

AGLBIC

News

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www.aglbic.org

From our President:

Brian J. Dew, Ph.D., LPC



Members of the AGLBIC board met in Wrightsville Beach, NC (September 21-24) to discuss the current functioning of the division as well as planning for future upcoming events. Here are some of the highlights that evolved from the meeting:

- 1) AGLBIC continues to rank in the top three of all ACA divisions for membership retention. Strategic plans were established to increase our membership by over 10 percent in the next year.
- 2) The division's journal is currently being printed and should be mailed out to members by the end of October.
- 3) AGLBIC has initiated the "Legacy Project" which will place focus on the early pioneers of the organization.
- 4) The 2007 ACA Convention in Detroit, Michigan promises to be another exciting time for our membership. Plans are underway to make this another memorable convention.
- 5) User-friendly changes on our website will be implemented over the next 2-3 months. Be sure to let me a board member know what you think of the new look.

If you have questions or need additional information about the fall board meeting, please do not hesitate to contact me at bdew@gsu.edu

With pride-

Brian

AGLBIC Wedding Project:

The Interviews

by Sue Strong and Philip Gnilka

The wedding sponsored by AGLBIC at the 2006 ACA Convention in Montreal under the leadership of Joy Whitman (President) and Brian Dew (President-Elect) was a momentous occasion for both the association and the couples involved. AGLBIC would like to commemorate this event for the association and the couples by a series of interviews for the newsletter and possibly periodic follow-up interviews.

Both AGLBIC and the GLBTQ community are grateful to the married couples for their courage to publicly celebrate their union and love. Eight couples married in Montreal on April 1, 2006:

- Bari Ayn Guibord and Lenka Reznicek
- Theodore Edward McCadden, Jr. and Todd Allen Rey
- Joy Whitman and Cyndy Boyd
- Cecil Rhodes Gibson III and Jeffrey Scott Tippie
- Robyn S. Zeiger and Dori Anne Steele
- David Bruce Winmill and Jeffery Bernhard Lensman
- Jean M. Parker and Marjorie M. Chapin
- Michael K. Pisarcik and Robert Graves Ratcliff, Jr.

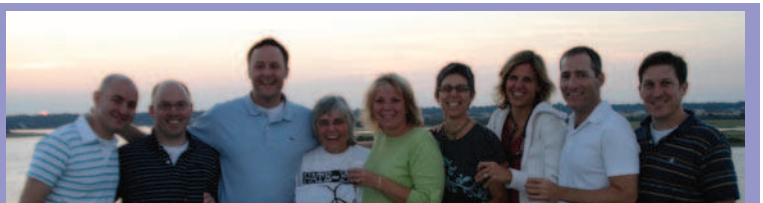
Continued on page 3...

AGLBIC Legacy Project

AGLBIC has launched the Legacy Project as a means of ensuring members of the roots, heritage, and history of our organization. Interviews of individuals associated with AGLBIC's development are sought for eventual publication in our website, newsletter, and journal. If you have any contact information on the early leaders of AGLBIC please contact Dr. Sue Strong (sue.strong@eku.edu, 859.277.3119).

At a GLANCE...

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Our Current Board Members at the recent Fall Board Meeting.
From left to right: Philip Gnilka, Michael Kocet, Brian, Sue Strong, Phyllis Mogielski-Watson, Joy Whitman, Cyndy Boyd, Ed Cannon, John Marszalak.

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John Marszalak, **Membership**
Joy Whitman, **Awards**
Joy Whitman, **Nominations and Elections**
Joy Whitman, **Bylaws**
Rhodes Gibson/Rob Mate, **Webmasters**
Bob Rohde, **Historian and Archivist**
Colleen Logan, **Media and Public Relations Chair**
Anneliese Singh, **Multicultural Consultant**
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Journal Editor Report

Ned Farley, Ph.D.

AGLBIC Membership Committee

John Marszalek, Membership Chair

By now, you all should have received your first copy of our new journal. I am pleased and proud of the work done by our editorial review board in putting together a premier issue that I think offers some wonderful and diverse articles. While I was a bit dismayed that it took longer than I had hoped, none the less, I feel increasingly assured that this journal will be something we can all be proud of, and that we will be adding to a body of literature a unique perspective on the issues relevant to LGBT issues in counseling. I hope you find this first edition helpful!

While we are a quarterly journal, please understand that any new journal takes about two years to get fully up to speed (something I have had to make peace with, and with the support and reassurance of our publisher, Haworth Press). Thus, for the first two years, editions may not come out like clockwork (e.g. every three months), but will have a bit more of a sporadic feel until we have reached a point where submissions are coming in regularly, and we are able to turn around new editions in a timely manner. With the help of my graduate assistant, we have put together a wonderful database tracking system of both submissions and the review process, thus from the time an article is submitted, we are able to turn around the blind reviews in about six weeks, any revisions within another four, and a final edition once we have a suitable number of pages.

To give you an idea of the process, once we have a complete journal ready to go to the publisher, it takes about six months before it is printed. This is the time it takes for the publisher to review the final draft, complete their in-house administrative processes, and for it to be plugged into the printing schedule. Haworth publishes around 100 journals, so we are part of a much larger system when it comes to turn around time. Once printed, there is about a two week period of time for it to be put into the queue for mailing. From date of bulk mailing, it takes about 4-6 weeks to reach your mailboxes. This publication process is pretty standard across journal publications. For any of you who are interested, you can always go to the Haworth website [at: www.haworthpress.com], click on 'journals' and plug in our journal name. Once to our journal webpage, you can click on the 'publication schedule' to see when the next journal is set to print. On occasion, this date might change due to circumstances outside of the publisher's control. For example, our first edition was delayed twice (from April to June, then June to August), first due to a back-log in printing, then due to the floods that hit the Northeast and which flooded the Haworth print shop.

Our second edition went to press on October 11, and we have just sent off the third edition to Haworth as of October 27. Slowly but surely, we are moving towards a more cyclical schedule.

Finally, we are currently accepting submissions for our first "special edition" which focuses on Counseling with LGBT Couples and Families. If you are interested in submitting (or know of someone doing work in this area that you want to encourage to submit), please do so. All journal submissions should be e-mailed directly to me at: nfarley@antiochseattle.edu. **Enjoy!!**

The membership committee has been busy since the convention in Montreal working to maintain the membership of those people currently belonging to AGLBIC and working to increase membership. Our goal is to increase membership by approximately 10% this year. To reach our goal, you may have already noticed that we're sending out reminders to members whose membership is nearing renewal and sending out letters to those whose membership has lapsed encouraging them to renew.

Because AGLBIC has so much to offer its members, the membership committee has an easy sell to recruit new members and encourage current members to renew their memberships. AGLBIC members will soon receive the first edition of our new journal, Journal of LGBT Issues in Counseling, and you are reading the revamped hardcopy newsletter published by Haworth Press. We continue to have a listserv (<https://lists.purdue.edu/mailman/list-info/aglbic-l>) for members to connect and discuss important issues related to LGBT and counseling, and our website at www.aglbic.org includes an extensive list of resources, a therapist resource list, and current updates on AGLBIC happenings. For those of you able to attend ACA conventions, we will again be holding an AGLBIC Day of Learning at the 2006 ACA convention in Detroit. We will also have several social events including our annual brunch and a special event. We are also working closely with members in various states to support existing state chapters and to encourage the creation of state chapters of AGLBIC.

Of course, the AGLBIC leadership is always looking for ways to serve its members and to make it an organization of which its members can be proud. Please let us know if there are other services you would like to see AGLBIC offer.

