere, Des Jarlais et al., 1989.) We achieved some measure of success in reducing the risk of injecting for a targeted, experimental group of heroin sniffers. We hope that others

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Requests for reprints should be sent to Don C. Des Jarlais, Coordinator of AIDS Research, Inc. (NDRI), 11 Beach Street, New York, NY 10013.

will attempt to expand and improve our injection-prevention efforts. We went through a trial and error learning curve in working with persons on the edge of injecting drugs, and hope to shorten that learning curve for others who may work with this population.

THE "HEROIN SNIFFER" PROJECT

This project originated with an observation in 1984 that the number of persons who were intranasal heroin users ("sniffers") was increasing dramatically at a special program for adolescents and young adults in New York City. Our first interpretation was that these persons knew of AIDS and were avoiding heroin injection in order to protect themselves from it. We interviewed 16 such persons in a pilot study. All of them were aware of AIDS and how it was transmitted, but none of them gave AIDS as a reason why they were not injecting (Des Jarlais et al., 1987). This convinced us that we needed to understand the transition process from sniffing to injecting heroin much better. It did not look as if simple knowledge of AIDS would be effective in preventing people from starting to inject heroin. It is not known what percent of those who sniff heroin will become drug injectors, yet it is clear that many heroin injectors begin their use of heroin by sniffing.

A grant was obtained from the Centers for Disease Control to do an experimental test of preventing the transition from sniffing to injecting heroin. A four-part psychoeducational prevention program was developed, based on social learning theory and the LifeSkills Training program of Botvin and colleagues (Botvin, Baker, Renick, Filazzola, & Botvin, 1984). Our reasoning in choosing this approach and the social learning skills which we were attempting to teach have been outlined in detail elsewhere (Des Jarlais, et al., 1987). The original research design called for 150 heroin sniffers to be recruited and then randomly assigned to either the experimental prevention program (50 subjects) or to a control group. All subjects would be followed for at least 6 months. Our target group was to be 18 to 25 years of age, old enough to give consent yet young enough for us to apply social learning principles developed with adolescents. Data gathered would include AIDS risk behavior and HIV antibody status at both baseline and follow-up.

Given how little was known about heroin sniffers, we felt a better ethnographic/clinical understanding of the group was needed. We therefore decided to keep extensive field notes on the subject recruitment process and tape the prevention sessions in order to fully document the process of working with these heroin sniffers. These notes and tape recordings are the primary data sources for this report.

INITIAL RECRUITMENT STRATEGY

Our overall recruitment strategy involved three stages: getting potential subjects to telephone us for a preliminary interview; screening the potential subjects in this telephone interview; and a face-to-face interview in which subjects who were appropriate for the study were counseled and had blood taken for hepatitis and HIV antibody testing. Our first task, then, consisted of finding potential subjects and enticing them to call us. This proved to be not an easy task.

From the pilot study, it was clear that the great majority of heroin sniffers did not yet see AIDS as personally relevant to their drug use or their potential for injecting drugs. We thus could not expect to recruit subjects through offering AIDS prevention services. This left two options: recruiting through "captive audiences" (e.g., correctional settings or social service settings) or recruiting "free subjects" using monetary payment as an inducement to participate. We decided to recruit "free subjects" through ex-addict street workers, referrals from sniffers in drug treatment, and snowball sampling. After several weeks of limited response to these recruitment methods, we placed advertisements in local newspapers. Table 1 outlines our experiences, observations, and suggestions in the area of recruitment strategies.

PROBLEMS MAKING INITIAL CONTACT

Patients in a targeted methadone clinic may have failed to bring us subjects because they had lost familiarity or intimacy with old drug-using friends. Most drug treatment programs discourage a patient's ongoing interaction with old drug buddies. Also, drug users in treatment may be ostracized by other drug users (Hunt, Lipton, Goldsmith & Spunt, 1985 & 1986). If a strong rapport were missing, it would probably be difficult for the clinic patients to convince their acquaintances to call us. The ex-addict street workers found it difficult to identify sniffers, since they were less familiar with the routines and "hang outs" of sniffers than with those of injectors.

