

Sexual Health in Drug and Alcohol Treatment

Group Facilitator's Manual

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Contents

Foreword ix

Acknowledgments xi

Introduction: The Creation of the *Sexual Health
in Drug and Alcohol Treatment Curriculum* 1

Note to Group Leader 23

Orientation Module 33

CORE ONE: SEX/DRUG-LINKED SEXUAL HEALTH 45

1 Sex/Drug-Linked Relapse Risk 47

2 Sexual Decisions in Recovery 63

3 Dating and Sexual Relationships in Recovery 77

CORE TWO: SEXUAL ATTITUDES AND VALUES 103

4 Motivations for Sex in Recovery 105

5 Talking about Sexual Health 129

6 Spirituality and Sexuality in Recovery 143

CORE THREE: SEXUAL PAST 169

7 Sexual Development 171

8 Nonconsensual Sex 187

9 Out-of-Control Sexual Behavior 221

CORE FOUR: SEXUAL HEALTH 239

10 Sexual Functioning in Recovery 241

11 Sexual Boundaries in Recovery 267

12 Relationship with My Body 295

Index 317

Foreword

In the past, substance-abuse treatment counselors focused only on the client's addiction and assumed that other issues would either resolve themselves through recovery or be dealt with by another helping professional at a later time. Over time, with additional research and increased clinical experience, treatment providers began to note the need for comprehensive, integrated services. Many treatment providers today follow the National Institute of Drug Abuse (NIDA) guidelines that state that drug addiction is a complex disorder that can involve virtually every aspect of an individual's functioning. The guidelines recommend that programs provide a combination of therapies and other services to meet the individual needs of each patient. However, even in these contemporary guidelines, the issue of sexuality is not mentioned.

The current neglect of sexuality as a core issue in addiction recovery reflects an experience I had in 1982. I still have a vivid memory of a presentation I gave at a national conference in Washington, D.C. The title of my paper was "Sex and Violence: The Unmentionables in Addiction Treatment." The responses from the attendees ranged from discomfort to anger. Many told me that their clients would relapse if these topics were discussed and that their clients were "not ready" for this work. I tried to explain that clients were at risk of relapse if we did *not* discuss these issues. Later I realized that it was the addiction professionals, not the clients, who were not ready.

In this new evidence-based curriculum, *Sexual Health for Drug and Alcohol Treatment*, Doug Braun-Harvey challenges our attitudes and beliefs as well as our traditional ways of providing treatment. He challenges us to "get ready" and he provides a way to do it. This material on sexual health can help to provide a missing piece for many recovering addicts.

Recovery means more than the elimination of one's drug of choice, either through harm reduction or abstinence. Recovery is also about

what is added or gained in one's life. To me, recovery means wholeness. It means having one's inner self (thoughts, feelings, values, and beliefs) *connected and congruent* with one's outer self (behavior and relationships). Developing sexual health in recovery is essential to becoming an integrated, whole person.

In a world in which sex is emphasized so much, in which alcohol and drugs are associated with sexual experiences, and in which the meaning of love is so bewildering to so many, Doug Braun-Harvey stands out as a pioneer in guiding the addiction-treatment field toward sexual health.

Stephanie S. Covington, PhD, LCSW

Acknowledgments

Countless sexual health conversations are reflected in this book. I am humbled by the generosity and enthusiasm of those who have contributed their resources, vision, hope, wisdom, measurement, opinion, criticism, and warm shoulder throughout the last 8 years. Sexual health is an act of collective connection.

In 2001 Cheryl Houk, the former Executive Director of Stepping Stone of San Diego, asked me for help. She was “tired of people dying” because her treatment program was failing to help those with what we have now come to call high sex/drug-linked behavior. Her belief that we can do better has been my centering mantra. The Board of Directors of Stepping Stone allowed Cheryl to explore her vision. We began a volunteer collaboration to change the way sexuality was addressed at Stepping Stone. Cheryl and I were determined to begin saving lives.

It was Cheryl who initiated a conversation with The California Endowment, which led to the grant to develop sexual health as a means of improving treatment. Greg Hall and Stacy Amodio from The California Endowment were invaluable in fostering and overseeing the 3-year grant. Marc d’Hondt, who unwaveringly believed in this project since its inception, remains a steadfast sexual health advocate at Stepping Stone. Maridia Harrington provided way too much laughter and joy during the many hours in my kitchen going about the work of writing the grant and sowing the seeds for the original concepts in this book.

I remain deeply grateful and indebted to the Stepping Stone staff and volunteers who leapt into a void and trusted the idea that becoming a sex-positive treatment center would help women and men recover. Their hard work, dedication, and inspiration are on every page.

This book reflects the enthusiasm and pride of the hundreds of Stepping Stone clients who completed the sexual health in recovery curriculum. Without their courage to change and daring to be different this book

would be yet another wish in the minds of countless treatment providers frustrated by yet another addict “taken out by sex”.

In this era of evidence-based treatment a researcher and evaluator with experience, intelligence, and rigorous standards is an important sexual health ally. I was fortunate to find all three in my collaboration with Jim Zians. Jim expertly guided the evolution of this project from clinical concept to funded grant to measurable intervention. He established protocols for Stepping Stone to assess and measure their essential evidence-based outcomes. Thank you Jim for teaching me: “If I can’t measure it then it can’t be in the curriculum.” San Diego social science researchers Linda Lloyd, Tom Patterson, and Tom Smith contributed time and wisdom to the internal review process. The publications of many sexologists, addictionologists, psychotherapists, and stages of change researchers have been essential primary sources of sexual health conversations. I found hope and inspiration in their ideas and science.

Beginning in December 2003 Joe Dintino and Nancy Busch began leading each new curricula and during the proceeding months improving on them each step of the way. They worked hand in hand with me to correct what did not work, confirm what was effective, and assist with strategic changes. It is a rare opportunity to experience this kind of teamwork, trust, and creativity. They were the right people at the right time. When Espen Correll joined the team he brought with him advanced training in human sexuality. He enthusiastically bridged sexual health education among addiction treatment professionals. He got San Diego treatment centers clamoring for sexual health. John De Miranda, the current CEO of Stepping Stone, is a tireless advocate for improving drug treatment. He knows first hand the benefits of the sexual health program at Stepping Stone and envisions sexual health in recovery as an important contribution for improving treatment outcomes across the nation.

