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Thomas Lyons PhD ^a, Gopika Chandra MD, MPH ^b, Jerome Goldstein MPH ^b & David G. Ostrow MD, PhD ^c

^a Great Cities Institute, University of Chicago, Chicago, Illinois, USA

^b School of Public Health, University of Chicago, Chicago, Illinois, USA

^c National Opinion Research Center, University of Chicago, Chicago, Illinois, USA

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Breaking the Bond Between Stimulant Use and Risky Sex: A Qualitative Study

Thomas Lyons, PhD
Gopika Chandra, MD, MPH
Jerome Goldstein, MPH
David G. Ostrow, MD, PhD

ABSTRACT. Stimulant-using men who have sex with men (MSM) are at increased risk for human immunodeficiency virus (HIV) transmission, and are more likely to practice unprotected anal sex than MSM who do not use methamphetamine and/or crack cocaine. In this paper the authors report on interviews with stimulant-using men who have sex with men who have participated in Crystal Meth Anonymous and other 12-step groups, focusing on those who did not have unprotected anal intercourse during a 6-month follow-up period and their reasons for doing so. The authors find 4 common themes cited: a diminished sexual drive; exclusive sex with a primary partner; greater sense of responsibility/commitment to safer sex; and most commonly of the four, an overall healthier sex life. Participants' use of terms such as "healthy," "enjoyable," and "fulfilling" to describe sex not on stimulants, and avoidance of these terms for sex on stimulants, suggests a distinct dimension of sexual experience.

KEYWORDS. Cocaine, gays/bisexuals, methamphetamine, peer support groups, sexual behavior

INTRODUCTION

Stimulant-using men who have sex with men (MSM) are at increased risk for HIV transmission (1, 2). Recent research has conclusively linked unprotected anal sex with use of methamphetamine (3–5) and/or crack cocaine (6). Explanations of this link fall into at least 4 categories: pharmacological, instrumental, trait-based, and contextual/situational explanations. (1) *Pharma-*

cologically, both methamphetamine and cocaine stimulate the mesolimbic dopamine pathways in the brain, causing heightened sexual desire (7). (2) Methamphetamines and cocaine are both used *instrumentally* to enhance the sexual experience (4, 8, 9), to facilitate meeting partners, and to obtain "time outs" from stress, including the stress of living with the human immunodeficiency virus (HIV) (10). (3) Observed associations between drug use and risky sexual behavior

Thomas Lyons is affiliated with the Great Cities Institute, University of Chicago, Chicago, Illinois, USA.
Gopika Chandra and Jerome Goldstein are affiliated with the School of Public Health, University of Chicago, Chicago, Illinois, USA.

David G. Ostrow is affiliated with the National Opinion Research Center, University of Chicago, Chicago, Illinois, USA.

Address correspondence to: Thomas Lyons, PhD, Great Cities Institute, MC 107, University of Illinois at Chicago, 412 S. Peoria Street, Suite 400, Chicago, IL 60607 (E-mail: thlyons@uic.edu).

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may reflect underlying personality *traits* such as risk-taking propensity or sensation seeking (11–14). (4) Finally, the link between stimulant use and unprotected sex may reflect *situational* factors, such as the fact that men meet sex partners in clubs, bathhouses, and other venues where drugs are also available (12, 15). Base prevalence rates of stimulant use and risky sex differ by region of the country (16, 17) and by HIV status, with HIV+ men in some studies more likely both to use stimulants and to engage in risky sex (e.g., 8).

These categories of explanation are, of course, not mutually exclusive, and the observed association between stimulant use and risky sex likely results from a combination of some or all of them. Moreover, the combination of factors that brought stimulant use and risky sex together may not be operative once the 2 behaviors are “fused.” Once a strong association is established between stimulant use and certain kinds of sexual behavior, sexual desire can trigger a stimulant relapse, and a relapse on stimulants can result in unsafe sexual behavior. This process can also make intervention for sex-drug usage much more difficult (18).

In focus groups with gay men in early sobriety, Paul and colleagues (19) found that participants needed specific training in having “sober sex.” Shoptaw and colleagues (20) compared 3 variants of contingency management interventions for methamphetamine addiction, one of which was tailored to MSM and focused in part on safer sex, and found significant declines in risky sexual behavior associated with declines in drug use in each treatment condition. In interviews with a subset of participants, Reback and colleagues (21) found that attitudes toward condom use, disclosure of HIV status, and sexual activities changed through participation in treatment. New desires to find a primary partner or for particular kinds of sexual experience may reflect decoupling the multiple links between stimulant use and risky sex.