The "snowball" technique also failed. It is not clear to us whether or not subjects did, as claimed, know many other heroin sniffers. They probably exaggerated when stating how many sniffers they knew, in order to feel more justified when telling us that they took heroin. But even with over-reporting, there is the problem of why subjects did not draw heroin sniffers whom they did know into the study. One possible explanation is the lack of trust and weak friendship bonds in this population (Kandel, Kessler, & Margulies, 1978). In the drug subculture many people share information, money, or drugs, but have little

TABLE 1
Recruitment Strategies

Methods of Finding Subjects	Disadvantages	Project Experience
Captive audiences (in prisons and social service settings)	Problem of obtaining institution's approval, ethics of control group	Did not pursue
Friends of treatment clients	Friendships ties may have weakened	Tried, little success
Ex-addict field worker	Sniffers difficult to identify and target	Tried, very little success
"Snowball" friends of subjects	Friends mistrustful	Tried, moderate success
Newspaper advertisements	Subject is not "known" by anyone at outset; subject pool restricted to whoever reads the advertisement	Greatest success

Suggestions
Future research might conduct comparison of strategies.
Assign staff time to develop client interest and skills in recruiting friends.
Must conduct more ethnography to see if field workers can have a viable role.
Use xeroxed newspaper ad, rather than cards, to look more official.
Combine with other methods.

certainty about who can be safely trusted at any given time (Des Jarlais, Friedman, & Strug, 1986).

Since newspaper advertisements produced a steady stream of inquiries, we continued to run advertisements throughout the study. Occasionally, the ads prompted misguided inquiries about where we were giving away heroin. Most callers, however, were active drug users who understood that we were seeking intranasal heroin users, although they did not assume an injection history would be a disqualifier.

TELEPHONE SCREENING

Once callers began to contact us, we found callers were much more diverse than the sniffers who participated in our pilot study. Most were not under 25 years old, many had drug injection experience, and there was a wide range in frequency of intranasal heroin use. In summary, the "sniffer type" seemed to encompass a much more disparate group than we had previously thought.

As we learned more about the target population, we made adjustments in the definition of who was appropriate for the study. We accepted those who had snorted heroin at least once in the preceding six months but who had not injected more than 60 times (the equivalent of about two months of daily injection) in the past two years. Subjects who had injected were required to have snorted heroin regularly before injecting and to have returned to snorting heroin.

We found we were spending a great deal of time during the screening call explaining the study. Many callers began by asking about the study; we could not delay answering and keep the caller on the line. We answered questions about the purpose of the study, as best we could, without defining the criteria of acceptance. Since we were using the financial payment to induce initial participation in the study, being explicit about our eligibility criteria would have tempted too many potential subjects to lie about previous drug injection.

The screening process constantly taxed our energy and creativity in attempting to sift out callers who guessed the eligibility criteria and who were lying. When a caller proved difficult to handle, for instance if he was resistant to being rejected, the telephone interviewer would make a note on the screening form. These "poor sports" were described verbally to the next person answering the telephone. We were alert for disguised voices and uncanny similarities between "different" callers, in order to discourage some deception before the interview date was made. Subjects were occasionally also excluded after being given appointments for interviews. Examples are given below:

1. Screening subject "X" admitted to a limited history of injection. He was given an appointment, but the interviewer was warned that the subject might have understated his involvement with needles. When the subject appeared for the interview he was observed to have track-mark scarred hands. He was given $5 to cover time and travel expenses and asked to leave.
2. Screening subjects "Y and Z" were a couple referred by another subject. They were prescreened and only the woman was accepted, as she was not an injector while her husband was. She did not keep her appointment.

Subsequently, a "different" couple was screened by a different person. They were given an interview date. This couple had different names from the couple above, and both fit the study criteria. When

they came for their interview they were identified as the same people. The man was not interviewed.

While constant vigilance was needed to screen out ineligible subjects, the candid discussions in the later sessions (after subjects had been paid) indicated the effort was quite successful.

PERSUADING POTENTIAL SUBJECTS TO PARTICIPATE

Many callers were reluctant to complete the screening. Careful assurance was needed to convince them to make an appointment for the interview. Subjects' reluctance arose largely from their high level of mistrust. They often asked who was conducting the study. It was not unusual for them to ask "Am I being tape recorded right now?" Staff answering the telephone referred to a script of carefully worded answers to common questions.

Confidentiality was an extremely important issue. Like other drug users, sniffers were afraid of being caught by the authorities. Unlike many long-term injectors, sniffers did not consider their drug use apparent to others. In some cases this was true: family and work acquaintances did not know of the sniffer's drug involvement. We stressed to all callers that we would respect their confidence.

