

Forbidden pleasures: Drugs and sexual desire

SEX AND DRUGS are popular topics of conversation, for some, their *favourite* topics. Others claim sex and drugs are their favourite recreational activities. Not only do people like talking about sex and drugs, they like doing them too. Despite the talk, there remains a mystique about 'sex' and 'drugs'. We need to begin to dispel that mystique, but before dispelling it we should get to know our target – what does the mystique consist of, where does it come from?

The very words 'sex' and 'drugs' seem to beg an 'and' in between. In some way they are seen to be *connected*, to mix well. This is because, in some social circles, taking drugs is widely thought to enhance sex. Equally, sex is often popularly perceived to enhance drug effects. The implication is that if you get a chance to do both at the same time, then your experience will be at least twice as good as if you had only done one or the other.

There are other reasons for the mystique. Sex and drugtaking are set apart from other domains of talk and interaction because they are clandestine. In British society, having sex and taking drugs are done *privately* and are either illegal or taboo. Why else is everyday sex and drug talk often characterised by giggles, whispers or lies on the one hand, or outright bragging on the other?

An example from our own (limited) experience. When the taxi driver asks what you do and you say "Research," you're hoping he's not going to ask "Into what?" When they *do* (inevitably) ask, you say, as casually as you can, "into sex and drugs". Their response is usually one or a more of the following: "Ooo errr!", "Alright for some!", "Wanna swap jobs?", "I only get the chance at home!", etc.

Those of us who work in the drugs field may know a different story, one of attempts to minimise the *dangers* of sex and drugs, whether separately or in combination. This is not a 'happy-go-lucky' story about the wonders of sex/drug-related experiences, but is about the potentially tragic consequences of unsafe sex in

*In Britain's first
in-depth exploration of
how drugs affect
sexual desire nearly
100 drug users open
the doors on the most
intimate and
potentially risky parts
of their lives*

by
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SUMMARY

In some drugtaking circles taking drugs is thought to enhance sex and sex is thought to enhance drug effects. Interviews with 96 opiate or stimulant users revealed that for many these drugs did not live up their reputations of diminishing or enhancing sexual enjoyment. Drug users want and need to know more about the effects of drugs on their sex lives, suggesting that drug services should provide advice about effects on sexual desire, behaviour and relationships.

the form of HIV, hepatitis and other sexually transmitted diseases.

There are other reasons for the different story that harm reduction provides. We know that drugs do not always enhance sexual pleasure, and that sex is not always enhanced by drug use. In this respect, the 'sexual myths' of drugs work differ from the 'sexual myths' of everyday life. In the drugs world opiates are associated with a loss of sexual desire while there is usually a consensus that, of all the drugs available, stimulants (including ecstasy) are the ones most likely to enhance sexual experience.

So much for what we know of the mystique(s) of drugs and sex, now to the real stuff of experience. We interviewed 96 users (of opiates and/or stimulants) to explore how drug users themselves saw the effects of their drug use on their sexual experiences. Are opiates always associated with a loss of sexual desire? To what extent are stimulants also *sexual* stimulants? Elsewhere (including in the last issue of *Druglink*) we reported findings from the same research on how drugs affect sexual safety and how sexual encounters are negotiated.¹⁻⁴ Here we concentrate instead on the perceived physical effects of opiates and stimulants on sexual desire and 'performance'.

Opiate beliefs and experiences

Only a minority of regular users saw heroin as simply irrelevant to their levels of sexual desire or activity. By far the most common view was that heroin and other opiates are the "kiss of death to anyone's sex-life". Men and women said heroin "kills the sex drive", "kills the sexual side" and "takes the passion and sensuality away". Among opiate users, in terms of its effects on sexual behaviour, heroin was generally thought the "lowest of the low". A heroin-chasing man said, "It really does kill my sex drive. I can perform, but under protest. I'd rather be sitting there watching the telly."

But this was not true for everyone all of the time. For most, it depended on when the drug

was taken, when it was next needed, how long they had been using and how stoned they were. While some described a lifestyle of opiate use devoid of sex, others described the sexual effects of heroin as largely dependent on timing and amount.

A woman heroin injector explained: "If you have your heroin in the morning, by the time the evening comes you're not feeling ill but you're not that stoned. But if you have a hit before you go to bed then you're not going to be able to ..." One injector, who had been using for 20 years, said that while most people lose their sexual desire, "I don't lose my sex drive on heroin". He added, "I don't really know why ... perhaps I've just got a high sex drive."

There may be a glimmer of nostalgia in the accounts given by some old-time heroin users about the drug's effects on their sex lives. For one, now in his fifties, heroin was part of a "lethal, powerful narcotic combination [of] sex, drugs and rock and roll". Back in the "hey-day", heroin was, he said, a "sexy" drug. "If you get the right combination for yourself, it turns you into Superman because you get this incredible confidence ... You get the right feeling in the right time ... and that takes care of your physical performance and your tactile performance." His conclusion was that "you can get hooked" on the combination of sex and drugs – and for 20 years, he had.

But for many users of heroin, whose experience is generally the opposite, this description has a 'mythical' quality.

