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A Guide to AIDS Research and Counseling

Counseling Pre-Operative Transsexuals with HIV Disease
James Grimaldi, CSW

Everything we learn about gender is based on a dichotomy of opposites: yes versus no, hot versus cold, wet versus dry. Of these dichotomies, perhaps the most significant for identity is female versus male: a person, from childhood finds his or her secure place in either but not both camps. No matter what happens in life, a person remembers and is fundamentally influenced by gender.

When an individual challenges the rules and assumptions of gender, overtly blurring the boundaries between male and female, other people respond with discomfort and confusion and often with disdain. This “transphobia,” which occurs even among people who are comfortable with same-sex relationships and the idea of an individual crossing gender lines, presents significant problems for transgender people and can be particularly burdensome for transgender people with HIV disease. This is especially true for pre-operative male-to-female transsexuals, the most likely among transsexuals to show up at public HIV clinics and emergency rooms. (Post-operative transsexuals get HIV disease, but are often identified as women.) This article offers an opportunity to begin to understand transphobic reactions, and the transsexual experience and how HIV infection affects it.

Transsexuality and HIV Disease

Mainstream society often misuses the word “transsexual” to label a range of people who break norms of gender and sexuality, lumping into one category a pre-operative male-to-female transsexual, a transvestite, a cross dresser, a drag queen, a hermaphrodite, and sometimes even a homosexual. (See “A Transgender Dictionary,” page 5 of this issue, for more information on the diversity of the transgender community.) A male-to-female transsexual is a person, born with testicles and a penis, who feels female and desires to change her appearance—for example, by growing breasts and removing the penis—to match what she feels inside. A pre-operative transsexual, unlike a post-operative one, has not undergone gender reassignment surgery to effect these physical changes.

Most male-to-female transsexuals resent being compared to drag queens, who are men who wear flamboyantly feminine costumes, make-up, and hair styles, while signaling an unmistakably male body beneath. Male-to-female transsexuals do not feel the need to overstate their female attire because they invest greater effort into simulating a female body beneath their clothing. Some insights into the lives of pre-operative male-to-female transsexuals also apply to post-operative transsexual and female-to-male transsexuals, however, in the context of HIV disease, seropositive pre-operative transsexuals face an added and fundamental obstacle: serostatus precludes gender reassignment surgery. Physicians, worried that HIV disease will affect the post-surgery healing process, are reluctant to perform gender reassignment surgery on seropositive transsexuals, and they hesitate even to prescribe hormones without further research regarding the effects of hormones on HIV progression.

Because hospitals classify patients as either male or female, it is difficult to compile HIV seroprevalence statistics on transsexuals or a demographic profile of those transsexuals most likely to have HIV disease. Yet, it is clear that many transsexuals who commonly seek care at public HIV clinics—often those with lower
A few years back, an acquaintance came up to me in the Guggenheim Museum in New York. I was a little confused—it’s always strange to meet people from home when I am traveling—but it’s safe to say that it was not that out-of-place feeling that was so uncomfortable.

Louise was now Lou (a fictional parallel of his name change). He was smiling, relaxed, clearly himself. I had known he was undertaking this transformation, so it was no real surprise to see him as a man—but I was nervous, much more than he was and more than I thought I should be. I still can’t really understand what was so uncomfortable, but the articles in this month’s issue of FOCUS have given me some insights.

There is something comforting about ideas we can count on, and none is more concrete than gender, the one thing that we—even those of us unphased by a range of sexual orientations—often accept as absolute. As James Grimaldi observes in this issue of FOCUS: “No matter what happens in life, a person remembers and is fundamentally influenced by gender.”

But, gender is not as obvious as we have learned to expect. It seems to be something more fluid, less exact: as confusing as life, and all the more confusing because it appears to be so clear.

I suspect that my discomfort at the museum was about facing the unreliability of my perceptions. First, I had to recognize that the way I had been taught to perceive such a fundamental concept of life was flawed. Then, I had to accept that the individual who stood before me no longer resembled my perception of him.