Sexual health conversations with respected and trusted professional colleagues are essential. Members of The Society for the Scientific Study of Sexuality [SSSS]; Southeast Conference on Addictive Disorders [SECAD]; The National Association of Lesbian and Gay Addiction Professionals [NALGAP]; American Association of Sex Educators, Counselors, and Therapists [AASECT]; The Society for the Advancement of Sexual Health [SASH]; The Hazelden Graduate School of Addiction Studies; and The American Group Psychotherapy Association [AGPA] have listened, advised, and confirmed my belief in sexual health becoming an ally with drug and alcohol treatment. Many of these organizations invited Stepping Stone, Jim Zians, and myself to present workshops, trainings, and forums

to report early findings and to discuss sexual health as a clinical intervention for improving treatment outcomes and increasing client retention.

I have worked with a diverse spectrum of sexual health allies from around the country. They include Kip Castner, Lori Jones, Carol Crump, Chuck Stonecipher, James Campbell, The Chadwick Center for Children & Families, Heidi Aiem, Steve Bolda, Kenny Goldgerg, Peter Taylor, and David Wohlsifer. Each from disparate professions yet all possessing a vision for sexual health as an ally for improving the lives of the people they serve.

Sexual health is all about the details. I have been privileged with particular gifts of wisdom from many people. Eli Coleman, Stephanie Covington, and Chris Kraft's 2003 curriculum draft peer review in Minneapolis was a turning point in conceptualization, content, and construct validity. Their expert criticism provided invaluable direction, mentoring, and encouragement on that September day and every day since. They are my sex/drug-link advisors. Corrine Casanova contributed early editorial expertise to the curriculum and was a welcome ally and advocate for this book to find a wider audience. George Marcelle provided timely nudging for me to find a publisher. Deanne Gruenberg (Dee Dee) and her husband, Harry, provided book-selling business expertise and matchmaking with Springer Publishing. Dee Dee is a determined advocate for sexual health.

Sexual health thrives among friends and family. Friends and respected colleagues G. Michael Scott and Ron Robertson were early contributors to the spirituality lesson. Writer Rebecca Cutter is not only a dear friend but also an invaluable mentor in the writing process. Thank you to my many friends at the Special Interest Group for Gay, Lesbian, Bisexual, and Transgender concerns at the American Group Psychotherapy Association. They are my allies in bridging sexual health and group work. With my colleague Michael Vigorito, I have been fortunate to have traversed from being sexual health mentor to collaborator. Peter Wayson, Paul Sussman, Dan Offner, Al Killen-Harvey, David Garmon, G. Michael Scott, and Dan Bjierke comprise a 15-year continuous monthly peer supervision group. Our mutual commitment to looking at ourselves to better the lives of our clients is cherished good fortune. These fine men have witnessed every step of this voyage. Gay Parnell and Rick Avery know all too well my personal and professional writing journey. Listening was their best medicine.

Over many years my sister and best friend Charlotte Braun has laughed with me across the country, lovingly attending many of my

conference workshops. Picturing her in 2003 sitting among the Minneapolis attendees at the first presentation of this curriculum is a cherished memory. I am blessed by her support and belief in my work as a sexual health advocate. I owe a debt of thanks to my niece Amy Peterson. She generously shares her hilarious sexual health conversations, sometimes by cell or text, moments after the hilarity. She is a beloved connection for great sexual health stories. My niece Ashley Braun is my tutor for social networking culture. I can humbly be very old with her and she is kind and caring.

My editor Jennifer Perillo has from day one understood the importance of sexual health and has guided the shape of this book with kind and firm enthusiasm. She has been the necessary voice of the outsider calling me to be clear, precise, and well organized.

Finally, to my husband, Al. I love you with all my heart. You have spent way too many weekends taking care of the life of our home, family, and friends while I gaze into my laptop. I could have never completed this book without you. Your support and generous heart is a daily gift of love. You have been my resident sexual health expert since 1987. How convenient!

Proceeds from the sale of this book will be donated to Stepping Stone of San Diego (steppingstonesd.org) and to the Douglas Braun-Harvey Fund for the Program in Human Sexuality in the Department of Family Medicine and Community Health at the University of Minnesota (<http://www.fm.umn.edu/phs/phsgift/home.html>).

The Creation of the *Sexual Health in Drug and Alcohol Treatment Curriculum*

FROM ABSTINENCE TO RELAPSE

Numerous experts and research studies have demonstrated that addicts in recovery are extremely susceptible to relapse. “Lapse, defined as reuse of alcohol or drugs at least once following treatment, occurs in at least 50% of those who complete treatment. . . . Relapse, defined as return to excessive or problematic use . . . [occurs] in approximately 20–30% of those who complete formal care in the prior year” (McLellan, 2007). Others agree: “There is now broad agreement in the clinical research community that addiction is best characterized by a chronic disease that for most people includes occasional relapses” (Leshner, 2003, p. 194). “Relapse rates for addictive diseases do not differ significantly from rates for other chronic diseases. Relapse rates for addictive diseases range from 50 percent for resumption of heavy use to 90 percent for a brief lapse” (Gordon, 2003, p. 6).

For addiction professionals, the question is: *Why* are addicts so prone to relapse? Scientific research is changing our understanding of the nature of addiction. New studies in brain imaging provide compelling visual data revealing changes in the brain circuitry of addicts (Childress et al., 1999; Volkow et al., 1999). Thus, we now understand addiction as a combination of changes in the addicted person’s brain structure and chemistry as well as his or her behavior and social circumstances (Leshner, 2003).

Such findings can increase our compassion for the persistent pattern of relapse among addicts in recovery, and help us understand that many addicts require multiple treatments before they achieve a stable abstinence. Normalizing drug and alcohol relapse as a predictable course in the treatment of a chronic disease (similar to relapses often encountered in the treatment of chronic illnesses like asthma, heart disease, obesity,

and diabetes) has allowed for a more reasoned discussion among drug treatment professionals regarding the role of relapse and for significant changes in treatment approaches.

