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Bridging HIV/AIDS Education, Research and Psychotherapy Practice

The Meth Issue



 **APLA**  
AIDS Project Los Angeles

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## The Methamphetamine-Sex Connection Among Gay Males:

# A REVIEW OF THE LITERATURE

### Introduction

There has been an increased popularity of “club drug” (e.g., methamphetamine, MDMA/ecstasy, Ketamine, GHB, ) use over the last decade among men who self-identify as gay (1-3). “Club drugs” are the pharmacologically varied collection of illicit substance used at circuit parties, dance clubs, and raves, frequently for sexual purposes. Many have pointed to the role these drugs have played in the health of gay men (4).

Perhaps the most significant of these drugs is methamphetamine, a potent central-nervous system stimulant. Since the early 1990s, methamphetamine has been the drug of choice for gay men (5), particularly along the west coast. Methamphetamine prevalence indicators throughout the 1990’s showed that its use was largely a regional phenomenon confined to the western portion of the U.S. (6). Data from national studies suggest a continued regional preference for methamphetamine among gay men, with higher percentages of participants in the western and mid-western regions of the U.S. reporting use of the drug (7-8). However, several recent studies suggest its use is becoming more entrenched in gay communities in the mid-west (e.g., Chicago) and on the east coast (e.g., Miami and New York) (9-13), and some researchers have suggested that the problems associated with methamphetamine will continue to escalate (14).

Commonly known as “crystal,” “crank,” “ice,” or “tina,” methamphetamine can be used in a variety of ways, including inhaling, smoking, inserting anally, and injecting. Methamphetamine works by hindering the reabsorption of dopamine, the neurotransmitter associated with pleasure, and can produce a high lasting 8-12 hours. It has many physiological and psychological effects, with users of the drug reporting heightened senses, increased energy, decreased appetite, euphoria, decreased inhibitions, and increased sex drive (15). After the stimulation effects of the drug fade, users often report experiencing severe depression (16). The drug’s sexual and emotional properties have made it attractive to many gay men (17), making it, what some have called, “the quintessential gay drug” (18). Others have described it as an important part of many gay men’s identities (19).

Sherry Larkins, Ph.D.

★ University of California, Los Angeles, Integrated Substance Abuse Programs (UCLA ISAP), Los Angeles, California

Cathy Reback, Ph.D.

★ University of California, Los Angeles, Integrated Substance Abuse Programs (UCLA ISAP), Los Angeles, California

★ Friends Research Institute (FRI)

Steven Shoptaw

★ University of California, Los Angeles, Integrated Substance Abuse Programs (UCLA ISAP), Los Angeles, California

★ University of California, Los Angeles, Center for HIV Identification, Prevention and Treatment Services (CHIPTS)

### Corresponding Author

Sherry Larkins, Ph.D.

UCLA ISAP

11075 Santa Monica Blvd., Suite #200

Los Angeles, CA 90025

Telephone: (310) 312-0500 x369

FAX: (310) 312-0552

E-mail: slarkins@mindspring.com



### The Methamphetamine-Sex Connection

Research has repeatedly shown that use of methamphetamine among gay men is connected to the drug’s perceived sexual properties (20-21). It is frequently used in gay-identified establishments such as bars, bathhouses, sex clubs, and circuit parties (22-23), and is seen as enhancing sexual experiences. Many report that the sexual effect of the drug is their primary reason for using (24), and the term “party ‘n play” (PNP) has become part of the lexicon to indicate using the drug and having sex simultaneously. Gay male methamphetamine users consistently report a connection between their methamphetamine use and sexual activities, and state that their sexual encounters are more “intense,” “heightened,” “prolonged” and “uninhibited” while using (25). Many have reported that the drug enables them to meet other men easily, connect socially and sexually with others, assert their sexual desires, change their attitudes about sex, acquire anonymous partners, and shed

self-consciousness (26-28). Homeless gay male methamphetamine users who engage in sex work report that methamphetamine allows them to stay up all night and perform in repeated sexual transactions (29).

