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Challenges to Practicing HIV Sex-Risk Prevention Among People in Continuing Care for Cocaine Addiction

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Abstract

Background—Intimate partnerships are discouraged during early recovery, despite research that highlights their capacity to be resources for change.

Objective—This study seeks to provide descriptions of intimate partnerships and how such partnerships challenge and/or support minimizing HIV sex-risk among participants in continuing care for cocaine addiction in order to inform substance use programming.

Methods—Forty-two recorded continuing care counseling sessions of 33 people who discussed HIV sex-risk behavior were transcribed and analyzed using thematic analysis. This sample was derived from a larger randomized controlled trial that looked at the impact of a continuing care intervention for people with cocaine use problems.

Results—Although participants expressed the desire for a primary intimate partnership, casual intimate partnerships that often involved HIV sex-risk behavior were more prevalent. Challenges to having a primary intimate partner included the belief that intimate partnerships do not support recovery, difficulty in developing friendships with women among heterosexual men, and the ubiquity of drug use and sex work in home environments with limited economic opportunity. Despite these challenges, some participants reported having primary intimate partners that supported their recovery through open communication.

Conclusion—Clinicians providing substance use interventions can consider encouraging components of intimate partnerships that support recovery. In addition, the strong environmental influence on individual HIV sex-risk behavior should be considered in delivering any substance use intervention.

Keywords

HIV sex-risk; substance use; cocaine; continuing care

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Declaration of interest

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Introduction

In early substance use recovery, existing intimate partnerships that do not support recovery and new intimate partnerships are discouraged (Asia Health Co., Ltd., 2015b). Such discouragement is based on the assumption that people with problematic drug use have dysfunctional relationships that will interfere with recovery (Simmons & Singer, 2006). As evidence of this assumption, intravenous drug users may be referred to as having “sexual partners,” instead of lovers or spouses, which stigmatizes people with substance use challenges (Glick Schiller, 1992).

Recovery programs caution against intimate partnerships for the following reasons: (1) relationships may distract from the goal of sobriety and learning about one’s self, (2) relationships may be stressful with the potential for break-up which could trigger relapse, (3) persons may choose a partner unsupportive of recovery, and (4) the relationship may become a substitute for the drug addiction (Asia Health Co., Ltd., 2015a; New Hope Recovery Center, 2015; The Ranch, Inc., 2015).

There is some research that supports the complicating factor of intimate partnerships in early recovery. For example, Rhodes and Quirk (1998) found that among couples in which both partners have substance use problems, it can be difficult for one partner to abstain from drugs if the other partner continues to use, as this shift can jeopardize the relationship. Individual-level substance use interventions are often ineffective because they do not consider the importance of the intimate relationship to the person and create unrealistic demands to reduce substance use when it may mean losing connection to one’s intimate partner. Rhodes and Quirk (1998) suggest that among people with substance use disorders who are in intimate relationships, the relationship can be a resource for change.

Women with substance use challenges may face particular risks within intimate partnerships, such as intimate partner violence (IPV) and a feeling of powerlessness. Porter (1999) found that women with heroin problems were unlikely to engage in treatment unless their male partner also attended. In addition, Porter (1999) found that 11 of the 12 women interviewed experienced IPV. Other research has shown that female empowerment within different-gender couples is associated with less HIV-risk behavior (Knudsen et al., 2008).

Despite some research supporting the complicating factors of intimate partnerships when in recovery, research also has shown ways in which such partnerships among people with substance use problems can be supportive. In qualitative interviews with ten drug-using couples, Simmons and Singer (2006) found that while the relationships were not without challenges, most had characteristics of any relationship that aspires to a long-term commitment. For example, partners cared for each other. At first glance, some of these efforts might look destructive, such as procuring drugs for the other partner. However, such activities are sometimes done out of a desire to prevent the loved one from experiencing withdrawal. In addition, in Simmons and Singer’s (2006) study, some intimate partnerships actually supported the recovery process by offering motivation and strategies that supported each other’s recovery process.

