Vol. XXI, No. 1, Winter/Spring, 2008 NALGAP The Association of Lesbian, Gay, Bisexual, Transgender Addiction Professionals & Their Allies

NALGAP reporter

Serving the Lesbian, Gay, Bisexual, and Transgender Communities since 1979

Save the date:

OUR **2008 NALGAP CONFERENCE** WILL ONCE AGAIN BE HELD IN CONJUNCTION WITH THE NAADAC CONFERENCE ON **AUGUST 28-31** IN **OVERLAND PARK, KANSAS**. STAY TUNED TO OUR WEB SITE FOR FURTHER DETAILS (www.nalgap.org).

In this issue:

NALGAP reporter

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A New Name, A New Era!

In a long-needed and long-awaited action, the NALGAP Board voted to change its name from the National Association of Lesbian and Gay Addiction Professionals to *NALGAP The Association of Lesbian, Gay, Bisexual, Transgender Addiction Professionals & Their Allies*.

This change accomplishes four things: 1) it allows us to keep the name recognition of the NALGAP acronym; 2) it makes room for not just national but also international members; 3) it now makes our association name all-inclusive of lesbian, gay, bisexual, and transgender addiction professionals; and 4) the name now includes and acknowledges our valuable allies.

Changing our name is an important step that indicates NALGAP's willingness and eagerness to meet the challenges of the coming years. Our new name truly represents our reality as the one national (and international) voice of conscience advocating for good prevention and treatment for LGBT substance abusers. In addition, our new name reflects the broad scope of our membership—not just national but international members; not just LGBT addiction professionals but our allies as well. We are grateful that in a homophobic society, our straight friends and allies bring their strength and heart to our cause. ■

Highlights of 2007 NALGAP Conference

Once again NALGAP joined with NAADAC for an annual conference in Nashville September 5-8, 2007. The NALGAP board met in an extended session on Tuesday, September 4th and made an historic decision to change NALGAP's official name to NALGAP: The Association of Lesbian, Gay, Bisexual, Transgender Addiction Professionals and Their Allies. This new name has been a long time coming and is a welcome change as it makes the name, NALGAP, inclusive of all concerned groups.

On Wednesday, September 5, CSAT and Prairielands ATTC provided an all-day "Train the Trainers" at which Barbara Warren, PsyD, taught the Curriculum that was written to accompany the CSAT document, *A Provider's Introduction to Substance Abuse Treatment for Lesbian, Gay, Bisexual, and Transgender Individuals (2001).*

L-R: Ed Craft, Barbara Warren, Candace Peters & Anne Helene Skinstad

Present at this "roll out" of the curriculum was Ed Craft for CSAT and Anne Helene Skinstad of the PATTC. After the all-day workshop, they moderated an early evening planning session to discuss implementing the curriculum and developing the capacity to offer the training across the country. NALGAP participants expressed enthusiasm and a willingness to help accomplish this goal.

(continued on page 2)

At the end of this session, Joe Amico, Board President, and Phil McCabe, Vice-President, presented the Finnegan-McNally NALGAP Founders Award to Barbara Warren, Psy.D., CASAC, CPP, Director for Organizational Development, Planning and Research for the LGBT Community Center of New York City, in recognition of her dedication to the cause of LGBT health, especially in the realm of substance abuse.

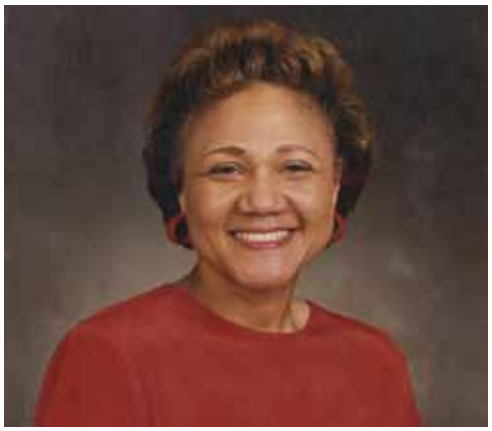
Also on Wednesday, NALGAP hosted a membership luncheon sponsored by Alternatives, Inc. and Pride Institute. To a group of 40, Joe Amico, Board President, and Phil McCabe, Vice-President, spoke about NALGAP's plans and its need for active membership participation. Both individuals and several organizations took advantage of the membership opportunity and joined NALGAP.