Although there are a few gay male users who report using methamphetamine for many years without consequence (30), more often, the sexual benefits of the drug are short-lived. Among one sample of treatment-seeking users, more than two-thirds report their sexual behaviors become “compulsive” while using methamphetamine (31). For many, the methamphetamine-sex connection becomes so fused that users report they can only engage in sexual activities while using, stating “sober” sex is mundane, awkward or unpleasant. Anxiety around sexual performance and pleasure leaves many vulnerable to continued methamphetamine use. Most importantly, many gay men begin to describe their sexual behaviors while on methamphetamine as “dark,” “repetitive,” “compulsive,” “obsessive,” and “risky.” For many, the obsessive nature of their sexual behaviors contributes to their sexual risk-taking (32).

## Methamphetamine and High-Risk Sexual Behavior

Methamphetamine’s affect on the sexual health of gay men has been devastating, and its powerful presence in the gay community has resulted in alarming public health concerns. More than other substances, methamphetamine use is highly connected to sexual expression and, for many, sexual risk-taking. Compared to users of other substances, including alcohol, powder and crack cocaine, ecstasy, and ketamine, methamphetamine users report significantly higher rates of sexual risk behaviors (33). Use of the drug has been associated with several sexual risk factors including, 1) increased number of sexual partners, 2) decreased HIV disclosure among sexual partners, 3) decreased condom use, 4) increased likelihood of engaging in receptive anal sex, 5) prolonged sexual encounters, 6) intentional unprotected sex (i.e., barebacking), and 7) “extreme” sexual behaviors (i.e., behaviors beyond oral and anal intercourse, including bondage, the use of sex toys, group sex etc.). Given the associations between methamphetamine use and sexual risk behaviors, it is not surprisingly that use of methamphetamine among gay men is also associated with HIV and other sexually-transmitted infections (STIs).

Use of methamphetamine has been associated with an increased number of sexual partners in studies on both heterosexual (34) and gay male populations (35-37). In one sample of gay men who were seeking treatment for substance abuse, methamphetamine users reported three times as many sexual partners in the previous 30 days as did users of other substances (38). Not only is use of methamphetamine associated with an increased number of sexual partners, but evidence also suggests that when using the drug, individuals are less likely to discuss HIV or disclose their HIV status to sexual partners (39).

Since the mid-1990’s, reports have demonstrated persistent increases in unprotected anal intercourse (UAI) among gay men (40-42), and methamphetamine has frequently been implicated in this trend (43-45). One study looking at a cohort of HIV-negative men found that use of methamphetamine was associated with UAI with HIV-positive and sero-status unknown sexual partners (46). Methamphetamine has not only been associated with an increase in unprotected anal intercourse, but an increase in unprotected receptive anal intercourse, in particular. In a sample of treatment-seeking gay men, the methamphetamine users were at least 10 times more likely than the users of other substances to engage in unprotected receptive anal intercourse in the previous 30 days (47) - the behavior that carries the highest risk for contracting HIV and other sexually transmitted infections (48). Another study investigated the sexual roles men took while sober in comparison to those they took while high on methamphetamine, and found that participants were almost two times more likely to be a receptive partner during sex when using methamphetamine (49). Use of the drug can cause both erectile dysfunction and anal sensitization. Many men report intense sexual interest and/or arousal, but state that they are unable to penetrate or ejaculate. This may result in more anal receptive behaviors while high (50), and more prolonged sexual encounters, both of which increase risk for HIV and other sexually transmitted infections (STIs).

Recent studies looking at intentional UAI, or barebacking, as well as other forms of “extreme” sex, have shown an association between these sexual behaviors and methamphetamine use (51-52). One study assessing “extreme” sexual behaviors while under the influence of methamphetamine and while sober found that methamphetamine use was associated with higher rates of “extreme” sex, including group sex, “water sports” (urination), and anal felching (sucking the ejaculate from the anus of a sexual partner) (53).

## Methamphetamine, HIV and other Sexually-Transmitted Infections

The upsurge in new cases of HIV, gonorrhea, and syphilis among gay men is cause for serious concern (54-57). Of the more than 40,000 new cases of HIV last year (58), gay men comprised the largest percent. The association between methamphetamine and sexual risk-taking among gay men has been well documented, and it has been repeatedly implicated in this population’s rate of new STIs, including HIV (59-63). In one sample of treatment-seeking gay men, those who used methamphetamine had an HIV infection rate nearly twice that of those who used other substances (64). In a longitudinal study of HIV-negative gay men, consistent use of methamphetamine was linked to later seroconversion (65).