In this paper we report on follow-up interviews with stimulant-using men who have sex with men who are participating in Crystal Meth Anonymous (CMA) (22, 23) and other 12-step groups. Recruitment and the baseline interview are described in Lyons et al. (24). Observations

at CMA meetings and analysis of baseline interviews described in Lyons et al. (24) indicated that sexual problems are frequently discussed in CMA, and that this may be one way in which CMA participation might help participants break the stimulant use–sex bond. The current paper presents selected qualitative data from follow-up interviews 6 months after the baseline interview, focusing on men who did not have unprotected anal intercourse during the follow-up period and their reasons for doing so. In particular, the notion that stimulant users in recovery must “mourn” the loss of sexual pleasure enhanced by stimulants, for an indefinite period of time (25), deserves further qualitative examination. We find that at least some men use qualitatively different terms to describe sex without using stimulants: terms such as “healthy” and “enjoyable,” which may reflect a different dimension of valuing sexual experience and may represent useful concepts for clinicians working with this population.

METHODS

Eligibility criteria for the baseline interview included (1) males who reported having sex with men; (2) use of either meth, cocaine, or both within the past 3 months; and (3) self-reported participation in 12-step meetings during the past 3 months. Among the exclusion criteria were inability to provide follow-up contact information. Although we were particularly interested in Crystal Meth Anonymous and methamphetamine users, a pilot study found frequent switching between methamphetamine and cocaine among methamphetamine users, suggesting the usefulness of targeting broader stimulant use. Simultaneous or prior participation in formal treatment other than 12-step was not an exclusion criterion, but was noted in the qualitative interviews. Sixty-one volunteers were deemed eligible for the study. All study participants gave informed consent for baseline and follow-up interviews, and the study was approved by the University of Illinois Institutional Review Board. In most cases, interviews were tape recorded and transcribed into computer files; detailed notes

were taken during those interviews for which the study participant declined tape recording.

At follow-up, closed-ended questions inquired into the frequency and nature of sexual experience and drug use since baseline, and open-ended questions focused on the participants' perceptions of the effect of 12-step program participation and program doctrines on sexual behavior and experience. Reported sexual activity between baseline and follow-up was dichotomized into any reported unprotected anal intercourse (UAI) partner during the interval versus no UAI partner; this dichotomy was not meant to measure risk behavior but to support qualitative findings reported below. To analyze the open-ended questions, a subset of 26 interviews were randomly selected and transcribed. A preliminary set of codes was developed on roughly the first half of transcripts, which was then applied to the second half and augmented by a second coder. Discrepancies were resolved by discussion among coders. Here we summarize participants' overall comments and descriptions of their sexual lives as well as specific sexual experiences with and without stimulants.

RESULTS

Forty-seven participants (76%) were located at 6-month follow-up. Sixty-seven percent were known to be HIV positive. The men interviewed at 6-month follow-up did not differ statistically from those lost to follow-up on race, age, HIV status, number of days using stimulants prior to entry into the 12-step program, or UAI prior to entry into the 12-step program. However, small sample size limits our ability to detect differences that may be significant.

At follow-up, 36% of those interviewed reported use of methamphetamine during the 6-month period since the baseline interview, and 33% reported use of cocaine. Fifty percent had used one or the other substance—hence half of those followed up had remained abstinent from both substances (although they may have used other drugs). Among those who reported continued use, frequency of use of either or both substances dropped from an average of 13 days/month in the month prior to program entry,

to 3 days/month during the 6-month follow-up interval.

As has been reported in previous treatment studies, rates of unprotected anal intercourse remained low in the follow-up period (20). Thirty-nine percent of the follow-up sample reported at least one instance of UAI over the 6-month follow-up interval. Those who reported stimulant use at follow-up tended to be more likely to report UAI than those who did not (45% versus 29%, $P = NS$). Unlike in the baseline interviews reported in Lyons et al. (24) however, low rates of UAI are not attributable to lack of sexual activity. In total, fully 60% of those interviewed at follow-up had had sex that did not include UAI during the 6-month follow-up period.

Given the finding that most men who were followed up did not engage in UAI, we turn to the subset of qualitative interviews to learn not only the men's subjective reasons for being less likely to engage in unprotected anal intercourse, but also how they were able to resume sexual activity of any kind decoupled from meth use. We focus on 4 common themes: a continued diminished sexual drive; exclusive sex with a primary partner; greater sense of responsibility/commitment to safer sex; and an overall healthier sex life.