It’s fitting that this confusion should arise at the Guggenheim, built as an atrium around which spirals a continuous, gently sloping ramp lined with art: a metaphor for the gender continuum. The landings, such as they are, are almost arbitrary, and while floor numbers sometimes indicate a change in the exhibit, they are often irrelevant as the viewer follows the spiral of art to wherever it leads. (Being at the museum always leaves me spinning, a disorientation that seemed particularly appropriate for my chance encounter with Lou.)

The articles by Grimaldi and Nora Gabriella Molina may also seem disorienting. Both authors reject easy definitions: being more precise by being less exact. The stakes are high—not simply about sexuality or gender—but about perceiving humanity and serving clients based on an appreciation of the complexity of their lives. The stakes are even higher when people have HIV disease, when the understandable temptation to simplify life may be overpowering.

incomes—face a variety of HIV-related risks ranging from sharing needles to inject sex hormones or drugs, to sex work with violent sex customers and those who refuse to wear condoms. (Ironically, there is an inexhaustible market for transsexual sex services—sex work and erotic dancing—in our transphobic society.) In addition, a large proportion of transsexuals, marginalized in society, have fewer opportunities for employment, insurance coverage, and access to medical care.*

For many transsexuals, the pressure to earn money extends beyond necessities such as food, clothing, and shelter to encompass the significant costs of gender transition. In response, many HIV-infected transsexuals continue sex work even though they are ill, placing themselves at greater risk of opportunistic infections. Once they are too ill to work, HIV may steal not only their health but also their control over their gender and their body.

Gender Transition

The turning point in a transgender person’s life is not in realizing that he or she is different—transgender people have often identified with the opposite gender for as long as they can remember—but in choosing to respond to his or her gender dysphoria. For this reason, an effective stance in working with transsexual clients is to focus more on the strength and courage that motivates a gender dysphoric person to actually begin the odyssey of changing gender than on how this action contradicts societal norms. Acknowledging this innate strength can help a client cope with HIV disease; focusing on the origins of gender dysphoria further marginalizes clients and risks invalidating what is most precious to them.

The physical process of gender transition can be divided into two phases—pre-operative and gender reassignment surgery. The pre-operative phase begins with adopting the opposite gender’s uniform and may include a legal name change. Hormone therapy (by pill, injection, or patch) is the hallmark of the pre-operative stage. Male-to-female transsexuals can use premarin and provera to foster breast growth and development, soften skin, redistribute fat to follow a genetic female shape, decrease testicular size, and decrease erections and libido. Hormones will not alter voice and bone

*It is important to note that a significant number of transsexuals who are economically successful and well-adjusted to mainstream society do not fit this mold; but they are less likely to be seen at public clinics.
structure. In addition to hormones, male-to-female transsexuals may use electrolysis to remove facial and body hair, tracheal shave surgery to remove the Adam's apple, silicone breast implant surgery (below skin surface or below muscle tissue), and direct silicone injection below the skin surface to sculpt hips, cheek bones, lips, and chin cleft.

Gender reassignment surgery involves removing testicles (bilateral orchiectomy), removing the penis (penectomy), and creating a vagina with sensory tissue from the penis head (vaginaplasty). The physical process of gender transition is extremely expensive. Gender reassignment surgery costs between $15,000 and $100,000, depending on the surgeon. Hormones cost $50 per month, which totals $30,000 over 50 years. Electrolysis costs $60 per session, and can total $2,000 for a chin alone, $30,000 for a chest. These costs become even more significant for transsexuals who have limited employment opportunities and face discrimination.

Health and mental health care providers can help respond to this socioeconomic challenge in four ways: by overcoming their own negative feelings about sex work so that clients feel comfortable talking about all aspects of their lives; by creating a resource network of transgender-friendly employers who can provide alternatives to sex work; by directing clients to emotionally supportive educational opportunities; and by being willing to prescribe hormones.

Prescribing hormones has become the staple of a harm-reduction model for transsexuals. First, it protects transsexuals from black-market hormones that may be impure. Second, it protects transsexuals who, in desperation, may accelerate their gender transition by doubling or tripling hormone dosages, which can damage the liver. Third, prescription allows for medical insurance coverage for expensive hormones that transsexuals would otherwise have to finance out-of-pocket, diminishing the incentive for sex work, and exposure to HIV-related risk, violent customers, and police harassment. Fourth, it eliminates the need for needle sharing for hormone injections.