In recognition of the resources within couples to create change, some research has focused on couple-based therapy to prevent HIV transmission. A systematic review found that couples-focused HIV preventative interventions are more effective than control interventions in reducing unprotected sex and increasing condom use (Burton, Darbes, & Operario, 2010). A more recent meta-analysis compared couple-based interventions to individual-level interventions and found that across seven countries, couple-based interventions were more effective in increasing condom usage, HIV testing, and Nevirapine uptake among pregnant women (used as a protective measure against HIV for the unborn baby; Crepaz, Tungol-Ashmon, Waverly Vosburgh, Baack, & Mullins, 2015).

While there is increasing research demonstrating the efficacy of couple-based interventions, gaps remain, such as limited research focusing on couple-based HIV-preventative interventions among couples with drug use problems (El-Bassel et al., 2010; Jiwatram-Negrón & El-Bassel, 2014). Yet the extant couple-based intervention research that looks at the interconnection of drug use and sex-risk is very promising. For example, one randomized controlled trial with HIV-negative different-gender couples found that those randomized to a couple-based HIV sex-risk and drug-risk reduction intervention had a 41% reduction in unprotected sex at 12-months followup as compared to those randomized to an individual sex-risk and drug-risk reduction intervention (El-Bassel et al., 2011). Another study of women with substance use problems and their male partners found that those randomized to couple-based HIV counseling and testing had a significant reduction in HIV risk as compared with those randomized to an individual intervention or a relationship-focused intervention for the female partner (McMahon et al., 2013). In addition, research has shown that among injection drug users in relationships, there is interest in and commitment to maintaining a healthy relationship (El-Bassel et al., 2013; Seear et al., 2012). A recent manuscript described the process of adapting a couple-based intervention to better address substance use, sex-risk and gender-based violence among different-sex couples in South Africa in which the male partner uses alcohol (Wechsberg et al., 2015). Thus, while there is burgeoning research that recognizes the value of HIV-preventative couple-based interventions that focus on the interconnected risks of drug use and sex, it is a relatively new area of research that requires further study to understand how interventions can best tackle these dual risks.

A further limitation with couple-based interventions is that none have focused on casual intimate partnerships (Jiwatram-Negrón & El-Bassel, 2014). As a result, couple-based interventions have a limited reach (Jiwatram-Negrón & El-Bassel, 2014). In order to develop couple-based interventions for people in casual partnerships, it may be helpful to consider how their risks do or do not differ from people in primary partnerships. For example, studies have found that people with drug use problems and in a primary partnership use condoms less than people involved in casual partnerships (Sherman & Latkin, 2001; van Empelen, Schaalma, Kok, & Jansen, 2001). In sum, there is a dearth of couple-based interventions targeted towards people in casual partnerships and development of such interventions requires a look at how their risks differ from people in primary partnerships.

Study objective

There is a tendency to conclude that the intimate partnerships of people with substance use challenges are problematic and should not be encouraged. However, this view negates the value that a person in recovery places on the intimate partnership and negates the resources within such partnerships to create change. This view is also at odds with the burgeoning research literature that demonstrates the value of couples-based therapies for HIV prevention. The present study seeks to inform couples-based substance use and HIV prevention interventions by learning about the types of intimate partnerships that people have in continuing care recovery for cocaine use and what HIV sex-risk challenges and supports are associated with these different partnerships. This study therefore begins to fill a gap in the limited research regarding couple-based interventions for drug users. Towards these ends, individual counseling sessions of people with cocaine use dependence who participated in a continuing care intervention with adaptive HIV risk-reduction components were analyzed. These counseling sessions included participant-driven discussion of relevant HIV sex and drug risks. The qualitative data gathered in this study can aid in the creation of relevant curriculum for HIV prevention within substance use programming (Gupta, Parkhurst, Ogden, Aggleton, & Mahal, 2008).

