A 31-year-old white male law student in his fourth year of law school had a long history of experimental drug use including alcohol (his first drug), marijuana and LSD; but at no time had he abused a psychoactive drug. Approximately two years ago he was introduced to cocaine in a social setting by a group of friends and fellow law students. He became a regular recreational user of cocaine and in a social setting during an evening would chop up and snort between 10 and 20 lines of cocaine in the usual fashion. (Often, as with this case, cocaine is used in a recreational setting along with alcohol and marijuana.) With this law student, the pattern of recreational cocaine use continued for some time, but moved to a more daily pattern when he found that the inhalation of cocaine stimulated his performance and ability to study at night, something he found desirable because he had begun to prepare for the bar examinations.

Despite the fact that the law student was independently wealthy as a result of a family inheritance, he found that he was rapidly consuming his inheritance as his cocaine habit was costing him $50-150 a day. As a consequence he began dealing his own cocaine to his friends in order to help support his own habit. While the injection of cocaine involved both male and female figures, he would almost invariably inject with a woman in sexual context, although he reported that as he became deeply involved with cocaine, his libido dropped dramatically; for both he and his female sexual partners, the orgasmic effects of the cocaine injection became a substitute for actual sexual experience.

One evening, a female friend with whom he was periodically having sexual relations produced a needle and syringe and indicated that the injection of cocaine produced a pleasurable, orgasmic-like “rush”. The law student injected the cocaine simultaneously with his female sexual acquaintance and found the orgasmic “rush” quite desirable. Over a several months basis he escalated his intravenous cocaine use on a daily basis, injecting from approximately 10 p.m. until 7 a.m., on a 15 minute to 1 hour repeated schedule, using approximately 2g of cocaine per night.

To help with the anxiety, depression and sleep disorder, 10mg of Valium p.o. was administered each night. As there was no evidence of a prolonged underlying depression which preceded the cocaine abuse or that lasted following the “fade out” period of the drug-induced depression, no tricyclic antidepressants were administered. He made a decision to self-medicate the lethargy and reactive depression with the intranasal use of cocaine, which he resumed on a daily basis. He expressed great surprise at the toxic effects of cocaine, but was also quite ambivalent about whether he would completely discontinue cocaine.