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Article

High-risk sexual behaviors in a context of substance abuse A focus group approach☆

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Abstract

Clinical studies show that heavy and dependant substance users engage with high frequency in high-risk sexual behaviors. To better understand the dynamics of unsafe sexual practices among alcoholics or non-intravenous drug users (IDUs), a series of focus group discussions was conducted with 26 single, sexually active men and women in treatment for substance abuse. Results show that unsafe sexual practices in this subgroup may be explained by three factors: (1) intoxication, (2) negative perceptions of condoms, and (3) cognitive distortions. Furthermore, men's negative perceptions of condoms and women's concerns about not opposing men by fear of being rejected seem to be synergetic to bringing about the negative outcome. Implications for clinical practices are discussed.

Keywords: Substance abuse; Alcohol use; Unsafe sex; Condom use; AIDS; Gender difference

A significant proportion of individuals diagnosed with substance disorders engage in casual sexual encounters and/or have multiple sexual partners while failing to use condoms. This behavior puts them at an increased risk of HIV infection (Avins et al., 1994; Fitterling et al., 1993; Keighan & Nadeau, 1994; Scheidt & Windle, 1995; Stiffman et al., 1992; Windle, 1989). Alcohol abuse and non-intravenous drug use are considered as contributing factors in the failure to use condoms (Leigh, 1990a; Plant, 1990; Santé Québec, 1992; Stall, 1988; Stall et al., 1986), but very little information is available on the unsafe sexual practices of addicted patients who are not intravenous drug users (IDUs).

1. General population studies

At the population level of both adults and adolescents, studies based on large survey data generally show a higher prevalence of risky sexual behavior among moderate to heavy drinkers, compared with light drinkers or abstainers (Bagnall et al., 1990; Ericksen & Trocki, 1992; Leigh et al., 1994; Ruefli et al., 1992; Santé Québec, 1992). These studies refer to a high incidence of multiple sexual partners as well as non-use of condoms. Furthermore, an important proportion of drinkers acknowledges the contributing role of alcohol as the most important reason for engaging in unprotected intercourse (McEwan et al., 1992; Williams et al., 1992). Leigh et al. have criticized the above studies, arguing that alcohol consumption prior to sex and condom use has not been simultaneously measured and, when considering the total number of sexual encounters, those following alcohol intake are neither more nor less unprotected (Leigh, 1990b, 1993; Temple & Leigh, 1992). A large Swiss prospective study (n = 724) confirmed this criticism (Läuchli et al., 1996). More than a third of the participants have had sex while under the influence of alcohol and 31% of these reported that safer sexual practices were neglected under the influence of alcohol. Yet, in the case of unprotected sex, no significant difference was found between those who combined sex and alcohol and those who did not. More interesting, however, was the significant association found between the amount drunk per occasion and the incidence

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of unprotected sex, suggesting that the level of intoxication is the main variable at play. For example, 88% of the respondents who had seven and more drinks per occasion had unprotected sex in comparison to 52% for one or two drinks. Other epidemiological data show that most alcohol-related problems are not associated with volume but with quantity per occasion, in general five drinks and more per occasion, or with the highest amount drunk during the last year (Bisson, 1997; Hilton, 1991; Stockwell et al., 1994). However, all the above populations of non-pathological drinkers may be quite different from clinical samples.

2. Alcohol and HIV vulnerability

American studies report seroprevalence rates varying from 3.5% to 10.3% among alcoholic in-patients (Avins et al., 1994; Mahler et al., 1994; Scheidt & Windle, 1995). Seroprevalence rates are always higher for women than for men. In one of the in-patient treatment centers which took part in this study, the seroprevalence was 9% in 1989 in a sample of 100 non-IUD patients who agreed to be tested (sex ratio not known). The inferred seroprevalence rate for the total clinical population, almost exclusively non-IDU, was 3% (L. Guyon, June 16, 1996, personal communication). The Centers for Disease Control (1991) state that the prevalence rate in groups which are not at risk is less than 1%. Canadian figures are lower (Centre de coordination sur le sida, 1996).

Higher vulnerability to HIV infection in this subgroup of alcohol/drug abusers has been explained by biological mechanisms. Chronic use of alcohol and other drugs appears to weaken the immune system, making a person more vulnerable to HIV infection or to the development of the full-blown AIDS syndrome (for a review, see Plant, 1990). Alcohol/drug abusers are also more prone to mixing with high-risk groups, including IDUs (Koopman et al., 1994; Stall et al., 1986; Windle, 1989). Between 45% and 53% of alcoholics in treatment has multiple sexual partners and 71% does not use condoms on a regular basis (Avins et al., 1994; Scheidt & Windle, 1995; Windle, 1989). It is argued that substance abusers engage in unsafe sexual practices because of the disinhibiting effect of alcohol or drugs (for a review, see George & Norris, 1991; Goldman & Roehrich, 1991). One strong piece of evidence of alcohol's or drugs' contribution to risky sexual behavior stems from a 5-year longitudinal study by Stiffman et al. (1992) which indicates that a reduction in alcohol/drug abuse is accompanied by a reduction in unsafe sexual practices among young adults with substance disorders. The issue before us relates to the possible mediating influence of heavy use of alcohol or other non-intravenous drugs on patients in addiction treatment who fail to protect themselves.

3. Women's vulnerability

With regard to condom use, a special case has to be made about gender differences. In the U.S., the proportion of heterosexual transmission from an infected partner has increased from 11% in 1984 to 36% in 1993 in cases of seropositive women (Centers for Disease Control, 1985, 1994). Male-to-female transmission is 12 times higher than female-to-male transmission (Amaro, 1995). Comparable data are available for Quebec (Centre de coordination sur le sida, 1996). It is women who have to negotiate the use of such an obtrusive protective means with their partners in a social context still marked by unequal power (Amaro, 1995; du Guerny & Sjöberg, 1993; Strebel, 1996; Worth, 1989). For instance, a focus group study among women over 30 years of age supports the existence of unequal power in love relationships and the difficulty in the negotiation of condom use because of partners' resistance and women's subordination to male sexual pleasure (Maxwell & Boyle, 1995). This situation may be worse for drinking and drug-abusing women who face the additional challenge of the negative image of female substance abuse which is often associated with sexual availability and promiscuity (Lisansky Gomberg, 1988).

4. Health belief model

Since the 1970s, the field of public health and psychology has been dominated by the health belief model (Becker, 1974), and its variants which focus on individual beliefs and perceptions of health and illness, as well as psychosocial variables (peer and reference group pressure, personal characteristics), and perceived control or self-efficacy in carrying out any particular behavior (for a review, see Coambs et al., 1995; Wulfert et al., 1996). Most studies on high-risk sexual behavior and AIDS have implicitly or explicitly referred to these models (Aspinwall et al., 1991; Bandura, 1990; Catania et al., 1994; Fishbein et al., 1995; Wulfert et al., 1996; Zimmerman & Olson, 1994). Since the proposed variables of these health models do not have equal influence in safer sexual practices (Fishbein et al., 1995; Wulfert et al., 1996), it is important to identify which of them are particularly relevant to a specific group. Moreover, divergent results point to the importance of considering specific group characteristics and gender differences which may explain why intervention strategies promoting condom use directed at the general population often fail (Cooper, 1992; Worth, 1989).

To our knowledge, no research endeavor has been carried out in an attempt to capture personal meanings, attitudes and beliefs regarding the sexual experiences of clinical samples of both men and women dependent on alcohol or non-intravenous substances. In addition, interpersonal and sexual dynamics within heterosexual relationships are an under-