FROM RELAPSE TO TREATMENT

Relapse during or following treatment has long been a source of consternation and frustration for addicts, their families, and those who treat them. The ideal of successful treatment is to maintain abstinence for the rest of the addict's life, yet few treatment programs meet this goal.

In the early 1990s, experts and researchers began comparing outcomes of varying addiction treatments in the hopes of improving relapse prevention. They wanted to discover if any particular treatment was statistically significantly superior to the others. One of the most widely cited research studies from this period was a multi-site alcohol treatment clinical trial matching alcohol treatments to client heterogeneity called Project MATCH. This 8-year study, conducted by the National Institute on Alcohol Abuse and Alcoholism (NIAAA), analyzed alcohol treatment outcomes among three groups, each utilizing a different treatment paradigm: 12-step facilitation (based on the principles of Alcoholics Anonymous), cognitive-behavioral therapy (based on social learning theory), or motivational enhancement therapy (based on motivational psychology). Participants in each group were matched to a particular treatment based on their characteristics, including severity of alcohol use, cognitive impairment, gender, motivational readiness to change, social support for drinking versus abstinence, and other factors (Project MATCH Research Group, 1993).

Overall, the findings of Project MATCH confirmed 1 hypothetical match and did not confirm 10 others, leading researchers to conclude that treatment outcomes were not correlated with patient-treatment matching. (National Institute on Alcohol Abuse and Alcoholism [NIAAA], 1996). Numerous follow-up studies have supported this initial data. Specific treatments targeted and matched with specific populations were no longer the singular focus of relapse prevention. A new direction beckoned.

FROM TREATMENT TO RECOVERY

In 1996, the U.S. Department of Health and Human Services (HHS) Center for Substance Abuse Treatment (CSAT) held its First National

Summit on Recovery. Over 100 invited stakeholders engaged in a variety of structured discussions to formulate a “recovery-oriented system of care” (CSAT, 2006, p. 6). The forum developed a definition of recovery: “Recovery from alcohol and drug problems is a process of change through which an individual achieves abstinence and improved health, wellness and quality of life” (CSAT, 2006, p. 9).

Twelve guiding principles of recovery were delineated. Most importantly, relapse was included as part of the process of recovery: “Recovery is not a linear process. It is based on continual growth and improved functioning. It may involve relapse and other setbacks, which are a natural part of the continuum but not inevitable outcomes. Wellness is the result of improved care and balance of mind, body and spirit. It is a product of the recovery process” (CSAT, 2006, p. 10–11). This represented a significant step forward in integrating the chronic and relapse-prone etiological formulation of addiction.

However, in my view, the summit’s report presented an unfortunate omission. Strikingly absent was any reference to human sexuality, sexual health, or sexual behavior. Even though the 12 guiding principles of recovery include references to health and wellness—such as “the holistic nature of physical, mental, social, and spiritual changes experienced by an individual throughout recovery” (CSAT, 2006, p. 51)—it is noteworthy that sex is not overtly referenced anywhere in the 12 principles.

I believe that this omission reflects a broader lack within the current discussion of treatment and recovery. While great strides have been made in treating women and men suffering from addiction, their sexuality—particularly as a part of the recovery process—is marginalized and even made invisible. When sexuality is not directly and positively addressed in drug and alcohol treatment, it can contribute to treatment failure, relapse, and untold costs in the lives of addicts and their families.

Sexual Health in Drug and Alcohol Treatment is an evidence-based curriculum to provide lifelong sexual health-based recovery tools as part of the treatment experience.

FROM RECOVERY TO SEXUAL HEALTH IN RECOVERY

In 2001, I was at a party with my good friend and colleague Cheryl Houk, then executive director of Stepping Stone of San Diego, a residential drug and alcohol treatment center. “Too many of our residents are relapsing because of their sexual behavior,” Cheryl declared. “We

can do better.” She wanted to find a way to address sexual behavior during and after treatment to “stop the dying” (C. Houk, personal communication, October 7, 2001).

I am a licensed marriage and family therapist specializing in treating men with out-of-control sexual behavior (OCSB) in San Diego for over 15 years. Over the years, several residents of Stepping Stone had been clients in my group and individual treatment program. These men were concurrently treating OCSB and their addiction. Cheryl knew of my work with the residents and wanted to discuss another problem at her center: crystal methamphetamine addiction. An increasing number of clients were presenting with crystal meth as their primary addiction. Over 75% of Stepping Stone clients identify as gay, lesbian, or bisexual, and crystal meth use is closely linked with sexual activity among gay males.

In Cheryl’s view, the men with crystal meth addiction were bringing their sexual lives with them into treatment, and far too many were being forced to leave treatment as a result of violating program rules about sexual behavior. I remember asking Cheryl, “I wonder how often they stop giving people chemotherapy because of their sexual behavior at the hospital?”

Cheryl wanted my help. I offered to volunteer a few hours a month to assess the situation and offer recommendations. Our goal was to see why, after 6–9 months of living clean and sober, residents completed treatment only to relapse because of sexually motivated drug-using situations. Sometimes this relapse occurred within days or weeks of completing treatment. On a few tragic occasions, recently discharged residents were found dead of overdose.

It did not take us long to find there was indeed a significant subset of Stepping Stone residents whose treatment failure was inextricably linked with their sexual behavior. The residents included not only gay men who used meth but also women and men of all sexual orientations who combined all sorts of drugs and alcohol with sex. We quickly came to call this sex/drug-linked behavior. For many addicts, drug use prolonged their sexual activity and enhanced their libido. Others were able to pursue unconventional sexual habits only after using drugs. In recovery, residents missed these sexual activities, and their treatment program did not prepare them for the absence of this sexual intensity.

We discovered that a high percentage of sex/drug-linked residents failed to complete treatment. However, treatment failure was not always due to a drug relapse. Many times it was due to sexual behavior that violated treatment program policies.

Two coexisting problems began to emerge. First, the program lacked specific interventions for the increasing population of high sex/drug-linked addicts and alcoholics in treatment. Second, we realized that Stepping Stone relied on impulsive, judgmental, reactive, and outdated procedures in addressing sexual concerns among their residents.