Thursday, September 6 and Friday, September 7 featured NALGAP track workshops on such topics as *Trauma, Interpersonal Violence and Childhood Sexual Abuse; Crystal Methamphetamine in the MSM Community; HIV & AIDS, The Alcohol and Other Drug Connection; and Clinical Issues in Assessing Client Sexual History*.

Thursday evening was the annual NALGAP Reception and Awards Ceremony sponsored by Alternatives, Inc. and Pride Institute. The NALGAP President's Award was presented to Edwin M. Craft, Dr.P.H., M.Ed., LCPC, Senior Public Health Advisor; for CSAT/SAMHSA and Bill Lundgren, NCAC II, who currently serves on the Colorado Commission for Persons with Disabilities. Music was provided by Judy Blackwelder and the speaker was Ted Casablanca, E! Network entertainment columnist. ■

Front (L-R) : Phil McCabe, Bill Lundgren (with service dog Archie), Ralph Rynes, Guest speaker Ted Casablanca, Joe Amico; Back (L-R): Ed Craft, Michael Ralke, Edwin Hackney, and Marty Perry.

Two New Board Members



NALGAP has the great good fortune to have two new members of the Board of Directors.

Pamela Alexander

Pamela Alexander, MS, NCAC II, CAC II, ICADC, has worked in the field of substance abuse for 17 years. In this time she has held positions as a counselor, supervisor, interim director, and program manager. Presently she is a program manager at one of Detroit's largest human service agencies, serving the adult offender population, women and children, and adjudicated youth population.

She was the former President and Vice President for the Michigan Association of Alcoholism and Drug Abuse Counselors. She was also a former Board Member for Affirmations in Ferndale, Michigan.

She is the founder of the Ruby Project, an advocacy, grassroots nonprofit agency in Detroit, Michigan, that opened in July 2007, to address the unmeet needs of the LGBTQ issues of healthcare accessibility. Ms. Alexander has been an LGBTQ activist for more than 15 years and is committed to seeking equality for LGBTQ people globally. She has marched from San Francisco to Washington D.C. for equal rights of LGBTQ people.

Pamela's leisure time activities include cooking home style meals for family and friends, and listening to classical music and traditional jazz. Her favorite classical artist include: Evgeny Kissin, and Nojima and favorite female and male jazz artist is Shirley Horn and John Coltrane. Ms. Alexander is the mother of 3 adult children who she is so very proud of. Her oldest daughter is an attorney, her second oldest daughter is a licensed social worker, and her son is an active duty Marine Sergeant, with decorated honors and has served three times overseas in the Iraq War.

Welcome, Pamela!

Devon McFarlane

I'm excited to get involved with NALGAP as a board member, and I believe there are a number of perspectives I can bring to the Board. One is that of taking a community-based approach to addictions issues. I work as a community developer, currently within the Addictions, HIV/AIDS and Aboriginal Health Department of Vancouver [Canada] Coastal Health (VCH). My first position as a community developer with VCH focused broadly on LGBT2S health, which was my introduction into LGBT2S addiction issues because substance use was a priority health issue for LGBT2S populations in Vancouver. As a community developer, I was involved in forming the LGBT Substance Use Working Group, a group which conducted consultations with diverse parts of LGBT2S communities about what people thought were needed for supports and services related to addiction issues. These consultations led to the report, LGBT Communities and Substance Use: What Health Has To Do With It! This report resulted in great interest and support from management within VCH's Addictions, HIV/AIDS & Aboriginal Health Department. VCH is taking some very innovative approaches to addiction & related issues, including oper-

ating InSite, North America's first legal supervised injection site.

I now work within this department, where my role is to implement some of the recommendations stemming specifically from What Health Has To Do With It! I'm coordinating the development of Prism Alcohol & Drug Services, which specifically serves LGBT2S people, and also supports mainstream addiction and mental health services to improve competencies in working with LGBT2S clients. Prism is a very new program (it was launched in March of 2007) and to my knowledge is the second program in Canada that focuses on LGBT2S addiction issues (the first, launched about 10 years ago, is Rainbow Services, at Toronto's Centre for Addiction & Mental Health).

As a Canadian board member of NALGAP, I also bring the experience of working in a national context that, due to our approaches to drug policy, universal health care, broader social policy and LGBT2S equality issues, has different histories and sets of possibilities and challenges.