Special Discount for Members

Ned Farley, Ph.D.

Editor, Journal of LGBT Issues in Counseling

As a part of the Haworth Press family of journals, AGLBIC members now have the benefit of receiving a 30% discount for the following Haworth LGBT related journals.

Journal of Homosexuality
Journal of Bisexuality
Journal of Lesbian Studies
Journal of LGBT Health Research
Journal of GLBT Family Studies
Journal of Gay & Lesbian Social Services
Journal of Gay & Lesbian Psychotherapy

To avail yourself of this benefit, you can order directly from Haworth by using the following code, **AGL30**, when subscribing via website, fax, telephone, e-mail or regular mail. I hope you can take advantage of this benefit!

The interviews are being conducted in an open-ended manner, with each couple taking the interview in any direction they prefer. A series of questions sent to the couples in advance; all, some, or none of these questions can be focused on by the couples interviewed.

What are your attitudes about the institution of marriage? What is/has been your experience with the institution of marriage? What are/were your immediate and extended family's attitudes about marriage? Do you have any religious/spiritual views about marriage? Are/were there any differences in views between the couple on marriage? What are your thoughts on civil unions v. marriage? What drew you to marry in Montreal? Have you perceived your relationship differently since your marriage? Have others perceived your relationship differently since your marriage? Was your marriage recognized as equal to heterosexual marriage by family, friends, and colleagues?

In addition, basic information was collected at the time of the interview:

What were your ages at the time of your marriage? How long had you been together before your marriage? Are you/have you been involved in co-parenting children or stepchildren with each other? Do you have any religious/spiritual identity/affiliation? Why did AGLBIC sponsor a same-sex wedding in Montreal?

The wedding brochure stated that:

Currently in the United States, same-sex couples are spending their lives together with love and commitment but are unable to access the more than 1,138 automatic federal and additional state protections afforded to legally married couples. They are denied benefits and discounts from employers, banks, insurers and businesses as well as social respect from family, friends and neighbors. As a result, these couples are left vulnerable to piece together a patchwork of legal and financial documents to protect each other and their children. Or worse, they must remain at risk since many benefits from marriage cannot be replicated through other means.

The ceremony of marriage for same-sex couples is only recognized in five countries around the world: Belgium, Canada, South Africa, Spain, and the Netherlands. In the U.S., same-sex couples can marry only in Massachusetts, and their unions are not recognized by any other state in the U.S.

Read the first

*Wedding Story:
Michael and David*

on page 13...

Call for Awards Nominations

In preparation for the 2007 ACA Conference in Detroit, and as AGLBIC Past-President and Chair of the Awards Committee, I am seeking nominations for outstanding contributions in three areas. These awards, which are described below, will be awarded at the AGLBIC Brunch at the ACA Conference. Please carefully consider who might deserve recognition in each of these three categories and send your nominations to me ASAP:

Joe Norton Award:

This award is presented annually for an outstanding contribution to the GLBT community. Nominees can be either an individual who has made a significant contribution in the city or region in which the ACA conference is held or an organization that has done so. This year we are seeking nominations in the Detroit area. When making a nomination, please include the person's or organization's name and contact information along with a letter outlining why you believe the nominee is a contender for this award.

AGLBIC Service Award:

This award is presented to an AGLBIC member who has served AGLBIC and/or the larger GLBT community through forwarding the mission and values of AGLBIC. Please include the nominee's name and contact information along with a letter of nomination outlining why you think this person should be considered for this service award.

Graduate Student Award:

This award has been established to honor a graduate student member of AGLBIC who has contributed significantly in one of three areas:

1. Representing or embodying the mission of AGLBIC through direct service for AGLBIC or in the field of counseling;
2. Furthering knowledge of GLBT issues through an outstanding research contribution; or
3. Providing service or research that specifically focuses on furthering the knowledge of and commitment to issues of diversity within the GLBT community.

Please send your nominations directly to me, either by e-mail or mail at the address below.

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Cyndy Boyd and Ed Cannon discuss AGLBIC issues at the Fall Board meeting.

10 Ideas

On How To Start A State AGLBIC Branch Sue Strong, P.h.D.

First, obtain a copy of AGLBIC's mission statement and bylaws (see below taken from www.aglbic.org).

Second, obtain a copy of the mission statement and bylaws of your state counseling association (contact the bylaws chair). Edit the mission statements and bylaws to match the purposes and policies of the proposed state AGLBIC. The bylaws of the national AGLBIC and the state counseling association must be congruent, edit for any conflicts. Then, solicit support from the present and past leaders of the state counseling association. Call or meet personally with these leaders on an individual basis to fully explain the role of and need for AGLBIC at the state level.

Third, hold an organizational meeting at a time and place convenient to many members, such as at the annual state conference. If you meet at a conference, schedule the organizational meeting of

Continued on page 6...

Call for AGLBIC Board Nominations

AGLBIC is seeking two board positions for the 2008-2009 election year. These positions will begin serving July, 2008 and will be nominated during the 2007 ACA conference in Detroit. We are soliciting for nominations for President-Elect to serve as President (2009-2010), and Board Trustee to serve a three-year term (2008-2011).

The AGLBIC board is a volunteer board whose focus is to promote the mission of AGLBIC. That mission is:

- to promote greater awareness and understanding of gay, lesbian, bisexual, and transgender (GLBT) issues among members of the counseling profession and related helping occupations;
- to improve standards and delivery of counseling services provided to GLBT clients and communities;
- to identify conditions which create barriers to the human growth and development of GLBT clients and communities; and use counseling skills, programs, and efforts to preserve, protect, and promote such development;
- to develop, implement, and foster interest in counseling-related charitable, scientific, and educational programs designed to further the human growth and development of GLBT clients and communities; to secure equality of treatment, advancement, qualifications, and status of GLBT members of the counseling profession and related helping occupations; and
- to publish a journal and other scientific, educational, and professional materials with the purpose of raising the standards of practice for all who work with GLBT clients and communities in the counseling profession and related helping occupations.

If this mission is important to you and you are interested in nurturing and guiding our organization, please consider joining the board. It is expected that you can attend both our fall and spring.

Fall 2006

Creating AGLBIC-AL

Edward Cannon, Ph..D.

On August 18, 2006, representatives from national AGLBIC joined founding members of Alabama AGLBIC in Birmingham, Alabama. National representatives included Dr. Brian Dew (current AGLBIC president), Dr. Edward Cannon (current trustee and Branch Chapter Co-Chair), and Dr. John Marszalek (current membership chair). The purpose of the meeting was to create a DVD interview of AGLBIC-AL founding members describing the pitfalls and success of starting a state branch. AGLBIC – AL was represented by Donna Melder (current state chapter president) and Frank Hrabe (current chapter historian), and Dr. Brian Dew conducted the interview. The goal is to provide a forum/teaching tool for others who might wish to start their own state AGLBIC branches and university affiliates. If the technology cooperates, look for a copy of the interview soon at www.aglbic.org!

If you are interested in chartering an AGLBIC Branch in your state, or if you would like to get a university affiliate started, please contact Edward Cannon at Edward.cannon@marymount.edu.



From left to right: Dr. Brian Dew, Frank Hrabe (current chapter historian), and Donna Melder (current state chapter president) during the interview process.

Governing Council Report

Ned Farley, Ph.D.

