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Sexual Violence in the Context of Drug Use Among Young Adult Opioid Users in New York City

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Abstract

Drug and alcohol use have been associated with increased risk for sexual violence, but there is little research on sexual violence within the context of drug use among young adult opioid users. The current mixed-methods study explores young adult opioid users' sexual experiences in the context of their drug use. Forty-six New York City young adults (ages 18–32) who reported lifetime nonmedical use of prescription opioids (POs) completed in-depth, semistructured interviews, and 164 (ages 18–29) who reported heroin and/or nonmedical PO use in the past 30 days completed structured assessments that inquired about their drug use and sexual behavior and included questions specific to sexual violence. Participants reported frequent incidents of sexual violence experienced both personally and by their opioid using peers. Participants described sexual violence, including sexual assault, as occurring within a context characterized by victimization of users who were unconscious as a result of substance use, implicit and explicit exchanges of sex for drugs and/or money that increased risk for sexual violence, negative sexual perceptions ascribed to drug users, and participants' own internalized stigma. Recommendations to reduce sexual violence among young adult opioid users include education for users and service providers on the risk of involvement in sexual violence within drug using contexts and efforts to challenge perceptions of acceptability regarding sexual violence.

Keywords

sexual assault; sexual violence; alcohol and drugs; nonmedical prescription opioids; sex work; situational factors; sexual violence prevention

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Introduction

The nonmedical use of prescription opioids (POs) has become an area of increasing public health concern in the United States and rates of use are particularly high among young adults (Substance Abuse and Mental Health Services Administration [SAMHSA], 2014). Of all drugs, POs now have the second highest rate of misuse and dependence after marijuana (SAMHSA, 2014). They are also the second most common drug class through which Americans are initiated into illicit drug use; while 2.4 million Americans over the age of 12 were initiated into illicit drug use through marijuana in 2013, 1.5 million people reported that the first drug they ever tried was a PO (SAMHSA, 2014). Research has found that young adults frequently use POs nonmedically with peers in social settings (e.g., at parties, while hanging out with friends) and young people report using POs to reduce anxiety, facilitate social interactions, enhance sexual experiences, and intensify the effects of other substances (Mateu-Gelabert, Guarino, Jessell, & Teper, 2015; McCabe, Cranford, Boyd, & Teter, 2007; Silva, Kecojevic, & Lankenau, 2013). When taken in large doses or in combination with other substances (e.g., benzodiazepines, alcohol), the effects of POs may lead to drowsiness, impaired judgment, incapacitation, loss of consciousness, and overdose (Frank et al., 2015; Jones, Mogali, & Comer, 2012; Lipman, 2010; Mateu-Gelabert et al., 2015).

Sexual violence is also a serious problem in the United States that is receiving increased national attention, and the relationship between substance use and sexual violence is well supported in the literature (Abbey, Zawacki, Buck, Clinton, & McAuslan, 2004; Brecklin & Ullman, 2010; Kilpatrick et al., 2007; Littleton, Grills-Taquichel, & Axsom, 2009; Testa, 2004). It is estimated that 1 in 5 women are raped during their lifetime and, although less frequently reported, males also experience sexual victimization at disturbing rates (Centers for Disease Control and Prevention [CDC], 2014, Stemple & Meyer, 2014). In addition to rape, the term *sexual violence* as used here encompasses other sexual violations, including sexual harassment, coercion (e.g., pressuring, verbal threats), and nonconsensual touching (Basile & Saltzman, 2002). Alcohol is by far the most common substance associated with sexual violence in the United States, with some studies estimating the presence of alcohol in up to half of all instances of sexual violence, either by the victim, the perpetrator, or both (Abbey et al., 2004). Other research presents lower estimates, but the presence of alcohol and other drugs remains substantial. For example, Kilpatrick et al. (2007) found that among the general population, one in five cases of rape involved drug or alcohol facilitation or incapacitation; among young people this was much higher, with college students reporting nearly half of cases involving drug or alcohol facilitation or incapacitation. McCauley, Ruggiero, Resnick, and Kilpatrick's (2013) survey of 104 women receiving posttrauma medical care found that 3 participants in their study reported only consuming "drugs" at the time of the rape and 6 reported consuming both "drugs" and alcohol.

Little research focuses on the specificity of drugs used, including POs, in association with sexual violence. Preliminary research suggests that nonmedical PO use, like the use of other illicit drugs and alcohol, may place users at heightened risk for sexual violence (Argento et al., 2014; Argento, Chettiar, Nguyen, Montaner, & Shannon, 2015; Mateu-Gelabert et al., 2015;). Young, Grey, Boyd, and McCabe's (2011) study of adolescent girls found a

significant relationship between PO use and sexual violence; participants who had experienced sexual violence in the past year were five times more likely to misuse POs during this same time frame. Lifetime prevalence of sexual violence has also been associated with PO misuse, further increasing the risk for subsequent trauma (Balousek, Plane, & Fleming, 2007; Buttram, Kurtz, Surratt, & Levi-Minzi, 2014; Snipes, Green, Benotsch & Perrin, 2014; Young et al., 2011).

