

# Drug use, sexual risk and sexual safety

FOR THOSE OF US in the drugs field it's easy to forget that HIV is *primarily* a sexually transmitted disease. As injecting drug users adopt safer drug use behaviours, it has become increasingly necessary to question whether risk reduction has also occurred in their sexual behaviour. Sexual transmission of HIV, hepatitis (B and C) and other diseases is going to be more and more important – perhaps even overshadowing needle-transmission – among drug injectors and their sexual partners.

Many UK harm reduction interventions have attempted to address sexual risk, but their effectiveness is still in doubt.<sup>1,2</sup> The next step for the prevention of HIV and other sexually transmitted diseases is to ask: Why is it so difficult to encourage changes in sexual behaviour and how can such changes be achieved?

This article provides an overview of our recently completed study of sexual behaviour and sexual safety among opiate and stimulant users,<sup>3</sup> research undertaken between January 1993 and December 1994 and funded by the Department of Health. Using a variety of qualitative methods, we aimed to investigate the relationship between drug use, sexual behaviour and sexual safety in a sample of 96 drug users, ranging from opiate to stimulant users, injectors to non-injectors, recreational to dependent users.

This is the first of two articles on sex and drugs for *Druglink*. In the next issue, we examine the effects of opiates and stimulants on sexual desire and behaviour. In this edition, the focus is sexual safety – what it means and the factors influencing the degree to which it is practised.

## The need for change

Our starting point is existing UK surveys of drug injectors' sexual behaviour. Almost all show a marked reduction in risky injecting behaviour, yet very few changes in sexual risk behaviour.<sup>4</sup> Drug injectors report low levels of condom use: two thirds never use condoms with primary

*With safer drug use now commonly practised, sexual safety will be the next great HIV prevention task for drug services. This report is from the research team leading Britain's effort to understand this new challenge.*

by

**Tim Rhodes and Alan Quirk**

*The authors are researchers at the Centre for Research on Drugs and Health Behaviour involved in qualitative research on sexual safety among drug users.*

## SUMMARY

Despite high sexual activity, drug injectors report low levels of condom use. A study of sexual safety among opiate and stimulant users found that alcohol and stimulants were seen to lower inhibitions; alcohol was also felt to cause loss of control. Drugs and alcohol provide both a 'reason' and an 'excuse' for unsafe sex. Other risks may be seen as more important than HIV. Condom use is negotiated and not just an individual choice. Most decisions are based on trust between sexual partners, yet this is often misplaced.

partners and one third report never using condoms with casual partners. This is despite relatively high levels of sexual activity (80 per cent report penetrative sex in a six-month period) and relatively high levels of partner change (on average, two in a six-month period).<sup>5</sup>

UK surveys have almost exclusively focused on opiate users and injectors. Most have sidestepped the relationship between stimulant use and sexual safety – despite North American warnings that use of speed, cocaine and crack may increase risk of exposure to HIV, not because of injecting, but because of sex.<sup>6</sup>

Nevertheless the picture seems clear: while HIV prevalence may have stabilised among drug injectors, most surveys conclude that sexual transmission is going to be increasingly important in the next stage of epidemic spread.

Recognising the need for a change in sexual behaviour is no more than a first step to achieving such change. We can all appreciate the importance of sexual transmission but understanding *why* it's so difficult to change sexual behaviour and *how* such changes are made is another matter.<sup>7</sup> One crucial finding of surveys is that condom use among drug injecting populations is almost identical to that of the general (non-injecting) population.<sup>8,9</sup> This, we believe, may tell us much about the difficulties of changing heterosexual behaviour as well as about how such changes may be encouraged.

Qualitative studies can provide answers to these questions. Unlike surveys, these can describe in detail, and from the perspectives of drug users themselves, the situations and contexts in which sexual behaviour and unsafe sex occur. This is the first step in understanding why people behave as they do, and whether and how they may be encouraged to change their behaviour.

In our research we began by asking the obvious question – What is sexual safety? – and found it was not a simple concept (see panel on page 18). The factors which make penetrative

sex safe, unsafe, protected or unprotected are many and varied. Our study mapped four key areas of influence. As mapped opposite, we found unprotected sex was a function of the *interplay* between:

- the effects of drugs on sexual behaviour;
- how 'risk' and 'danger' were perceived;
- how condom use was negotiated; and
- the nature of drug users' sexual relationships.