When we restated our pledge of confidentiality at the face-to-face interview, subjects gave an interesting response. They rarely questioned us or challenged us at this point in time; they told us that they deemed us trustworthy. "You look like you're o.k.," they might say, or, "I could tell from the way you talked that you're a nice person." They said such things with an air of pride, suggesting that the ability to judge people correctly was considered a valuable and accurate skill they possessed.

Once we understood this, we changed the nature of our appeal to reluctant callers. We did not merely tell them about our certificate of confidentiality, we spoke of our personal commitment to confidentiality (e.g., "I wouldn't work on any project that 'ratted on' people"). Also, we spoke in a relaxed way about confidentiality:

> We don't share information with police, welfare, the IRS, or any of those people. If we did, the word would get around pretty fast. Who would ever tell us anything?

Subjects became more easily engaged. There were fewer tersely ended calls in which we expressed interest but the caller did not.

Pre-interview attrition or "no-shows"

As the number of no-shows mounted, we developed strategies to combat wasted staff time and lost subjects. One strategy was to invite subjects to the office for their interviews, and postpone the drawing of a blood specimen. This strategy was problematic, as subjects often did not show up at the appointed time for their blood test.

The other more successful strategy used to limit the damage of no-shows was requiring confirmation on the day of the interview. We grew increasingly successful at contacting a subject on the morning of his appointed interview. We reminded the subject to keep his appointment, or we rescheduled the interview. Hence we prevented some wasted staff energy.

AIDS and initial recruitment

Fears and difficulties surrounding issues of AIDS (especially AIDS antibody testing) acted as an important obstacle to recruitment. Some callers reacted with shock to the mention of AIDS. A few callers hung up abruptly. Many more asked frantically "What do you mean, I thought this was for heroin sniffers. You can't get AIDS from sniffing, can you?" The mere mention of AIDS triggered subjects' mistrust. Moreover, we spent a good part of our time answering callers demands for information about AIDS and AIDS testing. They took the opportunity to question us and to express their opinions about facts and hearsay surrounding the topic of AIDS. Callers also described their particular risk behaviors, the dates of their risk behaviors, etc., and asked for advice and referrals.

In addition, we believe that fear of AIDS testing contributed to the reasons why callers who scheduled an interview often did not show up. Many subjects, not just those who had engaged in high risk activity, did not want to be tested for HIV antibody. We had to coax and appease reticent potential subjects who feared HIV testing, allowing them to be interviewed without taking the test. At first, we offered less money for this arrangement. This posed a danger, however, that money might entice reluctant but indigent subjects to take the HIV test. Eventually we arranged that all subjects would submit to blood testing, but those who would not agree to HIV testing would be tested only for Hepatitis B, another indicator of risk activities.

To illustrate subjects' fear of HIV testing, one case example is described below.

> Rick, a white, college educated man in his early 30s, was prescreened and approved, but he said he would not take the AIDS antibody test. He was asked to think more about taking it, and he was assigned an interview time.
>
> At the interview appointment, Rick was surprised when asked to sign his real name to the consent. He signed with a common last name, probably fabricated. However, he was friendly and outgoing; he did not seem paranoid. He spoke

candidly about his drug use, which involved weekly snorting of heroin.

Questions about sexual history revealed that he had had sexual relations with a female IV drug user in the late 1970's. We discussed his not using condoms, his various sexual partners (not a great number, none male), and the low but present risk for his testing positive for HIV antibody from possible exposure during heterosexual relations. He was reasonable in estimating his level of risk, and he became interested in reconsidering the advisability of condom use.

Then he was asked about being tested. He was firm about not wanting to take the test. He said he did not want to know if he had—by some slight chance—contracted the virus, as there was no cure. He said he also did not want to risk testing positive because he did not believe in the confidentiality promised by any HIV test givers. He feared that test results were sent to "the government" with identifiers. He said that if the government were giving out free needles to drug users and he wanted to inject drugs, he would not accept the needles being given out for fear that the government was trying to "get rid of addicts" by giving them AIDS infected equipment. He was questioned repeatedly about this: he believed it was not an improbable scenario.

