

## Chapter 3

# Stimulant Drugs and Sex

Many stimulant users report that their use of cocaine or methamphetamine is strongly associated with sex. Male users in particular report that stimulant drugs increase their libido and decrease their sexual inhibitions. Stimulant drug use may engender compulsive masturbation, prolonged sexual encounters involving numerous partners, promiscuous sex, and unsafe sex practices. In addition, the disinhibiting effects cocaine or methamphetamine opens the flood gates to sexual adventurousness leading some users to engage in sex acts they either do not find appealing or are too inhibited to try when not high on stimulant drugs. For example, only under the influence of cocaine or methamphetamine do some heterosexual engage in homosexual fantasies and behaviors (Washton, 1989b; Rawson et. al., 2002).

The combination of stimulant drug use and sex, two extremely potent reinforcers, creates a “super high” that is more addicting than the drug use alone. Individuals who experience these potent effects become addicted not only to the drug, but to the combination of the drug-induced high and the highly charged drug-induced sexual experiences. For these individuals, drugs and sex are inseparable.

It appears that the hypersexual response to stimulant drugs results directly from drug-induced biochemical alteration of brain function rather than predisposing psychological factors. To date, the only premorbid factor that appears to increase the likelihood and magnitude of the drug-induced hypersexual response is a history of sexual compulsivity that predates the individual’s use of stimulant drugs (Washton, 1989b). Hypersexuality induced by cocaine or methamphetamine typically occurs upon initial exposure to the drug, although an unspecified threshold dose appears to be required to produce the drug’s aphrodisiac effects. For example, some users report that only after switching from snorting to smoking did they begin to experience the sexually stimulating effects of cocaine or methamphetamine. Stimulant-induced hypersexuality does not appear to be more prevalent among individuals with a history of sexual abuse or other serious life traumas than among those who have no such history. Whereas other substances such as alcohol, sedatives, and marijuana may have sexually disinhibiting effects in some users, these agents generally do not produce dramatic increases in libido and the resulting hard-driving compulsive sexual behaviors often associated with cocaine and methamphetamine.

Although many stimulant users find that cocaine or methamphetamine use enhances their sexuality, the drug’s effects on sexual functioning is quite variable and may change over time as use continues. Some users find that cocaine or methamphetamine has little or no effect on their sexuality. Still others report that stimulant drug use reduces or eliminate their sex drive. Even when stimulant use does enhance sexuality, ability to perform sexually often becomes impaired over time as use continues, and especially as use becomes more frequent and intensive. Many chronic stimulant users find it difficult or even impossible to achieve or sustain an erection or to reach orgasm while high on cocaine or methamphetamine.

The entanglement of sexual behaviors with drug use may pose obstacles to successful treatment of stimulant dependence. This is especially true if the nature and extent of the drug-sex connection is not properly identified and addressed. For example, abstaining from cocaine or methamphetamine use may diminish an individual’s sexual desire or pleasure, creating a disincentive for sustaining abstinence. Furthermore, if sexual arousal and drug use are strongly

associated with one another, sexual thoughts and feelings can initiate drug cravings and relapse episodes. In the words of one client:

“For me, cocaine and sex are one and the same. Every time I feel sexually aroused, my brain immediately thinks ‘cocaine’. Last time I tried to give up cocaine I thought I could do it without giving up the escorts and the wild sex scenes. But, I was dead wrong. Every time I got turned on sexually, all I could think of was cocaine. The cravings got so bad that I had to stop everything and call my drug dealer. Sex without cocaine just seemed unexciting to me, even downright boring. I guess I’ll have to learn all over again how to enjoy sex without the hookers and the drugs. It won’t be easy, but unless I can break this connection between cocaine use and sex once and for all, I don’t see how I can remain drug free for very long. I don’t want remain stuck in this vicious cycle of cocaine and sex any longer. I feel like a dog chasing its tail.”