Furthermore, on a personal note, I bring strong knowledge of trans issues: I've been involved with trans communities in Vancouver for over 10 years, and transitioned on the job about 5 years ago. As a volunteer, I sit on the advisory committee of the Trans Health Program, which serves the province of British Columbia. When I'm not wearing my VCH hat, I sometimes co-facilitate workshops for anti-violence agencies on improving service provision to trans people. As a white trans person, I also strive to be an ally to other marginalized populations and take an anti-oppressive, intersectional approach to both the paid and unpaid community organizing that I do. Lastly, in terms of identity issues, I should out myself as using 'queer' as my preferred word to describe my sexual orientation.

And, in case you're thinking that all work and no play might make Devon a dull boy, I'm an avid knitter and maker of jams & other preserves, find great joy in making costumes, and am taking some classes in different types of performance. ■

Our Allies

By Dana Finnegan

The Fall, 2007 issue of *Lambda Legal Impact* contains a very timely article in relation to NALGAP's name change to NALGAP: The Association of Lesbian, Gay, Bisexual, Transgender Addiction Professionals and Their Allies. The article chronicles the fight that Cheryl Bachman, a 25 year old high school history teacher in West Milford, NJ, engaged in to prevent the school board from unjustly firing her.

Bachman enforced a zero-tolerance policy for anti-gay harrassment in her classroom. She had had three years of great reviews and had been recommended for tenure, when she clashed with two students who used the word *faggot* in her classroom. She sent them for disciplinary action, but one of them roamed the halls, yelling death threats. When Bachman requested that this student be transferred to another class, her tenure recommendation was revoked. The administration stated that, "Due to recent incidents, we have serious concerns about [Bachman's] classroom management and ability to effectively control and tolerate unacceptable behavior."

Bachman insisted on having an open-to-the-public tenure revocation hearing (held in the overflowing gymnasium). The school board delayed the hearing by meeting in executive session until 10:30 pm, but no one left. A Lambda Legal attorney spoke on Ms. Bachman's behalf, suggesting that a court case would likely find in Bachman's favor for enforcing federal and state antiharrassment laws. The superintendant ruled against Bachman, but when the board members were polled the ruling was four against, five in favor of Bachman, thus supporting her challenge.

It is heartening that NALGAP has gone on record with its name change to recognize and honor our allies. It is people like Cheryl Bachman whose courage and beliefs in fairness and non-discrimination support all LGBT people in their ongoing struggles to gain the civil rights that others automatically have.

Another ally who deserves mention here is Jeanne Phillips, better known as *Dear Abby*. She (and her mother, Pauline, before her) is consistently supportive of lesbians, gays, bisexuals, and transgender (LGBT) people and of their families and friends. She gives wise and helpful advice to those seeking her help with difficult and often painful problems resulting from homophobia. She has long been a champion of LGBT rights and a defender against the homophobia present in this society. ■

NALGAP Archives Update

We are pleased to announce that the Williams-Nichol Archives has completed an initial cataloguing of NALGAP materials. There is a bibliography listing over 280 volumes mostly related to LGBT addiction and recovery, and a collection of articles and papers which will be called the "NALGAP Founder's Collection." This collection of articles contains a large amount of "fugitive literature," material presented in conferences or training workshops that has never been formally published and which probably is not available anywhere else. One of these is a 1976 paper by Brenda Weathers about gays and addcition, the first known public presentation on this topic. Another is a series by Randy Schilts on gay addiction, published in the San Francisco Chronicle right when the AIDS epidemic started. We hope that this collection will be available for searches in the near future.

The Williams-Nichol Archives has indicated that materials donated by NALGAP will be searchable and available for research once they are completely catalogued. The collection—thought to be among the ten largest GLBT archives in the country--is located in the Special Collections Division of Ekstrom Library on the main campus of the University of Louisville. For more information, contact Delinda Buie at 502/852-6762 or David Williams at 502/636-0935. Visiting hours are 9-4:30, M-F and other times by appointment. KyArchives@aol.com ■

The 2007 Fall Meeting of the Health Coalition

By Cheryl Reese, MHS, LPC, NALGAP Board Member

According to those in the know, this was the most successful meeting ever. More than 65 organizations were represented on a national basis. The agenda was full, including trainings and an award to Westley Clark.