But, many doctors require transsexual patients to undergo a psychiatric evaluation before prescribing hormones, and many psychiatrists recommend treatment focusing on improving “body image” to match current sex rather than supporting a transsexual person’s desire to transition. Ironically, pathologizing transsexuality in this way is reminiscent of the ways in which homosexuality was pathologized earlier in this century. As mentioned earlier, physicians treating HIV are also uncertain about the effects of hormone treatment on HIV disease progression.

How is the desire of a transsexual who cannot obtain gender reassignment surgery any less valid than the aspiration of another seropositive person’s need to accomplish major life goals?

Psychological Support and Connection

Transsexuals—particularly those who lack the support of family or who have lower incomes—face a variety of psychological stressors, including the absence of stable interpersonal relationships, fears of abandonment, addiction disorders, narcissistic personality traits to defend against feelings of unworthiness, self-destructive behaviors, internalized transphobia, and depression. Transsexuals typically cope with a long history of rejection by isolating themselves, and this situation can be exacerbated as seropositive transsexuals lose the ability to live independently.

HIV disease, which may result in the loss of physical beauty, further damages self-worth that is based on self-image. Some transsexuals may devalue other transsexuals, especially those who exhibit both masculine and feminine physical characteristics, and may respect, even revere, those who look beautiful.

At New York Hospital, individual therapy enabled most clients to broach some of these difficult topics. But, as it became clear that peer support was crucial to helping such clients adjust to HIV disease, the hospital developed a support group for seropositive transsexuals.

The group facilitator’s first task was to protect all members by redirecting expressions of anger away from other participants and towards the leader. This process was draining, but it was important to establish relationships among members so that they could begin to feel positively about other transsexuals and consequently about themselves. Their anger took the form of insults pertaining to physical appearance (or as members term it “shade”). The facilitator empathized with the root of this anger—pervasive societal discrimination—and members soon realized that the leader could tolerate their anger and contain it. Control was a particularly important
dynamic in the lives of group members and the facilitator’s ability to cede control built trust and distanced the facilitator from an aggressive, dismissive society.

It was crucial for the group to deal with a range of other issues. Among these were: creating a family atmosphere and family rituals to replace lost biological families; fostering intimacy; and enabling participants to risk exposing vulnerable feelings. As part of this process, the group leader was active in helping members—who often rejected others or felt rejected—reach out to isolated group members. As members, many who lacked experience with intimacy, became less defended and self-protective, some mistook platonic friendship for erotic love. Those who expressed platonic feelings felt confused, sexualized, and rejected. The objects of this intense intimacy felt misperceived as anatomical males and disrespected as women of transgender experience.

As with all terminally ill people, confronting loss was central to the group process. Since surgeons in the United States will not perform gender reassignment surgery on people with HIV disease, these discussions most often focused on how HIV robbed members of the opportunity to die as anatomical women. The thought of dying with a penis and testicles horrified many group members. The topic of surgery became a catalyst for undertaking a life review. Some regretted having listened to psychiatrists who had deterred them from surgery while they were seronegative. Many acknowledged how poverty and lack of job opportunities had prohibited expensive surgery. Others regretted the ways in which depression and drug addiction had sidetracked them from their goals.

Over the course of four years, members developed long-term relationships with each other. When members began to die, they rallied around one another to guarantee that they would all die as women, attending each other’s funerals to ensure that biological families and church congregations would not dress their corpses in masculine clothes. As members made these promises to one another, their relationships deepened. By then, instead of mistaking intimacy for erotic love, members perceived it in female-enhancing terms: members viewed the “maternal relationship” as the ultimate female relationship and felt comfortable becoming surrogate mothers to one another. More experienced members adopted younger members as their “daughters.” The mother-daughter relationship safeguarded members from erotic feelings and acknowledged every member’s female identity.

Conclusion

The transgender community, as any community, comprises a range of people and problems. Not all transsexuals face the same psychological challenges as described here. But transgender people function in a transphobic world, and while this cannot be the source of all their problems, its fundamental effect is undeniable.