INTERVIEWING

Once subjects arrived at the interview site at the appropriate time, they were notably compliant and accepting of the interview process. They sat patiently through a very long interview (approximately 75 minutes), often drowsy with drugs or anxious with the longing for drugs. Although many had a fear of needles (one of the primary reasons cited for remaining a sniffer), they cooperated without too much complaint as their blood was drawn. And although urinalysis is a procedure much under attack in the media and among drug users, they hardly seemed to notice that we asked for a urine sample without having warned them about it beforehand.

Subjects' answers to open-ended questions reflected thought; they were rarely flip or fantastical. After the interview, many subjects were moved at having been able to communicate about their drug use, as if the interview provided insight into their behavior. It was not unusual for a subject to say, after the interview, "I hadn't realized I was using so much" or "I never thought about how many drugs I've used until you listed them all." We were surprised by subjects' seeming need to talk (Casriel, Rockwell, & Stepherson, 1988).

Along with the consent, subjects read a description of the study which mentioned the treatment groups. Many asked if they could be purposely selected for the groups. Later, at follow-up, some subjects asked why they had not been called to participate in the groups. The concept of random selection was discussed with subjects who made these inquiries; the subjects were never fully satisfied with this explanation. Their disappointment was clear.

INTERVIEW PARTICIPANTS

After the telephone screening, 124 subjects were interviewed in person. Of these, 20 were then dropped from the study because we believed that they exceeded the criterion of 60 drug injections within the past two years.

Of the remaining 104 subjects who were interviewed and not dropped from analysis due to extensive IV use, 29% were female. Fifty-two percent were white, 26% black, and 22% Hispanic. The mean age of subjects was 27. Almost three quarters of the subjects (74%) had completed 12 or more years of school. Forty-three percent of subjects were legally employed at the time of the interview, 22% had no stable income, 10% were supported by family, and the remainder had various sources of income such as government aid and illegitimate activities. Subjects' estimates indicated that they had worked an average of 27 weeks out of the preceding 52. Sixty percent of subjects had never had drug treatment.

The subjects were recruited as persons sniffing heroin. They tended to be sniffing at high frequencies. For the six months prior to the intake interview, 21% reported sniffing less than weekly, 40% 1 to 6 times per week, and 40% on a daily basis. Many were also sniffing considerable amounts of cocaine: 31% reported no sniffing of cocaine, 42% sniffing cocaine less than weekly, 24% sniffing cocaine 1 to 6 times per week, and 3% sniffing cocaine daily for the 6 months prior to the intake interview. Over a fourth of all subjects (27%) had injected heroin intravenously.

In summary, subjects were hard to find and to persuade to participate. They were mistrustful until they made a connection to a staff member. Mistrustfulness was exacerbated by AIDS testing. During the interviews themselves, however, we were successful in eliciting candid answers to questions about drug involvement, and many subjects seemed to benefit simply from the opportunity to talk about and think about their problems. Later, in groups, this candidness would be taken a step further, as group members took the opportunity to explore issues in depth.

PARTICIPATION IN THE GROUP SESSIONS

The curriculum for the experimental group sessions was based on Botvin's LifeSkills Training program (Botvin et al., 1984). It is broken down into modules which parallel those of Botvin. The outline of topics, or lesson plan, which we originally intended to follow is given below:

1. Facts and myths
   a. about AIDS
   b. about needle use
2. Lures into drug use and needle use (friends, availability, addiction)
3. Handling situations where needle use is a possibility
4. Coping skills
   a. self-assertion
   b. dealing with depression
   c. seeking treatment

A detailed curriculum was designed, with a handbook for subjects and an accompanying manual for leaders. Activities in the curriculum included the use of an "addiction checklist," the distribution of condoms, the presentation of an educational videotape on AIDS, the use of a puzzle exercise focused on drug injection, the dramatization of drug use situations in roleplays, and the completion of group evaluation forms. Group participants were paid $15 for each group meeting that they attended, with a bonus of $15 if they attended all four of the scheduled sessions.

Although we developed the curriculum for the groups based on Botvin's model of Life Skills Training, we were looking to create a support-group type of atmosphere in which subjects would be candid with each other and take some interest in each other. We especially wanted participants to break through their denial about the danger they were in, admit the depth of their drug abuse problems, and form bonds with the group leaders that might be a bridge to subsequent therapy. We did not know if these very ambitious goals were realistic.