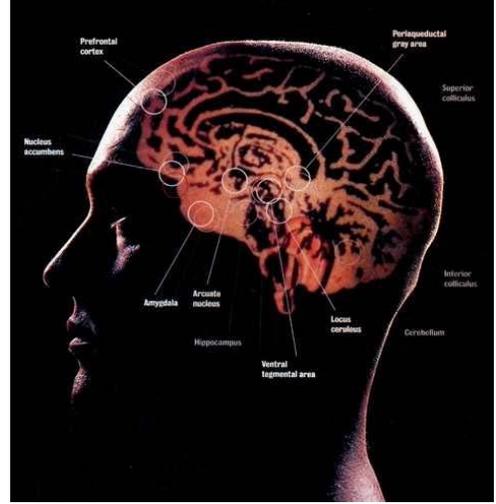
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# THE METH FACT SHEET



## CRYSTAL METH

- ⊙ Meth is a powerfully addictive stimulant.
- ⊙ Meth can be synthesized by anyone given they have the right ingredients.
- ⊙ Meth is often referred to as “crystal”, “crank”, “speed”, or “meth” on the streets.
- ⊙ Meth can be smoked, orally ingested, snorted, injected (slammed), or inserted anally (booty bumped).
- ⊙ Meth users who smoke or inject it get a brief, intense sensation or rush.
- ⊙ Meth users who snort it or use orally get a long-lasting high instead of a rush.



## THE EXPERIENCE

- ⊙ User’s experience an intense rush caused by the brain being flooded with the feel-good neurotransmitter dopamine.
- ⊙ Sometimes people start meth as something to “try” and think they will only use it once.
- ⊙ Usually those same people want to “try it again” because of the intensity of the high.
- ⊙ Meth is typically used in a binge and crash pattern—people sometimes spend as much time crashing as they do feeling high.
- ⊙ A “weekend high” can last as long as 5 – 7 days because of the duration of the crash.
- ⊙ Often meth users try to chase the high minutes after use because of decrease in pleasurable sensation causing them to use more and more.
- ⊙ Meth users are sometimes embarrassed of their habit and separate their life into “drug friends” and “non-drug friends.”
- ⊙ Meth effects can last 6 to 8 hours. People sometimes do a “run” which means using meth continuously to attempt to maintain the high.
- ⊙ People who use meth continuously for days or weeks are on what is called a “run.”



# THE METH FACT SHEET

## THE EFFECTS

- ⊙ Meth is even more powerful than amphetamine, a close cousin.
- ⊙ Meth causes increased activity, decreased appetite, a general sense of well-being, confidence, and euphoria.
- ⊙ Meth can cause pronounced agitation in some individuals and lead to violence.
- ⊙ Meth increases sexual feeling and activity and lowers sexual inhibitions.
- ⊙ Meth often encourages sexually risky behavior due to lowered inhibitions as well as decreased thoughts of consequences or “reality.”



## THE HIGHS AND LOWS

- ⊙ The high results from the release of very high levels of dopamine into pleasure areas of the brain.
- ⊙ Long-term meth use can lead to addiction, especially if you are prone to addiction historically (family history of addiction).
- ⊙ Chronic users can exhibit symptoms like anxiety, confusion, and insomnia.
- ⊙ Chronic users can develop psychosis including paranoia, auditory hallucinations, mood disturbances, and delusions, much like those found in schizophrenia.
- ⊙ The paranoia can result in homicidal as well as suicidal thoughts.



## THE BRAIN AND BODY

- ⊙ Researchers have reported that as much as 50 percent of the dopamine-producing cells in the brain can be damaged after prolonged exposure to relatively low levels of methamphetamine.
- ⊙ Researchers also have found that serotonin-containing nerve cells may be damaged even more extensively.
- ⊙ Meth can cause a variety of cardiovascular problems like rapid heart rate, irregular heartbeat, increased blood pressure, and irreversible, stroke-producing damage to small blood vessels in the brain.
- ⊙ Chronic meth abuse can result in inflammation of the heart lining, and among those who inject, damaged blood vessels and skin abscesses.