Since I have not yet engaged with Governing Council, I have nothing specific to report except to let you know that I have been appointed as the Governing Council liaison to the ACA Publications Committee and have attended (via conference call) one meeting of this committee. My primary role here is to listen, respond as appropriate when questions related to Governing Council come up, and to report back to Governing Council any questions/concerns or reports that are relevant. I'm looking forward to my first meeting as the AGLBIC representative on Governing Council which occurs November 16-19. I will be reporting back to the AGLBIC board as needed and to our membership anything of import in our next newsletter (pre-conference).

10 ways to start a Branch continued from page 5...

AGLBIC when it does not conflict with any other major events, for example lunch with some meeting time afterwards may work well.

Fourth, for a while AGLBIC may be a fledgling division in your state, you may consider limiting the number on the Executive Committee and/or the minimum membership required to start a division. Perhaps initially elect a President and Secretary/Treasurer for two year terms each, with the option to seek reelection, and set the minimum membership as low as the state counseling association will allow.

Fifth, in order to have a cooperative alliance with the state counseling association, you might require all AGLBIC members to also belong to the state association. Being unified with the state association may reduce potential conflicts.

Sixth, in order to build membership quickly to stabilize the organization, consider making first year membership free and keeping dues to a minimum thereafter. Contact counselor educator-allies to help encourage student membership. Invite members of committees, interest groups, etc. in the state association which have an interest in advocating for gay, lesbian, bisexual, and transgendered (GLBT) people to become members of AGLBIC (for example Human Rights Committee).

Seventh, run an article on AGLBIC in the state counseling association newsletter and in the newsletters of the other state divisions announcing the need and plans for a division that addresses the needs of GLBT people.

Eighth, encourage AGLBIC to be a welcoming organization for allies as well as GLBT people. Personally contact straight allies in the state counseling association and request their membership in AGLBIC. Write an article on the role of and need for straight allies in the state association newsletter and division newsletters.

Ninth, see who is interested in running for office prior to the organizational meeting and encourage several candidates.

Tenth, recognizing AGLBIC as a division at the state counseling association level is an excellent opportunity to educate members of your state. If nothing else, AGLBIC will appear in the state association directory which is often printed in the quarterly newsletter, will have a seat on the board of directors, and will provide workshops at the annual conference. Keep the faith and do not underestimate the power of the visibility of GLBT issues that recognition of a division at the state association level will bring.

Dr. Brian Dew takes the helm at the fall board meeting in North Carolina.



AGLBIC Board Nominations continued from page 5...

board meetings, and be available by e-mail for board conversation and decision making. Generally, there is some travel and/or lodging reimbursement for the fall meeting, and a small stipend to cover the cost of an extra hotel night for the spring meeting, which is always held in conjunction with the ACA conference.

All board members provide some level of oversight to the day to day functioning of the board, most often chairing a committee or work group. To nominate, please submit a written letter which includes the name of the person you are nominating (self or other) as well as a brief description of why you believe this person would be a good fit for the position. If you are nominating someone other than yourself, please check with this person to see if they are willing to accept the nomination, and if so, include that in your letter.

Please send your nominations directly to me, either by e-mail or mail at the address below.

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Brian Dew and Ed Cannon discuss details of the DVD interview of the AGLBIC-AL project. For more details see article on page five.

Sexuality, Gender and Islam

<http://www.safraproject.org/>



Safraproject web site provides information on Sexuality, Gender and Islam. It focuses on studies undertaken by reformist and feminist Muslim scholars challenging gender bias, homophobia and transphobia that exist in Muslim laws and in Muslim societies. It is a resource for LGBT Muslims as well as their families, friends and supporters. Its

purpose is to empower and to help dispel the misconceptions that lead to the stigmatization and discrimination against LGBT Muslims.

Chemical Dependency Among LGBT Individuals: A Closer Look

Brian J. Dew, Ph.D., LPC, President, AGLBIC

In a time when lesbian, gay, bisexual, and transgender (LGBT) individuals are increasingly concerned about political victories, the legality of marriage, and other equality issues, few people are willing to address one of this community's greatest risks. The impact of chemical dependency among LGBT persons remains a significant concern for mental health and school counselors, as well as other mental health professionals. In the gay and lesbian population, the incidence of substance abuse ranges from 28-35%, compared with an incidence of 10-13% in the general population. Furthermore, it is estimated that 10-18% of aging LGBT individuals suffer from alcoholism. LGBT youth even have higher alcohol and other drug abuse than their heterosexual peers.

Why are LGBT persons at high-risk for alcohol and drug problems? The relationship between sexual orientation and substance use disorders is often mediated by internalized homophobia. The self-acceptance of society's negative messages about what it means to be non-heterosexual (i.e., "being a lesbian is sinful", "gay men can not have lasting, monogamous relationships") can be especially debilitating to the construction of a healthy sexual identity for LGBT individuals. Internalized homophobia often results in considerable feelings of shame, depression, and self-hatred. Consequently, using alcohol and other illicit substances become part of an individual's coping strategy. Lack of support from fam-

ily of origin and peers can lead to isolation and further alienation, thereby only fueling the risk for substance-related disorders.

Another factor influencing alcohol and drug use among LGBT persons is the historical importance of bars and dance clubs. For many non-heterosexual individuals, the local gay club is the only space where one feels comfortable socializing with other LGBT individuals. These venues, although socially relevant, are typically associated with alcohol use. LGBT persons report that use of alcohol (and other drugs) helps to reduce anxiety and elevate self-esteem in bar or club situations.

Currently, one of the greatest public health concerns among gay men remains the rapid escalation of methamphetamine use. Research has demonstrated the emerging influence of methamphetamine in the gay male community, frequently linking it to high risk HIV sexual behaviors such as having multiple sexual partners, decreased condom use, and an increased probability of HIV infection and having another STD's. Other research has found a decrease in HIV seropositive disclosure and a reduction in HIV medication adherence among methamphetamine-using gay and bisexual men. Multiple social contexts where gay and bisexual men meet others and use methamphetamine, such as circuit parties, bath houses, sex clubs, and internet chat-rooms have also been identified.

Crystal's Sexual Persuasion

Michael Shernoff, LCSW

The gay community has a long history of alcohol and drug abuse above the rate that occurs in the heterosexual population. Research suggests that gay men use drugs in specific situations, such as during sex or during visits to specific "homosocial" venues like bars, clubs, sex parties or bathhouses. Thus, for many gay men, a unique aspect of gay culture is that drug use is very often specifically connected to seeking or having sex. When I was a young man in the 1970's, the heyday of disco, there was something that we referred to as "The five Ds": drugs, dancing, dick, dishing, and dining, which were all elements in the formation of an individual as well as a communal gay identity. Experiences shared on the dance floors of the clubs--including such legendary ones as The Sanctuary, Tenth Floor, The Loft, Twelve West, Paradise Garage, Flamingo, and the Saint in Manhattan, Trocadero in San Francisco, Studio One in LA, The A House in Provincetown, the Ice Palace and Sandpiper on Fire Island, and Warsaw in Miami--were venues where thousands of gay men created a celebratory, albeit sometimes self-destructive, tribal atmosphere. This spirit lives on in today's circuit parties, which are late-night, and often multi-day, dance events attended by thousands of gay men, characterized by a high level of drug use and sexual activity--and a heightened risk of HIV transmission.