Methods

This paper is a supplementary project to the main study that looked at the effect of a continuing care intervention on the substance use outcomes of people with cocaine dependence (McKay et al., 2013). Study recruitment occurred between July 2007 and November 2009 with approval from the Institutional Review Board. Participants were consented after completion of the initial two weeks of an intensive outpatient program for cocaine addiction. Eligibility criteria included lifetime DSM-IV cocaine dependence; recent cocaine use (within previous six months); no psychiatric or medical condition that prevented participation in outpatient treatment; within an age range of 18 and 65 years; no regular intravenous heroin use within the past year; having at least a 4th grade reading level; and providing an address and personal contacts. 321 people enrolled in the main study. Once enrolled, participants were randomized to one of three treatment groups, including treatment as usual (TAU), telephone monitoring and counseling (TMC) and telephone monitoring and counseling with financial incentives for participation in telephone contacts (TMC+). These treatment groups are described below:

TAU: Intensive outpatient treatment

All participants received about nine hours of weekly group-based treatment for up to four months, after which participants were offered up to three months of outpatient treatment. Group-based treatment focused on relapse prevention and discussion of HIV-risk reduction, including trouble shooting sex and drug scenarios that put one at risk to contract HIV. These group sessions were not recorded.

TMC and TMC+: Continuing care treatment conditions

Participants in the continuing care treatment conditions received cognitive behavioral counseling sessions (in addition to intensive outpatient treatment) by professionals

experienced in working with people with substance use challenges in the outpatient setting. TMC+ also received \$10 gift card incentives for counseling session attendance. Counseling sessions were comprised of 20-minute telephone calls offered weekly for eight weeks, every other week for 44 weeks, once per month for six months, and every other month for the final six months (for a total of 24 months). These individual counseling sessions were recorded, if permissible by the participant.

Intervention description for those in TMC and TMC+

Counseling orientation—Participants in TMC and TMC+ had two face-to-face sessions (45 minutes) early in their third and fourth weeks of intensive outpatient treatment with their study counselor. The purpose of these sessions were for the counselor to develop rapport with the participant, explain the protocol, establish treatment goals, and deliver a HIV risk-reduction intervention [developed by the Center for Disease Control and Prevention, and tested by Kamb et al. (1998)]. The goals of the HIV risk-reduction intervention were to assess actual and perceived HIV/STD risks and barriers to risk reduction, develop a risk-reduction plan, and support patient-initiated behavior change.

Counseling session format—After the orientation session, participants received counseling sessions over the phone, unless they preferred to do these sessions in-person. Each call began with a progress assessment of current substance use, HIV-risk behaviors, and intensive outpatient treatment attendance; risk factors; and protective factors. Any challenges identified in the progress assessment were further discussed in the remainder of each counseling session. To address any problems, coping behaviors were identified and rehearsed, using cognitive-behavioral, motivational interviewing and relapse prevention techniques. In addition, if any drug or sex risk behavior were identified in calls that warranted increased attention, participants received stepped-up calls (booster calls that were designed to address the increased risk). These stepped-up calls provided extra time to discuss the risk scenario. It was up to the counselor's and participant's discretion as to whether additional counseling was needed.

Data collection

Data used for this study included recorded TMC and TMC+ counseling sessions, either in-person or over the telephone. Discussion of HIV sex-risks and intimate relationships were either brought up spontaneously by the participant in the course of the session or counselors explicitly asked whether there were any HIV risks that the participant was experiencing. Out of all recorded counseling sessions, there were eight calls that triggered a step-up in care, in which the session was extended, or another session arranged, to allow for a more in-depth discussion of the HIV sex-risk scenario that came up in that session. For this study, we began data collection with these eight calls because they contained discussion of HIV sex-risk scenarios that were of imminent concern to the participant. In addition, we randomly selected another 100 recorded counseling sessions. We chose this number because we assumed that about one third of all counseling sessions would include discussion of HIV sex-risk scenarios, which would give us a sufficiently sized sample size. After listening to the 100 calls, we found that 34 calls included discussion of HIV sex-risk situations. Therefore for this study, we analyzed data from 42 transcribed calls; 8 stepped-up calls and

34 randomly selected calls. These 42 transcribed phone calls included counseling sessions from 33 people, as seven of the people had multiple phone calls chosen in the random selection process. Counseling session lengths were on average 30 minutes long with a range of 8 to 55 minutes long.