For example, early in my consultation with Stepping Stone, a counselor requested my advice on how to respond to a sexual situation. A resident had found a roommate's sex toy that the roommate used for masturbation and had reported this to the counselor. For years, the policy at Stepping Stone was to confiscate sexual aids—and follow up with the resident in a (often humiliating) discussion about how such materials were not allowed at the residence.

I asked the staff to consider the ramifications of this policy. Clients of Stepping Stone live in the center for 6–9 months. “Is the expectation that Stepping Stone is an orgasm free zone?” I noted that clients were not given any positive sexual health messages about masturbation; it was only addressed when a boundary crossing, such as the possession of a sexual aid, occurred. (It was later discovered that the person who raised the issue was angry with the roommate and knew from experience that the staff would react swiftly and negatively; thus, the program's negative attitudes toward sexuality were used as a weapon of passive-aggressive retaliation among residents.)

In my opinion, this inability to address sexual concerns and issues does a disservice to both providers and clients. Some treatment providers are frustrated by the knowledge that their clients might have a better chance for recovery if sex/drug-linked behaviors are addressed more directly and thoroughly in treatment. Clients, who have assimilated recovery information and are ready to apply it to their lives, unfortunately remain at risk and often relapse because their treatment provided inadequate skills for navigating sexuality in recovery.

In my experience, Stepping Stone is not the only treatment program to mishandle sexual issues. Some drug and alcohol treatment centers operate under significantly outdated, ineffective, and disapproving views about sex. Sexuality is often addressed only when a client's sexual behavior conflicts with treatment program policies (e.g., those concerning HIV infection, sex between clients, sexual activity off grounds, falling in love with other clients).

Most drug and alcohol treatment programs do not have designated locations, groups, or interventions that provide clients with positive,

affirming, and factual sexual health information. It is a rare chemical dependency treatment program that provides specialized programming for each client to explore, discuss, and understand how sexual behavior may possibly jeopardize recovery. Treatment fails these clients when they are not provided a safe place to discuss sexual health.

Furthermore, sexual health training is virtually absent in drug and alcohol treatment programs and counselor education training programs. The professional training of drug counselors focuses primarily on current treatment standards. Sex is only discussed in the context of HIV infection risk, pregnancy, history of sexual abuse, or possible co-occurring sex addiction (which is not the focus of this book). Many drug treatment professionals are directed by their supervisors and traditional treatment norms to limit any discussion of sexual concerns to these areas. If a client attempts to raise other sexual issues, it is a common drug treatment norm to classify such discussion as a deflection from treatment or something that the counselor is not competent to address.

Traditionally, alcohol and drug recovery centers have relegated addressing sexual behavior in early recovery to the back burner—or have believed that to address sexuality too soon in recovery risks client relapse. Chemical dependency treatment professionals often discuss sexual concerns from a sex negative or disease or pathology context. Therefore a client's sexual and relationship life is often limited to a focus on co-occurring sex addiction, sexually transmitted diseases, pregnancy, and/or the moral dimensions of conforming to an arbitrary set of sexual values and behaviors of specific staff or treatment programs. Additionally, the topic of sex is often taboo in the alcohol and drug treatment environment. Members of the staff have a difficult time broaching the subject. Chemical dependency treatment is inadequate and at times negligent when a client's sexual behavior, which is clearly linked with addictive drug use, is not carefully and thoroughly addressed in all phases of alcohol and drug treatment.

Cheryl Houk, her colleagues at Stepping Stone, and I began to realize that it did not matter how many treatment experiences high sex/drug-linked addicts had if their primary risk for relapse went untreated. At that time, Stepping Stone was no different than most treatment centers. Sex/drug-linked interventions were limited to a general recovery cultural norm of avoiding new relationships until a year sober. The slogan “sex took me out” was frequently mentioned by clients and provided us with an important lesson: the primary relapse prevention intervention was to make addicts become wary of sex and sexual desire. What seemed

to be missing was a sexual health–based relapse prevention strategy. Could sexual health be inextricably linked with staying sober? A new treatment plan was needed.

SEXUAL HEALTH IN DRUG AND ALCOHOL TREATMENT: THE CURRICULUM

Sexual Health in Drug and Alcohol Treatment is a pioneering psycho-educational class providing a sexual health–based curriculum to reduce risk of relapse and increase client retention for men and women with sex/drug-linked addiction and alcoholism. It was created through a collaboration between drug and alcohol counselors, sexual health advocates, psychological/sexological research specialists, and more than 250 Stepping Stone clients who participated in the program. It is the first curriculum designed to integrate concepts of sexual health, current sex research, and recent developments in relapse prevention research.

I was honored to have Eli Coleman, PhD, professor and director of the Program in Human Sexuality, Department of Family Practice and Community Health, at the University of Minnesota Medical School, Chris Kraft, PhD, Johns Hopkins Center for Marital and Sexual Health, Sexual Behaviors Consultation Unit, and Stephanie Covington, PhD, LCSW, codirector of the Institute for Relational Development in La Jolla, California serve as an external review committee. They gave me feedback, reactions, and suggestions as well as critique. They were instrumental in the developmental trajectory of the curriculum in its current form.

The curriculum is not a specialty program for clients with sexual problems. The curriculum is designed for *all* drug and alcohol treatment acuity levels. For it to be effective, each and every client in the treatment program must attend the class.

The curriculum originated in 2003, when the California Endowment funded a 3-year grant for Stepping Stone to develop, implement, and measure treatment outcomes of a sexual health–based, harm-reduction, relapse-prevention program targeted at sex/drug-linked addiction. The goal was to improve client retention rates and decrease sex/drug-linked relapse during all phases of treatment. I wrote the initial curriculum as the structure for the weekly psychoeducational sexual health in recovery group.

Theoretical Basis of the Curriculum

This curriculum is founded in three complementary theories, the most central being the transtheoretical model of change and motivational enhancement approaches that facilitate the change process (Miller & Rollnick, 1991; Prochaska, Norcross, & DiClemente, 1994). The readiness for change process is an excellent match for the necessary suspension of judgment and client-centered approach that is central to initial client engagement in addressing sexual health concerns among substance abusers (Braun-Harvey, 1997). The curriculum integrates a variety of change processes that are fundamental to the theoretical structure of the stages of readiness for change model (Prochaska et al., 1994).