As the AIDS epidemic has dragged on, there is less certainty than

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ever about the role of drugs and alcohol in unprotected anal intercourse and the spread of HIV. Many gay men using the Internet for "cyber cruising" state in their on-line profiles that they're "chem friendly" and want to "party"--code words for having sex while using one of the currently fashionable "club drugs," such as methamphetamine, GHB, Ketamine, or Ecstasy (MDMA). One drug, crystal methamphetamine (also known as crystal, meth, Tina, and crank) has become the premium fuel for unsafe sex. Crystal meth has the particular property of inducing its users to abandon caution and take sexual risks that they would otherwise avoid. To a greater extent than poppers (amyl or butyl nitrate), cocaine, or alcohol, crystal meth lowers inhibitions and heightens one's sensory experience, so it has the qualities of an aphrodisiac. A study by New York psychologist Perry Halkitis confirmed the relationship between crystal meth use and high-risk sexual behavior among men who have sex with men (MSM). Halkitis reported on studies of its use during the early 1990's that showed it was largely a regional phenomenon affecting parts of the western U.S. But more recent investigations have shown that crystal meth has reached the eastern U.S. as well.

Dr. Thomas Frieden, Commissioner of the New York City Department of Health and Mental Hygiene, reports that one in four MSM

Continued on page 8...

Crystal's Persuasion continued from page 7...

who are newly diagnosed with HIV infection in San Francisco had used crystal in the previous six months. Or, to look at it another way, gay meth users are almost twice as likely to be HIV-positive as non-users. And users are more than one third less likely to use a condom during receptive anal intercourse than users. But to say that meth use causes risky behavior may be an oversimplification. According to Halkitis:

Whether the relationship between use of the drug (crystal) and sexual risk behavior among gay and bisexual men is a direct one is unclear. What is more likely is that men with certain psychological profiles are attracted to methamphetamine, use it in environments and contexts that are sexually charged, and as a result are situated to engage in sexual risk. Whether men use the drug intentionally as a way to facilitate sexual risk-taking behavior or whether sexual risk-taking is a natural byproduct of methamphetamine use are issues that need to be further disentangled.

What is it about crystal that draws men to take it, and precisely what is the connection between crystal and unprotected anal sex, or “barebacking”? Manhattan psychiatrist Jeffrey Guss offered a succinct answer to this question in the title of a pioneering article: “Sex Like You Could Never Imagine.” In it, Guss writes: “Stimulant drugs, particularly cocaine and methamphetamine, are particularly appealing to gay men in a highly sexualized subculture that exists within the broader gay community.” Guss points out that a major source of the attraction to these drugs lies in their ability to counteract pre-existing anxieties about sex, so that sexual activity for six to twelve hours becomes “realistic and predictable.”

Crystal's appeal and seductiveness reside in its physiological and psychological effects. The drug intensifies the senses, elevates one's mood, increases sex drive, and gives the user energy while suppressing appetite and the need for sleep. Some men who use crystal report an increase in sensitivity in their anus, which leads to an increased likelihood of receptive anal intercourse. The psychological effects reported by crystal users include hyper-sexuality, euphoria, lower sexual inhibitions, increased self-esteem, and increased self confidence. Crystal meth use also reinforces the elements of escapism and adventure that underpin the desire to frequent dance parties, sex clubs, and sex parties.

Of 48 men surveyed by Halkitis in New York, a majority used crystal for sexual encounters because it helped them to achieve a specific sexual objective. For example, one man justified his crystal use by saying: “I want to be penetrated. It enhances that feeling.” Others explained that crystal enabled them to prolong their sexual encounters, often prodigiously, with one describing sexual encounters lasting from eleven to fifteen hours. Guss reports that many men in his practice report that the intensity of sex while on crystal surpasses even the most satisfying sex while not on the drug. Crystal users that I see in my therapy practice have described the sex as “mind blowing,” “phenomenal,” and “awesome.” In one man's words: “I would say that the only way to explain to someone who has not had sex on crystal is that all of the sex I had while not high on Tina is like watching a black and white television during the 50's. In comparison, sex on crystal is like watching one of the new, high-definition color televisions with surround sound.” Another man told me that crystal made him feel like a “sexual superman.”

Whether an amphetamine is pharmaceutically produced or illicitly manufactured as is “crystal,” the primary effect of this class of drug is to act as a stimulant on the central nervous system. Methamphetamine has been described by the Drug Enforcement Administration (1989) as the “most hyperstimulating of the amphetamine analogues.” As Gawin & Ellingwood (1988) state: “This kind of stimulant creates a neurochemical amplification of the pleasure experienced in most activities.” Crystal accomplishes this by effecting neurons that release serotonin, norepinephrine and dopamine, which produces major changes in a person's emotional state (NIDA, 1996).

The most common reason given for crystal use by the 48 participants in Halkitis's study was the drug's aphrodisiac effects. Those citing this reason were more likely to engage in unprotected anal sex, which is known to be highly correlated with HIV transmission. Halkitis also found that crystal use cuts across all economic and racial groups and is not, contrary to some stereotypes, confined to affluent white men.

In addition to its strictly sexual effects, crystal users also report changes in their psychological state that make social interaction easier and more rewarding. For many, crystal makes cruising for sex and communicating with other men less fraught and simpler, as pre-existing anxieties and inhibitions about sex melt away. Many of the men in Guss's study reported that other men are more attracted to them when they are high on crystal, thus confirming the subjective sense that one is sexier and more attractive. Because crystal meth lowers inhibitions and enables users to prolong sexual encounters, it is also associated with more marginal sexual behaviors such as fisting and group sex. Halkitis argues that the sexual and emotional effects of crystal meth conspire to make it “the quintessential gay drug.”

Michael Siever, director of the Stonewall Project, a San Francisco treatment program targeting gay crystal users, has expressed a similar sentiment: “Crystal is the perfect drug for gay men. What else allows you to party all night long whether you're dancing or having sex? ... at least, at first, before it becomes a problem.” Once the effects of crystal wear off, a user can suffer from severe depression that can last for several days, depending on how long he's been high. Regular users can become addicted. Long-term use has been linked to acute psychotic episodes characterized by paranoia, withdrawal, flat affect, and auditory, olfactory, visual, and tactile hallucinations. As Howard Grossman, a prominent Manhattan physician and chairman of the Academy of HIV Medicine, has said: “It's frightening. I've seen a huge increase of newly infected gay men that got HIV from unprotected sex during crystal meth binges. Our community is self-destructing with this drug. It just seems to be getting worse and worse and no one is doing anything about it.”

A recurring theme in interviews with crystal users is that the drug is de rigueur at circuit parties, those all night gay raves that started in the U.S. and have now spread to the Netherlands, the UK, Spain, Greece, Australia, and Canada, typically held in warehouses or other huge venues to accommodate the thousands of men who fly in from all over the world to attend them. It seems globalization has come to gay culture, producing a homogeneous system of

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AGLBIC News

Men on the down-low:

Nomenclature grounded in heterosexism and racism.

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On an April 16, 2004 airing of the Oprah Winfrey Show, mainstream America was introduced to the construct of “men on the down low (MDL).” Oprah’s guest was J. L. King, author of *On the down low: A journey into the lives of “straight” black men who sleep with men*. On the show King described a secret sexual lifestyle among African American men called on the “down-low,” a term used to describe men who have wives or girlfriends and who also have sexual encounters with men. Soon after Oprah’s interview, popular magazines, national newspapers, news channels, and television shows included segments about African American MDL. Most of the time the reports and television shows represented African American men who have sex with men (MSM) responsible for the disproportionately high number of HIV/AIDS infection rates among African American women. The bridging of African American MSM to HIV/AIDS infection rates among African American women is just another form of racism and heterosexism. Additionally, using the nomenclature “on the down-low” is a social injustice for an already stigmatized population.