The social context in which substance use occurs is an important factor influencing the risk for harm; therefore, understanding the contexts in which young adults use opioids and other drugs could be informative in preventing sexual violence among this population. In their qualitative study of “party rape” experiences at a large Midwestern university, Armstrong, Hamilton, and Sweeney (2006) demonstrated the need for a multilevel understanding of sexual violence that attends to the ways in which contextual factors—such as, in the case of their study, university policies and fraternity-controlled parties—contribute to sexual violence. Other contextual factors, including decreased ability to assess risky situations when under the influence of drugs, dependence on partners for drug supplies, stigma and self-blame surrounding drug use, and the low social status of female drug users, have all been linked to increased risk for sexual violence (El-Bassel, Gilbert, Witte, Wu, & Chang, 2011; Littleton et al., 2009).

The current article contributes to research on sexual violence within drug using contexts by specifically focusing on the experiences of young adult users of opioids (i.e., POs and/or heroin). This mixed-methods study explores (a) the potential role of drug use in increasing risk of sexual violence among young adult opioid users in New York City and (b) the specific social and contextual factors surrounding this group’s experiences of sexual violence. Although participants were recruited based on their opioid use, many users reported polysubstance use; therefore, ample data will be presented in which participants discussed the use of nonopioid drugs and their contribution to sexual violence.

Method

This article reports data from a mixed-methods study exploring the sexual and drug use behavior of young adult opioid users in New York City. Qualitative data are used to provide context in understanding how drug use, sexual behavior, and sexual violence intertwine; quantitative data are presented for key variables to illustrate the extent to which a sample of young adult opioid users experience different types of sexual violence. The present analysis includes data from 46 participants who were interviewed in the formative qualitative portion of the study and 164 participants who have been interviewed to date (from July 17, 2014, through February 13, 2015) in the subsequent (and ongoing) quantitative component.

Qualitative Data Collection and Analysis

Eligibility for qualitative interviews was determined through self-report using a brief verbal screening protocol. Participants were deemed eligible by meeting the following criteria: live in one of the five boroughs of New York City; report lifetime use of POs for nonmedical reasons (most reported use in the past 30 days); speak English or Spanish, and be able to provide informed consent. Of the 46 participants included in the qualitative sample, 23 were

referred by service providers, key informants, or other research projects and 23 were recruited via snowball sampling from other participants. Interviews were in-depth and semistructured, and lasted approximately 90 minutes each. Participants received a small monetary compensation at the conclusion of the interview. Topical domains addressed in interviews included drug use trajectories, social contexts of opioid use, sexual and drug using networks and practices. Questions were open-ended, allowing participants to introduce and elaborate upon issues relevant to their opioid use, and included probes related to participants' possible experiences of sexual violence. When reporting involvement in sexual violence, participants described incidents that occurred while using opioids as well as other drugs (e.g., benzodiazepines). In some instances, the particular drugs being used at the time sexual violence occurred were not specified by participants. Therefore, we seek to report experiences related to sexual violence as described by young adult opioid users but do not intend for these experiences to be understood as exclusively occurring during PO or heroin use. Opioid use often occurred in combination with other substances such as alcohol and other prescription drugs (e.g., benzodiazepines) and/or illicit drugs (e.g., marijuana).

Interviews were digitally audio-recorded and transcribed verbatim. Transcripts were entered into ATLAS.ti, a software program designed to facilitate the coding and analysis of qualitative data. Informed by grounded theory (Glaser & Strauss, 1967), portions of the interviews related to sexual violence were inductively coded for key themes. An initial code list based on these themes was established and refined using a subset of transcripts, with a final code list used to code the remaining transcripts. A comparative analysis was used to develop theoretical interpretations that included the most commonly presented themes and inconsistencies in the participants' interviews. The analysis explored emergent ideas and the connections between key themes and participants' experiences. All names have been changed to pseudonyms to protect participants' confidentiality.

Quantitative Data Collection and Analysis

For the quantitative component of the study, participants were recruited using Respondent-Driven Sampling (RDS), a form of chain-referral sampling designed to engage hard-to-reach populations that utilizes personal network connections to drive recruitment (Heckathorn, 1997; Heckathorn, Semaan, Broadhead, & Hughes, 2002). Participants were asked to recruit fellow opioid users, and for a vast majority of participants, PO use preceded heroin use, although not all participants conformed to this dominant pattern. Using referrals from participants in our qualitative sample ($n = 2$), from service providers and colleagues ($n = 8$), and individuals recruited directly from the community by study staff ($n = 4$), 14 eligible young adult opioid users were recruited as RDS "seeds" to initiate recruitment chains. After completing a screening and the structured interview, each seed was asked to refer to the study up to three eligible peers from their social network. This peer-referral process was repeated with the seeds' recruits and for successive sample waves thereafter, with each participant asked to recruit up to three eligible members of their network. As is typical in RDS methodology, the 14 seeds are included within the quantitative sample of 164.