Similarly, a gay male client reported a compulsive pattern of marathon 2-3 day methamphetamine binges involving sexual encounters with male prostitutes. During the first few weeks after stopping methamphetamine use, he found that sexual thoughts or fantasies set off powerful cravings for methamphetamine, and vice versa. In his own words:

“For me the really difficult part of trying to stay off methamphetamine is the sexual aspect of it. As soon as I start remembering the exotic and erotic experiences I’ve had while high on methamphetamine, I start to crave the whole scene again—the prostitutes and the crystal meth. It’s extremely difficult for me to separate them-- as soon as I feel anything sexual I think of crystal. My greatest fear about giving up meth is that sex without it will be just plain boring. Every time I’ve tried to give it up in the past, after a few weeks of staying clean I became obsessed again with sexual fantasies and before I knew it I was on the phone with my dealer. The only way for me to stay clean is to break the connection between crystal meth and sex.”

Knowledge of the relationship between stimulant drug use and sex can empower clinicians to educate clients about sexual relapse triggers and help them develop strategies to anticipate these situations and handle them safely. For patients who report a strong sex-drug connection, the relationship between sex and drugs will need to be sufficiently explored, understood, and addressed in order for treatment to be successful. We have seen countless patients who said that failure to address the connection between their stimulant drug use and sex was a major contributor to repeated relapse episodes and to premature dropout from previous treatment. Interestingly, many of these clients report that when not asked specifically in prior treatment episodes about the relationship between drug use and sex, they felt too ashamed to volunteer this information spontaneously and assumed that the clinician trying to help them simply was not prepared to deal with it.

### **Scope of the Sex-Drug Connection and Risky Sexual Behaviors**

For centuries, cocaine has been known to have aphrodisiac properties. During the late 1800s and early 1900s, cocaine gained notoriety for its ability to induce “sexual “frenzy” and the original

stereotype of the “dope fiend” was based on alleged instances of sexual aggression by men said to be driven by “uncontrollable lust”. In contrast to cocaine’s long-standing reputation as an aphrodisiac, methamphetamine has gained notoriety as a “sex drug” largely within the past two decades and especially among gay men. The aphrodisiac effects of methamphetamine became increasingly apparent as methamphetamine use became more widespread and virtually replaced cocaine as the stimulant drug of choice especially in western and central regions of the U.S.

The sex-drug connection appears to be more prevalent and more powerful for methamphetamine than it is for cocaine (Rawson et al., 2002). Similar to cocaine but even more dramatically, methamphetamine increases sex drive, lowers inhibitions, delays orgasm, and improves sexual performance in many users. The aphrodisiac effects of methamphetamine are considerably longer lasting than those of cocaine due to its longer half life and duration of action. In addition, methamphetamine is less likely than cocaine to impair sexual performance which makes it especially appealing to individuals seeking prolonged, highly erotic, and uninhibited sexual experiences. Methamphetamine use has become extremely popular among gay men (or more generically among men who have sex with men) where it is highly valued for its powerful aphrodisiac effects.

The link between methamphetamine use and sex has generated heightened public health concerns about the contribution of drug-related high-risk sexual behaviors to the spread of sexually-transmitted diseases such as HIV and hepatitis C. Regardless of the user’s sexual orientation or gender, methamphetamine -induced hypersexuality is often associated with unsafe or high-risk sexual behaviors. Under the influence of methamphetamine, individuals are less likely to use condoms, more likely to have sexual encounters with strangers whose health status is unknown, and more likely to engage in vigorous unprotected vaginal and/or anal intercourse with multiple sex partners. Recent studies indicate that among gay and bisexual men (i.e., men who have sex with men) methamphetamine use is associated with higher rates of HIV positivity, unprotected anal receptive sex, intravenous use and needle sharing, and engaging in unprotected sex with a partner who is HIV positive (Frosch et al., 1996). In addition, methamphetamine users who are HIV positive appear to be less likely to comply with antiretroviral therapy and, not surprisingly, to sustain higher viral loads (Ellis et al, 2003).

To our knowledge, only two studies have investigated specific aspects of the relationship between drug use and sexuality. In a survey of cocaine users enrolled in an outpatient treatment program, Washton (1989b) found that upwards of 50% of male patients reported that their cocaine use was associated with increased sex drive, sexual fantasies, and sexual acting-out behaviors. By contrast, fewer than 20 percent of female patients reported these effects. More recently, Rawson et al. (2002) found that among outpatients being treated for stimulant dependence, methamphetamine users reported a significantly stronger association than did cocaine users between their drug use and various aspects of sexuality. Whereas 60 to 70 percent of methamphetamine users reported drug-induced increases in sex drive, fantasies, pleasure, performance, obsession, and unusual or risky sexual behaviors, 40 to 50 percent of cocaine users reported these effects. Moreover, for methamphetamine users the powerful association between drug use and sex was as strong for women as it was for men whereas for cocaine users (similar to Washton’s earlier findings) the association between drug use and sex was not nearly as strong for women as it was for men.