When the down-low phenomenon invaded mainstream America, all forms of media presented it as if it were rampant among the majority of African American men. Many African American women became suspicious and paranoid that their male significant others may be engaging in sexual behavior with other men. The truth is that African American men who are currently bisexually active account for a very small proportion of the overall population of African American men, approximately 2%. Moreover, it is important to make a differentiation between an African American man’s sexual identity and his sexual behavior. Some African American males do not necessarily view same-sex desire and behavior as an indication that a person is gay or bisexual. Because some men identify with their African American identity in terms of history, family, and the black church, they may only interact with gay/bisexual men on a level of sexual behavior, not affectual desire. Laying this framework helps us to understand how heterosexism and racism play into the labeling of a subgroup of African American men as being on the down-low.

Due to heterosexism involving the privileging of all things heterosexual, the assumption that individuals are heterosexual, and the norming of heterosexual sexual activity, same-sex behavior among African American men was an easy target to pathologize. Same-sex activity among two men challenges the traditional view of what masculinity is supposed to be. Furthermore, sex among two men is viewed by our patriarchal society as going against heterosexual male cohesion. We have broken the unspoken (and often spoken) rules of the “Man Club.” As a result, MSM must be punished, pathologized, and oppressed. This is precisely what happened to African American MSM. By attempting to make a

connection between male same-sex sexual behavior and the high rates of HIV/AIDS among heterosexual African American women, dominant culture perpetuated the ideology that gay sex is unhealthy, abnormal, and inferior to heterosexual sex. Many black churches (and non-black churches in general) also perpetuate these heterosexist ideas by not confronting the issues of HIV/AIDS because of its historical relationship to gay men. If these issues are addressed in some churches, they are often associated with gay sex which is verbally pathologized. Some African American MSM may internalize these oppressive messages, resulting in feelings of voicelessness within their place of worship and/or feelings of fear associated with potential negative repercussions if they spoke out against heterosexist and homophobic messages.

Not only is the down-low construct a product of heterosexism but also is strongly born out of racism. First, the secretive behavior associated with down-low is not specific to African American men. Yet, it is African American men who are unjustly labeled with this term by popular culture, researchers, and initially the Centers for Disease Control and Prevention (CDC). It should be noted that the CDC now has statements on their website that down-low behavior is not specific to black MSM.

The labeling of African American men as being on the down-low focuses on behavior and dismisses and omits the complexities associated with one’s racial identity. Making an individual’s African American identity “invisible” perpetuates the individual’s lack of power in society, thereby promoting white superiority. Further, negative racial stereotypes are subtly reinforced when down-low behavior is attributed strictly to African American men, such as the myth of the “Black Stud.” Black men as sexualized, objectified beings who are so virile that they need to have sex with as many individuals as possible, men and/or women. Next is the stereotype that African American males cannot be trusted and therefore they are unable to be faithful to a partner. These stereotypes are clearly racist but are subliminal facets of the use of the term on the down-low.

“So what can WE do about it?” we collectively ask ourselves. First, we need to stop using the term “men on the down-low.” Men who have sex with men (MSM) is a more appropriate term and umbrellas several subgroups of males. When working with African American MSM clients, we should use gender neutral language when seeking information. For example, “Tell me about your past sexual partners. Are you in a relationship?” We should not assume the sexual orientation of another person, even if they engage in sexual activity with someone of the same sex. We need to educate ourselves on the convergence of race and sexuality. There

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is a scarcity of empirical and conceptual articles in the counseling literature that specifically addresses the experiences of African American MSM. Existing articles are primarily related to the prevalence of HIV/AIDS among this population. Publications are needed related to positive aspects of this community, such as love relationships, strength and resiliency, and social activism. It is our hope that this brief article will motivate some readers to advocate for this population by exploring the aforementioned issues in professional literature. Lastly, it is our hope that the ideas mentioned in this article will generate difficult dialogues that lead to socially just action for the African American MSM community.

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clubs, fashions, and values throughout the developed world. And while there's no evidence to suggest that the use of crystal is nearly as widespread in other countries as it is in the U.S., it may be only a matter of time before health care workers in these countries will be facing a similar situation. After all, the use of crystal meth by gay men in the U.S. initially began as a small subculture in southern California and, despite lots of publicity about its dangers in the national and local gay press, it eventually spread across the continent.

Does drug use, particularly crystal lead to barebacking, or do they simply tend to co-occur? We do know that risky health behaviors, such as smoking and drinking, tend to cluster together. Research by Halkitis and colleagues has found that men who use crystal are exceptionally active sexually. They have identified a class of hypersexual men whose behavior is sometimes characterized by sexual compulsivity. What isn't clear from the research is whether this pattern of hypersexuality existed prior to the use of crystal, which would suggest that such men were attracted to the drug for its purported sexual benefits, or whether they became hypersexual only after beginning to use crystal. What does seem apparent is that many of those who are drawn to crystal exhibit the characteristics of what Zuckerman called "high sensation seekers," who are defined by "the seeking of varied, novel, complex and intense sensations and experiences, and the willingness to take physical, social, legal and financial risks for the sake of such experiences." In the gay world, such men are more likely to bareback than men who do not rate high on that scale.

Halkitis adds a cautionary note: "While the most current knowledge points to a strong relationship between drug use and risky sexual behaviors, the emergence of methamphetamine, specifically its influence on sexual behavior warrants more scrutinized investigation." Their findings suggest that methamphetamine does not in and of itself induce gay men to take sexual risks, but that certain hypersexual gay men who are already predisposed to risky sex are attracted to crystal.

Crystal meth is a risk factor for contracting HIV for yet another reason that's unrelated to its psychological effects. In high doses it can make it impossible for some men to obtain a full or even a partial erection. Many users report impaired sexual functioning manifested by temporary erectile dysfunction or delayed ejaculation. This side effect of crystal use is commonly known as "crystal dick." Gay men who experience erectile dysfunction while on

crystal are more likely to be the receptive partner in anal sex, thus increasing their risk of contracting HIV. Some crystal users report that the combination of increased anal sensitivity and crystal dick tends to make them "instant bottoms." Yet, since Viagra first became available by prescription in the U.S. in 1998, men who use crystal report simultaneously also using one of the drugs used to treat erectile difficulty in order to function as both the insertive as well as receptive partner during anal sex, increasing the possibility of spreading HIV. Dr. Jeffrey Klausner, director of Sexually Transmitted Disease Prevention at the San Francisco Health Department, stated: "Viagra can turn people with chemically induced erectile dysfunction into more effective transmitters of HIV and other STDs."

Statistics on rates of new HIV infections seem to bear out a possible correlation between the arrival of Viagra (and drugs like it) and elevated rates of HIV transmission among gay men. According to the Centers for Disease Control and Prevention, new diagnoses of HIV in this population have increased by eighteen percent since 1999, a year after Viagra first became commercially available. "For a subset of gay men, Viagra's definitely found its way into the mix of party drugs," said Dr. Ken Mayer, a professor of medicine at Brown University and a past board member of the Gay and Lesbian Medical Association. Dr. Mayer is also Medical Director of Research at the Fenway Community Health Center in Boston, one of the premier medical facilities devoted to providing quality medical care to gay, lesbian, bisexual and transgender people in the U.S. "And in a bathhouse or other setting where there's an opportunity to have sex with multiple partners, to have a longer-lasting erection can be a prescription for HIV transmission."