To be eligible, participants had to report using opioids in the past 30 days (either nonmedical use of POs and/or heroin), be between the ages of 18 and 29, live in a borough of New York

City, speak English, and be able to provide informed consent. Eligibility was assessed using a combination of screening techniques, including a verbal questionnaire to collect self-reported data on drug use in the past 30 days, a visual quiz in which participants were asked to identify pictures of POs, and, for those who reported recent drug injection, a visual assessment for injection marks. To confirm recent opioid use (approximately the past 2–4 days), urine samples were also collected and tested for the presence of methadone, opiates, and oxycodone using a point-of-care screening device, the iCup (10-panel) manufactured by Alere Toxicology Services in Portsmouth, Virginia. Individuals whose urine samples did not indicate recent use of opioids could still be eligible if they reported using opioids in the past 30 days and correctly identified at least three POs in the visual quiz and/or were visually assessed for recent injection marks. In doing so, we were able to successfully identify eligible participants who had used opioids in the last 30 days and excluded those who were not current opioid users. For prospective participants who appeared to be older than their early 20s, age was verified by photo identification. Eligible participants were paid US\$60.00 for completing the interview, and additional incentives were provided for each eligible participant they referred.

Structured interviews lasted between 90 and 120 minutes and included questions on drug use, sexual behavior, sexual and injection networks, overdose, drug treatment, HIV and hepatitis C (HCV) knowledge and testing history. In addition, we inquired about, and report here, participants' experiences of sexual violence while they were using drugs. These experiences were assessed using a Sexual Violence Questionnaire based on findings from this study's qualitative interviews and also included some questions adapted from the Sexual Experiences Survey–Short Form Victimization (SES-FV) (Koss et al., 2006). The Sexual Violence Questionnaire asks whether participants have experienced various types of sexual violence and, if so, how many times. Questions include whether participants have witnessed sexual violence, have ever been touched in a sexual way without their consent, whether someone has ever had sex with them without their consent, and whether they have ever been propositioned for sex in exchange for drugs or money. The structured questionnaire also includes questions about sexual exchanges (e.g., whether participants have been paid for sex with drugs or money). Data from structured assessments were analyzed using MatLab R2012b. Gender difference comparisons of sexual violence were calculated using 95% confidence intervals and Student's *t* tests.

Results

Participant Characteristics

Of the 46 participants in the qualitative sample, 27 were male, 18 female, and 1 was transgender female. The mean age of participants was 25.3 years (*SD* = 3.9 years; range = 18–32 years), with 24 participants (52%) between the ages of 18–25 and 22 participants (48%) aged 26 or older. Thirty-two identified as White/Caucasian, 9 as Latino, 3 as African American/Black, and 2 as Asian/Pacific Islander. Fourteen attended some high school, 9 had received a high school diploma or General Educational Development (GED), 14 had attended some college, and 9 were either college graduates or had some postgraduate

education. Sociodemographic characteristics of the 164 participants included in the quantitative sample are presented in Table 1.

Types of Sexual Violence

Participants reported having experienced a range of forms of sexual violence, from sexual coercion or being pressured to have sex in drug using contexts (e.g., at parties, on dates), insults of a sexual nature referring to a participant's drug habit, and unsolicited propositioning of sex in exchange for drugs or money, to sexual assault (which ranged from unwanted touching to attempted and completed rape). For the purposes of this article, the term "sexual violence" is meant to encompass the entire range of these experiences.

Opioid Use and Sexual Behavior

Participants in the qualitative interviews described their first experiences of opioid use as social. Most qualitative participants described their first use of opioids as involving the nonmedical use of POs, which they used at parties and while spending time with friends. In these contexts, mixing POs with alcohol and other drugs was common. Veronica, for example, described attending parties in high school where she would mix and share pills with her friends.

There were all these pills on the table constantly. It was any pill that anyone had, we'd be like, "What do you have?" One of us would have weed and ... it would be like, "I'll give you an Ambien for weed" or like "Here's some Vicodin, try that," and we would just make cocktails. (Veronica, 22, White, Female)

Similarly, for the majority (76%) of quantitative participants, PO use preceded heroin use, playing a key role in the development of opioid dependence. Most participants in the quantitative sample reported initiating PO use in their teens; the mean age of nonmedical PO initiation was 16.4 ($SD = 2.9$ years; range = 10–25 years). Twenty-six percent of participants reported first engaging in nonmedical PO use while they were alone, whereas the remaining 74% reported first using POs while in social settings (e.g., while hanging out with peers and/or sex partners).

As some participants' drug use progressed, the variety of settings in which they used expanded to include everyday activities; participants described using alone and throughout the day, regardless of what they were doing. However, participants continued to frequently use opioids with others, and some reported having sex while high on POs and other drugs. Many participants described POs as facilitating casual sex when used with drug using peers and reported engaging in sex with casual partners while high on POs.

I know a lot of people who like to have sex when they're high [on POs]. They say they last longer, it's better. (Alissa, 22, White, Female)

Interviewer: So it really looks like of all the prescription opioid users, the females that you currently know, which I count three ... You had sex, you had sex with three of them.

Emilio: Yeah.

Interviewer: Okay. Is that common to have sex with other female partners among your group?

Emilio: Yes, it's common, yes. (Emilio, 24, Latino, Male)

Participants also described the use of opioids and other drugs as creating a sense of connection with partners that facilitated sex. Elizabeth, for example, described how she felt closer to her partner because they used drugs together.