A crucial first step to respond to these issues is for health and mental health care workers to move beyond their discomfort with gender ambiguity. How is a transgender person’s loss of beauty any different from a seropositive man’s loss of muscle mass? How is the desire of a pre-operative transsexual to obtain gender reassignment surgery any less valid than another person’s desire to accomplish major life goals? The transsexual people I have known have found ways to meet their unique life goals, and by doing so teach and inspire us to do the same with our lives.

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Clearinghouse: Transgender Issues

Authors

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References


A Transgender Dictionary
Nora Gabriella Molina

For many people, the concept of transgender is foreign and confusing, not least because it comprises a variety of different types of gender expression. Added to this variety is the fact that crossing genders may be threatening and may shut people down to understanding what is, in fact, a wonderful diversity. This brief article, written from the perspective of a transgender person, catalogs and defines the key concepts relating to transgender.

Under the Umbrella

Transgender (TG). Originally, transgender referred to the group of people, also known as full-time cross-dressers or nonsurgical transsexuals, who live and work as the opposite gender continuously and for always. Now, it more often refers to the group of all people who are inclined to cross the gender line, including both cross-dressers and gender-benders, the "umbrella definition" that covers everyone.

Assigned Gender at Birth. The gender of a person determined at birth based on the presence of external sex organs.

Bigendered People. People who feel they have a male and a female side to their personalities. Some bigendered people cross-dress, while others evolve into transsexuals and have sex change operations.

Cross-Dresser or Transvestite (TV). As above, a person who dresses, lives, and works as the gender opposite their anatomical gender. Unlike a gender-bender, cross-dressers seek to present themselves convincingly as the opposite gender. Transvestite means the same thing as a cross-dresser, but cross-dresser is the preferred term.

Gender-Bender. Anyone crossing the gender line who does not care about appearing "convincing." For example, a man wearing a dress, who looks like a man wearing a dress and does not care that he looks like a man wearing a dress.

Transsexual (TS). A person who takes medical steps—ranging from hormone treatment to gender reassignment surgery—to change his or her gender.

Crossing Over: Transsexuals

Harry Benjamin, MD. An endocrinologist, sexologist, and gerontologist, and one of the first researchers in transsexuality. In 1953, he coined the word "transsexual," and in 1966, he published The Transsexual Phenomenon, the first serious work on the subject.

Christine Jorgensen. The first person to be widely known for having gender reassignment surgery, but not, as is often implied, the first person to have undergone this surgery. News of Jorgensen's sex change in 1953 brought hope to many other transsexuals around the world.

Gender Reassignment Surgery. The surgical procedure to change the genitals and secondary sex characteristics of a transsexual. No sex change can change a person 100 percent into the opposite anatomical gender. A male-to-female transsexual can never bear a child; a female-to-male transsexual can never sire one. While there is nothing technically to


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See also references cited in articles in this issue.
stop a post-op transsexual from "going back," the results are limited: a male-to-female transsexual who returns to being a man is essentially like a post-operative female-to-male transsexual.

**Incurable Transsexual.** A transsexual with no hope of access to gender reassignment techniques, including those living in countries without access to advanced medical care, and all those who died before 1952.

**Manufactured Transsexual.** Some babies are born with sex organs (full or partial) of both genders, or with underdeveloped or ambiguous sex organs. Usually, the delivering doctor decides "what it's going to be" and performs "corrective" surgery without ever consulting or getting the approval of the parents—in effect, performing gender reassignment surgery. Some of these babies grow up to be adults who conclude that "They took everything I wanted and left me with the part I have no use for."

**New Man.** A post-operative female-to-male transsexual. Also used sometimes to mean a female-to-male transsexual who is well along in the transition process.

**New Woman.** A post-operative male-to-female transsexual. First used in a 1953 newspaper article in reference to Christine Jorgensen. Also used sometimes to mean a male-to-female transsexual who is well along in the transition process.

**Nonsurgical Transsexual.** A transsexual who seeks gender reassignment through hormones and who cross-lives, but stops just short of surgery. Cross-living is a process that may begin with an informal name change and extend to a legal name change, cross-dressing, and building interpersonal relationships in the context of a person's chosen gender.