The support group model did not form an exact complement to the educational framework used in the handbooks, nor were the two frameworks mutually exclusive. We learned to interweave and blend the two into a psychoeducational approach. As we conducted the groups, we learned what to emphasize and what to downplay in our curriculum, when to put the curriculum aside and let interactions flow, and how to guide discussions to reinforce the educational as well as therapeutic aims of the group. This learning took place over time, though; we were not entirely sure of ourselves at the start.

Differences among the groups of subjects, as well as leaders' development in putting the experimental group concept and curriculum into effect, created different experiences for the four different group cycles. It is important to note these differences when evaluating the outcomes of the groups.

The First Group

The first group was influenced by our newness to the group program. We were excited that members returned to the second and subsequent group meetings with a near perfect attendance rate. It was rewarding to guide group members in discussing their problematic relationships to drugs and in practicing how to decline offers to inject (using roleplaying). We were excited when they asked for more groups than the initial four (we added two) and when they said they were benefitting from the meetings. We were impressed by the interaction of group members from disparate backgrounds, the level of mutual interest and self-disclosure that was evoked within such a short period, and especially the willingness (by the third or fourth session, certainly not at the first) to define the activity of group discussion as "therapeutic."

On the negative side, we were slow to gain control of the group spirit and to guide the group's attitude toward subjects being discussed. We permitted evasion of the topic of "needles and AIDS" while the group digressed with a long discussion on the topic of "sex and AIDS." We could not manage successfully to work with tensions between members and to channel personality conflicts in a direction that benefitted group process. The idiosyncratic web of tension created especially by two group members worked strongly against the direction the leaders were taking the group. The oldest member of the group, John, presented soberly his experiences losing friends to drug overdoses and AIDS, but his comments were often unwelcome. Other group participants followed the lead of the youngest group member, Susanne, in dismissing John's contributions to the discussion as "preachy." The immature but attractive Susanne drew admiration and support from the our men in the group other than John. Susanne's thrill-seeking attitude steered the group discussion off course repeatedly.

Originally, three group members other than John tended to depict their heroin use as destructive and troubling (Kay, Paul, and Ramon). Two group members other than Susanne were inclined from the start to defend a carefree or glamorous—if mildly problematic—picture of their drug use (Jim and Nicholas). Susanne tended to be most vocal and to draw out her supporters in a seductive manner. Even two men in the other camp, Paul and Ramon, were wooed at times by Susanne, although they tended on the whole to be quiet. The other woman in the group, Kay, was depressed and rarely talked. Only John would try to restore the balance by playing devil's advocate, criticizing the direction the conversation was taking, and openly taking swipes at the upper-crusty, sexy portrayal of drug use that Susanne was pushing.

An example of how Susanne steered the group off coarse is found in the following segment of group discussion:

Leader: Suppose it's not very pure heroin at all. (Someone mentions the term "hot shot.")
Kay: I've had stuff that tasted like vinegar.
Jim: You don't know what they've cut it with. It could

even be a dummy. Injecting, it gets into you quicker, more direct.
Leader: So do you feel you have more control sniffing?
Susanne: (Turns the point around.) It's more intense injecting.
Jim: It gets into the blood stream either way.
Leader: What about smoking, is that the same too?
Jim: That's totally different. (Everyone agrees.)
Susanne: It's boring just doing lines, sometimes you feel like you will try anything.
Jim: Let's smoke it, let's hit it.
Susanne: I can see shooting.

In this passage, one sees that Kay supports the leader's efforts to talk about the dangerous aspects of drug use. Then Jim nearly states the point that the leader is hoping to make: injecting a foreign substance may be more dangerous than snorting it. Here is where Susanne picks up the ball and runs in the opposite direction with it, by rephrasing what Jim said in a way that evokes the excitement of drug use rather than the danger. Jim loses the direction of the discussion, the comparison of differences between injecting and snorting. The leader tries to bring the discussion back to differences, and the entire group agrees that smoking is not like injecting or snorting. But Susanne jumps in quickly and sets a new tone by endowing the different routes of drug use with appeal and excitement, and, clearly, Jim caves in. With Susanne's final comment here, the direction of the discussion had been changed by 180 degrees.

Here is another example, closely parallel. It shows how Susanne upstages and nullifies the input of one of the quieter members, Paul, much as she did with Kay in the preceding example.

Paul: I feel sniffing is better, but the (iv users) say "you're no different than me," and maybe they're right.
Jim: When I think of junkies with a needle sticking out of their arm—it's nauseating.
Susanne: It doesn't disgust me, it's a turn-on.