Focusing on why drug users do not always use condoms, we explore each of these areas in turn.



### The effects of the drugs

Paradoxically, the drug users we interviewed saw alcohol – a depressant drug – and stimulants as in some respects having similar effects on sexual behaviour. With either they reported losing their inhibitions in approaching potential sex partners, engaging in behaviour ranging from casual eye contact to flirtation.

Alcohol and stimulants were also both thought to make sexual encounters more likely. As one user said of the effects of speed: "I feel more chatty, more able to talk and be assertive, so I don't feel so shy and insecure and vulnerable, which all makes for getting one's clothes off much easier".

Once in bed, stimulants 'sped up' the sexual encounter by "shedding inhibitions", particularly when "going to bed with someone for the first time". This is because "you're not as embarrassed to do things" or to ask "for things that you wouldn't ask people for unless you've known them for longer". Alcohol and stimulants were seen to make communi-

cation in sexual encounters "a lot franker" which meant "you can try things that you wouldn't normally try".

**Losing control** Losing inhibitions is not the same as losing control, and represents the point where the perceived effects of alcohol and stimulants parted company.

Inhibitions are unwelcome obstacles to doing what you want to do – no great loss. Loss of control, on the other hand, is sometimes deeply regretted, as it can imply doing things you do *not* want to do.

Although alcohol and stimulants were both seen to lower inhibitions, alcohol was also felt to encourage sexual behaviours in which people said they had not wanted to engage – in other words, it sometimes made them lose control: "I've been really drunk and I've woken up the

next day and thought 'Why the friggin' hell have I done this?'. Another commented: "you can just really not know what you're doing."

**Alcohol** Alcohol was sometimes seen as causing unsafe sex. Asked why condoms were not used, a typical response was: "Because I was very drunk. And it just happened". Others commented that when drunk they "don't care" about condoms, despite prior intentions to use them: "When I drink alcohol I do things I wouldn't do if I were not on alcohol ... for example, having sex without contraception, which is something I normally would never do".

Alcohol was seen as encouraging unsafe sex because it interfered with thought processes. As described by a stimulant user, "If I were really drunk I might just pull her knickers off and shag her without any of my intellectual processes to reason me through, reason me against, such a silly thing".

As one respondent commented, such explanations can be interpreted as evading responsibility for doing things you "want to do... but know [you] shouldn't". Drink may be used as a justification or excuse for engaging in what you and others see as unacceptable behaviour (see *Is it all just an excuse?*).

**Stimulants** In contrast to alcohol, respondents believed stimulants did not make people in general lose control: with alcohol "anything can happen", but with stimulants "your brain's not affected" and "you definitely know what you're doing". One woman said of speed, "I don't think it makes you do anything you don't want to do, your mind doesn't bend completely out of shape".

Figure 1: sexual safety in context



Why do drug users not (always) use condoms?

Sexual behaviour and sexual safety are the outcome of an interaction between four key areas of influence

### IS IT ALL JUST AN EXCUSE?

Many of us have probably said at some time, "I'm sorry, I only did that because I was drunk. It wasn't me – it was the drink." Such a statement shows that alcohol and other drugs can provide people with 'reasons' which may in reality be justifications or excuses, distancing them from actions they later regret or know to be 'unacceptable'.

One stimulant user neatly illustrated the point. "If people say they didn't use a condom because they were on ecstasy I would think that they're just using it as an excuse", she said. But when it came to her behaviour, she said ecstasy made her "more blasé" and less "paranoid" about not using condoms. In other words, she saw the drug as the 'reason' why she had unsafe sex. She explained that people don't like to admit to wanting or having unsafe sex: "It's like you don't have to accept responsibility for it ... If I was in a normal state of mind then I would be really responsible ... I'll be the first to ... admit

that I've been hypocritical and that I'm probably not, like, the best person at practising safe sex. Maybe people just don't like to, you know, admit that."

Many surveys associate the use of alcohol and other drugs with an increased likelihood of unsafe sex.<sup>10</sup> Our findings support this but also shed light on why it is so difficult to establish what these associations mean. Alcohol or drugs may provide a justification for 'bad' behaviour, but this does not necessarily mean that they cause unsafe sex.

