

# Chemsex in Barcelona: A qualitative study of factors associated with the practice, the perception of the impact on health and prevention needs

## *Chemsex en Barcelona: Estudio cualitativo sobre factores asociados a la práctica, percepción del impacto en salud y necesidades de prevención*

JUAN M. LEYVA-MORAL\*, MARIELA AGUAYO-GONZÁLEZ\*, RUBÉN MORA\*\*, LUIS VILLEGAS\*\*, REBECA GÓMEZ-IBÁÑEZ\*, OLGA MESTRES-SOLER\*, RUBÉN MALDONADO-ALIA\*, NICOLAS LORENTE\*\*\*, CINTA FOLCH\*\*\*\*, \*\*\*\*\*.

\* Universitat Autònoma de Barcelona, Departament de Enfermeria, Facultat de Medicina. Cerdanyola de Valles, Spain.

\*\* Stop Sida. Barcelona, Spain.

\*\*\* Laboratoire de recherche communautaire, Coalition PLUS, Pantin, France.

\*\*\*\* Centre d'Estudis Epidemiològics sobre les Infeccions de Transmissió Sexual i Sida de Catalunya (CEEISCAT), Departament de Salut, Generalitat de Catalunya, Badalona, Spain.

\*\*\*\*\* Centro de Investigación Biomédica en Red de Epidemiología y Salud Pública (CIBERESP), Madrid, Spain.

### Abstract

Chemsex is defined as use of psychoactive drugs with the aim of having sexual relations between gay men, bisexuals and men who have sex with men for a long period of time. To study this phenomenon, this qualitative descriptive study was proposed with the objective of describing the practice of chemsex from the perspective of users, to determine the main factors associated with its practice, the perception of the impact on their health and to establish prevention needs. Data were obtained using conversational techniques: 12 semi-structured interviews and 3 focus groups. The purposive sample was made up of GBMSM with a mean age of 40.1 years, 78% born in Spain, and 68% with completed university studies. The qualitative analysis focused on three thematic areas: factors associated with the practice of chemsex, the impact of chemsex on health, and prevention and risk reduction needs. It is concluded that the practice of chemsex should be understood as multifactorial and multicausal, associated with the sociocultural context. Sexual satisfaction, increased libido and the search for more intense pleasure are identified as key factors among people who practice it. These men are still scared of being judged, even by specialists who may lack knowledge or training. A reanalysis and rethinking of the interventions and policies directed towards this population is necessary, putting the focus of action on shared decision-making, self-care, cultural competence and the humanization of care.

**Keywords:** Chemsex; sexual health; qualitative research.

### Resumen

El chemsex se define como el uso de drogas psicoactivas con el objetivo de mantener relaciones sexuales entre hombres gay, bisexuales y otros hombres que tienen sexo con hombres (GBHSH), por un largo periodo de tiempo. El objetivo de este estudio cualitativo exploratorio es describir la práctica del chemsex desde la perspectiva de los usuarios, determinar los principales factores asociados a su práctica, la percepción del impacto en su salud y establecer necesidades de prevención. Se obtuvieron los datos mediante técnicas conversacionales: 12 entrevistas semiestructuradas y 3 grupos focales. El análisis cualitativo se centró en tres áreas temáticas: factores asociados a la práctica de chemsex, impacto del chemsex en la salud y necesidades prevención y reducción de riesgos. La muestra intencionada fue conformada por hombres GBHSH con una edad media de 40,1 años, 78% nacidos en España, y 68% con estudios universitarios finalizados. Los resultados del estudio ponen de manifiesto que la práctica de chemsex debe comprenderse como multifactorial y multicausal, y asociada al contexto sociocultural. La satisfacción sexual, del aumento de la libido y de la búsqueda de placer más intenso se identifican como factores clave entre las personas que lo practican. Sigue existiendo miedo en estos hombres a ser juzgados, incluso por los especialistas que pueden carecer de conocimiento o formación. Es necesario un reanálisis y replanteamiento de las intervenciones y políticas dirigidas hacia esta población, poniendo el foco de acción en la toma de decisiones compartidas, el autocuidado, la competencia cultural y la humanización del cuidado.