Diminished Sex Drive/Celibacy

As reported in Lyons et al. (24) for the cohort at baseline, many men in the cohort at follow-up were still reporting at 6 months an overall diminished sexual drive (mentioned by 7 respondents) or complaining that sex without stimulants was inferior (4 respondents). Example statements include "I'm doing less sex because I'm not on crystal meth" and "my desire has diminished." The prior formation of the stimulant-sex bond interferes with normal sexual functioning, once stimulant use is removed from sexual activity: "I think crystal kind of ruined it forever. I used to feel orgasm from top of my head to my toe. It is not like that now, I don't know if it has to do with age or what. . . ." A diminished sex drive may also be sign of depression which often occurs after withdrawal from stimulants (26), and which can last up to 6 months or more if not treated (27).

One respondent articulated how sex continues to serve as a trigger for him, and advocated celibacy (although he himself reported having had at least one sexual encounter):

Using crystal triggers sex and vice versa. For that to cease there has to be a dissociation between sex and use. That is why we should stay abstinent [from sex] during recovery for a period of time—six months or one year—whatever it takes. It is like drinking coffee and smoking cigarettes.

A second man who had not had sex stated, “I think I need to get a firm foundation of recovery before even I think about sex,” and that he had unresolved issues around sex that he had yet to address. “Most people in recovery have had sexual dysfunction and so it is suggested to seek a little therapy about that. I was sexually molested as a young child and it has lot of bearing on my mind.” Although the current study did not explore psychopathology, this respondent points to the importance of resolving psychosexual issues as part of the long-term decoupling of sex from meth use.

Monogamy/Partner Intimacy

A number of participants were beginning to focus on an intimate and/or exclusive relationship with a primary partner (6 transcripts). If the participant had a primary partner, he described an increasing tendency to exclusivity. “I’m very reclusive [sic] now. . . Just me and my friend, just me and my partner.” The quality of sexual relations changes with the partners. “My partner and I have very good sex. It’s different, it’s intimate, you know what I mean. But it’s good.”

Respondents who did not have a primary partner expressed a desire to find one. One respondent cited the nonsexual benefits of an intimate relationship: “. . . Just to have that little [bit] of intimacy, someone to bounce things off of, trust, you have in that type of relationship . . . I think I’m at the point where I could handle it.” One respondent said that by identifying the emotional needs that could never be met through meth-driven sex, he was able to decouple the link:

Even at my highest, emotional stuff comes up. And that’s why, I think in essence, I knew I couldn’t be a part of the sex-drug world anymore. Because there’s part of me that so desperately yearns for love and trust and commitment.

Responsibility

Relative to other themes, it was less common for respondents to describe the change in their sexual behavior in terms of adherence to safer sex guidelines. Only one respondent in the sample explicitly linked safer sex with abstinence from drugs, and he was primarily concerned about his drug use, not sexual safety: “In order to stay clean I need to have safe sex.”

Healthier Sex

Finally, some participants mentioned a global notion of “enjoyable,” “healthy,” “fulfilling,” or “better” sex (mentioned in 8 transcripts). That is, in addition to disavowing stimulant-driven sex, respondents also found positive terms for the way sober sex is different. “I started to feel myself again after 6 months. I came back to healthy functioning as a human being after 6 months, enjoying sex.” Healthy sex often meant fewer partners and more discrimination about them. “Slow it down; have more time to think about what I am going to do; lesser partners.” One participant contrasted a situation in which “you’re doing it for some drugs, and someone says go down on me [have oral sex]” with a healthier situation in which “if there’s something you really don’t want to do, you’re not obligated to do it.” In this case the removal of the need to exchange sex for drugs leads to more freedom within the sexual situation. Another participant alluded to his sexual compulsiveness (a notion familiar to many because of the Sexual Compulsives Anonymous program), and elaborated a theory about meth use and compulsivity: “I can guarantee you if somebody is sexually compulsive and discovers crystal, if you get rid of crystal the sex will go away too . . . Not a single person is compulsive after getting rid of crystal.”

At baseline, several respondents spoke of how sex lacked excitement (24). At follow-up,

however, some participants stated that excitement and intensity can be replaced by the pleasures of intimacy. "The feeling of using crystal and having sex was ecstatic. I would continue to use if it didn't cause problems. [But] I love my boyfriend; I like being close and affectionate." One respondent claimed that his sexual life has improved in sobriety even beyond what he experienced before he began to use stimulants:

I've never, even when I was using I've never had a sexual appetite, it was more, like I said, exploratory . . . And now I actually enjoy sex. Before I didn't actually enjoy it, I was more curious about what this situation might be like. But now I enjoy sex.

One participant described sex without meth as a process of discovery.

I don't really know what turns me on . . . But it tends to be more on the ordinary side. Like I just want, just a very basic, homey sex life, you know . . . Maybe some more exotic behavior can come out of trust and love, rather than, you know, having the exotic behavior come first and then trying to get some of the trust. . . like the 50s housewife wanting to do it on the kitchen table. . .