The connection between drug use, particularly crystal meth, and barebacking has been clearly demonstrated. Working one-on-one with clients to help them reduce or eliminate their risky behaviors is all well and good, but barebacking and drug use are two interrelated community-wide problems, and I believe we need a community-wide movement to address the crystal meth problem, which is fueling the barebacking phenomenon. There are several innovative projects going on right now that use the Internet to educate the gay and bisexual male community about the risks of crystal meth and its connection to barebacking. One of these is www.tweaker.org, which offers a variety of educational information about how to make crystal use safer. They have on-line forums specifically dedicated to men who think they contracted HIV while doing crystal and true stories of men who did. A similar web site out of Seattle is www.crystalneon.org.

In response to the rise of both new cases of syphilis and crystal use among gay men in New England who met in Internet chat rooms Manhunt.net, one of the largest gay male websites in the U.S. began to provide space on the web site where gay men could become educated about substance use and treatment programs, as well as other matters related to sexual health. In March 2004, Manhunt revised its profile so that members' profiles could no longer contain PNP (party and play, which signals directly a desire to have sex while under the influence of drugs), and that any profiles that did not delete this would be removed.

Manhunt also collaborated with the Fenway Community Health

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AGLBIC News

Ethical issues related to conversion or reparative therapy

Written by Joy S. Whitman, Harriet L. Glosoff, Michael M. Kocet and Vilia Tarvydas

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American Counseling Association members have consulted ACA staff and leaders regarding the practice of conversion therapy and the 2005 Code of Ethics. For this reason, the ACA Ethics Committee is sharing its formal interpretation of specific sections of the ACA Code of Ethics concerning the practice of conversion therapy and the ethics of referring clients for this practice.

Committee members individually considered a hypothetical scenario that was based on actual questions posed to the members and staff. The Ethics Committee then met to reach a consensus opinion.

The scenario

During the third session of counseling, a client reports that he is gay and states, "I want to change my way of life and not be gay anymore. It's not just that I don't want to act on my sexual attraction to men. I don't want to be attracted to them at all except for as friends. I want to change my life so I can get married to a woman and have children with her." At the suggestion of a friend, the client has read about reparative/conversion therapy and has researched this approach on the Internet. He is convinced this is the route he wants to take.

The counselor listens carefully to what the client has to say, asks appropriate questions and engages in a clinically appropriate discussion. The counselor informs the client that, although she is happy to continue working with him, she does not believe reparative/conversion therapy is effective and no empirical support exists for the approach. She further states that this form of therapy can actually be harmful to clients, so she will not offer this as a treatment. The client says he is disappointed that the counselor will not honor his wishes. He then asks for a referral to another counselor or therapist who will work with him to "change his sexual orientation."

Interpretation

The ACA Ethics Committee considered many factors and derived a consensus opinion that addresses several sections of the ACA Code of Ethics and moral principles of practice present in such a scenario. We started with the basic goal of reparative/conversion therapy, which is to change an individual's sexual orientation from homosexual to heterosexual. Counselors who conduct this type of therapy view same-sex attractions and behaviors as abnormal and unnatural and, therefore, in need of "curing." The belief that same-sex attraction and behavior is abnormal and in need of treatment is in opposition to the position taken by national mental health organizations, including ACA.

The ACA Governing Council passed a resolution in 1998 with respect to sexual orientation and mental health. This resolution specifically notes that ACA opposes portrayals of lesbian, gay and bisexual individuals as mentally ill due to their sexual orientation.

In addition, the resolution supports dissemination of accurate information about sexual orientation, mental health and appropriate interventions and instructs counselors to "report research accurately and in a manner that minimizes the possibility that results will be misleading" (ACA Code of Ethics, 1995, Section G.3.b). In 1999, the Governing Council adopted a statement "opposing the promotion of reparative therapy as a cure for individuals who are homosexual." In fact, according to the DSM-IV-TR, homosexuality is not a mental disorder in need of being changed. With this in mind, we have a difficult time discussing the appropriateness of conversion therapy as a treatment plan. Regardless, there are clients who seek out counselors in hopes of changing their sexual behaviors, orientation or identity, so the ACA Ethics Committee conducted a review of the literature on reparative therapy.

We found that the majority of studies on this topic have been expository in nature. We found no scientific evidence published in psychological peer-reviewed journals that conversion therapy is effective in changing an individual's sexual orientation from same-sex attractions to opposite-sex attractions. Further, we did not find any longitudinal studies conducted to follow the outcomes for those individuals who have engaged in this type of treatment. We did conclude that research published in peer-reviewed counseling journals indicates that conversion therapies may harm clients (refer to the full article posted on the ACA website for references).

These findings bring several questions to the forefront:

- Is a counseling professional who offers conversion therapy practicing ethically?
- Since ACA has taken the position that it does not endorse reparative therapy as a viable treatment option, is it ethical to refer a client to someone who does engage in conversion therapy?
- If a client insists on obtaining a referral, what guidelines can a counselor follow?
- If professional counselors do engage in conversion therapy, what must they include in their disclosure statements and informed consent documents?

Ethics Committee members agreed that it is of primary importance to respect a client's autonomy to request a referral for a service not offered by a counselor. In the 2005 ACA Code of Ethics, Standard A.11.b. ("Inability to Assist Clients") states, "If counselors determine an inability to be of professional assistance to clients, they avoid entering or continuing counseling relationships. Counselors are knowledgeable about culturally and clinically appropriate referral resources and suggest these alternatives." Additionally, Standard D.1.a. ("Different Approaches") reminds us that "counselors are respectful of approaches to counseling services that differ from their own."

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Standard A.1.a. (“Primary Responsibility”), however, states that “the primary responsibility of counselors is to respect the dignity and to promote the welfare of clients.” Referring a client to a counselor who engages in a treatment modality not endorsed by the profession and that may, in fact, cause harm does not promote the welfare of clients and is a dubious position ethically. This position is supported by Standard A.4.a. (“Avoiding Harm”), which says, “Counselors act to avoid harming their clients, trainees and research participants and to minimize or to remedy unavoidable or unanticipated harm.”

Professionals also engage in treatment only after appropriate educational and clinical training and do not practice outside of their areas of competence (Standard C.2.a., “Boundaries of Competence”). This standard clearly states that “counselors practice only within the boundaries of their competence, based on their education, training, supervised experience, state and national professional credentials, and appropriate professional experience.” In addition, per Standard C.2.b. (“New Specialty Areas of Practice”), “Counselors practice in specialty areas new to them only after appropriate education, training and supervised experience. While developing skills in new specialty areas, counselors take steps to ensure the competence of their work and to protect others from possible harm.” Therefore, any professional engaging in conversion therapy must have received appropriate training in such a treatment modality with the requisite supervision. There is, however, no professional training condoned by ACA or other prominent mental health associations that would prepare counselors to provide conversion therapy.

In addition, requests by clients seeking to change their sexual orientation should be understood within a cultural context. Standard E.5.c. (“Historical and Social Prejudices in the Diagnosis of Pathology”) requires that “counselors recognize historical and social prejudices in the misdiagnosis and pathologizing of certain individuals and groups and the role of mental health professionals in perpetuating these prejudices through diagnosis and treatment.” Historically, the mental health professions viewed homosexuality as a mental disorder. But in 1973, homosexuality was removed from the Diagnostic and Statistical Manual as a mental disorder. However, within various religious and cultural communities, same-sex attractions and behaviors are still viewed as pathological. Yet the professional communities of counseling and psychology no longer diagnose a client who has attractions to people of the same sex as mentally disordered. To refer a client to someone who engages in conversion therapy communicates to the client that his/her same-sex attractions and behaviors are disordered and, therefore, need to be changed. This contradicts the dictates of the 2005 ACA Code of Ethics.