**Palabras clave:** Chemsex; salud sexual; investigación cualitativa.

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#### Send correspondence to:

Juan M. Leyva-Moral. Universitat Autònoma de Barcelona, Departament de Enfermeria, Facultat de Medicina. Avda. Can Domènech s/n. Edificio M. Despacho M2-213. Bellaterra, 08193. Email: [Juanmanuel.leyva@uab.cat](mailto:Juanmanuel.leyva@uab.cat)

In the Spanish context, chemsex is defined as the “*intentional use of drugs to have sexual relations for a long period of time (which can last from several hours to several days)*” (Fernández-Dávila, 2016a: 44) especially among gay men, bisexual and other men who have sex with men (GBMSM) (Bourne, Reid, Hickson, Torres-Rueda & Weatherburn, 2015; Weatherburn, Hickson, Reid, Torres-Rueda & Bourne, 2017). However, there is no agreed and internationally accepted definition (Ministry of Health, 2020a). The primary goal of the practice is to facilitate, initiate, prolong, maintain, and intensify sexual encounters (Bourne et al., 2015; Public Health England, 2015). Aspects such as increased libido, confidence, disinhibition, feeling more attractive, and heightened physical sensations have also been identified as motivating factors for practising chemsex (Weatherburn et al., 2017). Chemsex can be practised in spaces such as private sex parties (one-on-one sessions, threesomes, group sex) and/or commercial premises where sex is practised (saunas, sex-clubs) (Fernández-Dávila, 2016a, 2016b). The concept of chemsex is socially constructed, based on user preferences and the availability and popularity of certain drugs; the defining characteristics are thus determined by the socio-cultural context and the duration of use (Benotsch, Lance, Nettles & Koester, 2012).

The prevalence of chemsex is given in the literature with figures varying widely from 3% to 29% of MSM (Druckler, van Rooijen & de Vries, 2018; Frankis, Flowers, McDaid & Bourne, 2018; Glynn et al., 2018; Hammoud et al., 2018; Hegazi et al., 2017; Pakianathan et al., 2018; Rosi ska et al., 2018), and the most commonly used substances are methamphetamine, mephedrone and GHB/GBL in Anglo-Saxon contexts (Druckler et al., 2018; Frankis et al., 2018; Glynn et al., 2018; Hegazi et al., 2017; Melendez-Torres, Hickson, Reid, Weatherburn & Bonell, 2016; Pakianathan et al., 2018).

The fact that the practice and its impact has been spreading and becoming more visible has led to chemsex being addressed as a phenomenon coexisting alongside other sexual behaviours and substance use in this group (Folch et al., 2015; Ministry of Health, 2020b; Soriano, 2017). In countries such as the United States, where methamphetamine use among GBMSM is nothing new, it has become a public health problem (Halkitis, Parsons & Stirratt, 2001; Worth & Rawstorne, 2005). In the United Kingdom, the administration of these substances intravenously (slamming) has grown alarmingly in recent years, resulting in important biopsychosocial consequences such as rapid addiction, great difficulty in having sexual relations while sober, high risk of HIV and HCV infection, or acquisition of other sexually transmitted infections (STIs) (Gilbart et al., 2015; Hegazi et al., 2017; Petersson, Tikkanen & Schmidt, 2016; Rogstad, 2016). Likewise, the practice of chemsex has been associated with overdose,

attempted suicide, strong addiction, mental health problems, lower professional or academic performance, interference in social and affective life, and legal and financial problems (Ministry of Health, 2020b).

Given the subjectivity associated with the practice of chemsex and its evident relationship with the context in which it takes place, the phenomenon needs to be explored from the perspective of GBMSM who practise it. In this way, updated, realistic and contextual information will be obtained which is crucial for understanding the phenomenon and thus the ability to identify important aspects for managing possible health interventions. Consequently, the objective of this study is to describe the practice of chemsex from the perspective of users to deepen the understanding of the factors associated with the practice, the perception of the impact on health, and prevention requirements.

## Method

This is a qualitative descriptive study in which GBMSM chemsex users were invited to participate by intentional sampling, through the NGO Stop Sida (Barcelona), and by chemsex users trained as volunteers and integrated into the Stop Sida ChemSex Support commission.