**Post-Operative (Post-Op) Transsexual.** A transsexual who has undergone a sex change operation(s) and now has the physical anatomy he or she desires and which matches his or her self-conception.

**Pre-Operative (Pre-Op) Transsexual.** A transsexual who has not yet had his or her sex change operation(s), but who is working towards this goal, for example, by taking hormones, or by getting breast implants or silicone injections.

**Transsexual Female or Transsexual Woman.** A male-to-female transsexual. The medical literature tends to use the extremely demeaning term "male transsexual" to mean the same thing.

**Transsexual Male or Transsexual Man.** A female-to-male transsexual. The medical literature tends to use the extremely demeaning term "female transsexual" to mean the same thing.

**True Transsexual.** A transsexual who, after gender reassignment surgery, will be or is happy living the rest of his or her life with a new gender image, as opposed to someone for whom transsexuality is a phase or who undergoes gender reassignment surgery and regrets it afterwards.

**Out in The World**

**Clock(ed).** Being detected as transgendered, for example, when a male-to-female cross-dresser in public, living in her preferred female image, and someone calls out, "That's a man." This can be embarrassing at the least, and devastating at the worst. The word clock apparently comes from the phrase, "Read me like a clock." **Read** is a synonym. Contrast with **Pass.**

**Pass.** To live convincingly in your preferred gender image, for example, a female-to-male cross-dresser who looks like a man.

**Passing Woman.** Chiefly used in the historical sense to refer to a non-transgendered woman who lives as a man in order to have access to a career or way of living that was available only to men.

**Transphobia/Transphobic.** The groundless fear and hatred of cross-dressers, transsexuals, gender-benders, and what they do. Everything that results from this: ranging from disrespect, to denial of rights and needs, to violence.

**Conclusion**

Words are powerful, and the words transgender people have chosen reflect chosen images of the transgender experience. There is, however, some irony in a Transgender Dictionary, since many transgender people have been hurt by societal categorizations and do not want to get stuck in new definitions. Chosen definitions portray the more complex reality of transgender people; but the truest reality can be defined only by each individual.

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### Comments and Submissions

We invite readers to send letters responding to articles published in **FOCUS** or dealing with current AIDS research and counseling issues. We also encourage readers to submit article proposals, including a summary of the idea and a detailed outline of the article. Send correspondence to:

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Seroprevalence among Sex Workers

A three-year seroprevalence study found higher rates of HIV disease among male-to-female transsexual sex workers than among female sex workers. The data may reflect the greater number of anal contacts between transsexuals sex workers and their clients, more effective protective barrier use by female sex workers, the adverse effects of estrogen replacement, and the possibly increased efficiency of HIV transmission via an artificial vagina, which has a more fragile mucous lining.

Of the 216 subjects recruited in and around Tel Aviv, 180 subjects were biologically female and 36 transsexuals were biologically male at birth but lived and dressed as females. Both groups shared the same client population. The majority of the transsexuals had had their testicles surgically removed or were preparing to have the operation in the future, and 25 percent reported having undergone sex-reassignment surgery that included the formation of an artificial vagina. All of the transsexual subjects were on continuous estrogen maintenance.

During each visit (conducted once every six weeks during the first year and once every six months thereafter), researchers gathered demographic information and drew blood for antibody testing. The mean age for the entire group was 30 years. Fifty percent of females and 43 percent of transsexuals had practiced sex work for five years or longer.

Overall seroprevalence among the female sex workers was 1.1 percent, but was 11.0 percent among transsexual sex workers.

Overall seroprevalence among the female sex workers was 1.1 percent, but was 11.0 percent among transsexual sex workers. Of the 128 female who did not currently or previously inject drugs, none was HIV-infected, and of the 52 females who did use drugs, two were seropositive. In contrast, three of the 32 non-drug-using transsexuals, as well as one of the four who did use drugs, were seropositive. All of the transsexual sex workers, but less than 10 percent of the female sex workers, reported participating in anal intercourse at some point in their sexual lives.