While these findings show that the connection between stimulant drug use and sex is highly prevalent among individuals in treatment, it must also be recognized that a substantial number of

stimulant users report that cocaine or methamphetamine use has either no effect on their sexuality or only negative effects (i.e., reduced sex drive and performance). It remains a mystery as to why some users experience aphrodisiac effects from cocaine and methamphetamine while others do not, why methamphetamine is a stronger aphrodisiac than cocaine for both sexes, or why cocaine has less effect on sexuality in women than in men.

### **Drug-Induced Homosexual Behavior in Heterosexual Men**

An interesting phenomenon noted many years ago by one of the present authors (AMW), but rarely discussed in the literature, is the ability of cocaine to stimulate homosexual fantasies and engender homosexual behaviors in men who identify themselves as heterosexual (Washton, 1989b). Clinical experience suggests that this occurs in a relatively small but significant subgroup (perhaps 5 to 10 percent) of male cocaine users who experience a strong connection between their cocaine use and sex. These men report that when high on cocaine, they experience erotic fantasies and desires to have sex with other men. This may lead to a pattern of compulsive masturbation while viewing gay male pornography or to sexual encounters with gay male prostitutes, often transvestites known as “shemales” or “half and halves”—men who have a female persona and breast implants, but male genitalia. Some of these men say that having sex with “shemales” is less threatening to their heterosexual identity since they see it as tantamount to having sex with a man and a woman at the same time. After the drug high wears off, many of these men report feeling extremely dysphoric and upset about their homosexual behavior, especially those who claim to have no history of homosexual desires or fantasies in the absence of cocaine use. Many experience intense feelings of shame, guilt, and sometimes troubling thoughts that their behavior under the influence of cocaine may be unmasking suppressed homosexuality or bisexuality that is otherwise out of conscious awareness. In extreme cases, these reactions may trigger suicidal ideation and/or self-injurious behavior.

In our clinical experience, it appears that the overwhelming majority of these men are fundamentally heterosexual and that their atypical homosexual behavior under the influence of cocaine is drug-induced and not indicative of an underlying sexual identity conflict. Nonetheless, some of these men may indeed harbor sexual identity conflicts that underlie such behavior. Overtly heterosexual men who secretly suffer with conflicts about their sexual orientation may find that they are able to express and/or act on their homosexual desires only in a drug altered state and may actually use substances instrumentally to enhance their ability to engage in strongly desired sexual behavior they view as forbidden. The same is true for some openly gay men who find that only under the influence of cocaine or methamphetamine are they able to engage in and truly enjoy sex with other men.

### **Drug-Induced Sexual Dysfunction**

Typically, chronic cocaine use impairs sexual functioning whether or not it previously enhanced sexual functioning at an earlier stage of use. As stated above, chronic methamphetamine use is much less likely to impair sexual performance even at high doses. Cocaine-using males often experience erectile dysfunction at higher doses and as use continues. Both male and female users

experience delayed orgasm or anorgasmia; i.e., inability to achieve orgasm at all. Recently, an increasing number of users have turned to sildenafil (Viagra) or similar medications to help alleviate erectile dysfunction caused by chronic cocaine or methamphetamine use.

In general, the more frequently an individual uses cocaine and the larger the amounts consumed during each episode of use, the greater the likelihood that sexual functioning will become impaired as use continues. However, even when use severely impairs sexual performance it may continue to stimulate sexual arousal and fantasies. This is obviously very frustrating for a user who is mentally aroused, but unable to sustain an erection or achieve orgasm. Often the sexually impaired stimulant user engages in an increasingly frustrating attempt to attain sexual satisfaction that has become elusive and sometimes physically impossible. Sex may diminish to a point where it no longer involves any physical stimulation or touching at all even though the sexual compulsion and/or obsession stay strong.

### **Clinical Assessment of the Sex-Drug Connection**

The strong link between stimulant drug use and sex points the importance of addressing this issue routinely in all individuals who seek treatment for cocaine or methamphetamine abuse. The first step is to assess whether a client's cocaine or methamphetamine use is linked with sex at all, and if so, to determine more specifically the nature and extent of this linkage. This assessment is best performed as part of an initial intake interview since a pattern of drug-related sexual behavior is an important consideration in formulating an initial treatment plan.

