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A qualitative analysis of GHB use among gay men: Reasons for use despite potential adverse outcomes

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Abstract

This paper examines the use of gamma-hydroxybutyrate (GHB) among a sample of gay men in New York City, who identify GHB as their most frequently used club drug. The sample was drawn from a larger longitudinal investigation of club drug using men. Thematic analysis yielded findings regarding perceived stigma for GHB use, tolerance of potential adverse side effects, and reasons for why some prefer this substance to other club drugs. Specifically, our findings suggest that GHB is viewed unfavorably in many social circles, that side effects are tolerated by frequent GHB users, and that the drug is chosen over other substances because the short duration of action, energy boost, sleep assistance, increase in libido, and limited after-effects. Examining the reasons why men use this substance will lead to the development of GHB specific prevention strategies, which accurately address the consequences of use as well as the motivations that individuals possess for using the substance.

Keywords: gamma-Hydroxybutyrate; GHB; Club drugs; Stigma; Sex; Gay men

In recent years, club drugs, which include MDMA (ecstasy), methamphetamine, powdered cocaine, ketamine, and gamma-hydroxybutyrate (GHB) (Halkitis, Green, & Mourgues, 2005; Li, Stokes, & Woeckener, 1998), have become a very popular and accepted part of gay socialization (Green, 2003; McDowell, 2000). Club drugs are widely used throughout the gay and bisexual male community and are often used in the context of nightclubs and bars (Halkitis & Parsons, 2002). While these drugs remain a popular aspect of gay social culture, GHB has been frowned upon by many club drug users because of its potentially dangerous physiological effects (Nguyen & Bersten, 2004). The social stigma that surrounds the use of this drug is likely related to its high overdose prevalence. Many GHB users themselves predict that other users will eventually overdose at some point (Degenhardt, Darke, & Dillon, 2003). High overdose rates are demonstrated in the DAWN Report, which shows that GHB emergency room mentions in U.S. hospitals have recently peaked at 4969 mentions in 2000 (Drug Abuse Warning Network, 2004).

GHB, a central nervous system depressant, affects the body in much the same way as alcohol (Gessa et al., 2000). Users report that GHB induces a pleasant state of relaxation and tranquility (McDowell, 2000) and enhances one's libido (Nicholson & Balster, 2001). However, GHB has a steep dose–response curve (Galloway et al., 1997); small increases in dose greatly increase GHB's effect, oftentimes leading to adverse reactions such as drowsiness, nausea, vomiting, myoclonic seizures (irregular, involuntary muscle contractions), coma of short duration, or death (Kam & Yoong, 1998). Adverse effects are most commonly reported at doses greater than 1 tsp. (2.5 g) (Chin, Kreutzer, & Dyer, 1992; Dyer, 1991) and overdoses are likely to occur because concentrations of the drug vary, and thus users are not always aware of the amount they are ingesting. In addition, GHB overdose is likely when combined with alcohol and/or other illicit substances (Galloway et al., 1997; Miotto et al., 2001).

Thus, it is important to examine why people use this drug. Although numerous studies document GHB as being used less frequently than other club drugs (Colfax et al., 2001; Mattison, Ross, Wolfson, Franklin, & HNRC Group, 2001; Winstock, Griffiths, & Stewart, 2001), there are few studies that consider the motivations for GHB use. In particular, there is no data regarding use of GHB among those who consistently use this drug. The goal of our paper is to examine behaviors and motivations for GHB use among a cohort of gay and bisexual men who frequently use this drug.

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Methods

Project Boy's Using Multiple Party Substances (BUMPS), funded by the National Institute on Drug Abuse, was a longitudinal, mixed-methodologies study of 450 club-drug using gay and bisexual men in NYC. Participants were assessed via quantitative and qualitative measures in four waves of data collection over the course of a year (baseline, 4, 8, and 12 months post-baseline). The overall purpose of the study was to examine frequency of club drug use, behaviors associated with use, as well as psychological and behavioral correlates of use.