In client assessments or when speaking to a researcher, it may be easier for drug users to say they had unsafe sex because they were stoned than to admit that they had unsafe sex because they wanted to for other less easily 'justifiable' reasons. Equally, it's questionable whether a drug worker or researcher (or anyone else for that matter) can distinguish 'reasons' from 'excuses'.

But asked to account for their *own* behaviour, the same respondents might cite the effects of stimulants as a reason for unsafe sex: "When taking drugs like speed, condoms are sometimes the last thing on your mind".

Again, this is seen as a consequence of loss of control over thought processes where the pursuit of pleasure may take precedence over reason: "You just lose control of yourself ... your brain gets really tired and all you think about is what's happening at that moment"; "You get caught up in an act and you just push it a little too far." As described by one female user of ecstasy: "If I was shagging somebody without ecstasy... and we didn't have any condoms ... I'd be more in a position to say 'No'. On ecstasy...[I'd] be more likely to say, well, 'fuck it' if I haven't got a condom".

The key point here is the presence of a *contradiction*. On the one hand, there is the consensus that stimulants do *not* encourage a loss of control. On the other hand, users suggested that stimulants were a reason why they had unsafe sex. This contradiction again raises the question of whether drugs give people the excuse for having unsafe sex (see *Is it all just an excuse?*).



### Risk perception

Our findings highlighted the hierarchy of risks associated with drug using lifestyles. Other health risks (particularly overdose) were often prioritised above HIV risks. General welfare risks (eg, housing, money) were also seen to be more important by some users. This strongly suggests that perceptions of HIV risk are *relative* concerns. We also found that *within* the range of HIV risk factors, again drug users set their own priorities.

**Priorities** For many drug users and their sexual partners, sexual safety was often not a high HIV prevention priority. Our data show that everyday norms encourage *safer* drug use yet *unsafe* sexual practices. Unprotected sex was considered the norm within most heterosexual relationships. As one heroin user said: "It's normal for drug users ... I don't know anybody that uses [condoms]".

Part of the reason for this view is that HIV risks were seen in the context of other cost-benefits associated with unprotected sex rather than as an overriding priority. 'Benefits' included displays of love, trust, commitment or permanency and were sometimes seen to outweigh the risks. As one HIV-negative heroin user said of sex with his HIV-

## THE KEY POINTS

- Drugs provide both a 'reason' and an 'excuse' for having unsafe sex. Next time we hear someone say, "I only had unsafe sex because I was drunk," we should think twice about how to interpret this.
- Drug users view HIV risks associated with unprotected sex as a relative concern. Other risks and dangers may be seen as more important than HIV.
- Condom use is negotiated. Sexual encounters involve at least two people so protected sex is more than simply a matter of individual choice.
- Within relationships, some dishonesty about drug use and sexual history is common. Most decisions are based on 'trust' between partners, yet such trust is often misplaced.

positive partner, "We both decided to throw caution to the wind and have real sex for once and we enjoyed it all the more."

**Risk assessment** Assessments of the HIV risk in sexual encounters were more likely to be based on a partner's drug use than on their sexual history, which was often overlooked when decisions were made whether to have penetrative sex or to use condoms: "I didn't think about the sex ... it was just the drugs I thought about. I mean, he's got veins like bloody tree trunks".

Even if they accepted that their partner might be infected with HIV, respondents thought they were less likely to become infected through unprotected sex than through syringe sharing. Injectors who would refuse to share syringes with their sexual partners would continue to have unprotected sex, sometimes even when one of the pair was known to be HIV positive.

**Knowledge and trust** Presumed knowledge and trust between partners about drug use and sexual risk is often misplaced. As with the rest of the world, drug injectors have secrets, and often don't disclose their injecting drug use or sexual infidelities to their partners. In some cases, people may not disclose they are infected with HIV. One stimulant user put in such a position by his partner told us, "I wouldn't have done anything with him if I'd known."



### Negotiating condom use

The concept of 'negotiation' can help us understand why unprotected sex occurs and in particular why individuals may lack control or choice over the direction some sexual encounters take,

including whether condoms are used. This is because it recognises that sex is the outcome of *interpersonal interactions* rather than simply the product of individual choices. With this in mind, we were able to make two further observations.