When introducing the topic of drug-related sex, it is essential for the evaluating clinician to set the stage by putting clients at ease as much as possible before raising this highly personal and sensitive issue. For example, it is helpful to let clients know that various types of sexual behaviors are often associated with stimulant drug use and that failure to address this issue can contribute unnecessarily to a pattern of multiple relapses that could have been prevented if properly identified and addressed. Moreover, it is essential for the clinician to convey a compassionate nonjudgmental attitude toward the client and offer reassurance that uncoupling drug use and sex, although not an easy task, is indeed possible. Individuals who have acted out sexually under the influence of stimulant drugs often feel extremely embarrassed, guilty, and reluctant to discuss it without the sensitive prompting of a knowledgeable nonjudgmental clinician. Even then, it may require a few sessions to develop enough rapport and trust for the client to be willing to engage in an open dialogue about the details of drug-related sexual behavior- especially if the client and clinician are different genders.

The client must be asked specific questions about drug-related sexual behaviors in order for the clinician to obtain the information needed to be able to address this issue effectively in the treatment. Toward this end, the Sex-Drugs Questionnaire presented in Table 1 is designed to facilitate this process. This instrument is an outgrowth of a much briefer questionnaire developed many years ago by the first author (AMW) for cocaine-dependent outpatients (Washton, 1989). The original impetus for developing the questionnaire stemmed from reports by an increasing number of patients (especially males) that their cocaine use was intertwined with compulsive sexual behaviors and that this powerful connection between cocaine use and sex was making it extraordinarily difficult for them to achieve and maintain abstinence from cocaine. The original questionnaire was later modified and expanded for use as a data collection instrument in the

study cited previously by Rawson et.al. (2002). The questionnaire in Table 1 represents a further modification and refinement of the instrument in which certain items were added while others were deleted based on clinical relevance.

This 28-item questionnaire provides important information regarding specific types of sexual behaviors and situations connected with stimulant drug use. It also helps to identify some of the sexual triggers that will need to be avoided and/or managed as part of an overall plan to prevent relapse, as will be further discussed below and in Chapter 6. Items in the questionnaire cover various aspects of the relationship between stimulant drug use and sexuality including sex drive, sexual fantasies, performance, pleasure, obsession, unsafe or risky sexual practices, entanglement of drug use with sex, adverse reactions, and treatment considerations. This questionnaire is designed to be self-administered by the client, and can also be used to guide a structured clinical interview. Regardless of how it is administered, the questionnaire should be used to engage the client in a detailed discussion regarding the nature and extent of the connection between drug use and sexual behavior.

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### **Table 1: Sex-Drugs Questionnaire**

*When you use cocaine or methamphetamine:*

1. Do you feel a stronger desire to have sex?
2. Do you feel that your sex drive becomes abnormally high?
3. Do you have stronger or more vivid sexual fantasies?
4. Do you have trouble maintaining an erection or achieving orgasm?
5. Are you more likely to masturbate?
6. Are you more likely to watch pornography?
7. Are you more likely to have sex with another person?
8. Are you more likely to have sex with someone you don't know or just methamphetamine?
9. Are you more likely to have sex with an escort or prostitute?
10. Are you more likely to seek sex partners on the internet?
11. Are you more likely to engage in phone sex or cybersex?
12. Are you more likely to engage in certain types of sex acts that are out of the ordinary for you?
13. Have you engaged in sex acts that cause you to feel sexually perverted or abnormal?
14. Are you more likely to engage in marathon sex with multiple partners?
15. Are you more likely to have unprotected vaginal or anal intercourse without a condom?
16. Do you put yourself in dangerous situations that increase your chances of being physically harmed?
17. Do you engage in sadomasochistic sex or other forms of physically abusive, dangerous, or violent sex?
18. Do you feel degraded, guilty, depressed, or worthless after having sex on drugs?
19. Do you feel that sex and drug use are so strongly linked that it will be very difficult for you to be involved in one without the other?
20. Do you fear that sex without cocaine or methamphetamine will be boring and unsatisfying?
21. In prior attempts to stop using cocaine or methamphetamine, was sex a relapse trigger that led you back to using again?
22. When you think of sex, do you automatically think of cocaine or methamphetamine?