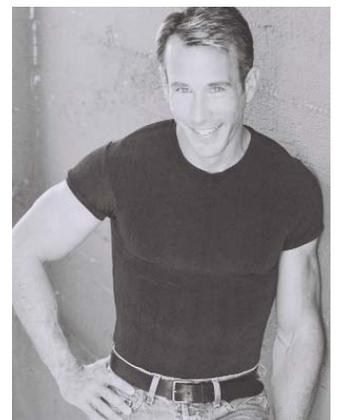
In thinking about gay men, sex, and crystal methamphetamine use, there are a number of considerations I'd like to offer other mental health professionals and researchers. First, when discussing gay men and sex, care must be taken to avoid generalizations, just as care would be taken to demonstrate cultural competency and absence of prejudice in discussing any subgroup of the general population. Why is it that gay men are still subject to a certain scientific, distancing condescension that is widely recognized as off-limits for any other American minority? Too often, I find that gay men are viewed in the literature as scientific subjects in a way that unconsciously or even just administratively de-humanizes us, that is all too reminiscent of the Dred Scott/blacks-as-three-fifths-of-a-person way, rather than realizing that what happens to gay men happens to important, human contributors to American society.

The need for more discussion around gay men, sex, and crystal is extremely compelling given the serious consequences of sustained crystal use. Addiction, economic loss, relationship harm, loss of professional status, HIV transmission, STD transmission, rotting teeth, emaciated bodies, and the deteriorating mental and physical health of otherwise robust gay men are just some of the spoils that crystal use has wrought far too often upon our community. There is a collective feeling that increased discussion and savvy, coordinated interventions among providers can work to prevent the threat of the community's further bio-psycho-social deterioration – but we must act boldly and responsibly.

# CRYSTAL... CLEAR?

Ken Howard, LCSW - (310-657-7044)  
- December, 2004

*Ken Howard, LCSW is an HIV-positive licensed psychotherapist in private practice, consultant, and author in Los Angeles. He is a nationally known educator and speaker on HIV and mental health topics, and can be reached for bookings or consultations at 310-726-4357 or at [gaypsychotherapy@aol.com](mailto:gaypsychotherapy@aol.com).*



This is a time for brave, unflinching, comprehensive discussion that does not merely re-state the problem, but is a call to action on what to collectively do about it as a community of consumers and providers of social services. We are all wary of waiting too long to take action that will help our community, after many of us have witnessed the many years of widespread official public administration denial and relative inaction of the early years of the AIDS crisis. Local gay male consumers and their corresponding treatment providers (such as physicians and psychotherapists) are in need of information that not only describes the nature, extent, and characteristics of crystal methamphetamine addiction among gay men as a targeted social problem, but is much more specific about interventions that are known to be effective in rescuing a drowning (or at least very wet) population. The readers of this newsletter will be hungry for tools and descriptions of specific “proven best practices” that they can use to intervene with people who are seeking treatment, and yet we seem to lack sufficient articles, trainings, conferences, and other resources to equip the reader with the frankness and specificity that the situation demands. Could it be that we aren’t asking the right questions? Could it be that we’re afraid to? Are we being squeamish when we really just need to use the words “booty bump” and “fuck” in professional discourse once in a while?

The unanswered questions and unsolved mysteries abound as soon as we combine the words *gay*, *crystal*, and *sex*. For example, there has been little to address the distinction between gay male crystal abusers and non-gay crystal abusers in terms of sexuality, when crystal methamphetamine addiction among various populations is a widespread national (and increasingly global) social problem. The implication of combining the words carelessly could be interpreted as yet another “demonizing” of the gay male community, reminiscent of the blame given to gay men for the AIDS pandemic as yet another manifestation of widespread national homophobia, particularly in the most recent national political context. Public health problem? Blame gay men! It’s easier than crying “Witch!” Do we find a problem in the connection between crystal use and sex because gay men are sex-crazed fiends by nature, or is there a problem because the physiological effects of crystal methamphetamine use dis-inhibits sexual behavior among all humans, even among heterosexual men and women – leading to not only HIV infection, but other STD’s, unwanted pregnancies, and public sex? Would the drug have the same sexually dis-inhibiting effect on lesbians? Is there any consideration, particularly in the literature review, as to the effect of crystal methamphetamine or other illicit drug use on the safer sex behaviors of all populations? How many teenage girls (with help from their teenage boyfriends) get pregnant on prom night while drunk?