It's interesting 'cause with the boyfriend that I'm talking about now, I don't really trust him but it's kind of like a complicated thing 'cause there's a lot of drugs involved with him mostly ... if I do drugs with a guy, I feel like there's more of a connection kind of, so then it's like I kind of trust them, I don't know. (Elizabeth, 19, White, Female)

Sexual Risk Associated With Drug Use

Although many participants described the use of opioids as facilitating sexual encounters that were consensual, participants also described how they increased risk for sexual violence. Participants described how using POs can place users in unconscious or semiconscious states, potentially heightening risk for victimization.

Zeus: A lot of times you don't have a sexual urge when you're using opiates. But if it comes down to it, a guy will be more focused because he has to do the work, and the girl could just lay down there and just be like, still be out.

Interviewer: ... Does that put girls at risk?

Zeus: With what?

Interviewer: The POs, the prescription opioids.

Zeus: They put them at risk to get raped? A hundred percent.

Interviewer: A hundred percent!

Zeus: What do you mean? If we just met girls and they're all doing drugs and whatever, it's easier to take advantage of them.

Interviewer: Right because they're—

Zeus: They're out.

Interviewer: They're out.

Zeus: Same thing if they're drunk. But this is worse because they're knocked out. (Zeus, 23, Male, White)

Participants described how users, especially females under the influence of opioids and other drugs, were viewed as easy to have sex with and were at risk for sexual violence. Mary, for

example, imitated the way some of her male peers perceive females who get very high and black out.

There's guys that will know that these girls have blacked out and have no idea what they're doing. And they're like, "I'm gonna hook up with her anyway"—and they end up having sex with them and I just think it's disgusting like, [imitating a male's voice] "Yo, I'm gonna get it. Anyone high tonight? Like yo, this girl's a fucking dumb bitch. Like she's a whore, like she doesn't know what she's doing." (Mary, 18, White, Female)

Negative Sexual Characteristics Ascribed to PO Users by Society and Peers

Although all participants in the qualitative portion of the study had significant personal experience with opioid use, interviews revealed that many held stigmatizing attitudes toward drug users that are common within mainstream society, with users characterizing opioid addiction as degrading and weak. Joe, for example, was a dealer who related how when he was being taught how to sell drugs, his boss made it clear to him that he could use marijuana and drink alcohol, but that there was a stigma attached to opioid use. He described how he would be seen as crossing an undesirable line if he were to use POs or heroin, although he did ultimately use POs himself despite these perceptions.

The majority of drug dealers kind of look down on their clientele because addiction they feel is a form of weakness because, you know, they're getting money from people who are addicted so there's a certain psychological trade-off going on ... He [my boss] said, "Okay, the liquor, the weed, that's acceptable 'cause we all do that type thing, you know? ... Anything else, that's what they [the people we sell to] do, so we're not going to accept you as one of us if you do any of that." (Joe, 32, Black, Male)

This negative view of drug users, especially those who were known or assumed to be physically dependent on opioids, also extended to how they were perceived sexually, both by their peers and by society at large. A common theme in participants' accounts was that drug users are frequently viewed as unworthy of sexual respect and as readily willing to sell sex for drugs or money. Participants reported being insulted sexually because of their drug use, with negative sexual characteristics ascribed to them through verbal insults. Some male participants indicated a belief that individuals, especially females who are drug dependent, do not deserve sexual respect, and some participants referred to female drug users in sexually demeaning terms. An example of these dynamics is provided by Zeus who described an incident involving a female he knew who accused three other drug users of raping her while she was high. He explained that they ignored her accusations and dismissed her as a "crackhead."

Zeus: They [the males she accused] didn't give a fuck ... they called her a crackhead.

Interviewer: Tell me about this. This is important.

Zeus: Just the terminology, they called her a crackhead.

Interviewer: You would call a crackhead a girl who gets high on pills?

Zeus: Crackhead or dopehead, she's a junkie. You know, there's a bunch of words, you know. (Zeus, 23, Male, White)

Results from the structured assessment support these qualitative findings. Thirty percent of participants reported having been sexually insulted about their drug use, and this was especially common among females. Of the female participants, 61% reported having been sexually insulted at least once, whereas 14% of males reported the same. Table 2 presents this and other structured data from the sexual violence questionnaire developed and informed by our qualitative interviews.

In addition to such perceptions, qualitative interview participants also reported being viewed as readily willing to exchange sex for money or drugs. Both males and females reported frequent instances in which they were propositioned for sex, especially by strangers, because they were presumed to be addicted to drugs. Bruce, for example, described how people would ask him to exchange sex for drugs, simply because they knew he used drugs and needed money.

Bruce: Oh for drugs in general I've been propositioned by men and women ... Like while panhandling on the street, or even just doing drugs with people I've had it come up ... Mainly [from] males. It—actually no it's been 98% males I've had three females—

Interviewer: Older males, or?

Bruce: Mainly. Creepy old guys.

Interviewer: And you, you do drugs with them?

Bruce: No, they'd be [anywhere]—cause I've gotten high at concerts, in clubs— (Bruce, 26, White, Male)

Another participant, Alissa, reported similar experiences.

Alissa: Like some people, they come up and ask me “Hey, you want to make some extra money?” I always say no, I say “No I don't do that.” Some people get pissed off when you say no. Other people laugh, other people just drive away.