23. When you think of cocaine or methamphetamine, do you automatically think of sex?
  24. Do you feel that treatment should address the linkage between your drug use and sex?
  25. Prior to getting more involved with cocaine or methamphetamine did you feel that your sex drive was abnormally high, that you were obsessed or preoccupied with sex, or that you were suffering with sexual compulsivity or addiction?
  26. Prior to getting more involved with cocaine or methamphetamine did you feel that your sex drive was abnormally low or that you were sexually inhibited?
  27. *For heterosexual men only:* Have you ever engaged in sex with other men while high on cocaine or methamphetamine?
  28. If so, have you experienced homosexual fantasies, desires, or sexual encounters when *not* high on drugs?
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## **Treatment Considerations**

### Identifying and Managing Sexual Triggers

When the assessment reveals a significant relationship between the client's drug use and sex, this issue will need to be addressed at the outset of treatment. The first step is to help the client develop an accurate perspective on the nature and extent of this connection and to identify sexual triggers likely to initiate drug cravings and relapse episodes. Once identified, the next step is to teach clients how to reliably anticipate, avoid, and respond safely to these potential relapse triggers. Clients must also be taught how to differentiate between sexual behaviors that are compulsive and potentially life damaging versus those that are healthy and life enhancing.

Sexual relapse triggers can include just about any type of sexual feeling or fantasy and any type of sexually-arousing stimulus or event. These may include viewing pornography or other sexually explicit material, engaging in sexually stimulating discussions on the internet or elsewhere, maintaining contact with available sex partners, reminiscing about previous drug-related sexual escapades, and simply having the desire for sex. Yet another potential relapse trigger is the fear that sex without drugs will be unsatisfying. An unwanted byproduct of establishing a strong connection between drugs and sex is that "ordinary" sex (i.e., without drugs) is seen as boring and unsatisfying when contrasted to the highly erotic and exotic sexual experiences attainable under the influence of stimulant drugs. Loss of interest in having "ordinary" sex with one's intimate partner during initial abstinence from stimulant drugs can be the basis for serious relationship conflicts that may in turn lead back to drug use.

### Breaking the Sex-Drug Connection

Disrupting the connection between drug use and sex requires abstinence from drug use and in many cases temporary abstinence from sex. A "cooling off" period (e.g., 30 days) can help to diminish the power of the drug-sex connection and facilitate the process of identifying sexual relapse triggers such as those mentioned above. The long-term goal, of course, is not celibacy but rather developing a satisfying sex life that does not involve using drugs. When stimulant drug use and sex are strongly linked with one another, attempts to stay off the drugs will not be successful if the client continues to engage in sexual behaviors previously associated with the

drug use. These sexual behaviors will inevitably trigger drug urges and drug relapse episodes. Similarly, returning to drug use will inevitably trigger sexual urges and sexual relapse episodes. This phenomenon in which drug use leads to sex and sex leads to drug use has been termed “reciprocal relapse” (Washton, 1989b).

When a strong connection has been established between drugs and sex, stopping the drug use does not automatically stop recurring thoughts and fantasies about previous sexual experiences. However, these fantasies do tend to fade over time as drug abstinence continues, but are likely to be rekindled in full force by any further instances of drug use. For clients who reject the idea of a sexual “cooling off” period, especially those who have been engaging in high-risk sexual behaviors (e.g., unprotected intercourse with strangers); a harm reduction approach can be a useful option. For example, clients can be asked to stop engaging in high-risk sexual behaviors and switch instead to masturbation (even daily masturbation, if needed) as a way to relieve sexual tension, reduce the likelihood of returning to drug use, and eliminate exposure to the potential harm associated with high-risk behaviors.