**Negotiation is a process** We realised that the negotiation of condom use is often a long process, both for drug users and non-users. In long-term relationships, this negotiation is not simply an explicit one-off exchange ('Are you sure about this?') but can be part of an ongoing implicit communication process. This has implications for how easy it is for individuals in an ongoing relationship to make 'choices' or 'decisions' about condom use. Overwhelmingly, we found that negotiation in long-term heterosexual relationships resulted in couples moving away from condom use, usually to other forms of contraception.

**A delicate matter** The negotiation of condom use was found to be an extremely sensitive process, particularly in drug users' first-time and short-term encounters. Many sexual encounters are highly ambiguous, lacking clarity over whether things will go far enough to make condom use a live issue. This makes the timing of negotiation crucially important – too soon, and you risk an embarrassing *faux pas* or rejection; too late, and it could be literally too late.

Condom use is most likely to occur when ambiguity and uncertainty about encounters is minimised with both partners *expecting* to use condoms. This tended to be the case in contexts where safer sex has become the norm, as in first-time encounters between men.



### Sexual relationships

We found that drug users' long-term relationships were a key influence on patterns of drug use and sexual behaviour. The 'seriousness' of a relationship was a significant factor: "If you make a commitment to stay together it makes it a more permanent thing if condoms aren't used".

**'Gear relationships'** In many cases, during their relationship one sexual partner had initiated the other into drug use. Relationships between opiate users (often called 'gear relationships') tended to evolve around the everyday priorities of taking drugs, making it seem very difficult for either partner to curb their drug use without seriously threatening the relationship. "People can be together for

20 years and if one partner decides to come off you can be sure that relationship is finished within six months. I have seen it happen to so many people." If abstinence was achieved, being in a relationship with a drug user was found to precipitate a return to drug use.

**Relating to non-users** Relationships between drug users and non-users often entailed an element of dishonesty about drug use, particularly injecting. As one male injector explained, "I didn't used to tell the girls that I was injecting. I used to keep it totally quiet." This clearly has implications for HIV risk in relationships based on 'trust' between partners.

### Interactions limit choice

In our research we found that condom use and sexual safety in general were complex outcomes of a combination of individual and social factors. Of key importance is the finding that unprotected and protected sex is not simply a product of individual choice. Rather, it is dependent on the interactions between sexual partners as these play themselves out in specific settings.

At one extreme, individuals may have little or no 'choice' with regard to condom use – the case, for instance, for a female injector whose partner did not disclose he was HIV positive yet insisted on unprotected sex. It was also true for another female drug user whose HIV positive partner physically coerced her to have unprotected sex.

At another extreme, individuals may have that choice, yet choose to ignore it. For example, a heroin injector without HIV reported having had unprotected sex with his HIV positive partner over a two-year period. Armed with the necessary knowledge and information about HIV and its transmission, he had made what can be termed as an 'informed choice'.

THESE EXTREMES illustrate the importance of understanding what unprotected sex and sexual safety mean to drug users. In the context of all the risks and dangers associated with their lifestyles, unprotected sex can seem relatively insignificant and the benefits of sex without a condom can be seen to outweigh the dangers. Most drug users we interviewed saw unprotected sex as 'normal' in heterosexual relationships. Despite HIV and AIDS, this is also likely to be the view of most non-drug users, suggesting that major and deep social change will be needed before future research studies can report that most drug users always use condoms. ○

## WHAT IS SEXUAL SAFETY?

'Sexual safety' is invariably equated with condom use. In most studies, unprotected penetrative sex is seen as 'unsafe' while the use of condoms is 'safe' or 'safer'. Our research shows that these definitions are inadequate.

### 'Protected' sex can be unsafe

'Protected' or 'safer sex' is often a matter of degree. Condom use within a sexual encounter where penetrative sex occurs does not guarantee that all the period of penetration is protected or that transmission of HIV or other diseases is prevented.

For example, condoms are very often used only after a period of unprotected penetration – a form of 'unsafe protected sex' which may minimise the risk of unwanted pregnancy but does not necessarily minimise the risk of transmitting HIV. This finding means that HIV-risk estimates based simply on whether or not condoms are used are likely to over-estimate the proportion of drug users who practice 'safer sex' and under-estimate the proportion having 'unsafe sex'. Asked whether they 'always use condoms', drug users may justifiably answer 'Yes' even if during these occasions they also have unprotected penetration.

