

Using drugs for sex: playing with risk?

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Drugs and sex. Taking drugs and having risky sex: forever intertwined in our imagination and in people's actual behaviour. In the field of sexual health, this is mostly taken for granted. Doctors, nurses, counsellors, educators and researchers alike know that there is a strong likelihood that someone who regularly takes drugs is also likely to engage in 'risky' sex, and the two activities are likely to be indicative of someone 'at high risk' in other aspects of their lives. Mostly, we understand this through the prism of vulnerability: individuals who take socially disapproved risks very often are thought of as victims, whether due to social disadvantage, or mental or emotional impairment. The fundamental question we need to address, though, is what the available evidence tells us about these 'taken-for-granted' links.

The linkages between drugs, sex, and disadvantage raise important questions. Is drug use necessarily problematic? Does drug use cause sexual risk-taking? Are both drug use and sexual risk-taking indicative of underlying emotional or other problems?

There are, of course, broader social harms associated with drug use in general and with specific drugs in particular, as alluded to by Mullens *et al.* published in a previous issue.¹ The negative consequences of specific drugs vary according to their particular effects, both biological and psychological, and depending on their level of use; and these also vary according to individual circumstances. In the case of methamphetamine, for example, its long half life means that users often remain 'up' (and then 'down') for several days, potentially disrupting their lives quite substantially. Nonetheless, these negative consequences do not automatically mean there will be negative consequences in users' sexual behaviour, and the evidence for this is complex and sometimes contradictory.

The link between drug use, sex and the risk of HIV or other sexually transmissible infections among gay men has been well documented,^{2,3} and common sense suggests that if drugs impair judgement and distort perception then this is likely to lead to poor decisions about sexual (and other) behaviour. That this happens to some people is, of course, undeniable, but most research in this field is based on cross-sectional data, with an association between the two behaviours over a given time period. A statistical association does not necessarily indicate

cause and effect. Regardless of the time period involved, this only tells us that those who use drugs are often the same people who take risks sexually.

Some studies⁴ are based on event-level data, indicating an association between drug use and sexual risk behaviour on a specific occasion: on occasions when gay men in these studies used drugs, they were also less likely to use condoms. However, not all studies using event-level data have found such an association.⁵ Australian data from two separate cohort studies of gay men, one HIV-negative and one HIV-positive,^{6,7} found otherwise. The most recent encounter involving unprotected anal intercourse (UAI) was compared with the most recent encounter involving condom use: among men who engaged in UAI, drug use did not distinguish these two events. These Australian data suggest that while drug use is associated with sexual risk behaviour in general, it may not be a primary driver for specific decisions not to use condoms. Many, perhaps most, of those who use drugs remain quite capable of making decisions about sexual risk.

Cohort studies have also identified a strong association between drug use and sexual risk events, and between drug use and HIV seroconversion.⁸ In most cases this is explored in one direction: does drug use predict subsequent sexual risk, or subsequent HIV seroconversion? In a recent analysis of some Australian data, however, it was found that this association was bi-directional: sexual risk behaviour predicted subsequent uptake of drug use.⁹ So, while cohort data provide a stronger case for the association between drug use and sexual risk-taking, they do not necessarily prove a specific cause-and-effect relationship. Indeed, it is probably not possible to obtain such direct evidence, but that may be the wrong question anyway. Perhaps what we really need is to understand the motivations for both behaviours – sexual risk-taking and drug use. What is the link between them and why are some individuals especially likely to engage in both?

The connection between drug use and sexual risk taking has been applied to all different types of drugs, both licit and illicit, including alcohol, as it has to drugs in general. Nonetheless, some drugs appear to be particularly implicated in sexual risk-taking over the past decade. Amyl nitrite was originally singled out as a potential and specific risk factor for HIV

infection¹⁰ and has been cited again in recent years,⁸ as have both methamphetamine¹¹ and oral erectile dysfunction medications (OEM).¹²