Interviewer: Oh, they will ask you in their car and say, “You want to make extra money?”

Alissa: Yeah.

Interviewer: Implying that you would have sex for money?

Alissa: Yeah. (Alissa, 22, White, Female)

Again, these qualitative findings were supported by survey data. Fifty-seven percent of participants reported having been propositioned to have sex for drugs or money. Of the female participants, 82% reported having been propositioned to have sex for drugs or money, and of the male participants, 43% reported the same. Participants also reported a high rate of incidence in terms of sexual propositioning; of those who reported ever having

been propositioned, 12% reported it happening once, 18% reported it 2 to 4 times, 13% reported it 5 to 9 times, 31% reported it 10 to 49 times, and 26% reported having been propositioned 50 or more times. See incidence rates for this and other sexual violence variables in Table 3.

Drug Exchanges and Quid Pro Quo Sexual Expectations

Participants also relayed in qualitative interviews how being perceived as sexually appealing was a means by which they were able to obtain opioids and other drugs. Drugs were provided to female users and to males who had sex with males (MSM) to attract casual sex partners. Users described obtaining and providing drugs to peers with whom they wanted to have sex. One participant who sold POs described how he generally did not sell or act as a middle man for people trying to obtain heroin; however, he would do so for a “cute” girl.

Interviewer: Okay, and currently you just middle man for prescriptions?

Bruce: Or once in a while for like, for a cute girl I’ll get some dope [heroin], but you know, it’s not ... I’m not trying to like, get rich. (Bruce, 26, White, Male)

Many participants described a quid pro quo expectation surrounding sex and drug use. When drugs were provided free of cost to potential partners, there was an expectation that those receiving the drugs would provide sexual favors to those who provided the drugs in exchange. Many PO users described fulfilling such quid pro quo expectations, which often occurred implicitly, with MSM and female users providing sexual favors to males who provided them with drugs.

Some people I guess think that if they buy you something and get you high, that maybe they can get you to have sex with them. (Denise, 28, White, Female)

Eventually it’s going to lead to sex ... I guess you feel like you have to, especially for a female, you feel like you have to have sex if you’re getting pills or if you’re taking pills together or shooting pills together. (Chrystal, 30, White, Female)

In some instances, opioid users described feeling sexually coerced or pressured to have sex in such contexts and as a result, sometimes had sex with people they did not want to have sex with to fulfill normative expectations.

I think that there is an expectation that if a man gets a woman high, she’s supposed to sleep with him or give him pleasure, and ... Yes, that’s definitely happened and honestly, I have had sex, I think, with a couple of people that I didn’t really want to just to shut them up. (Karen, 30, White, Female)

In the structured interview, 57% of participants reported having been in situations in which they felt that someone expected them to have sex because they were using drugs together. Forty-nine percent of males and 73% of females reported experiencing this expectation at least once.

Participants were at increased risk for sexual victimization when expectations were unmet or those seeking sex did not receive the sexual favors from opioid users they felt entitled to.

JoAnn, for example, described a friend who was assaulted because she refused to have sex with someone who was sharing drugs with her.

The girl that I told you had a relationship with the dealer, I know that she was in like two compromising situations where the guy gave her a pill to do and he thought she was going to have sex with him, she said no. One of them gave her a black eye, and I don't remember the other, but I know it was two situations.
(JoAnn, 26, White, Female)

Drug Exchanges and Explicit Expectations

Although many exchanges of sex for drugs were implicit and occurred according to quid pro quo norms, some participants engaged in overt exchanges of sex for drugs and/or money or engaged in sex work. Several participants in qualitative interviews reported having engaged in explicit exchanges or sex work themselves, and the majority reported having at least one peer who had done so.

Interviewer: Do you know anybody who has exchanged sex for prescription opioids?

Jeremy: Yeah.

Interviewer: Tell me. Who is that person?

Jeremy: Just people I know when I've been to like that rehab I spent the 3 years in, you go to groups all the time. I've heard a bunch of girls say they've done it. They had sex for drugs. (Jeremy, 27, White, Male)

Another participant described having had sex with a woman who offered him sex for drugs.

I had this one girl, Jennie, call me, you know what I mean? She's like, "You know, I'm really sick. I'm really sick and I have no money. I don't know what the fuck to do." And I'm like, "Well I don't know either." And she's like, she's like, "Come on," she's like, "Could you hook me up one on the credit?" I'm like, "No, I can't give credit, I need money." And she's like, "Aw come on," she's like, "can we work anything out?" She's like, "I'll do anything." She's like, "Let me come over." She's like, "Let's just hang out, you know what I mean? Like, I'll do anything, you know what I mean?" She said, "I'll sleep with you," you know what I mean? Yeah, yeah, I did. I slept with her. (John, 21, White, Male)

In the survey, 28% of participants reported having received drugs or money in exchange for sex and 12% reported paying for sex with drugs or money. Twenty-two percent of males and 39% of females reported receiving drugs or money for sex. Of those participants who reported being paid for sex, 31% reported doing so once, 26% reported doing so 2 to 4 times, 13% reported 5 to 9 times, 17% reported doing so 10 to 49 times, and 13% reported 50 or more exchanges. Data on sexual exchanges are reported in Table 4.