Other forms of 'unsafe protected sex' include encounters where condoms come off or split. Some of our interviewees said condom breakage or failure was more likely during the prolonged penetration associated with delayed male ejaculation through the use of opiate or stimulant drugs. As one woman said, "Condoms aren't made for fucking on ecstasy."

### 'Unprotected' sex can be safe

With respect to infection, there can also be 'safe unprotected sex' if neither partner is infected with a sexually transmissible disease. For many

people in long-term relationships, who may use other forms of contraception to prevent pregnancy, not using condoms was seen to be safe. An HIV-negative woman explained, "I don't see any reason why sex shouldn't be safe ... I knew he wasn't having sex with anyone else and I knew he wasn't using anyone else's needles."

But our data also showed that there is a relatively high level of dishonesty between partners about their drug use, sexual history and sometimes their HIV status, so 'safe unprotected sex' is rarely based on certainties. One heroin user learnt this the hard way – "That girl I caught 'the clap' off, I mean, she told me she was a virgin."

### Beyond HIV and babies

Though in this article we focus on HIV risk and safety, our interviews convinced us that 'sexual safety' is best treated as a broader category which encompasses all aspects of safety in sexual encounters. This is why we defined 'safe' sex as "encounters in which participants perceive themselves to be at no risk or danger".

For example, the risk of a violent reaction if they raised the issue of condom use was seen by some women as a greater danger than catching HIV through unprotected sex. One woman said even mentioning condom use to her partner made him "go absolutely ape-shit ... He wanted 50 million kids ... He hadn't heard of contraception." Another said, "At the very mention of the word 'condom', he just exploded".

In these situations, unprotected sex may be seen to carry less risk than suggesting protected sex, highlighting one advantage of qualitative research – its ability to understand condom use and infection risks in the context of other risks and dangers associated with drugs and sexual relationships.

## FOR MORE INFORMATION

Contact the authors on 0181 846 6565 if you are interested in any of the following publications related to the research reported in this article.

- **SAFER SEX EDUCATION WITH DRUG USERS: AN EXPLORATORY STUDY.** Centre for Research on Drugs and Health Behaviour (CRDHB) and AVERT, 1995.
- **SEXUAL BEHAVIOUR OF INJECTING DRUG USERS.** Executive Summary 19, CRDBH.
- **SEXUAL SAFETY AND DRUG USE.** Executive Summary 39, CRDHB.
- **DRUGS AS 'REASON' AND 'EXCUSE' FOR UNSAFE SEX.** Executive Summary 40, CRDHB, 1995.
- **CONDOM USE BY DRUG USERS: WHETHER, WHY NOT AND HOW?** Executive summary 41, CRDBH.
- **SEXUAL BEHAVIOUR OF DRUG INJECTORS IN LONDON.** *Addiction*: 1994, 89, p. 1085-1096.
- **SEX, DRUGS, INTERVENTION AND RESEARCH.** *International Journal of the Addictions*.
- **WHERE IS THE SEX IN HARM REDUCTION?** *International Journal of Drug Policy*.
- **WHAT IS THE RELATIONSHIP BETWEEN DRUG TAKING AND SEXUAL RISK?** *Sociology of Health and Illness*: 1994, 16, p. 109-229.
- **RISK, INTERVENTION AND CHANGE: HIV PREVENTION AND DRUG USE.** London, HEA.

1. Rhodes T. et al. *Safer sex education with drug users: an exploratory study.* Centre for Research on Drugs and Health Behaviour and AVERT, 1995.
2. Advisory Council on the Misuse of Drugs. *AIDS and drug misuse: update.* HMSO, 1993.
3. Rhodes T. et al. *Sexual safety in the context of drug taking and sexual lifestyles.* Centre for Research on Drugs and Health Behaviour, 1995.
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10. Bolton et al. op cit.
11. Stall R. et al. "Understanding the relationship between drug or alcohol use and high risk sexual activity." *Addiction*: 1994, 89, p. 131-134.
12. Rhodes T. et al. 1994 op cit.

**NEXT ISSUE: from the same authors, how opiate and stimulant drugs influence sexual desire and performance**