Clients may ask for a specific treatment from a counseling professional because they have heard about it from either their religious community or from popular culture. A counselor, however, only provides treatment that is scientifically indicated to be effective or has a theoretical framework supported by the profession. Otherwise, counselors inform clients that the treatment is “unproven” or “developing” and provide an explanation of the “potential risks and ethical considerations of using such techniques/procedures and take steps to protect clients from possible harm” (Standard

C.6.e., “Scientific Bases for Treatment Modalities”).

Considering all the above deliberation, the ACA Ethics Committee strongly suggests that ethical professional counselors do not refer clients to someone who engages in conversion therapy or, if they do so, to proceed cautiously only when they are certain that the referral counselor fully informs clients of the unproven nature of the treatment and the potential risks and takes steps to minimize harm to clients (also see Standard A.2.b., “Types of Information Needed”). This information also must be included in written informed consent material by those counselors who offer conversion therapy despite ACA’s position and the Ethics Committee’s statement in opposition to the treatment. To do otherwise violates the spirit and specifics of the ACA Code of Ethics.

Informing clients about conversion therapy

So what do ethical counselors do if clients state they are still interested in pursuing a referral for a counselor who offers conversion therapy? We advise professional counselors to discuss the potential harm of this therapy noted in evidence-based literature from scholarly publications in a manner that respects the client’s decision to seek it. This again relates to Standard A.1.a. (“Primary Responsibility”) and Standard A.4.b. (“Personal Values”), which requires counselors to be “aware of their own values, attitudes, beliefs and behaviors and avoid imposing values that are inconsistent with counseling goals.” The responsibility of counseling professionals at this juncture is to help clients make the most appropriate choices for themselves without the counselor imposing her/his values. To do so respects a client’s request and leaves open the possibility that the client can return to the professional counselor if the conversion therapy is ineffective and harms the client.

Again, Ethics Committee members agree that ethical practitioners refer clients seeking conversion therapy only under the conditions previously discussed. Further, it is imperative that counselors provide clients seeking conversion therapy with information about this form of treatment, including what types of information clients should expect from referral counselors. The following must be included in informed consent material and communicated to clients seeking referral:

1. Conversion therapy assumes that a person who has same-sex attractions and behaviors is mentally disordered and that this belief contradicts positions held by the American Counseling Association and other mental health and biomedical professional organizations. Additionally, the ACA passed a resolution in 1999 stating that it does not endorse reparative therapy as a “cure” for homosexuality. Any professional who engages in conversion therapy is not offering the professional standard of care and would need to include that he or she is offering it not as a professional counselor but is providing counseling within the scope of practice of some other profession (i.e., Christian counselor).

2. Conversion therapy as a practice is a religious, not psychologically-based, practice. The premise of the treatment is to change a client’s sexual orientation. The treatment may include techniques based in Christian faith-based methods such as the use of “testimonials, mentoring, prayer, Bible readings, and Christian weekend workshops” (Shroeder & Shidlo, 2001, p. 150). It may also use

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A Wedding Story:



Michael K. Pisarcik and Robert Graves Ratcliff, Jr.

Mike was living in Tennessee, and Rob was attending college in South Carolina when they met online in 1997. They felt like their relationship began even before meeting face to face. Describing themselves as very different, Mike was a “Pennsylvania farm boy” brought up in a Catholic tradition, and Rob came from a conservative Protestant family in Mississippi. Together they have now co-constructed a patchwork of faiths leaning toward Universal Unitarianism. Mike stated that he has always wanted to marry and have children, and he has two teenage sons from his previous thirteen-year marriage. Although Rob had never dreamed of marriage and having children, he is very involved with Mike’s sons, as well as his own niece and nephew.

Rob’s previous views on marriage (a deeply flawed institution in which he had little belief or faith) have been changed by his relationship with Mike. Though it may still have the same name, marriage now has a very different meaning for him. Mike view’s on marriage have also changed tremendously since his relationship with Rob, and he feels a “genuine, real, spiritual, and true expression of love.”

The couple experienced a journey mirroring their nine-year relationship by driving to Montreal to be married. During the year prior to their marriage, Mike had suffered a series of minor strokes, putting his dissertation on hold and leaving him with limited financial resources. In addition, the couple relocated three times during the past year due to Rob’s career. With these challenges, they were not sure that making it to Montreal and participating in the wedding would be possible. The odyssey became symbolic of the life struggles they had experienced together during their relationship. Along the trip to Montreal, they felt like they were “hanging on for dear life, had to make it, were not going to give up, and were going to be together no matter how difficult the way.”

Although the couple felt very supported by UNGC and their friends, they did not and have not felt much support from either of their families. Mike’s two sons were prevented from attending the wedding, and despite his sister’s strong support for their relationship, she still refers to Rob as Mike’s “best friend.” None of Mike’s other family (siblings and parents) acknowledges his relationship. Mike’s mother will “barely say Rob’s name, and he is not welcome in her home.” Rob’s family acknowledges their relationship only as roommates, not partners. His mother makes a vague reference to “your special trip to Canada” without accepting the marriage, and she has encouraged him not to disclose the nature of the relationship in his workplace. Rob stated that his family feels he has made a life choice separating himself from them, rather than realizing his family’s unwillingness to accept the couple as the decision that has “torn them apart.”

Mike and Rob feel that both families have “put plenty of wedges” between themselves and the couple. However, both remain optimistic that things may change in time with their families, as they continue to create opportunities for interaction. In particular, their hopes lie with the next generation, Mike’s teenage sons and Rob’s niece and nephew. The younger members of their families appear to be open and accepting of their relationship, while members of their own and older generations are in “constant denial.” They both feel that not having the support of their families was a “mutual loss.” Mike and Rob miss out on being a part of a united family group with whom they can care and share; their sons have another set of grandparents they will never know for greater family support; and, both of their families lose out by never getting to know who Mike and Rob really are as a couple.

The couple described their marriage as a “simultaneous celebration and grieving process, in that the joy of their marriage could not bring them any closer to their families.” They stated that they can only “be there for their families and wait,” and they find it ironic that their marriage “brought them closer together and yet further isolated them from their families at the same time.”

Both Mike and Rob feel that a civil union somehow inherently means “separate and unequal, one step down, or settling for less.” Mike stated that he would like to use neither the term civil union that connotes government influence, nor marriage, connoting religious doctrine rather than true spirituality. He feels that the ceremony is a celebration and declaration of a couple’s love and commitment, and we are “losing its true meaning by arguing over who should/could do it.”

The couple expressed appreciation to AGLBIC for organizing the wedding and allowing them to experience something that they may never have the opportunity to experience in the U.S. Mike and Rob feel that it was very validating to have their love and commitment publicly acknowledged. They felt supported by the ACA president and the counseling organizations and further appreciated AGLBIC as an agent of change. Rob stated that he had previously felt like Mike’s “silent partner” in ACA/AGLBIC, but he felt like he had “gained a whole new family” after the wedding. They both stated that several ACA members had contacted them after the wedding, stating they were “proud to be a part of it.” Mike and Rob both felt like they were so much in love that they wanted to express it to everyone. Even though this was their third time to exchange rings, they felt that their marriage in Montreal had changed their lives and, hopefully, those of others. They remain open to any loving comments and support you care to share with them (mkpisarc@uncg.edu).