Second, sexual health in recovery is a harm-reduction technique for improving abstinence-based recovery. Harm-reduction strategies are often utilized in nonabstinence-based substance abusing treatment approaches or to address substance abuse problems among precontemplators (Denning, 2000). Harm-reduction approaches are integrated within the curriculum by approaching sexual health as harm reduction. Building sexual health skills within the recovery process will reduce the risk of relapse. However, sexual health in recovery is not an all-or-nothing behavior (like complete abstinence from drugs and/or alcohol). Sexual health is a process of change incorporating sexual health behaviors, attitudes, and understanding that support the recovery process.

Last, the curriculum utilizes cognitive-behavioral learning principles that have been applied to other conditions, such as depression and anxiety management. Affect regulation skills are an important component of mental health. Thoughts and feelings in response to sexual situations are significant relapse risks at many stages of recovery. The curriculum is designed to be applicable to men and women at various stages of the recovery process. It is not limited to initial treatment or acute treatment settings. The cognitive-behavioral skill sets for each of the 12 curriculum lessons are designed for repeated practice. Sexual health is a process of change, not an event. The curriculum reflects this basic principle of recovery.

The structure of the psychoeducational group provides the container in which participants can experience feelings about their individual sexuality. Sessions are designed to raise consciousness about sexual health; each class is an exercise in sexual self-reevaluation. Each session provides an opportunity for clients to understand more about their sexual selves.

The most important task in this reevaluation process is to continually connect recovery with sexual health. Sexuality as an ally in recovery, rather than an adversary, is a central treatment frame. The curriculum helps women and men in recovery to identify sexual thoughts and feelings associated with increasing or decreasing risk of relapse. Several of the sessions emphasize the importance of not prematurely entering sexual situations without adequate preparation and consideration of recovery. The repetitive nature of the skill-building exercises allow for an ongoing commitment to sexual health in recovery that will be evidenced by repeat usage of the recovery tools over months and years of recovery.

Most sexual health discussions will arouse a wide variety of emotions within each participant as well as within the group; these emotions are an important part of the change process. A central element of the curriculum is to present a sex-positive attitude about sex and recovery. Sexual health in recovery is being deeply committed to believing in one's ability to maintain recovery and have an active, pleasurable, and emotionally meaningful sexual life. Of primary importance is reducing shame associated with choosing to avoid a sexual situation or emotional circumstance that will elevate risk of relapse to an unmanageable level. It is only through sex-positive, shame-reduction interactions that men and women in recovery will increasingly seek out relationships that support the goals of abstinence and sexual health.

Implementation of the Curriculum

The pioneering nature of this intervention required the development of two new drug and alcohol treatment tools. Dr. Jim Zians developed for Stepping Stone an assessment survey for determining each client's level of relapse risk linked to sexual behavior; this survey was also used to develop an evidence-based outcome evaluation process. The assessment survey was given to each resident upon admission and thereafter at 3-month intervals. The survey determined each resident's level of sex/drug relapse risk by evaluating factors such as: client drug use, sex/drug-linked behavior, influences of cognitive and interpersonal style, frequency and intensity of sexual secrets and shame, pervasiveness of negative sexual health attitudes, and frequency of risky sexual practices. Clients were given feedback by the sexual behavior relapse prevention specialist, a professional who was trained to conduct the assessment and feedback session.

From November 2003 to May 2007, more than 250 Stepping Stone residents completed the initial assessment survey. Residents completed

a second survey following 3 months of residential treatment, during which they attended weekly sexual health in recovery group sessions. The group sessions were attended by every Stepping Stone client during that period; group attendance was not based on client level of sex/drug-linked relapse risk. Attendance was a required component of the program. Additional program components included one-on-one counseling sessions for residents assessed to be a high relapse risk because of sex/drug-linked addiction patterns.

Concurrently, numerous staff trainings, programmatic changes, and ongoing staff supervision of sexual health interventions, policy, and group sessions were held to develop sex-positive treatment norms and to ensure that the curriculum content was integrated within the entire treatment program. Eventually, the sexual health in recovery group sessions were provided free to Stepping Stone outpatient clients and the greater San Diego recovery community. Several other mental health programs in San Diego have now incorporated the initial Stepping Stone curriculum within their overall clinical services. Meanwhile, Stepping Stone has become the go-to treatment center in San Diego for addressing crystal meth and other drugs and their link with sexual behavior. The curriculum is so integrated within their programming that even though almost every staff member involved in the 2002 pilot program has moved on, the commitment to sexual health based recovery remains unwavering.

Format of the Curriculum

The curriculum in this book differs in several ways from the 2003 original. I have added components based on client and staff feedback as well as the latest sexual health research. However, the original structure (four core themes, each taught in three focused lessons) remains.

This version includes more experiential learning than the initial version, which relied too heavily on cognitive learning and group process. It lacked sufficient variety of psychoeducational group formats to meet the diverse learning styles of men and women in treatment. Thus, each of the 12 sessions begins with a brief lecture followed by an expanded experiential learning group process. This is the heart of each session. Experiential learning allows for a group process to unfold within a structured task completion, either as the full group or as separate gender or relationship status groups. The final lesson section, “Topic Skill Practice,” creates an opportunity for each group to work with a sexual health skill set and practice completing a recovery tool worksheet. This is another

shame-reduction intervention. Feeling ignorant, uninformed, or awkward about sexual information is an enormous barrier to sexual health discussions. The practice session provides a shared moment of vulnerability and openness. This group process is done in the context of learning how to fill out the sheet while serving a central function for improving treatment outcomes for high sex/drug-linked participants: reducing sex/drug linked shame.

Implementing the Curriculum at Stepping Stone

As mentioned earlier, *Sexual Health in Drug and Alcohol Treatment* was tested at Stepping Stone. Founded in 1976, Stepping Stone currently operates both a residential and a nonresidential nonprofit social model recovery program in San Diego, California. The residential program is located in an urban residential neighborhood in central San Diego. Stepping Stone relies on the 12 steps of Alcoholics Anonymous and peer interaction and involvement to create a social environment where clients help each other in the recovery process. Stepping Stone has a reputation for integrating new approaches to treatment.

The residential program provides treatment for 28 adults, 75% of whom identify as lesbian, gay, bisexual or transgender and who voluntarily self-identify with drug or alcohol dependency. More than half of the men in treatment are living with HIV infection.

