Addiction Professional

From `Party and Play` to `Clean and Safe`

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Certain trends in our culture start on the coasts and work their way to the middle of the country, or start with specific groups of people and then work up to the general public. For example, methamphetamine has been around much longer than most people realize. In World War II, the German, Japanese, and U.S. militaries sanctioned meth to assist combat troops and long-distance pilots with their stamina.

Curiously, the rise of the current “meth crisis” started in rural areas, such as in Missouri. Five years ago, the lead author was conducting substance abuse treatment for probationers in Maricopa County, Arizona, and 80% of his clients had meth-related charges. We see the use of crystal rising in all socioeconomic and ethnic groupings in our treatment facilities.

Gay folk have been trendsetters in fashion, music, theater, and the revitalization of neighborhoods across the country. But the latest trend that has been attributed in particular to gay men is not one to be proud of. For years in the gay community, there was a “quiet revolution,” if you will, going on. It started with the clubs and circuit parties associated with the “cookie-cutter” great-looking, shirtless men more than 15 years ago. Meth, this cheap-to-produce and easy-to-procure drug, allowed these partygoers to dance the night away with tons of energy, to hook up with other men for sex, to have sex for hours, and to not have to sleep. Even better, users rationalized, one lost weight on the drug, which contributed to its popularity in a culture obsessed with body image.

Over time, the connection between this drug and what it does to libido mushroomed among gay men. After decades of safer-sex ads, lectures, and education around AIDS, new sex clubs and parties evolved, advertising “bare backing” (anal sex without use of a condom) and “PNP” on the Internet. PNP stands for “party and play”; “party” is a euphemism for crystal meth and “play” means sex. So today, gay chat rooms are loaded with messages from gay men “seeking others for PNP.”

The result has been a documented rise in new HIV/AIDS cases because of this drug's use. The Los Angeles Gay and Lesbian Center reports that one-third of all new HIV infections are related to meth use, a figure consistent with that of other major cities such as New York City and San Francisco.

We all know that drugs lower inhibitions. So even those who would never think of unprotected sex while sober may engage in risky behavior under the influence of this party drug. Many of the patients we see at our facilities talk about the “incredible sex” they had while under the influence of this drug, to the extent that they fear having sex while sober.

The HIV connection

We know that HIV weakens the immune system and that the partying lifestyle, with its accompanying lack of sleep, food, and liquids, only leads to further deterioration. What you may not know is that meth actually eats through the immune system, causing a drop in T cells and natural killer (NK) cells that destroy cells infected by viruses. The drug, the lifestyle, and HIV take a major toll on those who are immunocompromised.

Not much is known about the interaction between meth and HIV medications. This is largely because of a lack of funding for such research from pharmaceutical companies and the government, as well as that the purity of meth varies significantly. Even if funding were available for research, it would be hard to get a consistent supply of crystal meth to create a baseline study. What we do know is that bad things happen.

For example, certain HIV medications, such as ritonavir and nevirapine, are designed to boost the effects of other medications. In 1997, a man with AIDS who had been taking ritonavir died suddenly after taking two hits of Ecstasy. His blood level of MDMA was the equivalent of 22 hits of Ecstasy.

Both meth and HIV medications are processed out of the bloodstream through the liver. The liver can accommodate only so much, and HIV medications take priority in the liver. Thus, meth can build up to dangerous levels in the bloodstream, which can lead to overdose and other conditions such as heart attack, stroke, and coma.

“Drug holidays” (not taking HIV meds for a period of time) are common among even occasional meth users. Unsupervised drug holidays, especially when partying, can lead to a drop in T cell counts and a rise in viral loads. Drug holidays are also dangerous because they can give the virus a chance to mutate and become immune to medications that an individual may be taking.

Consider these statistics about the gay and bisexual male population:

- 24% of MSM (men who have sex with men, the term used instead of "gay/bisexual men" in epidemiologic measures and most journals) in the Pacific region (California, Oregon, Washington, Hawaii, Alaska, and Guam) reported recent meth use. Those in this group reporting recent unprotected anal intercourse were four times more likely to have used meth before or during sex than those reporting no unprotected anal intercourse.[1]
- More than 2,800 meth-related emergency-room mentions occurred in Los Angeles and San Diego alone in 2002.[2]
- Meth use by HIV-positive MSM is associated with decreased medication adherence, which threatens treatment goals of viral suppression.[3]
- MSM meth use is closely connected to sexual identity and sexual expression.[4–6]

Addressing sexual behavior

We have commonly heard these types of statements at our treatment facilities, which specialize in treating gay men, lesbians, bisexuals, and transgenders: "I had the most incredible sex while using meth that I've ever had in my entire life"; "Having any kind of sex will trigger me to want to do Tina [a street term for meth] again because sex was never like that before"; "It allowed me to be free"; "I forgot about my HIV status"; and "I didn't care about catching anything. I just wanted to party and play for days."