So here are some highlights we need to follow up on, personally or collectively. Some of these ideas we may want to link to our website, etc.

http://thetaskforce.org/downloads/reports/reports/bi_health_5_07.pdf is a document which can be downloaded free. *The Bisexual Health: An introduction and model practices for HIV/STI Prevention Programming* by Marshall Miller, Andre, Ebin and Bessonova received excellent feedback. There is also a *bi-health@yahoo.groups.com* List serve.

They produced data regarding the Federal Policy Update for NCHS. (National Center for Health Statistics requesting GLBT data in the gathering of this data and the coalition has produced documents discussing inclusion of GLBT folks in this data).

I also have a white paper on the Federally Qualified Health Center and funding support for LGBT and HIV/AIDS service organizations.

Scout, Director, National LGBT Tobacco Control Network was able to get an LGBT question placed on a huge survey for smoking cessation, I think the website which speaks to that question is *http://www.lgbttobacco.org/*. Also, there is a new national 800 quit line with posters to boot. Just log on and get your posters, they look great. For more details you can also contact Scout at *scoutout@gmail.com* There is also a document entitled *State LGBT Tobacco Disparities Best Practices: 2007*.

One of the final important documents that was released was the Special Population Series entitled *Reaching Out to the "Other" Special Populations: Providing Services to Lesbian, Gay, Bisexual and Transgender Patients*. This document is not clinical in nature but was hailed as a good introduction to assisting the GLBT communities in the health clinics and was created by a collaboration of folks, including the National Association of Community Health Centers, Inc. (You can contact that organization to find out where to get the bulletin). The Task Force has several initiatives they advocated for in Congress, one being a Hate Crimes bill. ■

Gambling Problems In Gay/Bisexual Men

By Jon Grant, MD, MPH, JD

Pathological gambling is a relatively common mental health issue more frequently found in men. Due to its similarities to substance use disorders, pathological gambling has been described as a "behavioral addiction." Pathological gambling is associated with impaired functioning, reduced quality of life, and high rates of bankruptcy. In addition, those with pathological gambling report increased rates of depression, substance abuse, and nicotine dependence. Rates of problem gambling have been estimated at 1%-5% of the general adult population.

Although gay and bisexual men account for approximately only 3% of men in the general population, gay and bisexual men appear to suffer from substance use disorders at two to three times the rate found in the general population. Although a variety of addictions appear common among gays and lesbians, rates of problem gambling within the gay community have not been examined.

Although no epidemiological studies of problem gambling within the GLBT community have been conducted, we recently examined 105 consecutive men presenting for treatment for problem gambling and found that 22 (21.0%) identified as gay or bisexual. Given that the proportion of gay/bisexual men in this study was considerably higher than in the general population, it raises the possibility that gay/bisexual men might be at increased risk for pathological gambling as appears to be the case for other addictions. We also found that those gamblers who were gay/bisexual were more likely to acknowledge compulsive sexual behaviors and substance use disorders than their heterosexual counterparts.

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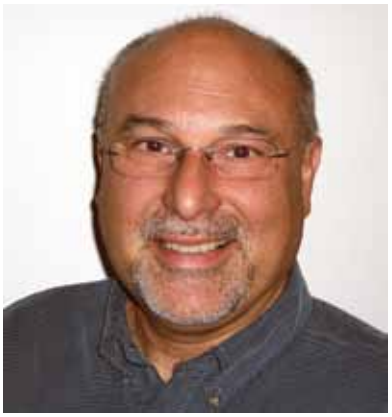
Because there are promising treatments (for example, cognitive behavioral therapy, medications) for pathological gambling, gay/bisexual men should be screened for this behavioral addiction as part of a general mental health assessment. Because pathological gambling frequently co-occurs with other addictive behaviors, gay/bisexual men may require more intensive or specialized treatment services, and the treatment interventions may need to address a wide range of impulsive behaviors and disinhibition. ■

[Dr. Jon Grant is an Associate Professor of Psychiatry at the University of Minnesota and co-directs a clinic for Impulse Control Disorders at the University of Minnesota Medical Center in Minneapolis, MN. He also serves as the Medical Director of PRIDE Institute, a national treatment program specializing in LGBT mental health and chemical dependency care. He is the author of ***Stop Me Because I wCan't Stop Myself****, a book on impulse control disorders, editor of* ***Pathological Gambling: A Clinical Guide to Treatment****, and* ***Textbook of Men's Mental Health****. Dr. Grant's research is funded by the National Institutes of Mental Health.]*

President's Corner



In the last President's Corner I stated that the Board of Directors would be addressing a possible name change to reflect more of our organization's inclusivity as well as address international issues. I am proud to report that we wrestled with those issues at our annual face to face meeting at the Conference in Nashville. We reported our recommendation at the Membership Lunch. The proposal was greeted with high enthusiam. We tried the new title out for a month at presentations across the country and were greeted with positive reponses.