Jim is supporting Paul's underlying assumption that sniffing "is better" than injecting. Admittedly, there is much Jim could learn (from Paul or the group, if not his own experience) to reach the point that Paul is making. That is, Paul comes to the group ready to acknowledge that he is in danger of becoming something he does not want to be. Jim defies this view of sniffers and himself, but he is "on track" in terms of the group's work in discussing what he bases his sense of differentness upon. Susanne usurps the group process that was developing in the dialogue between Paul and Jim, and says something to make every man sit on the edge of his seat. Unfortunately, her words are not only a distraction, they are very destructive.

The outcome of this first round of groups was disappointing. Two of the four men captivated by Susanne's grandstanding, Jim and Nicolas, were the only two group members from any of the four group cycles who later admitted using needles during the follow-up period. While they probably did not use needles together, these two group members admitted taking drugs together. The bond that formed between these two group members reflected a spirit created in the group discussions, but they were rebelliously opposite to the particular bonds the leaders were striving to create (ie, mutual support in avoiding risk behaviors). Ramon, another of the men attracted by Susanne, admitted to having injected when we contacted him one final time, long after his follow-up interview.

Twenty persons who participated in multiple sessions of the experimental group were re-contacted. Three of the 7 good attenders of the first group had injected after participation and none of the 13 good attenders of the second through fourth groups injected after participation ($p < .03$, Fisher's exact test).

We would assess this first group as ineffective in preventing injection. The reasons for the group's ineffectiveness have already been discussed: interactions among group members that drew the focus off course, and our newness and consequent difficulty in gaining control of the group under these circumstances. However, we learned a great deal from this round of groups and saw much that was positive. We learned that

1. This type of drug user can be lured into a therapy group, actively engaged, and enticed to attend consistently;
2. Even sniffers can be very resistant to information linking drug injection and AIDS;
3. Simple knowledge of routes of AIDS transmission may not be enough to elicit the commitment to avoid risk behaviors;
4. In groups with heroin sniffers, peer influence is important;
5. Roleplaying is an applicable and engaging tool for use in these types of groups;
6. Despite the characteristic mistrustfulness of these heroin users, a positive relationship of respect and even warmth can develop with authority figures in this type of setting;
7. These drug users, though not seeking treatment and largely denying drug problems, can be led through a few group sessions to consider the possibility of seeking help.

Subjects' attachment to the groups was not merely monetary. They were asked whether they would have come to the groups if no money had been offered. They candidly stated that they would not have come to the first group without the enticement of money, but they were unanimous in asserting that they would

have continued to come to the group sessions if no money were offered at subsequent sessions.

Further, subjects reported that their consciences were giving them difficulty when they went to get high. Our message about the danger of injecting was generalizing to convey the dangers of noninjection drug use. Group members felt guilty when sniffing heroin or cocaine, although the setting did not involve injecting the drugs. Ramon related this to something he had heard in Narcotics Anonymous meeting: "When you get high, we're going to mess up your head."

Finally, strong connections were made between the leaders and group members. In the fourth group meeting, when the theme was on endings, subjects joked with one leader: "We're all moving into your home." The leaders were called upon for help or advice with educational, employment, and therapy needs of five of the group's seven participants. Susanne, in particular, seemed to have made some very positive changes in her life. She left a drug-saturated work environment and stopped using cocaine (her primary drug of abuse), as evidenced by both self-report and significant weight gain.

The Second Group

The second group was influenced by members' age and length of time using drugs. The mean age of members in this group was 32 years as compared to the 27-year mean age of all subjects. The three oldest group members set the tone of the group. A somber attitude was taken toward drug abuse, and subjects eagerly discussed issues of needle use and AIDS. However the group members created an almost detached atmosphere. They infused the discussion with past tenses, as if risk activities and drug problems were no longer salient issues in their lives.

An example of how the mood of this group expressed itself is seen in the following illustration. In the third group meeting of each cycle we asked each group member to answer the question: In what situation could you see yourself injecting? In the first group subjects offered a wide variety of responses. In the second group, there was no response. Finally, a leader said, "There must be something you can think of, even if it is far-fetched, like the world coming to an end." A few subjects proceeded to give that—the world ending—as an answer, while others echoed other ideas offered by the leaders. No one actually named a personally threatening situation.