So users' experiences of the effects of heroin or other opiates on sexual desire are variable. In general opiates are associated with a loss of desire, but this is not necessarily the case.

Precisely how these effects manifest themselves also vary from one user to the next. For some men, it may be problems in getting and keeping an erection. For others, it was difficulties in ejaculating or having an orgasm. For others still this was not the case. Such variations cannot entirely be explained by what users told us about the impact of heroin dosage, timing and duration of use on sexual desire and behaviour.

Stimulant beliefs and experiences

Our respondents saw almost all stimulant drugs as potential 'aphrodisiacs' – a perception common among stimulant users and non-users alike. Amphetamines (speed) were described, for example, as making "people horny", creating opportunities for "amazing sex". These effects were seen to be self-evident: "Obviously speed makes you horny as a

jack rabbit", said one heroin user.

Previous researchers have reported that cocaine has perhaps "the most prestige among drug connoisseurs as the paramount sexual stimulant".⁵ Our respondents were no exception. Many saw cocaine powder as an aphrodisiac which made you "very randy" and encouraged "amazing sex ... all the time". One user noted, "When you're on coke you wanna bonk 'til next week." Crack also was seen as potentially "the most intense sexual drug" which makes "some people very, very horny".

One woman drug user described the effects of crack, cocaine or speed: "It's mental ... They [men] don't want to bloody stop ... The pair of us would start in the bedroom and end up in the kitchen or somewhere."

Despite its reputation as an asexual 'hug drug', ecstasy was also seen by some as the "sexiest drug out today" because it makes people "unbelievably horny". When "up on it ... I just become interested in absolutely everybody sexually", said one.

It's time to put the sex into drug services

But stimulants were also seen *not* to be aphrodisiacs. Both recreational and regular users saw speed, for example, as "no good for sex". Other users talked of never having had the "amazing sexual experiences" supposedly associated with cocaine. Of the first time he and his partner tried cocaine, one respondent complained: "We did it especially ... we'd been told that it was kind of an aphrodisiac. Well, it wasn't you know." Another said: "Everybody is always talking about cocaine being an incredible aphrodisiac ... I never ever felt a stimulus in any sense being high on coke."

So in general there is support for the popular perception that stimulants are aphrodisiacs, but this was certainly not the case for everyone all the time. For some, stimulants had never lived up to their reputations as sexually stimulating. Whether speed ("If I took a bit of whizz, I'm not interested in sex"), cocaine ("It'll never make me horny") or crack ("We nearly slept in separate rooms"), people's experiences do not tally with the myth that stimulants are *universally* sexually enhancing.

The elusive erection

Beyond the effects on sexual desire described above, drugs were often seen to influence the mechanics of sexual behaviour. A woman said of her male partner, "If he hadn't done any heroin, it [an erection] would be like instant!" She was not the only one to link opiate use to problems in getting and keeping erections. A long-term chaser of heroin said, "When you're actually on it, it's hard to get an erection ... and when you do, it's hard to keep it." Even when possible, erections might not be "100 per cent"; during sex they could "just [go] limp".

Despite generally being seen to enhance sexual desire, stimulants were sometimes seen as interfering with sexual performance. Some men said getting an erection on speed was "virtually impossible". "It is impossible to get a hard-on if you've had speed. Just lies there." Then there is 'stimulant shrivel'. One woman explained: "It's undeniable [that] men are less endowed when they have a load of speed." Speaking more eloquently than the men, women remarked, "They can't deny the fact that their dick's gone smaller. It's disappearing!"; there's "quite a lot of shrinking" so "it's harder to get it up as well".

For other men, speed was associated with an inability to sustain erections, described as a "hit or miss" process where erections were "trigger happy". As one woman described it, "and then it'd be like stiff again and go floppy and stiff and floppy". One man lamented, "You have no idea at all" that this is going to happen since "you don't know until you actually try".

Far from universally enhancing, the effects of stimulants were seen as "strange" and unpredictable: "You can never tell how speed can take you ... sometimes I get a hard-on, sometimes you can shag for hours and hours before you come, other times ... the spirit is willing but the flesh is weak".

For both heroin and stimulant users these effects were sometimes "embarrassing" or awkward, particularly in the context of new relationships: "It's not very pleasant for somebody ... to see that you're not aroused by them at all."

Male opiate users said problems in getting and sustaining erections were due to loss of concentration, particularly when stoned. Sex demanded a level of concentration made difficult when "wafting" or "wandering off" on the high from heroin. "I think my mind just wanders off and ... I just go soft"; "I didn't realise it was happening ... You suddenly realise, 'Oh, I've been thinking about something else'." Sustaining

KEY POINTS

1 Norms, talk and reality

Often to their surprise, for many people opiates or stimulants did not live up to their reputations of diminishing or enhancing sexual desire or performance. Most associated heroin with difficulties in ejaculating and having an orgasm, but others associated it with premature ejaculation. So heroin was seen as an aid to "brilliant" performance for those who might "have trouble controlling their orgasm" as well as a hindrance in bringing about "a ten-second wonder".