At our October board conference call, we officially adopted the changes to NALGAP's name and title. Wanting to keep the acronyn for its long time recognition, we followed another national organization in their name change: NAADAC, The Association for Addiction Professionals. We are now NALGAP The Association of Lesbian, Gay, Bisexual, Transgender Addiction Professionals and Their Allies.

The subtitle encompasses the bisexual and transgender population who have felt left out of our former name. It also recognizes that we would not be where we are without our straight allies and that they have a place in our organization, as well.

In the past month, I have talked with two more treatment programs who have decided to join NALGAP at the organizational level because we now include "and their allies" in our title! We currently have more organizational members than I have witnessed in the decade I've been part of this board.

Our board now has a Canadian member, Devon MacFarlane; and Stepping Stones Addiction Centre of Kommebie , South Africa has joined at the organizational level. We are truly becoming an international rather than national organization. Even though we have kept the acronym, NALGAP, you will note that our title does not make reference to "national" any longer.

We will be printing new brochures, letterhead, and changing the look on our web site, as well as this publication to reflect these progressive changes.

Our participation in the NAADAC/TAADAC conference was hugely successful. Once again our membership surged as a direct result of the conference. When I was introduced at the opening session, one of our allies spoke up from the floor and shouted that he had joined at last year's conference and found it was the best bargain for a national organization and encouraged others to do the same.

The premiere of the new training curriculum released by Prairielands ATTC and CSAT/SAMHSA was also well received and marks a new direction for our organization. We have committed to assist CSAT/SAMHSA and Prairielands ATTC in providing trainers to sweep across the country to get this curriclum into the hands of as many providers as possible. Stay tuned to our web site and this publication to find out how you can become more involved.

I am excited about the new directions we are taking, the energy of new members coming on the board, and actually living our mission to be more inclusive of gender, orientation, and international issues.

Be sure to put August 28-31 in your calendars for our 2008 conference. You may not be in Kansas any more, Dorothy, but the conference will be! I have a feeling this will be just the beginning for our part of the conference!

Dig out your ruby slippers,

Joe Amico, President
joecd1@aol.com

Addiction Psyciatric Help:

The Doctor is Out...

Dear Dr. Penny: A friend of mine just started drinking again after being sober for over 25 years. Now she's in the hospital with liver failure and jaundice. The psychiatrist there told her she relapsed because she stopped going to A.A. meetings. But I know lots of sober people who no longer go to Alcoholics Anonymous after not using alcohol and drugs for many years—they don't seem to need it anymore. So what's the deal? Do you need to keep going to meetings forever, or not??

—Meeting Maker in Miami

Dear Meeting Maker: Over the last fifty years, all of the research on addiction has shown that this disease is characterized by *chronicity*. Like many other human illnesses, once you have it, it never completely goes away.

To illustrate, let's look at another chronic disease: Type II diabetes. One person may learn she has this disease and immediately make major changes, resulting in losing a lot of weight, not consuming concentrated sugar and other simple carbohydrates, exercising regularly, following all of her physicians' recommendations. Within a few months her blood sugar and other labs are in the normal range, and she does not need to take any medication. In fact she's healthier than she has been in years. Another person learns he has diabetes, becomes despondent, eats even more carbohydrates than ever, gains weight, has no motivation to exercise, gets sicker, needs more and more medications, ends up on kidney dialysis and develops severe vision problems. Clearly this man is chronically ill. But our first person, who is in good health at present is also living with a chronic disease. If she does not remain vigilant and continue to practice good health maintenance, her diabetes will recur and she will become sick again.

The majority of persons with addiction to alcohol and other drugs, sadly, follow the example of the second individual. Their disease takes a general downhill course, perhaps with some brief attempts at recovery, but inexorably progressing to worse and worse consequences. But persons who are given an opportunity to find recovery and who can accept that they have a chronic vulnerability to relapse can recover and do very well, often much better than before they became addicted. But because of the chronic vulnerability to relapse, continued vigilance is the price of maintaining that recovery. One way to practice that vigilance is to continue to attend and participate in 12 Step programs, and research shows that this approach is associated with an improved prognosis for long-term sobriety.