Internalized Stigma Among Opioid Users

Qualitative interview participants also described themselves in terms that revealed the internalization of negative social attitudes they held toward themselves as drug users.

I have very low self-esteem, I don't really like myself very much. I haven't for a long time. I've made a lot of mistakes in the last couple of years. I've run myself into the ground you know, physically, mentally ... (Lana, 30, White, Female)

I felt guilty. I felt really guilty ... I don't like being a manipulative, disgusting drug addict. I just am one. (Karen, 30, White, Female)

Feelings of low self-worth and guilt over one's status as a "drug addict" may have deterred participants from viewing themselves as worthy of protection from the police and other authorities when sexually violent incidents occurred. With the exception of one participant (who reported only one of several experiences of sexual violence), qualitative participants uniformly stated that they did not notify the police or other authorities following an experience of sexual violence. Instead, participants described these incidents in ways that minimized their severity and emotional impact, reporting that they just tried to "forget about it." John, for example, who identified as heterosexual, described how an older man "took advantage of" him sexually, but he did not consider himself to have been raped and did not want to discuss it.

John: He would give you a hundred fifty dollars if you masturbated on camera and you recorded it, you know? And I went and I did it to get drugs, to get Roxi's ... And you know, I really didn't want to do it. I was really disgusted by it down to the core of my human being. But I was addicted to pills and I wanted to get high, and that was the only opportunity I had to get money, you know? And you know, that night I got taken advantage of.

Interviewer: What do you mean by that?

John: The man took advantage of me sexually.

Interviewer: You were raped?

John: (pause) Not raped, no.

Interviewer: Okay, but it's clear that you were taken advantage of by an older man, is that correct?

John: Yes.

Interviewer: Okay. Are you okay? Do you want to take a break?

John: No, I'm all right. (pause) And after that, I never spoke of it, I never told anyone. And I just went, I took the money, I owed him money, I paid him back, and I bought drugs and got high, and I did my best to forget about it. And you know, my addiction continued to get worse. And I ended up kicking him out of the house and I just felt from that worse and worse, and that's right around the time that I shot prescription, I shot Roxi's and I shot blues, Oxycodone, 30 milligrams. (John, 21, White, Male)

Drug Use and Sexual Assault

The results above describe a drug using context characterized by risk of sexual violence; it is not surprising then that participants reported numerous experiences of sexual assault, including rape, among themselves and their peers. Corroborating our qualitative findings, 21% of participants in the survey reported being forced to have sex without their consent while they were using drugs. While rates of victimization among males were high, prevalence rates among females were significantly higher. For example, 41% of females and 11% of males reported being forced to have sex without their consent, a difference that is statistically significant ($p < .001$). Likewise, for all other types of direct experience of sexual violence queried about and reported above, women experienced these incidents at significantly higher rates than men in our sample. Participants were also asked about the types of sexual violence they may have witnessed happening to someone else, with 9% of males and 11% of females reporting having witnessed sex without consent happening to someone else.

Qualitative interviews provide insight into the range of situations and interpersonal dynamics that can place drug users at heightened risk for sexual assault. Participants described instances in which they or others they knew were victimized while passed out from using POs or heroin in combination with other drugs. Participants reported how heroin and POs used in conjunction with benzodiazepines or alcohol rendered users in an unconscious or blacked out (semiconscious) state, making them vulnerable to sexual assault.

Interviewer: Does that [mixing benzodiazepines with alcohol and/or POs] put you at risk for sexual risk in any shape or form?

Linda: Oh yeah, definitely, you're waaaaay—

Interviewer: How so?

Linda: Well, because you're not—your guard is down obviously. You're physically almost incapable of defending yourself, you know, you're not thinking. It puts you in a vulnerable state physically and mentally, you know. (pause) It's, I don't know, it's [benzodiazepines] a really nasty drug and those three unfortunately—heroin, benzos, and alcohol, or methadone, benzos, and alcohol—are like very common ... And so, well, I mean actually I know someone [that was sexually assaulted] ... this guy came along and acted like he was helping her and, you know, she needed help, she could barely walk, and so he walked her right into his car and took her and raped her, and unfortunately, like I said, with benzos and alcohol, you black out a lot so you don't really know what happened, but it just makes you very, very vulnerable because you really don't know what's going on. (Linda, 31, White, Female)

Participants also reported incidents in which their peers and/or sex partners set them up for sexual assault to get money or drugs from other people.

Robin: A lot of bad stuff happens when you do drugs. A lot of people try and trick you, like “Oh, let's go over here and hang out,” and then they'll leave and you realize they just tried to sell you to the people they left you with, like that kind of stuff.

Interviewer: Whoa. Did you have that experience?

Robin: Yeah. So one of my best friends that I thought was looking out for me, he told me, “You know, I’m going to run to the corner store. I’ll be right back.” As soon as he left, they locked the door and they’re like, “All right, do your thing.” I was like, “What are you talking about?” And he said, “We just gave him 50 bucks for you.” I was like, “Are you kidding me?” And so I basically got trapped in the house.

Interviewer: And you had to have sex with that person?