The outcome of the second round of groups was still less than satisfactory to us. Although group bonds were formed and two subjects followed through on leaders' treatment referrals, most of these subjects remained an enigma to us. The subject who displayed the greatest self-confidence, who boasted of a successful recovery from drug addiction, called subsequently to say she had resumed using heroin and needed help. We were finally given a glimpse into the true level of her drug problem, which had been guarded with denial throughout the groups.

The Third Group

The third group is a good prototype for how we would want the groups to be conducted in the future. This was influenced by the high degree of disclosure and acceptance shown when a member admitted to heavy needle use and leaders permitted him to remain in the group. The needle user, Tim, spoke soberly about his needle use and his past, which was full of failed treatment attempts. But he did not paternalistically scorn other members' thoughts about the attraction of injecting (a problem with the more experienced group member, John, in the first group cycle). Members of this group cycle evinced less defensiveness and denial discussing their current drug use and their curiosity about injecting (major obstructions for the second group).

The fact that this group worked out so well can in great part be attributed to subjects' willingness and ability to work together with each other and the leaders. But there were other factors contributing to the group's success. Subjects were more aware of AIDS at the start. As one subject stated, "It used to be once a month someone would bring up AIDS but now it's like everywhere you go; I'll just be sitting on the train and people behind me will be talking about AIDS." After the video, Sex, Drugs & AIDS, group members complained that the material was oversimplified, incomplete, and aimed at a less sophisticated audience. They asked more numerous and intricate questions about AIDS than those asked in either of the two previous groups. Their knowledge, combined with their concern for the injector in the group and their IV-using friends outside the group, set the stage for forthright and dynamic discussion of the dangers of addiction and AIDS.

Leaders were much quicker to take the reins, direct discussions, and pull group members back "on track" when necessary. It clearly aided the group process greatly to have the tone set from the beginning at a very high level of candidness. Naturally, subjects occasionally veered away from this tone. But the leaders, knowing what they could expect of the subjects, challenged group members when necessary.

For example, the first session ended with the following statement by a group member, expressing a sense of hopelessness in protecting against AIDS:

Joey: You can put people in a room and have them watch tapes all day but they're still going to have sex if they

want to, and they're going to do drugs if they want to. It just doesn't change things watching some AIDS films.

At the second session, the leader brought this idea out for discussion. The aim was to highlight members' feelings of vulnerability and hopelessness about AIDS. We sensed that as long as these feelings remained unacknowledged, group members would not be motivated to learn what they could do to protect themselves. At first members responded as if it were others who needed to learn about AIDS prevention, not them. The leaders asked subjects, "If you were going to inject, would you share needles on the assumption that your partner was healthy?" This question prompted Joey to admit how close he had been to injecting, and how risky was his attitude about AIDS.

Joey: Every time I really think about shooting up—the people I'm with when that happens—I think, "Oh, I know him for a long time. He looks healthy. I'm with him all the time and if I didn't get it by now... I'm going to get it anyway so give me the needle."

Others followed Joey's example and talked about their attitudes toward AIDS prevention.

The outcome of the third round of groups, as we gathered from follow-up interviews, was much as we had hoped. A strong group feeling was created in which members conversed with each other outside the group but did not take drugs together. At the follow-up, members in this third group reported that they were doing better in terms of their drug problems. None were using needles.

The Fourth Group

The fourth group was influenced again by the concern of the group for a particular member who was at greatest risk. In this case, a very young woman, Gena, was beginning to use needles, and she could not grasp the connection between sharing a needle with her boyfriend and the risk of contracting AIDS. In response, the educational component of the group was extended over more sessions while leaders and group members worked together to clarify the information that Gena needed in order to protect herself. Again this set the stage for discussion that was candid and charged, and for roleplays in which subjects energetically applied themselves.

The outcome of the fourth round of groups was satisfactory also. Much as for the third cycle, a strong group feeling was created. Even a less talkative member, who missed the third meeting, returned to attend the last meeting, despite losing his opportunity to be paid the bonus. At the follow-up, group members were found to be using less heroin, and none had used needles.

THE GROUPS: ADDITIONAL POINTS

Some important points we learned about running groups with this type of subject were discussed above. The following are some additional conclusions that can be drawn from analyzing the process and outcomes of our groups.