Stop Sida is a community-based organization addressing sexual health for and from the perspective of the LGTBI+ community since 1986. In 2015, the ChemSex Support Service was created with a team of LGTB professionals (psychologists, social workers and community agents) responding to the needs expressed by users coming to the organisation. In this state-wide service, psychological care is offered to individuals or groups, both in person and by video call, in addition to social and work-related care. Since 2020, training in approaching chemsex and promoting sexual health has been available to users of the service who could then become volunteer members of the entity and join the decision-making bodies of the NGO. These volunteers offer information on risk reduction, accompaniment in managing chemsex, leisure activities and spaces for exchanging experiences and emotional support. During 2020, 112 health professionals were trained in the approach to chemsex, peer-to-peer information was offered to 214 users, 88 new chemsex users received psychological care (1,572 individual interventions), and 10 chemsex users were trained as volunteers of the service.

The data was collected using two conversational techniques: semi-structured interviews and focus groups (FG) conducted in December 2020 and lasting approximately 80 minutes. The interview question script (Table 1) and the areas to be explored in the FGs (Table 2) were drawn up based on the needs of the research team; they were agreed upon and verified by the team before beginning the data collection (Polit & Beck, 2017).

The interviews and FGs were carried out by two researchers with previous experience in the subject in a private and secure room, arranged for this purpose at the Stop Sida facilities. In the FGs, one researcher moderated the session while the other only observed and recorded the non-verbal details, disagreement, agreement, etc., occurring during the session (Krueger & Casey, 2015). All conversations were audio recorded and transcribed verbatim immediately afterwards. Participation in the study was voluntary, as was withdrawal. Participants received an incentive of €25 at the end of their participation. Written informed consent was obtained once the details of the study had been explained and any possible doubts resolved. The data was kept in a secure digital space, accessible only to the research team. No data was recorded that could reveal the identity of the participants.

Data were analyzed in parallel by two researchers (JLM and MAG) following the thematic content analysis method proposed by Braun and Clarke (2012). This method comprises six steps whose main characteristics are summarized in Table 3.

The Atlas.ti® computer program was used to analyze the data. Verbatim extracts from the interviews were included to illustrate the findings. Interviews were conducted until the data became repetitive, that is, when data saturation was reached (Saunders et al., 2018). On obtaining the first version of the results, these were discussed and agreed upon by the group in several discussion sessions. The study was approved and financed by the Government Delegation for the National Plan on Drugs.

Table 1. *Semi-structured interview script.*

1. Please, talk about what chemsex means to you.
2. What effects do you look for when you use drugs during your sexual relations?
3. What impact does the practice of chemsex have on your life?
4. At what age did you have sex under the influence of drugs for the first time? What led you to start? Important people, source, places...
5. How do you get the drugs?
6. What would you say is the reason why you do chemsex? What benefits do you find? And drawbacks?
7. What moments, situations or factors do you think more it more favourable? And which make it difficult?
8. Are you worried about your drug use? Why?
9. In what aspects? (studies, work situation, physical appearance, income, relationships with friends, family, partner, life plans ... problems with your boss, authorities).
10. Have you talked to anyone about chemsex? With whom? What makes it easy for you to talk about chemsex and what makes it hard for you?
11. Is there something that worries you in terms of mental health and substance use? Tell me about it, why, what do you need ...
12. Currently, if you think about consulting a professional for a mental health problem, what would lead you to do so? Where would you go? Why?
13. Do you think you have enough information to manage the pleasures and reduce the risks when practising chemsex? Why?
14. Where do you usually get that information from? Do you check it in any way?

Table 2. *Areas explored in the focus groups.*

1. Motivations for the practice of chemsex.
2. What happens in a chill-out?
3. What are the best and worst aspects of chemsex?
4. Starting chemsex.
5. Management of chemsex. Beginning, end and possible complications.
6. The days after practising chemsex. Emotional, social and physical management.
7. Chemsex and gay identity.
8. Management of HIV and other STIs.
9. Health care.

Table 3. *Methodological characteristics of the thematic analysis.*

Step	Necessary Actions
Familiarization with the data	- Data transcription. - Reading and rereading of the texts. - Identification of initial ideas.
Coding	- Systematic encoding the relevant fragments of the entire text. - Checking the relevant contents of each code.
Categorization	- Grouping codes by similarities.
Review of the categories	- Checking if the categories are related to the assigned codes and to the totality of the data. - Making a category map.
Definition and name of the categories	- Dynamic analysis to refine specificities of each category and of the final analytical product by providing a clear definition and name for each category.
Report Writing	- Selection of exemplary significant extracts. - Relating the findings to the research question to proceed with final report writing.