Robin: Yeah. (Robin, 24, White, Female)

Homeless drug users were particularly at risk for sexual assault. Heather, for example, reported being raped by a peer.

Heather: Well, I was, I was raped by this guy that I was with, and we were—

Interviewer: Is he a fellow traveler?

Heather: Yeah, and he forced me to have sex with him. He said if I didn’t have sex with him, he would kill me. (Heather, 26, White, Female)

Discussion

The findings reported above describe a context of drug use that places young adult opioid users at increased risk for sexual violence, as has been reported with regard to the use of alcohol and other illicit drugs (Basile & Smith, 2011; McCauley, Ruggiero, Resnick, & Kilpatrick, 2010; Testa & Livingston, 1999). Our analysis highlights the interplay of several factors that may contribute to this risk. Both quantitative and qualitative participants reported frequently using drugs with others (e.g., while hanging out with friends, at parties). In these settings, sex between casual partners was common and sometimes featured both implicit and explicit exchanges of sex for drugs or money. Opioid users were at risk for sexual coercion, harassment, and/or assault if they did not fulfill the expectation that sex would occur in these situations. Participants described the negative sexual perceptions that others held about them as drug users, and how these perceptions may contribute to being propositioned for sex by strangers or targeted for sexual assault. Participants also revealed the internalized stigma they held about their status as drug users.

Our findings describe a social setting in which opioids and other drugs are used that is conducive to sexual violence. The internalization of stigma associated with drug use and the negative sexual perceptions held about users contribute to a drug using culture with few social consequences for perpetrators of sexual violence and little support for those who are victimized. In Bourgois, Prince, and Moss’s (2004) work among homeless heroin and speed injectors, the authors portray a culture in which violence against women, including sexual violence, was normalized and commonplace, and the authors describe how older males often used the provision of drugs as a way to control and sexually exploit women. The drug using culture described by the young adult opioid users in our study—most of whom initiated opioid use as teens with the nonmedical use of POs—appears to encourage sexual violence

as well, suggesting that prevention efforts should not only target the general public but also opioid users themselves to effect a normative change in attitudes, challenge perceptions of acceptability, and acknowledge the range of contexts in which sexual violence can occur and to whom.

Quantitative results also indicate that females were at increased risk for sexual assault and other forms of sexual violence as compared with males in the study; however, a high prevalence of sexual violence was also experienced by males in our sample. Service providers and educators are encouraged to address sexual violence risk among all drug users and are cautioned against gendered interpretations that rely exclusively on a female victim/male perpetrator paradigm. Recent research has found a high prevalence of sexual violence victimization among young adult males in the United States (Snipes et al., 2014; Stemple & Meyer, 2014) further supporting our emphasis on a drug using context and culture.

Sexual violence among young adult opioid users should be addressed through prevention efforts targeting all users to effect a normative, cultural change. Service providers and educators are encouraged to prevent sexual violence by addressing and challenging sexual coercion in the context of drug exchanges and the negative sexual characteristics assigned to drug users. Efforts to reduce victim-blaming and perceptions of sexual violence acceptability have the potential to create a safer environment for all users. One way to help effect this normative change is to create supportive environments for reporting incidents of sexual violence to the police and other authorities, including on college campuses. Without a sense of safety and confidentiality in these environments, users may be fearful to report incidents of sexual violence for fear of legal or social reprisal resulting from their own drug use.

Our findings should be interpreted with a few limitations in mind. Our qualitative results are not intended to be generalizable to all young adult opioid users; rather, their purpose is to portray the lived experiences of participants with regard to their opioid use and sexual behavior. Information related to sexual violence emerged from qualitative interviews that were flexible and open-ended. It is probable that other perspectives and experiences related to sexual violence exist among this population that were not discussed by participants or inquired about specifically in the interviews. In addition, our study explored the context of opioid use within New York City. It is possible that experiences of sexual violence may differ for young opioid users in other more rural or less populated parts of the United States. With regard to the quantitative data, although RDS sampling methodology is intended to produce a statistically representative sample of a population, present results are limited in their generalizability as they represent the preliminary data from an ongoing study that aims to recruit a much larger sample. Finally, while the eligibility criteria used in the qualitative and quantitative components of this study were similar, the respective criteria differed with regard to the specific type (POs-only vs. POs and/or heroin) and frequency of opioid use and the findings from these two samples should be interpreted with this in mind.

This article demonstrates the risk for sexual violence associated with the nonmedical use of POs, heroin, and other drugs among young adults. As described by participants, the typical social context in which young people use opioids is conducive to involvement in sexual violence. Future research should build on the work that has already been done on alcohol

and illicit drug use and its relationship to sexual violence. Increased focus on the connection between nonmedical PO use and sexual violence, given the prevalence of both behaviors in the United States, is needed to fully understand and address risk. Our findings also highlight the need for interventions aimed at reducing sexual violence among drug users to effect a normative change in how sexual violence is perceived.

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Biographies

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Table 1 Sociodemographic Variables by Gender (*N* = 164).