*In the past 24 years, we've seen  
AIDS, now crystal, and a  
backlash against our civil rights.  
Who will lead us into the new  
true Gay Age of Aquarius?  
Talk amongst yourselves.*

***We are all wary of waiting too long to take action that will help our community, after many of us have witnessed the many years of widespread official public administration denial and relative inaction of the early years of the AIDS crisis.***

Yet somehow, the literature's link between "alcohol and unwanted pregnancy" doesn't have the current sexy ring to it that "crystal and gay male sex" has. As a community of researchers and providers, are we exploring widespread, relevant social problems or producing the next segment of a ratings-grabbing, prime-time, pseudo-news magazine show? There is also not enough consideration to date of the socio-political context of the crystal-gay male sex connection. When gay men in recovery from crystal report sex without crystal is mundane, awkward, or unpleasant, why is this so? What socio-political factors facilitate the connection between crystal and gay male sex? At least some foundation of the social environment of homophobia, heterosexism, gender expectations, political oppression, hate violence, specific denial of equal federal/state rights (such as civil marriage), and their impact on the self-esteem and self-concept of gay men should be mentioned if we are going to cite the inherent "social problem" of crystal use and gay male sex. Similarly, there is not enough discussion of the psychological utility of crystal as a

facilitator of gay male sex. Why are gay men using it in the first place? What social factors contribute to, or, conversely, inhibit its use? The same gay male community that makes crystal use "cool" can just as easily make it "uncool"; heaven knows gay men wield great power as the arbiters of fashion. And just how many gay men are using crystal in their sex, as opposed to an entire community of sexually active gay men (presumably the larger group) who aren't? There is also little discussion of the widespread phenomenon of gay male users who report using methamphetamine for many years without consequence. The reason for the paucity of information on this could be attributed to a conspicuous absence of direct input from non-treatment-seeking gay male users in recent articles and studies. This phenomenon contributes to the frustration in trying to understand the haphazard, inconsistent, elusive, gradual, and insidious nature of the development of crystal methamphetamine addiction. If these users are truly "without consequence," then this is a fascinating phenomenon worthy of our investigation: Who are these

men, why is their use without the development of harmful addiction, and what distinguishes them from users who become addicted relatively quickly? Why are apparently some gay men able to use this physiologically and psychologically powerful drug in moderate doses indefinitely "without consequence" (assumed to mean "without impact on social and occupational functioning," as the DSM-IV would say) while some aren't? Is it the same distinction between "normal social drinkers" and "alcoholics," or is there another mechanism, social or physiological, at work that we haven't discovered yet? Answering this question in our research designs and subsequent literature will be critical in the future if the academic and clinical communities are to have an impact on social marketing to the gay community. We, as a community of curious clinicians and pondering researchers, are off to a good start, but in many ways, we lack new information at a time when new information is desperately needed. Plenty of examples of crystal's harm surround our community; it's time we started talking and comparing recipes for how to break out of its circle, so that we can all move on already. In the past 24 years, we've seen AIDS, now crystal, and a backlash against our civil rights. Who will lead us into the new true Gay Age of Aquarius? Talk amongst yourselves.

# HOW DO THERAPISTS PROCEED? Abstinence or Harm Reduction?

Art Bowler, Psy.D.

In the therapeutic community, there is a difference in opinion regarding how sober an individual must be before therapeutic work can be started. Some psychotherapists believe that complete abstinence from crystal methamphetamine is necessary before any therapy can occur. This perspective asserts that it is only through abstinence that a therapist can gain an accurate assessment of a client's level of functioning. Others believe that abstinence is not a necessity, but rather an improbable, unrealistic expectation for a person abusing drugs that fails to allow drug abusing clients the opportunity toward any possibility of change due to exclusion from therapeutic care. These therapists promote the idea of harm reduction, which asserts that because some people will continue to use drugs despite negative consequences, clinicians should work with clients to reduce potential harm from drug use when possible as they work in therapy with their clients. These clinicians believe that doing so establishes a therapeutic alliance which can not only prevent harm but also allows for the possibility for a client to become motivated for change within the dynamic of therapy. Ideas like being aware of potentially hazardous drug/drug interactions before using drugs or appropriately cleaning needles before injecting drugs are examples of harm reduction techniques aimed at lessening the danger involved in using.