(continued on page 8)

Clinical Supervision Notes

By Edwin Hackney, NALGAP Board Member

There are several significant themes in providing clinical supervision to counselors working with gay, lesbian, bisexual and transgender clients.

A young man in his 20s states in his initial outpatient evaluation "I have a drinking problem because I'm queer and I don't want to be." He is self-referred. He has some support from family and friends who he says don't know "everything about my problem." He is a college graduate, employed, and says that his weekend drinking binges haven't interfered with work "yet." His main reason for seeking help is a warning from his supervisor about Monday absences. He appears to be remarkably candid from the first interview, and is very eager to share his story about alcohol and drug related sexual experiences over the last several years. He presents a struggle with his sexual desires for men which conflict with his beliefs that homosexuality is a sin. Only after several weeks in treatment does he reveal that the warning from work was after he missed several days because he'd been assaulted and badly beaten by a man he was cruising.

In providing consultation and supervision for counselors and therapists in training, this scenario has been presented in numerous variations. One of the striking things I have noticed in the course of supervision is how often the response of the counselor seems guarded or hidden. There is often a discomfort or inability to discuss sexual matters in general, and homosexuality in particular. Cues from the supervisor will be very important in determining how much we enact a parallel process in supervision with what is happening in the therapy setting. For instance, should we agree in supervision that the substance abuse problem should be the primary focus of treatment? Even when the client is very ambivalent about what comes first for him? Can we resist the temptation to solve all the problems for the client in advance?

Miller and Rollnick in Motivational Interviewing describe a "righting reflex" in which the counselor will make a strong effort to demonstrate to the client how important it is to change behavior and often exactly how to make the changes. They add that this approach has been found to be self-defeating and to actually promote resistance among people who are ambivalent and that a key task is to facilitate self-directed change as much as possible.

Another area of concern in supervision is a diagnostic/philosophical consideration. Once the circumstances and symptoms of the substance abuse behaviors have been well established and a substance use disorder diagnosis made, what about the homosexual behavior? A counselor states that the sexual behavior appears to be out of control, against the client's wishes, providing negative consequences, and that he wants to change it. So why not diagnose this also and set goals for change?

Miller and Rollnick in *Motivational Interviewing* describe a "righting reflex" in which the counselor will make a strong effort to demonstrate to the client how important it is to change behavior and often exactly how to make the changes. They add that this approach has been found to be self-defeating and to actually promote resistance among people who are ambivalent and that a key task is to facilitate self-directed change as much as possible.

Why not, indeed? Is homosexual behavior, even unwanted homosexual behavior, a psychiatric or behavioral problem to be targeted by therapeutic intervention? Since there has been a lively debate about the subject for decades now, shouldn't it be important to help counselors learn what the debate is about?

A discussion about heterosexist bias in specific diagnostic categories and a history of the changes in the DSM regarding homosexuality could be an introduction to the scientific approach to sexual orientation. And, yes, there remains a *persistent and marked distress* about sexual orientation criteria for a 302.9 diagnosis of Sexual Disorder NOS. This is a residual category including such diagnoses as Don Juanism, zoophilia, and a variety of rarer paraphilias. Does this seem helpful? How can we inform the client of such a diagnosis and the bias that it includes? And do we always need to pathologize everything that a client is concerned about?

"Cultural heterosexism often evokes persistent and marked distress about sexual orientation (or sexual *differentness* in those not yet aware of their homosexuality) that can contribute to various psychiatric disorders." (Ritter & Terndrup, p. 149). Can we clarify with the client how much of his discomfort is due to "cultural heterosexism" and disapproval by family and peers? Could this be the source of much of his discomfort? Where do religious beliefs fit in? Often when this comes up in supervision there is the question about the place of religious belief in the average American family. For example, should it be considered abnormal or deviant if children do not follow the family tradition?

It is important here to distinguish, if possible, between sexual orientation (generally considered fixed), and sexual desire and sexual behavior (within the control of the individual).