	Total	Male	Female
<i>N</i> (%)	164 (100)	108 (66)	56 (34)
Age (years)			
<i>M</i>	24.5	24.8	23.8
<i>SD</i>	3.1	3.1	3.1
Range	18.2–29.9	18.3–29.9	18.2–29.8
Race, <i>n</i> (%)			
American Indian or Alaska Native	0	0	0
Asian	3 (2)	2 (2)	1 (2)
Black or African American	4 (2)	4 (4)	0
Native Hawaiian or Pacific Islander	0	0	0
White	131 (80)	82 (76)	49 (87)
Multiracial	18 (11)	14 (13)	4 (7)
Missing	8 (5)	6 (5)	2 (4)
Ethnicity, <i>n</i> (%)			
Hispanic	30 (18)	21 (19)	9 (16)
Non-Hispanic	134 (82)	87 (81)	47 (84)
Education level, <i>n</i> (%)			
Less than high school	33 (20)	23 (21)	10 (18)
High school diploma or equivalent	54 (33)	39 (36)	15 (27)
Some college or associate degree	66 (40)	38 (35)	28 (50)
College graduate	11 (7)	8 (8)	3 (5)
Household income growing up, <i>n</i> (%)			
US\$0–US\$50,000	60 (37)	43 (40)	17 (30)
US\$51,000–US\$100,000	51 (31)	36 (33)	15 (27)
US\$101,000+	36 (22)	19 (18)	17 (30)
Missing	17 (10)	10 (9)	7 (13)

Table 2 Sexual Violence in Drug Use Setting by Gender ($N = 164$).

Type of Sexual Violence	Total ($N = 164$)		Male ($n = 108$)		Female ($n = 56$)		p Value
	n (%)	95% CI	n (%)	95% CI	n (%)	95% CI	
Touched/rubbed in sexual way	56 (34)	[26.9, 41.4]	24 (22)	[14.4, 30.1]	32 (57)	[44.2, 70.1]	9.26E-6***
Fingers/objects inserted	25 (15)	[9.7, 20.7]	8 (7)	[2.5, 12.3]	17 (30)	[18.3, 42.4]	2.76E-5***
Sex without consent	35 (21)	[15.1, 27.6]	12 (11)	[5.2, 17.0]	23 (41)	[28.2, 54.0]	5.40E-6***
Felt sex expected because using together	94 (57)	[49.7, 64.9]	53 (49)	[39.6, 58.5]	41 (73)	[61.6, 84.8]	2.87E-3**
Sexually insulted	49 (30)	[22.9, 36.9]	15 (14)	[7.4, 20.4]	34 (61)	[47.9, 73.5]	4.61E-11***
Positioned for sex	93 (57)	[49.1, 64.3]	47 (44)	[34.2, 52.9]	46 (82)	[72.1, 92.2]	1.11E-06***
Felt sexually violated but does not remember	35 (21)	[15.1, 27.6]	14 (13)	[6.6, 19.3]	21 (38)	[24.8, 50.2]	2.29E-4***
Witnessed someone touched/rubbed in sexual way	53 (33)	[25.7, 40.2]	36 (34)	[24.7, 42.6]	17 (32)	[19.1, 43.9]	.701
Witnessed oral sex without consent	6 (4)	[0.8, 6.7]	4 (4)	[0.1, 7.3]	2 (4)	[-1.3, 8.7]	.966
Witnessed finger/object insertion	22 (14)	[8.4, 19.0]	13 (12)	[6.0, 18.3]	9 (17)	[6.7, 26.6]	.475
Witnessed sex without consent	16 (10)	[5.3, 14.6]	10 (9)	[3.8, 14.9]	6 (11)	[2.7, 19.5]	.768

***
Significant at $p < .01$.

Table 3

Sexual Violence Rates in Drug Use Setting ($N = 164$).

	Number of Times (%)					
	n (%)	1	2–4	5–9	10–49	50+
Touched/rubbed in sexual way	56 (34)	9 (16)	22 (39)	11 (20)	13 (23)	1 (2)
Fingers/objects inserted	25 (15)	14 (56)	5 (20)	1 (4)	4 (16)	1 (4)
Sex without consent	35 (21)	17 (48)	13 (37)	1 (3)	3 (9)	1 (3)
Felt sex expected because using together	94 (57)	11 (12)	36 (38)	16 (17)	25 (27)	6 (6)
Sexually insulted	49 (30)	2 (4)	10 (20)	12 (25)	16 (33)	9 (18)

Table 4 Sexual Exchange by Gender ($N = 164$).

	Total ($N = 164$)	Male ($n = 108$)	Female ($n = 56$)
	<i>n</i> (%)	<i>n</i> (%)	<i>n</i> (%)
Received drugs/money for sex	46 (28)	24 (22)	22 (39)
Number of times			
1	14 (31)	11 (46)	3 (13)
2–4	12 (26)	7 (29)	5 (23)
5–9	6 (13)	2 (8)	4 (18)
10–49	8 (17)	3 (13)	5 (23)
50+	6 (13)	1 (4)	5 (23)
Paid drugs/money for sex	19 (12)	18 (17)	1 (2)
Number of times			
1	6 (32)	6 (33)	0
2–4	10 (53)	10 (55)	0
5–9	2 (10)	1 (6)	1 (100)
10–49	1 (5)	1 (6)	0
50+	0	0	0