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## Results

Twelve individual interviews and three focus groups were conducted with five, five and eight participants, respectively. They are a sample of male chemsex users who identified themselves as GBMSM, with a mean age of 40.1 years, 78% born in Spain, 68% with completed university studies, 81.8% in active employment with an average monthly net income of €1,483.33, mostly living independently (54.54%). In the last 4 weeks, the participants reported having attended an average of 6.08 chill-outs (chemsex sessions), in which the substances most consumed were methamphetamine (tina) (77.27%), gamma hydroxybutyrate (GHB, G, liquid ecstasy) (81.81%) and ketamine (27.27%).

### **Factors associated with the practice of chemsex**

Access to substances was described as easy. It only requires having the right contact that supplies them. Usually, these contacts are acquaintances of friends who also use. Another common option is to obtain the substances at the chill-out itself, where it is known that the substance can be obtained before going.

*I go to a chill-out and I put in my money, but instead of taking my things [drugs] I get them through a contact. Now I already have friends who do this and sell substances (P3).*

*You can ask anyone “hey, have you got this or that?” ... I have my contacts and well, it’s just a case of calling, meeting, buying and that’s it. It’s very easy, super easy really, just, ok, I want that, and that’s it (P8).*

Participants agreed that curiosity and the excitement of trying new things appeared to be one of the main reasons for starting chemsex. The great majority had previously used drugs in nightlife spaces, but not associated with sex. The opportunity arises casually and high expectations of obtaining maximum pleasure are generated. It is an act of curiosity, also mediated by group pressure since “*seeing as everyone was doing it, I wanted to try it too*” (P7), or as P8 says, “*I tried it just like that, without thinking. You meet friends, and they’re like “you have to try this” and you say “okay”. It was a social thing, just among friends (P8).*”

The homophobia experienced by some of the participants, internalized in many cases, is linked to earlier difficulties in being able to develop full sexuality. Frequenting saunas and cruising areas was common in many cases before starting chemsex; as P1 says “*it was something hidden*”. The practice of chemsex is described as something typical of GBMSM, becoming part of the group identity for many of the informants. They do not rule out that heterosexual people may practise it, but not in such a visible, intense and frequent way as among GBMSM.

*Things like cruising came from the fact that us homosexuals had to stay hidden; so, habits like a using a dark room started in which the possibility of hiding your identity made sexual encounters more likely. Not having come to terms with the fact of being gay in a healthy way could have something to do with it because when you have a relationship or when you know that you are doing something that is condemned socially, there is undoubtedly an internal issue with guilt that is not clear and that might be linked to nobody judging me in the chill-outs (P1).*

*I think it’s part of the saunas, those kinds of places, the environment. I think taking using drugs to fuck is like, sure, you find it in these gay places, in saunas, parties. I’ve never come across a party of heterosexuals who do chemsex, the truth is, sure, they take drugs and fuck, yes, but not for the purpose of it (P2).*

*People who have had a shitty childhood and have been hammered for our sexuality. These types of people sometimes want to lose their inhibitions, and drugs are an easy way ... if you’ve had all these problems, you think you’re inferior, and you have a hell of an insecurity complex that of course also applies to sex. So, when you take drugs, you feel disinhibited and you*

*also feel safe and then you experience more pleasurable sex and when you use drugs, sex feels more powerful (FG3).*

Discontent with one's own body, shyness, difficulties in socializing in leisure environments, the desire to show strength and manliness all contribute to beginning the practice of chemsex. Drugs allow informants to socialize easily in a context which they perceive as safe since nobody judges them on their physical appearance. They feel safe knowing that the chill-outs are spaces where they can enjoy sex and where they can connect with others in a more personal way. In addition, drugs offer them the ability to have longer lasting sex, even incorporating practices that would be difficult for them to implement without them (such as fisting).