What connects amyl nitrite, methamphetamine and OEM, and makes them different to many other drugs, is that they play a very specific role in enhancing and extending sexual function and excitement. Also, in certain highly sexualised subcultures, particularly some gay men's sexual networks where 'intensive sex partying' is common, the use of these three drugs, in particular (and often in combination), is both culturally sanctioned and relatively normative.¹³ So the fact that these particular drugs commonly emerge as specific risk factors is not surprising, given their use is highly correlated with sexual behaviour in general, and with sexual networks where risk-taking is relatively common specifically. There are some other, less commonly cited, drugs that are also similarly used to enhance sex, such as gamma-Hydroxybutyric acid (GHB) and ketamine (Special K). The specific effects of any of these sexual enhancement drugs in heightening and extending the sexual experience makes it possible for those who use them to engage in activities they might otherwise be physically, and psychologically, incapable of doing. Clearly, for some individuals, the effects of these drugs on sexual behaviour and decision-making can be problematic, even dangerous. Others can be overwhelmed by the experience and the drugs may begin to interfere with their capacity to function in other aspects of their lives. Interventions that provide realistic information, and preparation, for those who will use drugs, and interventions that provide appropriate support to individuals for whom their drug use is a problem, are an appropriate response. However, this description does not apply to all those who use these drugs and take risks sexually. The available research suggests that they are possibly only a minority of users.

Nor do we need to turn immediately to boredom or escape as explanations for taking drugs or having sex that is more likely to result in infection. It is pleasure that is often central – the sheer simple enjoyment of having a good time with others. These multiple possibilities are not, however, necessarily mutually exclusive. In fact, they often coincide, though too often they are juxtaposed, if not in theory then certainly in practice. Often, we see these behaviours purely as 'risk-taking' and evidence of pathology. In our risk-averse society, the idea that individuals might willingly and knowingly engage in behaviours that are associated with risk is difficult to understand in non-pathological terms.

In the end, though, the reliance on single, simplified, explanations often fails to consider the actual experiences and understandings of many of those who regularly take drugs and who engage in risky sex. Before assuming anything about them, we need to consider:

- Is it possible to measure relative risk and pleasure, and how do we do it?
- How much actual risk is involved in these behaviours? To what extent do we account for context and prevalence?
- Is there agreement that the behaviours are risky? By us? By everyone else?

- Is the motivation for people's 'risk-taking' behaviour the pursuit of pleasure or escape from reality, or both?
- When does 'enough' become 'too much' and at what point do individual 'rights' have to give way to judgements about 'right' and 'wrong'? Who decides?

Each of these issues would benefit from further research. Understanding this relationship between drug use and risk depends particularly on more sensitive information about the context and motivations for both. In particular, we need to explore how values and norms are developed and reproduced within respective social networks and how individuals within these networks adapt their personal desires and circumstances to these established, peer-based, norms. This requires a broad approach that encompasses both individual and social pressures and desires: simply demonstrating an association between drug use and sexual risk behaviour is no longer sufficient, particularly when it is based in a presumption of vulnerability with little evidence of an understanding of the pursuit of pleasure.

In our efforts to promote individual health and well being, we seek to ensure that people have access to relevant, and realistic, information. Sometimes their decisions will be unhealthy for themselves and for those around them, but our capacity to understand their situation and their priorities is essential to our ability to effectively intervene. More broadly, though, individuals' capacity to make informed decisions about both drug use and sexual health is dependent on more than just their access to information. Those decisions are also affected by social context. What do their peers and their communities think about these issues? What is expected of them? How easy is it for them to choose otherwise? While we might affect, at least temporarily, individual decisions, changing social norms and the values common to particular social networks or communities is more likely to have a long-lasting effect, but to do so means understanding and working with them.

Much of the literature about drugs and sex presumes that the observably heightened risk associated with these intertwined co-factors is necessarily problematic; particularly when these behaviours are more extreme, as in 'intensive sex partying'. But individuals who engage in these behaviours often have different risk-thresholds than their professional observers. Also, for some, it may be the risk itself which is attractive to them. Regardless of the degree of actual risk involved, or the appropriateness of any intervention, we all have differences in how we perceive risk. In the end, though, we still need to make judgement calls about such risk-taking, but such judgements, and any possible interventions, are meaningless without first acknowledging, respecting, and working with our differences in perception of risk. The lack of a simple cause-and-effect explanation may be frustrating, but more contextualised and sensitive analysis of the issues will undoubtedly lead to more effective interventions, regardless of their desired outcomes.

Conflicts of interest

None declared.

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