On the whole, most psychotherapists will agree that when clients are dealing with issues around drug use, it is important that they feel comfortable discussing all of the associated factors with their provider. Because of fear, shame, guilt, and denial, individuals with addictions are often deceptive and secretive about their use with their families, friends, and others in their lives. Therapists in practice will no doubt experience these consequences as well with clients in their practices. On the whole and despite these ideas, a supportive environment with gentle confrontation is sometimes thought of as a middle-ground. If, when working with a particular client, you believe their drug use stems from a well-meaning attempt at dealing with problems or emotional issues, it may be helpful for the clinician to bring these up as possibilities for discussion. If, on the other hand, your client sees their use as purely "for fun," it will probably not help if you starting talking about underlying conflicts—the client will not feel heard. Therefore, it is important to accurately assess where each individual client is in terms of their want for change and act accordingly. One technique called motivational interviewing puts forth this perspective.

**In sum, adopting an abstinence-only approach or one of harm reduction is a personal call on the part of the therapist. It is important to recognize, however, that there is value in both and each perspective has its place in treatment.**



Many will agree that whether a clinician believes in abstinence or harm reduction, a number of ideas often come into play when talking about substances. Some might be:

- ⊙ Identifying high-risk situations in which clients typically use substances which cause problems for the client and others.
- ⊙ Identifying situations where substance use affects decision-making and judgment and monitor such situations.
- ⊙ Looking at the underlying issues or problems from which substances help the client escape.
- ⊙ Looking at the pros and cons of such drug use.
- ⊙ Helping a client understand what factors make drug use a reasonable choice for them at this point in their lives and help the client identify other reasonable choices that may be more healthful.
- ⊙ Looking at relapse triggers if a client is sober and navigating safety plans.
- ⊙ Educating clients on the benefits of social networks available through fellowships such as CMA, NA, or AA.
- ⊙ Discussing possible treatment options ranging from inpatient detoxification programs, residential treatment programs, outpatient treatment programs, sober living, and twelve-step meetings.

**In terms of actual treatment plans, they will obviously differ with different clients. Some areas which may be worth exploring with your clients may include:**

*Anger*  
*Antisocial Traits*  
*Depression*  
*Anxiety*  
*Attention Deficit Disorder*  
*Experiences of Trauma*  
*Family Conflicts*  
*Sex Addiction*  
*Eating Disorder*  
*Unresolved Grief and Loss*  
*Impulsivity*  
*Legal Problems*  
*Living Environments*  
*Medical Issues*  
*Psychosis*

In sum, adopting an abstinence-only approach or one of harm reduction is a personal call on the part of the therapist. It is important to recognize, however, that there is value in both and each perspective has its place in treatment. Working with clients who abuse substances can be hard work that is both extremely frustrating and also extremely rewarding. It is important, therefore, to not go it alone as a therapist, but seek support yourself from others in the field as you work with individuals in your practice. Taking care of yourself is integral to any type of treatment—and don't forget to role model this in your own life.

# SOME WEBSITES TO CONSIDER

The National AIDS Treatment Information Project  
[www.natip.org/index.html](http://www.natip.org/index.html)

The Measurement Group  
[www.themeasurementgroup.com](http://www.themeasurementgroup.com)

JAMA HIV-AIDS information center  
<http://www.ama-assn.org/special/hiv/hivhome.htm>

Critical Path AIDS Project  
[www.critpath.org/critpath.htm](http://www.critpath.org/critpath.htm)

Centers for Disease Control and Prevention (CDC)  
[www.cdc.gov](http://www.cdc.gov)

San Francisco AIDS Foundation home page  
[www.sfaf.org](http://www.sfaf.org)

Bulletin of Experimental Treatments for AIDS  
[www.sfaf.org/beta](http://www.sfaf.org/beta)

Spanish Bulletin of Experimental Treatment for  
AIDS  
[www.sfaf.org/betaespanol](http://www.sfaf.org/betaespanol)

ACT UP/Golden Gate  
[www.actupgg.org](http://www.actupgg.org)

ACT UP/New York  
[www.actupny.org](http://www.actupny.org)

AIDS Action Committee, Boston  
[www.aac.org](http://www.aac.org)

AIDS Project Los Angeles  
[www.apla.org](http://www.apla.org)

East Harlem HIV Care Network  
[www.aidsnyc.org/network](http://www.aidsnyc.org/network)

AIDS Research Information Center  
[www.critpath.org/aric](http://www.critpath.org/aric)

Gay Men's Health Crisis  
[www.gmhc.org](http://www.gmhc.org)

Harvard AIDS Institute  
[www.hsph.harvard.edu/Organizations/hai](http://www.hsph.harvard.edu/Organizations/hai)

The Lambda Center  
[www.lambdacenter.com/index.htm](http://www.lambdacenter.com/index.htm)