*The novelty; when you are young and discovering your sexuality, well then you get older and it gets less, and you always want to be high and also when you go out partying when you're young with two big drinks inside you, but then, well, when you're 27, well, no and you look for other alternatives, and remember that I was very anti-drug, well anyway, there comes a time when you say damn I'm 27 years old, if I don't try it now! (FG1).*

*I use drugs to give me confidence. For me, sexual practices don't change, except fisting because I dilate a lot (FG3).*

*My insecurity goes with me hand in hand. Sometimes I think "it's great that I can fuck this hot guy, he's really stoned" and I attribute it to the fact that he agrees to be with me because that's how it goes (FG2).*

Among participants with HIV, the diagnosis also marked a before and after in their lives and in the beginning of the practice. Later, once it became undetectable, they describe that moment as a liberation since they knew that they could no longer become infected nor infect others. Furthermore, chemsex allowed them to interact and obtain pleasure in an environment where they would not be judged.

*At that moment HIV came into my life, I felt like an atomic bomb. Chemsex was the space where I didn't have to explain to anyone whether it was positive or not; everyone understood, no one asked. I got involved without thinking, for not explaining something that I was not prepared to give at that moment (FG2).*

*When they found me [HIV] it was an absolute liberation. I said I'm free now, now I'm undetectable and medicated, so let's enjoy life, with sex and with drugs. It was a real release (FG3).*

### **Health impact of chemsex**

Physical fatigue stands out as the main complication, appearing after several sleepless nights, continued drug use and sex. Participants describe this situation as

extremely exhausting. The next day, they feel they do not have the physical strength to face family, social or work responsibilities, which has a direct impact on their social relationships, leading to their isolation in many cases. Chemsex also has an emotional impact, since emotional lability after chill-out is common, as well as mood swings.

*The hardest thing is when I'm tired, I have to work or pretend I'm fine and it's hard for me, the tiredness issue. Before, I had emotional lows; if I'm partying for three days, the next day I'm not going to go to work, no way, I know I'm going to be sleeping all day, I'm going to be resting, I'm not going to want to get out of bed (P2).*

*Many times, you start on Friday and finish Sunday afternoon with hardly any sleep, which means tiredness the next day, you're not focused and the opportunity cost, if you spend your time on this, you take it away from friends and family (P3).*

*With family, friends, questions about what's wrong with you, you're apathetic, are you okay? they ask. The more parties, the bigger the downer (P6).*

Some participants are aware of their own process of denial regarding the pattern of use or loss of control, especially with tina. They are aware that chemsex ends up playing an important role in their lives, and this causes anxiety when they reflect on it.

*There is a lot of denial about self-control in using tina. There is something very brutal, that is, there are many reactions and what happens is that you deny it and do not control it. That makes you vulnerable, then it's a danger that comes about because you're denying the action that's going on in your life (P1).*

*Always being worried about this topic, because you talk to friends and say, damn, you really notice that you're hooked (P8).*

Other emotional complications identified in the reflections refer to apathy, isolation, difficulty concentrating and understanding, frustration, loneliness and sadness. They also suffer from the fear of feeling judged outside the context of chemsex, especially in the healthcare setting, or from not being able to control their use, guilt and regret.

*Let them judge me, that's why I hide it ... I hide it and smoke myself silly with joints, and that's the worst thing because in the end I won't let myself be helped, and as time goes by, I'm more vulnerable and I'm taking drugs more and more and I feel sadder and sadder, more alone (FG3).*

*I've always been very afraid to go there [drug dependency unit] because I didn't know if the person there would treat me without judging me (FG1).*

Participants describe experiencing a higher incidence of secondary STIs when practising chemsex. They report that infections are more frequent and sometimes recurrent; as a consequence, sexual health checks have increased and they have the perception of having more control of their own sexual health.

*The frequency with which I might catch an STD has increased. And I have caught them, a few of them, with some frequency, others fortunately not, but I think that, on this STD menu, I have been through most of them. Yes, some more than once (P10).*

*I think it has been for the better, because for example I hadn't had blood tests for 3 years and now that I've started that again, I've had blood tests again, as I was worried about the sex life I was having, before I didn't care (P2).*

The financial impact is important given the price and frequency of use. Depending on income, the costs of use can interfere with the maintenance of basic daily expenses such as housing or food. Participants adopt individualized strategies to obtain more affordable prices.