Most interviewees saw stimulants as sexually enhancing, including those who had never experienced these supposed effects. This highlights the importance of 'norms' or expectations of drug effects. When they experienced unexpected effects (such as when stimulants were not sexually enhancing), interviewees fell back on their drug's reputation ('Cocaine makes you horny'; 'Heroin kills your sex drive'). In short, there is often disparity between the socially expected effects of drugs and the individual's sexual experience.

2 HIV - not the only concern

Many drug users, including those who used stimulants recreationally, were concerned about the effects on their sex lives. These could create problems in sexual relationships, problems which were seen as far more immediate and worrying than the risk of HIV.

For example, opiate-induced loss of sexual desire was reported to have communicated negative feelings to users' partners ("She tended to interpret it ... that she was unattractive"; "He sort of feels unloved I think") leading many to "go through the motions" and have sex "just for the sake of it". Likewise, drug users' inability to reach orgasm could make partners feel "unattractive", "boring" or "sexually inadequate", creating a "distance" between partners, and leading to "frustration", "horrendous rows" and even the "destruction" of relationships. Some said the deterioration in the sexual part of their relationship with a partner was the reason why both would give up drugs.

erectons, particularly after having recently taken heroin, demands equally sustained concentration: "I'm thinking about staying hard, that's the main priority ... to try and stay hard."

Coming ready or not?

Heroin was often said to cause difficulty in ejaculating or having an orgasm. For women and men alike, opiates made it "harder to become aroused and stay aroused". For women this was associated with loss of "sensitivity" but also - as for men in sustaining an erection - with impaired concentration while stoned. "I'd nodded off, completely went off ... forgot what I was supposed to be doing." From another, "I had a hit once and I remember going to bed and all of sudden I said [the ceiling] looked lovely, it was really light blue, and he went, 'Am I boring you?' ... I even forgot where I was." Under these circumstances, maintaining arousal to the point of orgasm could be "too much hassle" since "you can't stay awake long enough".

For women these difficulties were seen by to be exacerbated by men's difficulties in ejaculating which sometimes led to uncomfortable and boring bouts of prolonged penetrative sex. "When you get round to having sex, it takes so long ... you can't help it, you keep sort of drifting off"; "It takes ages, drives you mad"; "It gets incredibly boring having sex with speed freaks"; "It takes them nearly forever to come". For men too, "the longer it takes the easier it is to lose interest in what's happening". Even if they could get and keep an erection, many found it "impossible" to ejaculate.

For both men and women, delayed male ejaculation also led to feelings of frustration and lack of 'climax' ("It takes the climax out of the whole experience"). Partly to do with loss of concentration ("You can be thinking about fucking ... and suddenly you're thinking about space ships or what's on TV") and partly to do with the perceived physical effects of heroin ("For six years [sex] didn't involve having an orgasm"), difficulties in coming were seen as "frustrating", "upsetting" and "annoying". Sex was less "spontaneous", less "enjoyable", "hard work", "a hassle" and "too difficult". As a male heroin chaser remarked, "Let's face it, that's the last thing you want".

One common exception to the rule of delayed ejaculation among heroin users is when withdrawal sets in. As one user explained, "Every time that I've cleaned out I've been really shit in bed, I come too quick". Another said: "We stayed the night in the same bed and she gave me a

blow-job and I came in about two seconds".

Stimulants were also thought to prolong penetrative sex by delaying male ejaculation - for some a positive effect enabling "mammoth sex sessions" lasting "hours and hours and hours". Men may deliberately use stimulants "to go on longer" or "to impress a woman". Heroin was also talked of in this way, particularly by those fairly new to opiate use. But there is a fine balance between the right amount and too much: "I can have really good sex. I can go on all night if I've had the right amount ... If I've had too much then you lose a hard-on after a while."

THERE ARE SOME clear implications for drug services arising from our research. Acting on these could take the workers involved into new and potentially uncomfortable territory. Our research indicates that drug users want and need to know more about the effects of drugs on people's sex lives. The implication is that services for drug users should aim to provide advice about the effects of drugs on sexual desire, behaviour and relationships as well as on the risks of sexually transmitted diseases; perhaps this should be a standard feature of their sexual health advice work. Drug workers will need training and guidance to enable them to broach what is seen by both clients and workers as a delicate and sensitive issue.⁷ In this context, interventions working with experimental and recreational users of stimulants should be careful to provide information on both the positive and negative effects of stimulants on sexual desire and behaviour.

In other words, it's time to put the sex into drug services. ○

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.
- **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. (See review on page 17 in this issue)

1. Rhodes T. & Quirk A. "Drug use, sexual risk and sexual safety." *Druglink*: 1995, 10(5), p. 15-18.
2. Rhodes T. et al. "What is the relationship between drug taking and sexual risk?" *Sociology of Health and Illness*: 1994, 16, p. 209-229.
3. Rhodes T. et al. "Sexual behaviour of drug injectors in London; implications for HIV transmission and HIV prevention." *Addiction*: 1994, 89, p. 1085-1096.
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6. Green A. & Rhodes T. *Sexual health promotion among drug users.* Information Pack. Horsham: AVERT, 1994.
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