Many young gays and lesbians begin to differentiate, or split, early in life and learn to hide the actual self and develop a false self that is more acceptable, a dynamic that may negatively affect adult development. Substance abuse counselors sometimes are able to understand this as similar to the splitting that occurs with alcoholism where there is a "sober self" and a "drunken self" with considerable ambivalence about both. Where we can point to stages of progression for change such as Contemplation with its ambivalence and need for addressing discrepancies, we can also point to stages of development of sexual identity using the Cass model

(available in the CSAT Provider's Introduction). This can provide counselors with great help in managing the substance abuse treatment by setting goals that are appropriate and congruent with a client's sexuality. In this case, the client may be in the stage of Identity Tolerance in spite of the negative reactions to his orientation. Note the presenting comment "because I'm queer" and note that the ambivalence concerns his disapproval, not the identity formation itself.

A variety of treatment approaches that will enhance this client's chances for a successful recovery from substance abuse and a more accepting attitude towards his sexual orientation are possible. Helping the counselor explore issues of countertransference and possible anti-homosexual bias are important. The use of the term *homophobia* has not been particularly useful, particularly since it now tends to provoke people of faith to complain that they are being discriminated against because of the religious belief that homosexuality is wrong. Indeed, this argument has begun to appear in professional journals such as Social Work widening the debate about what is acceptable in the so-called "treatment of homosexuality." It is important then to clearly establish that the substance use disorder is the disease, not homosexuality.

Finally, a few tips from the 2001 CSAT publication, *A Provider's Introduction to Substance Abuse Treatment for Lesbian, Gay, Bisexual, and Transgender Individuals*: "Counselors need to be aware of and monitor their use of authority so that they do not push or force clients to do something they are not ready to do. In the case of LGBT clients, counselors should not "out" or push a client to share his or her sexual orientation or gender status in the name of honesty and good treatment." (p. 116).

Some important questions counselors need to ask themselves:

- "Are there myths and stereotypes about LGBT people that I believe? Do I, for instance, believe that gay men are child molesters? That lesbians, gay men, and bisexuals would all choose to be heterosexual if they could? That transgender people want to change genders because they are really homosexual?
- Do I believe that having sexual feelings or having sex with someone of the same sex indicates that the person is lesbian, gay, bisexual? Do I believe that the sexual act, by itself, constitutes sexual orientation or identity? Do I believe that having a lesbian or gay or bisexual or transgender orientation is unnatural, immoral, sick, or disgusting?" (p.117).

These are just a few of the questions and issues that must be considered and worked with in counseling LGBT substance abusers and in supervision of those providing such counseling. ■

References:

CSAT. (2001). *A Provider's Introduction to Substance Abuse Treatment for Lesbian, Gay, Bisexual, and Transgender Individuals*. www.samhsa.gov

Miller & Rollnick. (2002). *Motivational Interviewing*, 2nd ed., pp. 20-21. NY: Guilford.

Ritter & Terndrup. (2002). *Handbook of affirmative psychotherapy with Lesbians and Gay Men*. P. 149. NY, Guilford.

NALGAP Needs You!

NALGAP needs a grant writer. In the past years, one member wrote a grant and got funds for us from the Gill Foundation. Since then we have been grantless—though we certainly have tried. NALGAP is short on cash, but long on dedication to its mission to educate, inform, and create networks. We need help to support this mission. Remember—NALGAP is the ***only*** voice of conscience about treatment for LGBT substance abusers.

If you (or someone you know) can write grants—PLEASE—help out.

CONTACT:
Joe Amico, President,
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Want to Join NALGAP?

Visit our website and register online: ***www.nalgap.org***

Special Thanks to
ALTERNATIVES
Newsletter printing

Edwin Hackney Presented Lifetime Service Award

Edwin Hackney (MSW, 1987) was the recipient of the 2007 Kentucky Society for Clinical Social Work Lifetime Service Award. Edwin was presented the award at KSCSW's February membership meeting with a moving introduction that chronicled his illustrious and influential career as an innovative clinical social worker and a faithful social reformer. Though partially retired, Edwin continues to teach in the College of Social Work and provide clinical supervision. Our sincere congratulations to Edwin for being honored for his many professional contributions!

Spirit Health Education Circles

By Cheryl Reese, MHS, LPC, NALGAP Board Member

The combination of spiritual connectedness, education, and innovative thinking launched the one-of-a-kind health education program for African-American lesbians and bisexual woman in the country. The program, Spirit Health Education Circles (S.H.E. Circles)™, was born out of the Black Women 2 Women Spirit Health Study funded by the Susan G. Komen Breast Cancer Foundation five years ago. The study concluded that many standard health messages encouraging a variety of regular health screenings and improved health behaviors such as quitting smoking were not resonating with African American lesbian and bisexual women. Studies show that African American women often are at risk for poorer outcomes due to later detection from breast and other various cancers (e.g., there is a 50 percent higher incidence rate of cervical cancer among African Americans women compared to Caucasian women) due to actual or perceived barriers to care.