*I have several dealers, I ask about prices, contacts and buy directly (P4).*

*What always happens, when you use a lot you end up getting favours from the dealer, or you end up changing dealers because of the price. So how much I spend, I'm not really calculating because I don't want to know; between what I earn and how much I spend on rent and food, I don't want the number (P1).*

### **Prevention needs and risk reduction**

Strong hangovers were described after chemsex sessions; in most cases these were managed through rest, moderate eating and hydration. Although it was common to spend several nights without sleep, especially at the weekend, participants reported controlling this situation by limiting the number of nights without sleep (usually no more than two). Self-care actions prior to the practice of chemsex were also observed, mainly to prevent complications related to hypoglycemia, hypotension and dehydration.

*It's a matter of doing intensive rehydration and trying to regulate circadian patterns again, rest, and then, in a few days you get back to normal (P10).*

*So, like, for me, it's super important to sleep. I try not to spend a night without sleep, okay, but not two. And I have been doing*

*this lately, spending two nights without sleeping and it has made me feel terrible (P12).*

*On Saturdays we used to go to the supermarket and buy isotonic drinks so as not to dehydrate ourselves and cokes so that our blood pressure didn't drop, and as with tina sometimes you don't feel like eating, I would buy those jars of baby food with yogurt to improve the bacterial flora (FG1).*

Information on drugs was obtained from various sources in an autonomous and sensible way. First indications about the practice were usually obtained through a friend. Participants consult the Internet about effects, routes of administration and secondary effects of the substances to be consumed. Community bodies that help through risk reduction practices and other entities or specialists were also used to obtain help with substance use management. It should be noted that the help obtained from specialists was described as unsatisfactory given the little training shown in this regard; on occasion they themselves felt they had to explain what chemsex is to the professionals. A certain degree of ignorance regarding chemsex was observed on the part of the services that specialized community bodies offer.

*The information I look for, on side effects, routes of administration, all that, I already get from there, the effects, the time that needs to pass between doses, those are the things that interest me about drugs, Well, I get it from there [Energy Control] (P2).*

*Right, well, I met a friend, who stopped me and told me look, this is how you do it, it has to be wet, you wait a while, then it dries, and that's also how you learn. In the group itself, sharing information (P12).*

*It makes it easier for me to talk when the other person also uses and knows what I'm talking about, talking about it with someone who does chemsex; I have more confidence than if a nurse or whoever comes along, no matter how understanding she is, she's still judging you (P3).*

The search for help starts when the need is felt to self-manage the practice, due to side effects or complications or on the advice of someone they know. Such professional help is usually found through acquaintances who have used the services, or on their own initiative after previous experiences with an organisation of which they have good memories. They found it very difficult to talk to their friends about their relationship with drugs and sex, especially among those who practice slamming. They mentioned feeling stigmatized and under the shadow of the injected heroin user stereotype that the 90s left behind.

*The fact that I can see I'm not handling drug use well, I can't talk about it with certain friends, with people who also use. With friends who don't use I just can't talk about it. I'd go to a professional to help me manage and control it (P6).*

*You need tools to be able to manage all this and tools to manage your affections and your emotions or your frustrations, and the desires, the complexes, the difficulties (FG2).*

*There is quite a lot of prejudice [slamming]; using a needle is associated with heroin (P4).*

## Discussion

This qualitative study has revealed that one of the factors associated with the practice of chemsex is the ease with which substances and their distributors are accessed, as well as the high frequency of use among GBMSM, as if the practice were part of their identity. This data is consistent with the results of Ahmed et al. (2016), who already showed that drug use among GBMSM was common and normalized in South London. Their study participants reported that between 70% and 90% of MSM in South London took drugs, and the focus groups concluded that the substances were very accessible and that the number of distributors had increased considerably in recent years, both in clubs and dating apps for MSM (Ahmed et al., 2016).

The reasons given for starting chemsex are diverse, with curiosity, excitement, expectations of maximum pleasure, increased confidence and intensified sensations standing out, which coincides with other studies (Ahmed et al., 2016; Bui et al., 2018; Deimel et al., 2016; Hammoud et al., 2018; Prestage et al., 2018; Weatherburn et al., 2017). A belief held by several focus group participants, but reported by only a few interviewees, was that initiation in chemsex was typically the result of stressful life events, such as a relationship break up or an HIV positive diagnosis.