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cognitive-behavioral techniques such as aversion therapy (i.e.; stopping clients from masturbating to same-sex images; encouraging imagery of getting AIDS paired to same-sex arousal), reinforcement techniques that emphasize traditional gender role behavior (i.e., for men to “engage in team sports, to go the gym, and to attend Promise Keepers” and for women “to learn how to cook, sew, and apply make-up”; Shroeder & Shidlo, 2001, p. 149), and use of sexual surrogates. However, there is no training offered or condoned by the American Counseling Association to educate and prepare a professional counselor wishing to engage in this type of treatment.

3. Research does not support conversion therapy as an effective treatment modality. There have been “no objective screening criteria, no consensus about outcome measurement, and no blinded or side-by-side studies” (Forstein, 2001, p. 173) and there is “no article in a peer reviewed scientific journal” stating that conversion therapy alters someone’s sexual orientation (p. 177). The results of some research indicate that some clients seeking this treatment do change their behavior approximately 30% of the time, but the same clients report changing only their behaviors but not their sexual orientation. This is an important distinction to share with clients, helping them understand the difference between behaviors and sexual identity. Further, no long-term studies have been conducted to discern whether research participants who reported a change in their behaviors maintained these changes over time.

4. There is potential for harm when clients participate in conversion therapy. Results of studies indicate that there are clients who enter this type of treatment and then report that they function more poorly than when they entered (Nicolosi, Byrd, & Potts, 2000; Schroeder & Shidlo, 2001).

5. There are treatments endorsed by the Association for Gay, Lesbian, and Bisexual Issues in Counseling (see <http://www.aglbic.org/resources/competencies.html>), a division of the American Counseling Association and the American Psychological Association (see <http://www.apa.org/pi/lgbic/guidelines.html>) that have been successful in helping clients with their sexual orientation. These treatments are gay affirmative and help a client reconcile his/her same-sex attractions with religious beliefs.

In summary, if clients still decide that they wish to seek conversion therapy as a form of treatment, counselors should also help clients understand what types of information they should seek from any practitioner who does engage in conversion therapy. The Committee members agree that counselors who offer conversion therapy are providing “treatment that has no empirical or scientific foundation” (ACA, 2005, C.6.e.) and, therefore, must “must define the techniques/procedures as ‘unproven’ or ‘developing’ and explain the potential risks and ethical considerations of using such techniques/procedures and take steps to protect clients from possible harm” (ACA, C.6.e.). Additionally, any client seeking treatment is entitled to complete information about the treatment. This is consistent with A.2.b (Types of Information Needed) that state “counselors explicitly explain to clients the nature of all services provided. They inform clients about issues such as, but not limited to, the following: the purposes, goals, techniques, procedures, limitations, potential risks, and benefits of services; the counselor’s

qualifications, credentials, and relevant experience; continuation of services upon the incapacitation or death of a counselor; and other pertinent information.” Counselors who do not include this information would be considered by the Committee to be in violation of the ACA Code of Ethics.

There also was agreement among the Committee members that any counselors stating that they can offer conversion therapy must also offer referrals to gay, lesbian, and bisexual-affirmative counselors and should discuss thoroughly the right of clients to seek these professionals’ counsel. In doing so, counselors must explore with clients the underlying reasons for their interest in changing their sexual orientation and discuss the social, political, and religious influences that underpin homophobia that may be harming the client.

Counselor Education

Finally, in addition to educating potential clients about conversion therapy, the members of the Ethics Committee agreed that counselor education training programs must also adhere to section F.6.f (Innovative Theories and Techniques), which states that “when counselor educators teach counseling techniques/procedures that are innovative, without an empirical foundation, or without a well-grounded theoretical foundation, they define the counseling techniques/procedures as ‘unproven’ or ‘developing’ and explain to students the potential risks and ethical considerations of using such techniques/procedures.” A similar approach to informed consent for clients seeking conversion therapy must be upheld when discussing this treatment with counseling students.

References

- American Counseling Association (2005). Code of ethics. Alexandria, VA: Author.
- American Counseling Association (1995). Code of ethics. Alexandria, VA: Author.
- Association for Gay, Lesbian, and Bisexual Issues in Counseling. (n.d.) . Competencies for counseling gay, lesbian, bisexual and transgendered (GLBT) clients. Retrieved February 7, 2006, from <http://www.aglbic.org/resources/competencies.html>.
- American Psychological Association. (1998). Guidelines for psychotherapy with lesbian, gay, and bisexual clients. Retrieved February 7, 2006, from <http://www.apa.org/divisions/div44/guidelines.htm>.
- Forstein., M. (2001). Overview of ethical and research issues in sexual orientation therapy. *Journal of Gay and Lesbian Psychotherapy*, 5(3/4), 167-179.
- Nicolosi, J., Byrd, A. D. & Potts, R. W. (2000). Retrospective self-reports of changes in homosexual orientation: A consumer survey of conversion therapy clients. *Psychological Reports*, 86, 1071-1088.
- Shroeder, M., & Shidlo, A. (2001). Ethical issues in sexual orientation conversion therapies: An empirical study of consumers. *Journal of Gay and Lesbian Psychotherapy*, 5(3/4), 131-166.

Crystal's Persuasion continued from page 10...

Center in Boston and developed a series of public information messages about crystal that appear as banner advertisements on the site. A button was also added that reads "Need Help," and when this is clicked a list of local AIDS service organizations and drug treatment facilities appears. Finally, just before one logs off of Manhunt, the following banner AD appears: "If you use crystal, you are digging your own grave." These kinds of innovative programs are an important step in reaching men who use crystal and who bareback who otherwise might not be seeking help with education and information.

References

Centers for Disease Control and Prevention. (2003). Increases in HIV Diagnoses - 29 States, 1999 - 2002). *Morbidity and Mortality Weekly Report*, 52, 1145-1148.

Drug Enforcement Administration (DEA) Strategic Intelligence Section Domestic Unit, Washington, D.C. (1989). A special report on "Ice" (D-methamphetamine Hydrochloride), *Proceedings of the Community Epidemiology Work Group Public Health Service, NIDA*, 69-83.

Gawin, F. & Ellinwood, E. (1988). Cocaine and other stimulants: action, abuse and treatment. *New England Journal of Medicine*, 319, 1173-1182.

Guss, J.R. (2000). Sex like you can't even imagine: "Crystal," crack, and gay men. *Journal of Gay & Lesbian Psychotherapy*, 3, 105-122.

Halkitis, P.N., Parsons, J.T., & Stirratt, M. (2001). A double epidemic: Crystal methamphetamine use and its relation to HIV prevention among gay men. *Journal of Homosexuality*, 41,17-35.

Halkitis, P.N. & Parsons, J.T. (2002). Recreational drug use and HIV risk sexual behavior among men frequenting urban gay venues. *Journal of Gay & Lesbian Social Services*, 14, 19-38.

National Institute on Drug Abuse (1996). Stimulants, *Proceedings of the Community Epidemiology Work Group Public Health Service, NIDA*, V. 1, 61-71.

Zuckerman, M. (1994). Behavioral expressions and biosocial bases of sensation seeking. Cambridge, England: Cambridge University Press.



John Cannon and John Marszalak in Birmingham, AL for the DVD detailing the successes and pitfalls of starting a state chapter of AGLBIC. (See page five for further details.)

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Submission Deadline: May 15th

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