During the program evaluation period (2003–2007), the client demographics of the sexual health in recovery program reflected the general demographics of San Diego. Clients were White (60%), Latino/a (16%), and African American (7%), with the rest being Asian-Pacific Islander, Native American, or biracial. More than 70% of the study participants were between 25 and 44 years old.

Stepping Stone relies on a large volunteer program to provide daily support for residents. The staff is composed primarily of paraprofessionals and certified drug and alcoholism counselors; most have high school diploma or bachelor degree. Three master's-level counselors who had just completed their schooling taught the curriculum to the sexual health in recovery group. I supervised the implementation of the curriculum and trained the staff, but they did the work. None of the staff had specialized training in human sexuality; in fact, only one of the three group facilitators had taken any advanced sexuality coursework at a master's degree level.

One of the most encouraging and inspiring outcomes of this project was seeing the Stepping Stone counselors, staff, volunteers, and administration enthusiastically integrate the curriculum and recommended program changes. The sexual health in recovery project was presented as a pioneering opportunity to see if changing from a sex-negative to a sex-positive treatment environment could improve client recovery and retention; it also met head-on the pervasive feeling of hopelessness that had permeated the program surrounding crystal meth and other sex/drug-linked addictions.

The experience at Stepping Stone has increased my belief that sexual health is an aspiration for almost everyone in recovery. This curriculum can be taught by a wide variety of drug and alcohol professionals; the only requirement for leading the course are personal qualities of non-judgmental open-minded curiosity about sexual health in all its facets. The enthusiastic implementation of this curriculum at Stepping Stone significantly challenges the current orthodoxy that drug counselors cannot address issues of sexual health within recovery.

The wonderful staff at Stepping Stone demonstrated to me that there is a tremendous hunger for sexual health recovery tools among drug and alcoholism professionals. Their dedication to learning and changing was an inspiration. As for the clients, the residents of Stepping Stone embraced this program with excitement, relief, and increasing confidence in their ability to stay sober. They finally had a place to talk about sex and drugs! The men and women whose lives were on the edge of destruction before entering treatment were not to be underestimated. From the first day of the experiment they looked forward to the class and were so grateful to be in a treatment program where sexuality was positively addressed rather than feared and avoided.

Most importantly, Stepping Stone found sexual behavioral problems within the treatment center plummet after implementation of the program. We theorized that when you provide a place for sexual health discussions, it eliminates the need for sexual issues to spill out in other rooms or places.

In September 2008, a news program on the sexual health in recovery program at Stepping Stone included an interview with Gabriel, a 30-year-old gay male crystal meth addict who had just completed 6 months of the program. "I was learning to be in touch with Gabriel, with me, my body, how to communicate what my needs were, how to communicate what I wanted," he said in the interview. "[As a crystal meth addict] I had learned a whole way of living where all of my safer sex

practices had gone out the window and my self-esteem had gone out the window. . . . I had to rebuild that from scratch” (Goldberg, 2008).

Evaluating the Curriculum

The sexual health in recovery curriculum was developed as part of a grant from the California Endowment. The grant funded a 3-year evolution of this program through conception, design, implementation, evaluation, and outcome data. Jim Zians, PhD, rigorously expected every component of the program to be measurable before we began. Thus the Stepping Stone curriculum was part of a well-designed, evidence-based program.

As mentioned earlier, Zians developed a client assessment survey for Stepping Stone, which not only gave us greater definition and clarity into the problem of sex/drug-linked relapse but also provided an excellent outcome measure to determine if the program met our goals: increased client retention and decreased client relapse due to sex/drug-linked behavior. The most important treatment outcome, in our opinion, was client retention. When men and women with high sex/drug-linked relapse risk complete treatment that includes a sexual health relapse prevention program they increase the likelihood of remaining abstinent and engaged in recovery.

The survey also included measures of psychological constructs related to positive outcomes for residential substance abuse treatment. Several measures were adapted to survey targeted behaviors and attitudes specific to treatment outcomes related to sex/drug-linked patterns of use. The survey also measured sexual health attitudes and behaviors, especially those connected with the client’s anticipation of treatment completion given his or her history of sex/drug-linked behavior. Depression, anxiety, and other symptoms associated with mental disorders were included.

The most salient measure turned out to be an assessment of shame and stigma associated with sex/drug-linked history and current behavior: the Personal Feelings Questionnaire (PFQ) (Harder & Lewis, 1987), a validated measure of proneness to shame and guilt. I proposed to Dr. Zians that a measure for shame was essential for the overall survey, given the debilitating sexual shame I had witnessed in my work with men and out-of-control sexual behavior. Jim chose the PFQ for its flexibility and adaptability to create additional items that describe shame associated with sex/drug-linked behavior (e.g., “I often think about a sexual

secret I hide from others”; “I worry that some aspect of my sexual behavior may cause me problems with my program at Stepping Stone”). The PFQ also asks about the frequency of subjective body sensations and emotional states of shame without naming or labeling the sensation as “shame” (e.g., “feeling ridiculous,” “laughable,” “humiliated,” “stupid,” and “childish”).

Since Stepping Stone serves primarily lesbian, gay, bisexual, and transgender adults, an outness measure was included to distinguish shame between sex/drug-linked activity and that which might stem from sexual identity development and behavior of sexual orientation. It was filled out by self-identified lesbian, gay, bisexual, or transgender residents.

It was unclear how prevalent co-occurring symptoms of sexual risk taking, HIV infection risk, or HIV virus transmission risk and compulsive sexual behavior were among low or high sex/drug-linked addicts at Stepping Stone. Thus the assessment integrated components of sexual sensation-seeking measures, condom use, safer sex boundaries, as well as symptoms associated with out-of-control sexual behavior.

A modified measure based on readiness for change with a focus on the preparation and action stage of change was included to address motivation for change and self-efficacy. Since sexual health in recovery is based on the transtheoretical model (TTM) of change, we were interested in motivational readiness for addressing sexual health in drug and alcohol treatment (e.g., “When I feel my problem behavior coming on I think about it or go talk to someone at Stepping Stone about it, I feel more confident that my sexual behavior will not lead to relapse”).