Sex and Seroprevalence among Transsexuals

A study of the sexual activity and seroprevalence of female and male transsexuals in Singapore found that none of 277 subjects was HIV-infected and that there were marked differences in the frequency of sexual activity between these two groups.

Researchers interviewed subjects who had requested gender reassignment surgery and took blood samples from them upon hospital admission and before surgery. The 154 male-to-female and 123 female-to-male transsexual subjects had a mean age of 26.3 and 28.3 years respectively. Most of the participants were Singaporean Chinese, and the majority of subjects had completed at least secondary education.

None of the female-to-male subjects and 9 percent of the male-to-female transsexuals admitted to sex work. Almost half of the female-to-male subjects—48 percent—but only 10 percent of the male-to-female subjects were sexually inactive. Male-to-female transsexuals began sexual activity at an earlier age than female-to-male transsexuals, and were also more likely to engage in anal intercourse and in sex with casual acquaintances. Female-to-male transsexuals reported longer lasting sexual partnerships.

None of the transsexuals was HIV-infected. While more data is needed, the researchers suggest that the lack of HIV infection may reflect Singapore’s overall low seroprevalence and low incidence of illegal drug use. In addition, the results may be explained by the large number of sexually inactive subjects and the low number of sex workers.

Perspectives on “Sex” and “Gender”
Parlee MB. Situated knowledges of personal embodiment. Theory & Psychology. 1996; 6(4): 625-645. (Massachusetts Institute of Technology.)

Psychological theorists continue to conceive of gender and sex as binary categories, an approach that contrasts with the perspective of transgender activists, who have found it necessary to move beyond bedrock concepts of “woman,” “man,” “female,” “male,” “lesbian,” “gay,” or “straight” to suggest that gender resides along a spectrum of possibilities.
Sex and gender have a variety of meanings in contemporary psychology. Generally, theorists assume that sex—the characteristic of being male or female based on biology or anatomy—precedes and is consistent with gender, a person’s perceived masculinity or femininity. This formulation leads to the conclusion that gender differences are based upon the biological or anatomical dimensions of a person’s sex. Some theorists have challenged this conception by adopting a “social constructionist” position with respect to gender: gender, though linked with the idea that biological sex is historical, fixed, and binary, is variable along a continuum. While this position recognizes the fluidity and variability of gender, the binary sex categories of male and female remain firmly entrenched.

One psychological theorist—Rom Harré—considers the application of “nominal” versus “real” sex. In his model, genetic differences comprise the real or “covert” essence of a person’s sex, while the public manifestation of sex differences functions as the nominal or “overt” expression of that sex. In this context, physical interests take precedence over practical interests.

Transgender activists as a group have tried to end public discrimination and intolerance against their community by challenging medical and scientific definitions of “normal” sex, gender, and sexuality. Activists recognize the importance of language—the power to name—and emphasize that specific terms cannot be used interchangeably in all settings. Activists have also endeavored to change academic research, targeting traditional disciplines such as psychology, history and anthropology, as well as non-traditional disciplines such as feminist theory, lesbian, gay, and bisexual studies, history of sexuality, and queer theory. Through the presentation of novel discourse that mirrors the complexity of sex/gender/sexuality, activists hope to eradicate beliefs that individuals who transcend conventional sex/gender categories are devoid of moral agency.

**Art Therapy for Transgender People**


By providing an outlet for them to create images that more accurately represent themselves, art therapy helps transgender people living with HIV disease communicate with others, express their feelings, and create a sense of connection. Three case studies of male-to-female transgen-

**Next Month**

The drug use epidemic is constantly changing and demonstrates significant differences in shape and scope from one geographical region to another. In the February issue of *FOCUS*, Michael Gorman, PhD, MSW, a research scientist and clinical social worker with the Alcohol and Drug Abuse Institute of the University of Washington, charts the twin courses of the HIV and drug use epidemics. He focuses, in particular, on the epidemiology of methamphetamine use in the United States.

Also in the February issue, Michael Siever, MPH, Director of the Stonewall Project, a program of the Department of Addiction Medicine of the University of California’s San Francisco General Hospital, discusses clinical interventions for methamphetamine users.
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