Project Inform  
[www.projinf.org](http://www.projinf.org)

The Body Website  
<http://www.thebody.com/apla/dec00/crystal.html>

Do It Now Foundation  
[www.doitnow.org/pages/101.html](http://www.doitnow.org/pages/101.html)

Crystal Meth Facts/Drug Effects  
[www.urban75.com/Drugs/meth.html](http://www.urban75.com/Drugs/meth.html)

National Institute on Drug Abuse  
<http://165.112.78.61/DrugPages/Clubdrugs.html>



## 1 *What originally motivated you to volunteer for the Pacific Center Program?*

At the time, back in the late 80s, I had several close friends that had either died of AIDS or were living with HIV. One night at Louise Hay's "Hayride" meeting, while having taken a friend there for support, I heard about the Pacific Center. Because of my personal relationships and experiences with those with AIDS, I felt comfortable and interested in accepting a new client from the Pacific Center and saw this as a wonderful opportunity to help those that wanted or needed help coping with this disease. I called them the following day.

## 2 *What has been the most rewarding aspect of your volunteer experience? What has been the most challenging or most difficult?*

The most rewarding and challenging aspects of this experience, is treating clients that initially seek treatment for stress or depression triggered by this diagnosis, but who have often been also dealing with a dual diagnosis. Symptoms triggered by living with HIV or just recently being diagnosed, often bring people into treatment that have long suffered from other issues, (for example substance abuse, or sexual addiction), but who may have never sought treatment before. For many, they have been dealing with grief and loss, shame and guilt, codependency, or anger issues for years. Treating these existing issues in addition to the new adjustments they need to make and coping skills they need to develop, can be challenging. The most rewarding, as well as challenging aspect, has been being able to see them make positive change, work through their fear and emotional pain, develop trust and faith, self-respect and dignity. The greatest reward is helping them get back their joy of living, or find it for the first time in their lives.

## 3 *HIV disease, and people living with HIV disease, have undergone enormous changes in the past 17 years. How have these changes impacted your work with your clients?*

Being a cognitive behavioral therapist, much of my work with clients is reframing cognitive distortions, and teaching them to change negative thought patterns and beliefs. Over the years, because of the continued knowledge and many positive changes that have taken place in the field of HIV, including understanding about transmission and new treatments, I am able to more sincerely and realistically offer clients a more positive outlook in living with this disease. Although HIV remains a growing and serious problem, the quality, as well as the quantity of one's life today living with HIV, has dramatically improved since the 1980's.

with the HIV community and continue to learn about this disease and how it affects everybody. Pacific Center does a great job of matching you and the client together. There is not a lot of paperwork and they provide you with opportunities for continued education such as the annual "Coping with Hope" workshop, which is one of my favorites.

## 5 *Anything else that you would like us to know about your experience as a volunteer Pacific Center therapist?*

The Pacific Center allows low-income HIV and AIDS clients the chance to afford the luxury of counseling. In the many volunteer programs I have been involved in over the past 20 years of private practice, I would have to say this has been one of my most satisfying experiences.

# VOLUNTEER

# SPOTLIGHT QUESTIONS

Kari Anderson, MFT

The process of helping my clients change their negative beliefs, renew connections, take different actions than they may have at one time, develop and understand new goals and options, believe there is hope for a more positive future, as well as present, and change their life for the better because of HIV, are more realistic therapeutic goals today than ever before.

## 4 *What would you say to a colleague who may be interested in volunteering for the Pacific Center?*

It's a wonderful opportunity for you to do something that is not only helping another, but yourself as well. It gives you the opportunity to be involved