Data analysis

Transcripts were coded using NVivo software. To answer the study's research questions, thematic analysis was used. Thematic analysis is a methodology used to identify ideas in qualitative data (Braun & Clarke, 2006). With the belief that substance use recovery is a unique experience for every person, this paper aims to elucidate the individual experiences of intimate relationships and practicing HIV sex-risk behavior when in recovery. Analysis was guided by the following questions:

- What type of intimate partnerships do people have in recovery?
- What HIV-prevention strategies do people use?
- What HIV sex-risks do people experience?
- What are supports that help prevent HIV sex-risk (with particular consideration of intimate partnerships)?
- What are challenges to preventing HIV sex-risk (with particular consideration of intimate partnerships)?

Three coders read through the transcripts in NVivo, highlighting quotes and identifying themes. The three coders then discussed their findings to arrive at themes that answered the above research questions. They created a list of themes with definitions so as to inform the subsequent round of coding (see the Appendix). The three coders then read through the transcript a second time to identify instances of the agreed upon themes. If there were any disagreements regarding findings, the team referred back to the transcript and reached a consensus regarding the correct interpretation. After completing individual coding using the agreed upon themes, interrater reliability was high across all themes ($\kappa = 0.97$). Interrater reliability was high because it was calculated after one round of initial coding and after the three coders had spent considerable time discussing and agreeing upon themes that answered the research questions.

Finally, one coder created a table that included the themes. Within each theme, one of the coders listed quotes that were representative of the theme and described the context and background of the quote. Once the table was completed, one of the coders integrated observations from the table in memo form and discussed these final results with the other two coders. The results were discussed with one of the main study counselors in order to corroborate the interpretation of the counseling sessions.

Results

Sample population

The sample of participants in this report ($N = 33$) were largely male (85%), African-American (88%), had an average age of 43 years ($SD = 6.00$), and had an average of 17 years of regular cocaine use ($SD = 6.70$). These demographics were similar to the rest of the study population (Table 1).

Interview findings

We identified five themes that answered our questions regarding sex-risks that were experienced and six themes that answered our question regarding preventative strategies that were practiced by our study sample (Table 2). Preventative strategies included condom use, HIV testing, selectively choosing intimate partners, communication within one's intimate partnership, enacting coping strategies to avoid risk (such as practicing spirituality or conscious avoidance of a potential risk situation) and demonstrated knowledge regarding HIV. Risks included not using protection when having sex, having sex with multiple partners or partners of unknown HIV status, not getting tested for HIV, not perceiving HIV as a serious health issue, and feeling obligation to engage in HIV sex-risk to please one's partner.

While only six people (18%) reported having a primary intimate partnership, 17 people (52%) reported having casual partnerships. For the purposes of this study, a casual intimate partnership was defined as a partnership with no exclusivity or longevity. A primary intimate partnership was defined as a partnership with expectations of commitment and often of exclusivity. While intimate partnerships of a casual nature were more prevalent, study participants expressed the desire for a primary intimate relationship.

Casual intimate partnerships often put people into situations in which they were exposed to HIV sex-risk. Of the 17 casual intimate partnerships discussed, all included some sort of risk behavior, such as not using protection or not knowing the person's HIV status. Casual intimate partnerships were viewed as condoned during recovery, as they were considered devoid of emotional challenges. Further, sex was viewed as a necessary human need, much like food or water. However, such partnerships were not without complications, as they put people into the following HIV sex-risk situations: unprotected sex, multiple sexual partners, transactional sex, and having sex partners who were using drugs. While participants desired a primary intimate partnership, they described challenges that prevented them from attaining such a relationship. These challenges are described below.