Dr. Zians and I coordinated the development of the curriculum and assessment in tandem. His mantra was, “If I can’t measure it, it can’t be in the curriculum.” The curriculum was developed with specific constructs associated with recovery and sexual health. These constructs included sexual attitudes and beliefs, peer attitudes and beliefs, stage of readiness for change, skill efficacy (can I and do I believe I can implement sexual health in recovery skills and practices?), self regulation (how does sexual health in recovery contribute to the process of moving from a large scale breakdown in self-regulation to increasingly stronger levels of self-regulation?), and of course shame (how does a client’s self-reported level of shame contribute to increasing or decreasing his or her risk of sex/drug relapse?).

Each time a resident completed a survey, the Stepping Stone staff completed a one-page evaluation using chart entries from the client’s file.

Entries included such information as: changes in HIV status, a recently acquired sexually transmitted infection (STI), number of sexual health in recovery groups attended, number of individual counseling sessions with the sexual behavior relapse prevention specialist, and, most importantly, staff opinion ratings on program compliance and sex/drug-linked relapse risk during the measurement period. We were interested in the correlation between staff perceptions of sex/drug-linked relapse and the residents' own self-reports of relapse risk.

At 3 months and 6 months, each resident was given the same assessment with one addition: a confidential Behavior Outcome Questionnaire, which addressed drug use, sexual behavior, and sex/drug-linked behavior over the previous 3 months. The outcome data from this assessment hinged on Stepping Stone agreeing to a privacy boundary they had never before been asked to consider: would program staff be willing to allow Dr. Zians to anonymously know resident drug use over the past 3 months (from the questionnaire) and *not* require him to disclose that information? In other words, any anonymous self-reported relapse or sexual behavior by clients, as recounted on the questionnaire, would *not* be reported to the program staff. After much consideration, the staff at Stepping Stone agreed to this. Thus, the results from two measures—the Behavior Outcome Questionnaire and a client satisfaction measure—were kept confidential from program staff.

It should be noted that a different boundary was established regarding suicidal risk or acute psychiatric symptoms that might become evident in some of the psychological measures. The sexual behavior relapse prevention counselor checked one question pertaining to suicidality prior to implementing the confidentiality procedures, thus assuring that clients deemed in need of care would come to the attention of the staff.

Evaluation Results

Two significant evaluation outcomes warrant attention. First, client retention improved by over 50% when compared with the 3 years prior to the implementation of the sexual health relapse prevention program. This is important given that a primary goal of the intervention was to stem the increasing number of premature discharges due to sex/drug-linked relapse. This suggests to us that sex/drug-linked behaviors are learned. By adopting a sexual health-based model of treatment combined with clinical interventions (psychoeducational curriculum, drug/sex-linked relapse prevention skill practice, and self-reflection experiences), these

learned responses could be separated, and, over time, clients would have increased confidence in their ability to sustain sexual activity and relations without jeopardizing their recovery.

Second, assessment measures revealed a strikingly salient risk factor: sex/drug-linked shame. Stepping Stone residents assessed to be at highest risk for sex/drug-linked relapse entered treatment with *double* the measured levels of shame when compared with the lower risk sex/drug-linked clients. Three months later, after completing the first of two cycles of the Stepping Stone curriculum, this high-risk group lowered their shame levels to the same range as clients who entered treatment with low sex/drug-linked histories. Thus, *Sexual Health in Drug and Alcohol Treatment* is a shame-reduction intervention that provides sexual health-based relapse prevention tools.

A commitment to integrating sexual health into drug and alcohol treatment is a comprehensive endeavor. This text will outline the client intervention. The forthcoming book *Sexual Health in Recovery* (Springer Publishing Company) will address the process of integrating sex/drug-linked, sexual health-based relapse prevention into all aspects of treatment and recovery.

REACTIONS TO SEXUAL HEALTH IN RECOVERY

I have presented trainings and workshops on the sexual health in recovery program since 2003, in forums as diverse as: the Society for the Scientific Study of Sexuality (SSSS); the American Association of Sexuality Educators, Counselors and Therapists (AASECT); the Society for the Advancement of Sexual Health (SASH); the National Conference on Methamphetamine, HIV and Hepatitis; Hazelden Graduate School; the California Association of Marriage and Family Therapists (CAMFT); the California Association of Drug and Alcohol Counselors (CAADAC); the National Association of Addiction Treatment Providers (NAATP); the American Psychiatric Association (APA); the Maryland State Office of AIDS; and the Whitman Walker Clinic in Washington, DC. At nearly every presentation, attendees endorse the curriculum and its challenging of entrenched traditional drug treatment sexual behavior messages. The most common question I get is, “When will the curriculum be available?”

In 2008, I co-presented a session at the Western Regional SSSS with David B. Wohlisfer, PhD, a Pennsylvania sex researcher. Dr. Wohlisfer

conducted qualitative interviews and analyzed the sexual beliefs and behaviors of six men who have had sex with other men while using crystal methamphetamine (CMSM) for his doctoral dissertation. Although entirely unrelated to our research (at the time, Dr. Wohlsifer was unaware of this curriculum), his findings supported our outcome findings: “Shame about their homosexual sexual behavior appeared to play a key role in motivating these men to use crystal. Crystal seemed to provide an escape from sexual shame. Sex Positive Cognitive Therapy is suggested as an optimal treatment model for CMSM” (Wohlsifer, 2006, p. iv). Dr. Wohlsifer concluded that

treatment research needs to be sex positive especially in areas related to crystal use. What I have learned from these six men is that crystal either facilitated or mitigated their sexual encounters. They were able to be sexual, and enjoy sex with other men, which made using the drug all the more appealing. The crystal induced alternate state of sexual reality was far more enticing than its sober shame based alternative. Thus to respond to the community health problems that crystal use presents, it is essential to understand that crystal use is a mechanism that eradicates sexual shame. (Wohlsifer, 2006, p. 53)

IMPLEMENTING SEXUAL HEALTH IN RECOVERY AT YOUR FACILITY

The positive outcomes of the sexual health in drug and alcohol treatment at Stepping Stone suggest that this curriculum is a new resource for a subset of treatment-seeking clients whose sexual shame is an unseen treatment barrier. All levels of addiction treatment can implement this curriculum in an existing treatment program. It will, however, require a commitment to acquiring skills in sexual health-based treatment approaches as well as addressing program policies and entrenched patterns of ignoring or denying sex/drug-linked relapse risks.