Listed below are 10 tips to help break the sex-drug connection (Washton, 2008):

1. Refrain from all sexual activity for at least a while (e.g., 30days) as a “cooling off” period to let your sexual thoughts, feelings, and fantasies wind down
2. Identify sexual triggers associated with your drug use and develop an action plan to anticipate, avoid, or respond safely to these triggers
3. Develop a list of alternative activities that you can get involved in immediately when confronted with urges to act out sexually
4. Develop a social support system you can turn to
5. Dispute and discuss your unrealistic thoughts and fantasies about being able to engage in erotic and exotic sexual experiences without getting high again
6. Be proactively open and honest with your therapist and/or group about secret desires to act out sexually
7. Recognize that it is normal and expectable for you to feel afraid and frustrated that sex without drugs will be boring and unsatisfying. Learning how to enjoy sex again without using drugs is a process that may take some time. It will not happen overnight.
8. Recognize that if you have little or no sex drive after stopping your drug use, this too shall pass. For most people, it takes at least few weeks for their sex drive to return to normal.
9. Examine your unhealthy sexual attitudes toward others and possible your fear of intimacy
10. Do not drop out of treatment prematurely, no matter what!

### Individual and Group Therapy

At the beginning of treatment, many clients simply are not ready or willing to discuss drug-related sexual issues in a group setting even though sex may be their strongest relapse trigger. Accordingly, clinicians should be prepared to work with clients individually on these issues with an eye toward preparing at least some of them to enter a group at the appropriate time. Often there are thorny issues that need to be processed individually regarding some of the

consequences and fallout from sexual acting-out behaviors under the influence of cocaine or methamphetamine, not the least of which is lingering shame, guilt, and humiliation. In addition, some clients who are married or involved in other committed relationships have engaged repeatedly in risky sexual behaviors of which their partners have no knowledge. This raises important issues for clients such as when and how to notify their partner and how to access appropriate medical services. Another issue that may need to be addressed in individual therapy, at least initially, concerns the unhealthy attitudes toward women often displayed by heterosexual who have used women as sex objects or “playthings” during their drug-related sexual escapades. These attitudes either predate stimulant drug use or emerge de novo and intensify as a result of engaging repeatedly in drug-related sex with prostitutes and/or other women. By definition, these experiences split off sex from intimacy and create obstacles to relating to women as real people with legitimate thoughts, emotions, and needs. Clients who have developed sufficient insight into these issues and are genuinely motivated to change often find it very helpful to process these issues in coed groups with women who can offer useful feedback.

Many clients are receptive to entering group therapy from the outset while others may become willing to do so after some initial preparation. Two recent publications—a cocaine recovery workbook (Washton, 2008) and a behaviorally-oriented group treatment manual for gay and bisexual male methamphetamine users (Shoptaw et al., 2005) -- can be useful guides for addressing drug-related hypersexuality. Group therapy can be an effective intervention for clients whose drug use is strongly associated with sex, but with some important caveats. First, these clients will generally find it easiest to assimilate into a group in which at least some other group members share and can identify with these problems. While it is not necessary for all group members to have a history of these problems, the group should provide an environment of trust and safety in which these types of issues have been discussed and can continue to be discussed openly and honestly without fear of judgment or rejection. It is neither necessary nor advisable to segregate patients who present with drug-related sexual acting out behaviors into separate groups. We have successfully conducted mixed recovery groups containing members who present with this problem and others who do not. Some of these groups have included both men and women as well as clients with different sexual orientations. The leadership style and therapeutic atmosphere of the group in terms of unconditional acceptance and positive regard for its members is far more important than the demographics of its members.

## **Final Comment**

A strong connection between stimulant drug use and sex, if not properly identified and addressed, can pose serious obstacles to successful recovery from stimulant dependence. When sexual arousal and drug use are strongly associated with one another, sexual thoughts and feelings can initiate drug cravings and relapse episodes. Combining sex and drugs, two potent reinforcers, creates a compelling “super high” that is more addicting than drug use alone. Sexual acting-out behavior linked with stimulant drug use is not only highly addicting, but also potentially dangerous. While under the influence of cocaine or methamphetamine, some users engage in high-risk sexual behaviors that may contribute to transmission of HIV and other serious diseases. Methamphetamine tends to be more strongly associated with hypersexual behavior than cocaine in both men and women and less likely to impair sexual functioning. The

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prevalence of drug-related hypersexuality among cocaine and methamphetamine users suggests that clients entering treatment for stimulant dependence should be assessed routinely for these behaviors. Treatment must initially help clients to acquire a realistic assessment of the relationship between their drug use and sexual behavior and then to identify sexual triggers that may lead to drug relapse episodes. Clients must be taught how to reliably anticipate, avoid, and respond safely to these triggers and to develop other strategies to help break the connection between drug use and sex. Both individual and group therapy can be effective treatment modalities for addressing these behaviors and related issues.