1. Many subjects have a negative feeling about schools, so the less structural similarity to a classroom, the better. Distribution of the handbook for subjects to use during the sessions or for their perusal at home is not recommended. We found the use of written material during the group disruptive.
2. These subjects do not perceive themselves as having difficulties asserting themselves. When they respond submissively to peer pressure, they view their submission as choice. Although rehearsal of situations is beneficial, the development of rationales for not injecting seems even more critical.
3. There was not enough time in four sessions to develop either (a) strategies for coping with stress and emotional difficulties while pursuing abstinence from drugs, or (b) mutual support outside of groups for abstinence from drugs. At least two additional group sessions would be useful to cover these areas.
4. Since they believe that they will not be using injection equipment, subjects do not attend carefully to information about needle cleaning.

Overall, we appear to have had some success in limiting the proportion of subjects in the experimental situation who resorted to injecting drugs during the follow-up period. Eighty-three subjects completed a follow-up interview, at an average of eight months after the initial interview. Of 43 subjects who were assigned to the experimental groups, 6 injected drugs during their follow-up period, while 14 out of 40 subjects assigned to the control condition had injected during this period. This difference was statistically significant in a multiple regression analysis (Des Jarlais et al., 1987).

CONCLUSIONS

In our project working with heroin sniffers, we learned a great deal about a previously unexplored population of drug users. As we began our work, our strategy was built largely from theory, with some prior knowledge of the population gathered from the pilot study. What we learned by trial and error should be noted by others who intend to work with this population so that they may benefit from our knowledge and avoid repeating our errors.

When we first learned of the increase in heroin sniffers seeking and enrolling in treatment, we made a false assumption: people were afraid of AIDS and were hence not shooting up. This assumption was initially challenged by our pilot study findings and has been further challenged by the present study's findings. Subjects cited many reasons for refraining from injecting, but the fear of AIDS was not a major one. In group discussions, subjects candidly admitted that knowledge about AIDS and needle use was not going to be adequate to prevent them from using needles if and when they wanted to use them.

On the other hand, sniffers are not receptive to training about the use of clean needles. Since these subjects perceive of themselves as sniffers, they do not listen to and retain information about needle sterilization practices. Neither the distribution of brochures to all subjects nor careful discussion during group sessions resulted in subjects being more knowledgeable at follow-up about the use of bleach for cleaning needles to prevent AIDS transmission. Those who might plan to educate this population in needle cleaning should consider how to teach this more effectively than we did, perhaps having sniffers role play needle cleaning. And to those who argue that the teaching of needle cleaning techniques would lead to the use of needles by nonusers, we should point out that our subjects were not eagerly awaiting this information so that they might use it and inject. They were unreceptive.

Two false assumptions were the firm distinction we posited between sniffers and injectors, and the posited homogeneity of the sniffer "type." The sniffer population we studied was an amalgam of "chippies" (weekend users) and multiple-times-daily addicts, with every possibility in between. It was a mix of those who had never once injected, those who had experimented with needles a few times, and those who had begun to inject regularly but stopped after a short time.

Any work with this population is likely to be influenced by the issue of trust versus mistrust. The sniffers we knew were often able to deny to others and themselves the extent of their involvement with drugs. Thus it was particularly striking when, as we gained their trust in the interview setting as well as in groups, they became candid about the problems their drug use was causing them. Although we lured subjects for interviews and groups with the promise of payment, it is arguable whether or not payment was the primary or genuine motivation for participation. The trust and acceptance which subjects experienced, especially as they explored the intensity of their problem, was a relief and reinforcement in itself.

There are many unanswered questions at the end of our efforts to define this population of heroin users. Central among the unresolved questions are those that deal with friendship ties. Why was it that most subjects did not convince friends to participate in the study? How does this reconcile with the contrasting ease of friendship ties formed in the groups? How could the more constructive group friendships be reinforced so that they might lead to lasting support networks (oriented away from drug injection)?

Overall, it is our impression that curbing the spread of AIDS by preventing beginning injection is a viable approach. A target population of heroin sniffers can be found and drawn into a study or program at a relatively small expense (ie, the cost of newspaper advertisements and modest payments to participants). The denial of addiction and of AIDS risk inherent in these subjects' daily lives can be broken through to some extent by a mere first interview; it can be broken through to a much greater extent by skillfully led treatment groups. Our experience at running such groups, as documented in this paper, should serve as a guideline for others, who may then be able to improve the outcomes for group participants.

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