Challenge 1: Recovery involvement—Twelve counseling sessions contained conversation regarding the idea that one should avoid primary intimate partnerships when in recovery. Participants expressed the idea that because they were in recovery, they did not have the time or capacity to devote to a primary intimate partnership. While primary intimate partnerships were considered to contrast with recovery goals, casual intimate partnerships were viewed as permissible because there was less emotional involvement.

Five men discussed the belief that primary intimate partnerships compromise recovery goals. For example, two men discussed the potential for such partnerships to distract from one's

recovery goals, as through emotions such as jealousy. One man discussed how once a year of sobriety is attained, it is conceivable that he could manage a primary intimate partnership. For these men, a primary intimate partnership is viewed as a distraction from one's self and one's recovery goals. Relationship complications, such as jealousy, hinder the recovery process.

Four participants indicated that having experienced previous failed primary intimate partnerships during recovery was the reason they now shied away from such partnerships during recovery. For three others, they reported that the message came from recovery programs. Those participants, all men, reported that recovery programs directed them to refrain from intimate partnerships for a year, so as to avoid emotions that might incite a relapse. One man questioned this belief, noting that it is not officially documented in recovery literature. He further hypothesized that this idea comes from people who are already in primary intimate partnerships, and so are unsympathetic to the difficulties of being single. In sum, participants were reticent to involve themselves in a primary intimate partnership because of the belief that it would compete with their recovery goals. These ideas were supported by previous failed relationships during recovery and by recovery programs.

Challenge 2: Heteronormative gender roles—While two of the men talked about how they wanted to develop friendships with women, they also had difficulty envisioning having a relationship with a woman that was not sexual in nature. While they discussed it being valuable to have female friends, they noted that this was challenging because their previous experiences with female peers had been in a sexual context. Further, these sexual experiences were associated with drug use. Curbing sexual lust was difficult, even though it jeopardized recovery.

Challenge 3: Environment—Participants described home environments rife with transactional sex, drug activity and money struggles. In such environments, the goal of a primary intimate relationship is a difficult one to attain.

Ubiquity of sex: Four men described feeling as though the ubiquity of women, including sex workers, made infidelity and casual sex difficult to avoid. Even for those men who were in a primary intimate partnership, infidelity was difficult to avoid because of the easy availability of sex workers. Although women were seen as available for casual intimate partnerships, one man still had trouble finding a partner with whom he would consider having a primary intimate partnership, because he viewed women in his neighborhoods as prioritizing drugs or money.

While men described the difficulty in avoiding infidelity and the difficulty in finding constancy in relationships, women's stories often included victimization. Women were frequently in roles of engaging in transactional sex in order to make an income, which put them in dangerous situations. For example, one woman in a primary intimate partnership was pressured by her husband to engage in transactional sex to earn money. In another example, one man described relapsing with a female friend of his. To procure more money for drugs, his female friend engaged in sex work and was raped.

In sum, economic need within home environments encouraged transactional sex. For men, this resulted in the view that it was difficult to avoid casual sex. Women in this environment often experienced situations of victimization.

Links between drugs and high-risk sex: Five participants described environments in which drugs were readily available. They felt it was difficult to avoid drugs in an environment plentiful with sex-risk scenarios and vice versa. For five participants, drug use was a precursor to sex-risk, as with one man who uses with a woman with whom he had previously been intimate. While this participant did not engage in sex-risk behavior with this woman, he is tempted to do so. Another participant discusses having run into a previous female acquaintance who is using drugs. When she asked him to have sex, he refused and attributes his refusal of the proposition to not having been under the influence of alcohol that day. Finally, another participant discusses how he does not know what it is like to have sex sober as his drug use and sex are so linked.

For seven others, sex was a precursor to drug use. For example, in one participant's experience, he used cocaine while also hiring sex workers. Therefore, to avoid substance use in his current recovery, he focused on avoiding the hiring of sex workers. However, at the same time, he could not resolve the fact that he would have to give up sex all together, as he describes this activity as natural. He wonders whether depriving himself of sex might cause him to relapse. Sex as a precursor to drug use came up with multiple participants, especially when participants' intimate partners used drugs. In such situations, even if one did not intend to use drugs, it was difficult to avoid using when their intimate partner was using and/or offered drugs to them.