This study shows how many of the participants reported going without sleep for long periods of time, even exceeding 48 hours, with the consequent impact on their social relationships and work and family responsibilities. Evidence shows that methamphetamine users described difficulties maintaining social activities and compliance with daily activities and social networks, with a negative impact on mental health, especially anxiety and depression (Glynn et al., 2018; Hammoud et al., 2018). This study shows that almost half the men highlighted the negative effect of chemsex on their job, on the ability to work effectively and on their professional development. They generally reported being absent from work the day after chemsex due to withdrawal symptoms from the substance(s), poor concentration, and decreased cognitive ability, negatively affecting their performance.

Similar findings were found in different contexts, including also an increase in work absenteeism (Hegazi et al., 2017). Along the same lines, the evidence indicates a negative impact on the mental health of people who practice chemsex, especially in terms of depression, anxiety, somatization (Berg, Amunsen & Haugstvedt, 2020; Bohn et al., 2020) and drug dependence (Íncera-Fernández, Gámez-Guadix & Moreno-Guillén, 2021). These data underline the need to offer appropriate mental health services; indeed, the literature shows that one in four chemsex users in the Netherlands expressed the need for specific and culturally adapted mental health services (Evers et al., 2020).

The participants in this study reported having contracted more than one STI, even repeatedly, a fact that is consistent with available evidence which associates the practice of chemsex with previous STI diagnoses (Bourne et al., 2015); the high number of sexual partners during chemsex sessions thus substantially increases the risk of contracting an STI. In addition, evidence shows that chemsex is associated with condomless anal sex (Ahmed et al., 2016; Druckler et al., 2018; Frankis et al., 2018; Glynn et al., 2018; Hoornenborg et al., 2018; Melendez-Torres et al., 2016; Ottaway et al., 2017; Pufall et al., 2016; Pufall et al., 2018; Reback, Fletcher & Swendeman, 2018), and with some extreme sexual practices such as fisting (Ahmed et al., 2016; Frankis et al., 2018; Hegazi et al., 2017; Pakianathan et al., 2018). Other studies show a statistically significant association between the practice of chemsex and anal sex without a condom, detectable HIV viral load, hepatitis C and STIs, with the association increasing among people who practice slamming (Pufall et al., 2018).

This study indicates that the participants did not feel comfortable with health services specialized in addictions, given the lack of training experienced in their visits with health professionals. European data indicate similar findings, with participants not seeking specialized help, believing that they will find models of care focused on disease, a fact that makes them seek help in specialized LGBT associations with staff familiar with the subject (Bourne et al., 2015). This data helps to understand why chemsex users do not exclusively ask for help with detoxification but rather with self-management and harm reduction.

This study has a number of limitations that need to be considered. One of them has to do with the generalizability of the results. Due to the cost involved in probability sampling, it is difficult to obtain a representative sample and, therefore, to generalize the quantitative results. However, the results obtained from this qualitative study will be valid for the participating GBMSM, and as a result of the meanings constructed and shared in social and sexual interaction, their testimonies regarding their experiences of drug use are a sample or reflection of what happens to

many other GBMSM who use drugs and practice chemsex. The study design uses a triangulation of methods that allows greater validity of the results to be obtained. Likewise, the current situation given the COVID-19 pandemic may have influenced the results of this study due to the restrictions implemented during this period.

This study concludes that the practice of chemsex, like many other health-related phenomena, must be understood as multifactorial and multicausal, associated with the sociocultural context, so that the management of the phenomenon must be focused and adapted to the needs of each user. Given the particularity of the phenomenon, it is crucial to focus on the understanding of sexual satisfaction, increased libido and the search for more intense pleasure in people who practice chemsex since these are identified as key factors among its practitioners. Consequently, instead of focusing only on the risks associated with chemsex, it is also necessary to work on issues related to desire, excitement, identity and self-image, thereby requiring a transdisciplinary understanding beyond biomedical sciences.

Fear of being judged, even by specialists who may lack knowledge or training in chemsex, remains, and this can limit access to health services. Likewise, there is a lack of accessible professional information sources adapted to the needs of the participants, a fact that leads to self-training, peer teaching and self-management of substance use. A reanalysis and rethinking of the interventions and policies directed towards this population is needed, with a focus of action on shared decision-making, self-care, cultural competence and the humanization of care, leaving aside paternalistic attitudes, verticality and disease-focused care.

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## Conflict of interests

None were identified.

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