Professionals must address sexual behavior as a part of treating meth-dependent clients. Sexual behavior is the single most important trigger for this population. Some users are fearful they will never be able to have sober sex, and others are so obsessed by the sex they had while under the influence that it leads them back to using the drug.

The figure is a simple worksheet the lead author has developed to assist our patients in looking at the issue and to begin developing a plan for healthy sexual behavior as part of their recovery. When patients have completed the worksheet, we divide them into small discussion groups of three or four people. We assure them that no one is forced to participate or answer questions. We let them know before we pass out the worksheets that we are not going to collect them, encouraging participants to be as honest as possible. In the small groups, we encourage them to share how they answered each question.

A worksheet the authors use to help patients develop a plan for healthy sexual behavior as part of their recovery.For question one,patients are asked to write a percentage.

After everyone has had a chance to share their answers in the small groups, we invite them back into the large circle. We then ask them to think of the room as a continuum, with one end of the room being 0 and the other end being 100%. We ask them to place themselves on the continuum where they put the answer to question one ("How often did sex and using go together?"). This gives group members and the facilitator a chance to see where this group falls: In our program, the majority are always on the upper half (50 to 100%), with a few around the middle and usually one or two at the lower end of the continuum. That gives us a chance to say that not everyone had the same experience but that the correlation between drug use and sexual behavior is high for most of the participants.

We do not ask patients to share the answers to question two (regarding common times, places, and people) in the large group. We find that sharing the answers to question three (listing boundaries) can be very enlightening. When one person shares a list, others often will say, "That's a good one. I need to add that to my list."

The goal of the activity is not only to have patients look at their own correlation of sexual behavior with drug use, but also to find a way to bring healthy sexual behavior back into their lives as a part of their recovery and relapse prevention. We encourage patients to share the list with sponsors, therapists, friends, or anyone who may be able to support them in recovery.

If obvious sexual acting-out occurs, or patients express apprehension about being able to maintain boundaries, we suggest that they attend at least one of the many "S" fellowships as part of their recovery. These are the 12-Step groups formed around out-of-control sexual behavior. Best-known and most helpful are SAA (Sex Addicts Anonymous), SLAA (Sex and Love Addicts Anonymous), and SCA (Sexual Compulsives Anonymous). SCA, founded by gay men, has meetings that tend to include more gay members, and therefore is seen as gay-affirming and -welcoming.

Our treatment plans may even include "sex dates" where the client seeks behavior on the "SAFE" column on the worksheet. If these dates or even their planning become triggering, we know the client needs to alter the plan.

We believe we need to teach our recovering meth addicts how to engage in responsible sexual behavior that will support their recovery and not contribute to relapse while they are still in our care. Our groups have to be safe environments where patients can discuss their sexual behavior. Not to do this represents a disservice to those seeking relief from the most insidious drug the lead

author has witnessed in his 23 years in this field.

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References

1. Hirshfield S, Remien RH, Humberstone M, et al. Substance use and high-risk sex among men who have sex with men: A national online study in the USA. AIDS Care 2004; 16:1036-47.
2. Drug Abuse Warning Network. The DAWN Report. July 2004. Available at: https://dawninfo.samhsa.gov/old_dawn/pubs_94_02/shortreports/files/DAWN_tdr_amphetamine.pdf.
3. Arnsten JH, Demas PA, Grant RW, et al. Impact of active drug use on antiretroviral therapy adherence and viral suppression in HIV-infected drug users. J Gen Intern Med 2002; 17:377-81.
4. Reback CJ. The social construction of a gay drug: Methamphetamine use among gay and bisexual males in Los Angeles. City of Los Angeles AIDS Coordinator's Office 1997.
5. Frosch D, Shoptaw S, Huber A, et al. Sexual HIV risk among gay and bisexual male methamphetamine abusers. J Subst Abuse Treat 1996; 13:483-6.
6. Gorman EM, Morgan P, Lambert EY. Qualitative research considerations and other issues in the study of methamphetamine use among men who have sex with other men. NIDA Res Monogr 1995; 157:156-81.

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