The link of drug use and sex led to situations in which the sex had higher risks, in particular the lack of condom use. Across the transcripts, there were eleven instances of unprotected sex coded, and of those eleven, seven referenced multiple instances of unprotected sex. For example, one female participant notes that she wants to use condoms, but drug use breaks down her ability to care for herself. Another woman discusses how unprotected sex occurs while engaging in transactional sex. Condom negotiation is difficult when in the subordinate position of client. In sum, participants described environments filled with opportunities for drug use and sex-risk behavior, making the two activities difficult to avoid.

HIV preventative strategy: Supportive primary intimate partnerships—While casual intimate partnerships were the norm, six participants shared that they were in primary intimate partnerships that supported their recovery process. The recurring theme within those intimate relationships was communication. (Conversely, communication was not coded in any of the descriptions of casual intimate partnerships.) Participants viewed the open communication regarding previous or potential HIV sex-risk with their intimate partner as being helpful to their recovery. Of those six participants, only two were coded as having any HIV sex-risks in that relationship (in contrast to the 17 casual relationships that all involved sex-risk). Examples of ways in which these intimate relationships supported HIV prevention included abstaining from sex until one was comfortable with and felt trust in the partner, turning down nonmonogamous solicited sex or transactional sex, partners providing support for sober activities, and partners offering opportunities to discuss HIV drug and sex-

risks. In one situation, a male participant discusses that he had used cocaine and told his girlfriend about this use after the fact. She was supportive and was only frustrated that he did not tell her about his desire to use so as to avoid any further relapse. Another participant describes how his female partner sometimes accompanies him to recovery meetings. She also asks about his recovery process daily and he appreciates being able to discuss issues and concerns. Another man living in a recovery house discusses how beneficial it is to have his female partner to talk with as she provides a different perspective than the men in the recovery house. Further, they have weekly outings that he considers a highlight of his week. Primary intimate partnerships supported the recovery process for some participants as they provided coping resources such as emotional support and the opportunity to discuss HIV-risk situations.

Discussion

This study found that experiencing intimate relationships was a primary concern among a sample of people in continuing care recovery from cocaine addiction. Although participants were desirous of a primary intimate partnership, they expressed difficulty in achieving such a relationship. Further, some people viewed primary intimate partnerships and recovery as not complementary. Casual intimate partnerships were the norm, which often exposed people to HIV-risk scenarios. Attaining a primary intimate partnership was difficult due to: (1) discouragement of relationships when in early recovery, (2) heteronormative gender roles, (3) home environments replete with economic challenges, and (4) bountiful drugs and transactional sex. Despite these difficulties, some participants shared stories of primary intimate partnerships that supported that person's recovery through open communication. This finding reinforces the need for couples-based interventions that include components on communication (El Bassel et al., 2010). Such stories of supportive intimate relationships while in recovery suggest that healthy intimate relationships are possible during recovery and can support the recovery process.

Recovery involvement

Some participants believed that primary intimate partnerships during recovery jeopardize the recovery process. They described being fearful of emotions such as jealousy and fearful of a preoccupation with the relationship that would distract them from their recovery goals. These findings are consistent with qualitative research among homeless, dually-diagnosed persons (Padgett, Henwood, Abrams, & Drake, 2008).

While recovery programs often caution against intimate relationships within the first year of recovery, this study found examples of primary intimate partnerships that were very supportive of the recovery experience through open communication regarding HIV sex-risk. For example, such relationships were helpful in avoiding HIV sex-risk situations because of a commitment to their partner and committed partners providing support for sober activities and discussing HIV drug and sex risks. These findings are supported by Simmons and Singer's (2006) study that highlighted the supportive aspects of some couples with substance use problems and how these relationships have the potential to support recovery. This study also supports the need to increase research of couple-based therapy for HIV prevention

targeted to couples with substance use challenges (El-Bassel, Shaw, Dasgupta, & Strathdee, 2014; Wu, El-Bassel, McViney, Fontaine, & Hess, 2010) and to extend such research to people in casual intimate partnerships (Jiwatram-Negrón & El-Bassel, 2014). The finding that there were no coded instances of communication within casual intimate partnerships suggests that this may be a key component for couple-based interventions targeted towards casual intimate partnerships.