Compatibility With Existing Treatment Programs

Although it was developed within a residential and outpatient social model 12-step treatment program, sexual health in drug and alcohol treatment is not based on the 12 steps of Alcoholics Anonymous. It is a harm-reduction, cognitive-learning, sexual health-based intervention that can be conducted in a wide variety of treatment programs.

The curriculum is founded on an abstinence-based treatment model where sex/drug-linked behavior is addressed to mitigate relapse from an abstinence-based approach to recovery.

Program Clientele

The program does not espouse sexual values founded on any particular religious creed or belief; it is based on sexual science and concepts of sexual health. Thus, men and women from any religious background, from devout believer to atheist, can participate in sexual health in drug and alcohol treatment groups.

The program was developed in a treatment environment in which heterosexual clients were the minority; the majority of Stepping Stone's clients were lesbian, gay, bisexual, or transgender men and women. This unique setting provided for daily evidence that this curriculum is not limited to a specific sexual orientation, gender, or socioeconomic circumstance. Stepping Stone treated homeless and unemployed clients, as well as well educated, wealthy clients who had lost everything in their addiction. Sexual health became another great equalizer among the treatment community.

Stepping Stone agreed with my recommendation to have the sexual health in recovery group be a required component of treatment for every resident and outpatient client. I think this was a fortuitous decision; I could well imagine the potential embarrassment of clients who were singled out to attend the special sex class. This split would create an anti-sexual health environment. The necessary message is that everyone in recovery needs to learn about sexual health; those with high sex/drug-linked patterns merely have more at stake.

Program Schedule

The curriculum is composed of an orientation, plus weekly lessons, each of which takes 90 minutes to implement; thus the entire program can be taught in a minimum of 13 weeks. Each lesson is self-contained; skills and topics do appear in more than one lesson but are not prerequisites for future lessons. This allows for creativity in adapting topics, schedules, and targeted sexual health skills within a wide variety of treatment settings. The curriculum can be one component of a comprehensive treatment program; it can also be offered as a separate treatment service, with enormous potential for community outreach and education. (For

example, Stepping Stone continues to offer community-based groups for men and women who long ago completed an inpatient or outpatient treatment program.)

Staff Requirements and Preparation

This curriculum can be led by a skilled psychoeducational group leader with basic sexuality education and an interest in learning about sexual health. As mentioned earlier, at Stepping Stone the class was taught by master's-level counselors who were just embarking on their professional careers. None of the staff had specialized training in human sexuality; in fact, only one of the three group facilitators had taken any sexuality coursework at a master's degree level. A high level of comfort and openness when discussing sexuality and sexual topics is essential to convey the sex-positive message of the curriculum.

Stepping Stone spent a year preparing to implement this program. They conducted surveys to find out what the residents would find valuable in such a program. In addition, top leadership staff attended monthly sexual health meetings that I facilitated to discuss their own ambivalent feelings and attitudes about embarking on this venture. Consensus was difficult, and fears needed to be respected and addressed.

They did not have any path to guide their way. There was no one to pick up the phone and ask, How did you decide to write your statement of affirming sexuality? What is your approach to providing masturbation guidelines for gay men sharing rooms with heterosexual men? What programmatic sexual health responses do you implement when two residents form an attraction?

How long would it take to implement this program in your treatment setting? It depends on your goals. The most significant variable I can suggest is how well-entrenched sex-negative attitudes and policies are within your current treatment program. The more frequently you feel discouraged by current approaches to sexuality in treatment, or the more often discussions of sexuality are met with age-old defenses common among drug treatment professionals, the more time you may want to take in implementing the curriculum.

Stepping Stone learned this lesson in a surprisingly harsh manner. A female Stepping Stone resident needed to transfer to another local treatment center. She had attended numerous sexual health in recovery groups and had enjoyed the general open and honest sexual discussions related to recovery that were daily occurrences there. In her interview

with the program director at the new treatment program, she took out her skill set sheets from the sexual health in recovery group and asked who in the program would support her in continuing this work. The director clenched her fist, pounded it on the desk, and said, “We don’t talk about sex here!”

SUMMARY

As the sexual health in recovery program proceeded at Stepping Stone, a general tone of sexual knowledge and information permeated attitudes and discussions not only with clients but also among staff. The volunteers, paraprofessionals, drug counselors, and professional staff took pride in their developing competence and confidence in engaging in matters of sexual health. However, it was not an easy or one-way trajectory. I have enormous respect for the difficult conversations, risks, conflicts, and disagreements that took place as we moved toward sex-positive treatment.

One of our most surprising findings was that the staff (many of whom were also in recovery) began to envy the residents. They remembered their own struggles with sexual health in recovery and saw how this issue had been neglected in their own treatment. This created many poignant moments of tears and healing. I was privileged to earn their trust and confidence as a consultant and facilitator for implementing the program as well as supporting their own recovery process.

Stepping Stone had to navigate the antisexual attitudes common to a wide variety of treatment programs. Their resolve never waned. They continue to be the biggest advocate of sexual health-based recovery in the country, and for that they are to be applauded. However, their hard work will be for naught if you, having read this far, decide “well, it’s not for me.” Had this been the response of Cheryl Houk, I would not have written this curriculum. More importantly, there would not be several dozen men and women grateful to be alive.

On my last consultation, after 3 years of groundbreaking work, I overheard a conversation between a recently hired female counselor and a female resident. The worried resident initiated the conversation. She had been masturbating in her room the previous day and had an arousing fantasy involving her former drug using partner. She was concerned about this and had learned in the sex class not to keep these worries to herself. The staff member was poised, welcoming, and first and

foremost congratulated the resident for caring enough about her sobriety to proactively address a sex/drug-linked relapse risk. I am convinced that such a conversation would not have been possible prior to implementing the curriculum at Stepping Stone, and that conversations such as this can make the difference in helping a client achieve and maintain sobriety. I hope that this curriculum helps other treatment programs achieve the same level of awareness, openness and comfort in discussing sexual issues and their relation to recovery.

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