Procedure

Participants were recruited from February 2001 through October 2002 using active and passive techniques in venues frequented by gay and bisexual men. Potential participants were screened for eligibility via telephone interviews. Eligibility requirements included being 18 years of age or older, self-identifying as gay or bisexual, and self-reporting six instances of club drug use in the year prior to assessment. For the purposes of our study, club drugs were defined as GHB, ketamine, ecstasy (MDMA), methamphetamine, and powdered cocaine. Those who met eligibility requirements were scheduled for a baseline interview, when the initial assessment, consent, and confirmation of HIV status occurred.

All quantitative assessments were administered via the *Audio CASA system* (*ACASI*), using a computer and voice recording so that the participant heard (through headphones) and saw (on the screen) each question and response list. After completing the quantitative portion of the assessment, trained staff members conducted semi-structured qualitative interviews covering a variety of topics related to drug use, sexual behavior and psychological states. The Institutional Review Board of New York University approved the protocol for this study.

The transcribed interviews from men who identified GHB as their most frequently used drug were selected for this analysis. The qualitative data derived from these participants were analysed using a multilevel process to determine reoccurring themes. Two authors independently identified important points discussed by the participants and a consensus was reached regarding the occurrences and classification of significant themes, and yielded an agreement of over 90%.

Sample

The sample consisted of 192 men who identified GHB use in the 4 months prior to baseline assessments (42.7% of the BUMPS sample). Of these 192, only 15 men identified GHB as their most frequently used club drug. We chose to focus on these men who were frequent GHB users to more fully understand the motivations for consistent use of this drug in the gay population. In addition, all of these 15 men, also had used each of the other four club drugs that we key to our study (i.e., cocaine, ketamine, methamphetamine, MDMA) but at less frequent rates at which they were using GHB.

This sub sample from Project BUMPS consisted of 15 gay men from the New York City Metropolitan Area. With respect to race/ethnicity, one participant identified as African American, three identified as Asian/Pacific Islander, one identified as Latino/Hispanic, and ten identify as White. This ethnic/racial distribution of GHB users paralleled the diversity of the total sample. In terms of education, five had a level less that a B.A., nine possessed a B.A., and one held a graduate degree. The participants ranged in age from 24 to 50 years old. In terms of HIV status, 12 participants tested negative at baseline and 3 tested positive. Again, the characteristics of the sub-sample reflect the sociodemographic characteristics of the overall sample.

Results

Our thematic analysis of these 15 transcripts provided information on three main domains: perceived stigma associated with GHB use, tolerance of potentially deadly outcomes associated with GHB use, and explanations for why GHB is preferred over other substances. Each of these themes is described below.

GHB stigma

A common theme involving social stigma surrounding GHB use was prevalent within this sub-sample of men. Unlike the stigma many club drug users suffer from mainstream society (Ritson, 1999), GHB users tend to be additionally stigmatized by other club drug users who have heard of or seen incidents of GHB overdose within their own social circles. In fact, a subset of participants in our own study held such beliefs about GHB prior to initially using the substance; three participants described their original negative attitudes toward GHB yet decided to try the drug anyway. One participant explained overcoming his initial fears of the drug and gaining confidence in safety as his use increased.

> At first I was afraid to try G (GHB) because I saw a few of my friends passing out on it, but then I started on it with small dosage and it doesn't really do much, and then I went up in dosage to like another level and it hit me really good and I-since I have started on G, I have never passed out on G on any occasion. (Asian/Pacific Islander, age 27, HIV-negative)

> I had only heard bad, bad things about G at that time . . . I kind of didn't know what to expect. (African American, age 36, HIV-negative)

One other summarized the perception of the community as follows:

> . . . people think it's just suicidal or stupid to take G, but I think that it's the cleanest drug. (White, age 39, HIV-positive)

Interestingly, one participant who stigmatized GHB inadvertently used the substance because he was unaware that the