One theme raised that deserves further study is whether the message to avoid intimate partnerships in recovery in fact leads to *greater* relapse and HIV-risk activity through casual intimate relationships, a hypothesis supported by the finding that all 17 casual relationships in this study included some sort of sex-risk behavior. Some participants expressed the idea that engaging in casual sex and transactional sex was simply satisfying a natural need, such as hunger or thirst. It may be that participants felt that such situations were permissible within the parameters of recovery as they were less emotionally taxing. However, this may lead to more HIV-risk scenarios such as unprotected sex, multiple partners and the combination of drug use and sex. This is a hypothesis and deserves further research.

Gender differences

As in other research, this study also found that women and men had different relationship and HIV prevention struggles. Male participants felt overwhelmed by the ubiquity of sex-workers and had difficulty in conceiving of women as friends, yet they still yearned for a primary intimate relationship with women. This suggests the need for interventions with men that address communication with women and gender stereotypes. This is supported by research that has found that a male-centered psychoeducational group in a residential treatment facility that focused on communication skills, gender roles and intimacy found that participants experienced an increase in knowledge in these areas (Bartholomew, Hiller, Knight, Nucatola, & Simpson, 2000). Female participants in this study expressed stories of victimization and abuse, and challenges with condom use negotiation suggesting the need for substance use interventions for women that incorporate these themes. For example, research has found that substance use programs that focus on IPV for female partners are effective (Gilbert et al., 2006).

These gendered roles occurred within the backdrop of home environments that have numerous economic challenges. Selling drugs and sex work were common means of economic gain. Therefore, it may be presumptuous to assume that intimate relationships with no HIV sex-risk can occur when there are structural barriers that do not support them. By the same token, to deny a person the opportunity for an intimate partnership in the sensitive time of recovery and in environments that offer little economic comfort is harsh and punitive. Rather, it may be more helpful to think about the possibilities for intimate relationships and how to foster supportive ones.

Limitations

This study analyzed transcripts of dialogue between the counselor and participant. The counseling sessions covered sensitive material about intimate partnerships and HIV sex-risks. It may be that participants experienced concerns and challenges but did not feel

comfortable discussing them with the counselor. Indeed, 66 of the 100 randomly selected counseling sessions did not include discussion regarding HIV sex-risk behavior. A further limitation is that the findings have little generalizability due to the small sample size. Findings mainly have applicability among people in Philadelphia with cocaine dependence who attend publicly funded IOP programs. However, discouragement of intimate relationships is a theme that runs through many recovery programs. Future research can look at whether there are similar findings regarding intimate relationships across other sociodemographic groups.

Conclusion

It is difficult to conceive of recovery as a solitary activity. People in recovery often succeed with support from other people in recovery, friends, family, and therapists, as well as intimate partners. It may be difficult and counterproductive for a person in recovery to be told to avoid intimate relationships in the first year of recovery while also working to remain abstinent from substances. Rather, recovery programs may instead want to include curriculum about intimate relationships that have the potential to support the recovery experience and mitigate HIV sex-risk. For example, instead of discouraging all relationships, interventions can discuss the components of intimate partnerships that can support recovery. For example, communication was a key component for recovery support within primary intimate partnerships. This may be an important component to address in future interventions that target either casual or primary intimate partnerships.