This respondent's attitude toward "exotic behavior" is significant, because stimulant, particularly methamphetamine, users often claim the drug allows them to transgress sexual boundaries and engage in sexual adventures with partners they would be too inhibited to approach sober. This participant argues that sexual experimentation in itself is not harmful, if it "come[s] out of trust and love." Overall, the notion that sex without methamphetamine can be healthier and a process of discovery is exemplified in the following quote: "I'm more willing to try all different things, more gentle, easier than before, no violent things. Before it had to be intense in a certain manner."

DISCUSSION

Clearly, reductions in drug use and in risky sex are intertwined, just as drug use and risky sex are themselves syndemic (27, 28). Among the 4 factors we have cited that may theoretically link stimulant use and risky sex, some are less apparent in these transcripts than others. For instance, avoidance of risky situations such as bathhouses or sex parties was not mentioned as the primary way sex was decoupled from drug use (although one participant mentioned no longer participating in exchange sex). Few participants mentioned sexual responsibility or safer sex guidelines per se, which does not mean that they do not act on such guidelines, but instead that safer sex is not central to their experience of the effect of 12-step program participation on their sexual lives. In contrast, the decoupling of the instrumental link is evidenced by the frequently stated desire to find or maintain an intimate relationship that would not require the instrumental use of stimulants to facilitate meeting multiple partners.

Some participants' use of terms such as "healthy," "enjoyable," and "fulfilling" to describe sex at the 6-month follow-up is of particular interest. These terms may reflect restoration of the neuropsychological capacity to feel pleasure, with continued abstinence from the drug (the psychopharmacological link). These terms were never used either at baseline or follow-up to describe sex in the context of stimulant use, which was more likely to be described as "hot," "intense," or "exciting." Note that these 2 sets of terms are not opposites: they are to some degree independent or orthogonal dimensions. (One respondent illustrated this succinctly by describing a sober sexual encounter as "boring but enjoyable.") This dimension of sexual experience is different from, but not clearly inferior to sex while on stimulants.

This study is focused for the most part on those who are successful in recovery, and the limitations of the study should be understood in this context. All data are self-reported, and social desirability may lead respondents to provide answers consistent with 12-step ideology. Quantitative data on drug use, etc., are limited by sample size and are intended to bolster the

qualitative findings rather than to describe underlying population prevalences. Selection bias operates in that subjects not followed up may have differed in their behavior in systematic ways from those we were able to follow up (those successful in recovery may have been easier to follow up). Finally, the causal effect on behavior of involvement in the 12-step program cannot be distinguished from involvement in prior or concurrent outpatient or inpatient treatment. In continuation of our previous work, qualitative interviews focused on 12-step involvement. For these reasons, this study should be viewed as exploratory.

In summary, at the baseline interview very few participants had positive things to say about their sexual experience sober (24). At 6-month follow-up, almost half of those in the subset analyzed qualitatively are still experiencing low sex drive and/or unsatisfactory sex. On the other hand, about a third have begun to describe their sexual lives in positive terms—"enjoyable," "intimate," "healthy"—terms that were not used to describe drug-driven sex. Further research is needed to determine whether differences in the way participants think of their sexual lives 6 months after involvement in the 12-step program, as reflected in the qualitative interviews, affect long-term drug use and sexual behavior. If some of these self reports indeed reflect a refocusing of sexual desire (such as the participant who wanted "no violent things"), they may signify changes in HIV risk beyond simply reducing UAI, since it has been shown that under the influence of methamphetamine, the way men have anal sex—lengthy, "rough" anal sex sessions that are guaranteed to damage mucosal tissue—contributes to transmission of HIV (29). Our findings confirm previous research that the development of healthy sexuality is a crucial element of recovery from stimulant abuse for gay and bisexual men (5, 19). Clinicians who have worked with MSM stimulant users have stated that their clients must go through "mourning" of the loss of stimulant-driven sex, and accept that sex will never be as good again (25). Our findings suggest that for at least some men recovering from stimulant use, sex may take on a new dimension, described as "healthy" or "enjoyable," that is different but not clearly inferior

to stimulant-driven sex. These findings are significant for interventions because, as reported in our earlier work, in early recovery some men express the fear that they will never be able to have sex again without relapsing. Behavioral interventions are needed that specifically address the way stimulants are used instrumentally to facilitate or negotiate sex, as well as the neurobiological aspect of the link. For example, these findings could be adapted for motivational discussions with clients, in which discrepancy is developed (30) around whether stimulant-driven sex was truly enjoyable. Other group and individual interventions could emphasize and enlarge upon clients' own statements about how their view of sex has changed. Finally, any behavioral intervention with stimulant users in treatment must provide hope that the individual will eventually have enjoyable sex free of stimulants.

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