The Mautner Project recognized there was an urgent need to galvanize health promotion messages among this group of women. They reviewed the early results of the Women 2 Women Spirit Health Study and accepted the challenge to find new and innovative ways to deliver these messages while acknowledging the rich cultural heritage of African American women.

The Center for Disease Control, (CDC) partnered with the Mautner Project to foster its idea of creating a community of women responsive to and for each other's health. The idea threaded the natural Afrocentric foundation (the cultural and historical history of African American people) into the natural spiritual tone that emerges among a community of Black women. This framework suggested delivering the message in a different way that would awaken and empower women to actively choose health for themselves. Through these ideas, a different form of delivering the health promotion message emerged. The elements of creating sacred space, story telling, art, music and meditation coupled with the important health messages about colorectal, reproductive and breast health education fed the magical flames of S.H.E.

She sums up the project in these words, "I am left in awe and inspired by the spirit of these women who come together in community."

This seven week creative and interactive transformative circle relies on the bond that is created among the women as they learn more about identifying methods to reduce risk factors associated with reproductive and colorectal health. The women also get tips and techniques regarding access to good health care by using the coming out process to become acquainted with their health provider. As the women adapt their new skills and knowledge about their own health status they develop a questioning/partnering attitude when they approach working with their health care provider.

The Mautner Project's training coordinator for this national project, D. Magrini, is excited about her cross country trips to Black Gay Pride events and gatherings of African American women in both urban and rural areas. Her goal is to increase the current number of four groups that are actively completing the cycle now. She sums up the project in these words, "I am left in awe and inspired by the spirit of these women who come together in community. I am happy we have found one way that will help improve the health and hopefully save lives through this program." For more information on S.H.E. Circles or other Mautner Project programming, please contact *Dmagrini@mautnerproject.org* ■

The Doctor is out... *(cont. from page 5)*

This does not mean that persons who do not continue to attend AA or NA meetings will inevitably relapse. Millions of persons have been abstinent for decades without attending meetings. But continuing to attend meetings is one reminder that one is never cured of the disease, that vulnerability is forever, and relapse can happen. Another benefit is that "hanging out" with other recovering alcoholics and addicts provides an opportunity for others to notice indications of problems that one may not have noticed and chances to hear others speaking about issues one may not have realized were eating away at one's confidence, peace of mind, etc.

Any recovery-oriented activity that reminds the addict that a danger of relapse is ongoing and that support and open-mindedness can prevent relapse can provide essential recovery maintenance. In addition to 12-Step meetings, these can include:

- Small informal support groups of persons who share common interests including recovery; for LGBTs, these are social alternatives to the "bar scene"
- Religious/ spiritual groups focusing on maintaining recovery
- Individual counseling with a professional knowledgeable about addiction and relapse prevention
- Group therapy for persons in longer term recovery
- Sponsorship type relationship with a person in long term sobriety who is available to talk about high-risk situations, like family crises
- Consultation with an addiction professional about concerns including possible co-occurring disorders
- Alternative recovery groups such as Rational Recovery, Women for Sobriety, and specialized GLBT groups

Another important aspect of the Twelve-Step programs is service. The opportunity to help others plays a vital role in decreasing self-absorption and isolation and maintaining focus on the risk of relapse—AA's "keeping it green."

Other useful information may be those circumstances which most often accompany relapse or near relapse in persons with long-term sobriety, which include:

- Major loss, e.g., death of a close family member, break-up of a long-term relationship, loss of a job
- Relocation with disruption of support systems
- Exposure of the CNS to therapeutic doses of intoxicants in surgery, dental procedures, treatment for severe pain, etc.
- Retirement

None of these situations will inevitably lead to relapse, but they are high-risk periods. Planning ahead if possible, or responding with increased vigilance, can prevent problems. Someone who no longer attends meetings regularly but who is facing surgery or who is coping with a loss might consider going to some 12 Step Meetings for additional support. Preventing relapse is a critical aspect of sustained recovery, since a return to active use after many years of sobriety may jeopardize a return to comfortable recovery. ■