Future steps

Future research can look at whether participants who are encouraged to not engage in intimate relationships compensate by engaging more in casual intimate partnerships. HIV prevention interventions for people in substance use treatment should consider encouraging positive intimate relationships, rather than advocating “no” relationships and should continue to consider gender-specific issues within interventions. While this study supports the need for couples-based interventions for people in primary intimate partnerships, it also supports the need for the development of couples-based interventions for people in casual intimate partnerships. Structural interventions are needed to mitigate the economic need that drives HIV sex-risk behaviors.

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Appendix: Themes coded for in qualitative transcripts

What type of intimate partnerships do people have in recovery?

Primary: Partnership is considered primary; there are aspirations of longevity in the partnership, and often exclusivity.

Casual: There are no expectations of exclusivity or longevity within the partnership.

What HIV-prevention strategies do people use?

Condoms: condom usage, carrying condoms.

Testing: HIV testing, checking in with a healthcare professional.

No sex: turning down partners for reasons such as not knowing the other person's HIV status or not wanting to use drugs with that person.

Communication: Within their intimate partnership they communicate regarding sex-risk scenarios.

Coping: Enacting coping strategies to avoid risk (such as practicing spirituality or conscious avoidance of a potential risk situation).

HIV knowledge: knowledge about HIV sex-risk behaviors.

What HIV sex-risks do people experience?

Partners: multiple partners, partners who engage in risky behavior, unknown HIV status of one's partner.

No protection: don't use condoms or other protective sexual behaviors.

No test: not getting regularly tested for HIV, not checking in with a healthcare provider regularly about HIV risk.

No big deal: perceive HIV as not being a serious health risk.

Pressure: engage in risk behavior because they want to please their partner.

What are supports that help prevent HIV sex-risk (with particular consideration of intimate partnerships)?

Communication: within their intimate partnership, they practice communication regarding sex-risk scenarios, honesty about drug and HIV sex-risk behavior.

What are challenges to preventing HIV sex-risk (with particular consideration of intimate partnerships)?

Environment: multitude of crack houses, lack of partners that support non-HIV risk, lack of housing/financial opportunities, need money to subsist and get high, HIV/drug risk can alleviate stressors from the environment.

Gendered roles: associations with women as prostitutes, women as devious and promiscuous.

Drugs and sex: sex that puts one at risk for contracting HIV occurs when using drugs, drug use causes person to lose inhibitions, drug use causes person to be less interested in sex.

Intimate partnership views: Beliefs about whether or not intimate partnerships are a good or bad thing in recovery and whether such partnerships support HIV drug and sex-risk behavior.

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Table 1
Characteristics of random sample who discussed HIV sex-risk versus the remaining study population.

	Sample (N = 33)		Study population (N = 288)		
	N	(%)	n	(%)	Significance test P
Gender					
Male	28	(84.85)	217	(73.75)	$\chi^2 = 1.47$.22
Race					
Black	29	(87.88)	255	(88.54)	Fisher's test .82
White	3	(9.09)	21	(7.29)	Fisher's test .82
Other	1	(3.03)	12	(4.17)	Fisher's test .82
HIV Status					
HIV-Positive	1	(3.13)	30	(10.53)	Fisher's test .34
	M	(SD)	M	(SD)	Significance test P
Age					
At baseline	43.38	(6.00)	42.25	(9.28)	$F = 0.32$.57
Education					
Years	11.33	(1.57)	11.41	(1.99)	$F = 0.75$.39
Cocaine Use					
Years	16.72	(6.70)	14.72	(7.81)	$F = 1.88$.17
Percent of days used in past 6 months	43.33	(31.41)	45.05	(30.97)	$F = 0.05$.81

Table 2HIV sex-risks and HIV prevention ($N = 33$).

Number of times coded in the transcripts	
HIV sex risks	
Sex with multiple partners and/or unknown HIV status	17
No protection	8
Engage in HIV sex-risk to please partner	4
Belief that HIV is not a serious health threat	3
No HIV testing	2
HIV prevention	
Communication within intimate partnership	17
HIV testing	13
Selectively choose intimate partners	12
Use condoms	11
Enact coping strategies to avoid risk	11
Display knowledge about HIV	9