## THE PACIFIC CENTER THANKS OUR CURRENT VOLUNTEERS FOR THEIR CONTINUING HEALING WORK:

Kari Anderson • Maureen Bailey • Ray Bakaitis • Daniel Ballins • AJ Barnert • Kallon Basquin • Bonnie Bearson • Joan Bell • Cheryl Berum • Alan Berkowitz • Gerald Betzen • Susan Bilow • Cathryn Blake • Carol Bloom • Susan Brace • Thomas Brod • William Caplan • Noemi Carpio • Sally Cassidy • Virginia Chapman • Elizabeth Clark • James Cloud • Jessica Cohen • Jill Conway • Cele Cooper • Rita Coufal • Barbara Crofford • Paul Dorin • Vicki Ebeling • S. Eileen Emley • Carol Fred • Bernadine Fried • Mary Galloway • Cara Gardenschwartz • Cheryl Grant • Richard Greene • Bruce Gregory • Dann Grindeman • Shirley Hafter • June Hagen • George Harangody • Lynda Harbert • David Harris • Douglas Harvey • Lilla Hashemi • James Henderson • Jean Hendricks • Keith Henning • Dennis Hicks • Joan Horner • Annette Hymes • B.J. Jakala • Scott Allen James • Robert Jameson • Lora Joe • Angel Kahane • Harron Kelner • Carol Kelsy-Palmer • Karen Kenney • Curtis Knecht • Barbara Kobrin • Katherine Koch • Charles Kurgan • Robert Lark • Thel Levine • Fern Lipert • Roxane Lipton • Karyn Maag-Weigand • Jon Maher • Chiyo Maniwa • Lorrin McCornick • Deborah Miora • Renata Mirabella • Mary Nalick • Sheila Newton • Nola Nordmarken • Sally O'Mara • Linda Owen • Zecharia Oren • Paquita Pierpont • Scott Polenz • Liliane Quon-McCain • Bruce Rays • Philip Reichline • Carol Reznichuk • Mary Ann Rosenfeld • Marcia Rorty • Dale Rose • Wanda Rosen • Martin Ross • Pat Rubinstein • Pamela Rudman • Stephanie Sabar • Lois Samuels • Linda Sanserino • Ann Schofield • Lynne Scholnick • Seth Schulweiss • Matthew Seidman • Tere Sievers • Julie Siri • Corie Skolnick • Edward Smith • Dan Spector • Cynthia Speich • Michael Stample • Bobbi Stoll • Marilyn Stolzman • Anita Storm • George Suel • Nancy Talley • Ellen Tarlow • Marcia Teichman • Jonathan Thompson • Penelope Thompson • Kathi Turner • Catrien Villamil • Tina Vince • Linda Waldheim • Fredda Wasserman • Jane Waterman • Carla Wegener • Lee Weinstein • Nancy Weston • Joanne Wolf • Greg Wuliger • Robin Wynslow • Jean Young • Tony Zimbardi • John Fox • Payam Ghassemlou • Mel Rappaport.

## WE NEEDED YOUR HELP EIGHTEEN YEARS AGO, AND WE NEED YOUR HELP TODAY.

Please volunteer.

The Pacific Center recruits licensed marriage and family therapists, psychologists, licensed clinical social workers, and psychiatrists to provide weekly psychotherapy in the therapist's own office to a person with HIV disease.

Please volunteer to provide psychotherapy for a minimum of one hour a week in your office, to a person with HIV disease. Please complete the form below and return it to us.

### Yes, I want to help.

Please contact APLA for information about the Pacific Center Program or e-mail APLA's Pacific Center staff at [mrobbins@apla.org](mailto:mrobbins@apla.org) and [mayala@apla.org](mailto:mayala@apla.org).

Name \_\_\_\_\_  
 Office Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Office phone ( ) \_\_\_\_\_ Fax ( ) \_\_\_\_\_  
 E-mail \_\_\_\_\_  
 Mailing address (if different) \_\_\_\_\_  
 \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Check appropriate license: MFT \_\_\_\_\_ LCSW \_\_\_\_\_  
 Psychologist \_\_\_\_\_ Psychiatrist \_\_\_\_\_

*Return form to:*  
 AIDS Project Los Angeles,  
 The David Geffen Center, Pacific Center Program,  
 611 South Kingsley Drive  
 Los Angeles, CA 90027  
 (213) 201-1621  
 Fax : (213) 201-1606

Connections Journal is a publication of the Pacific Center for HIV/AIDS Counseling and Psychotherapy, a Program of the Mental Health Services at AIDS Project Los Angeles · 611 South Kingsley Drive · Los Angeles, CA 90027 · 213/201-1621  
 Fax: 213/201-1392. This publication is made possible by a grant of Ryan White Title I funds from the Los Angeles County Department of Health Services - Office of AIDS Programs and Policy.

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#### Layout and design

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 APLA Publications Department

#### Mental Health Program Manager

MICKIE ROBBINS, LMFT

#### Mental Health Program Assistant

MARCELLA AYALA

#### Pacific Center Supervisor

RICHARD LEVIN, LMFT  
 213/201-1445

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