The words “heroin” and “injection drug use” have come to be equated with HIV transmission. But, other drugs are injected, and other attributes of these drugs, including sex-enhancing properties and impaired judgment, may increase sexual risk-taking and HIV infection. Chief among these “other” drugs are the stimulants: amphetamines, methamphetamines, and cocaine.

This article looks at stimulants and their relation to the HIV epidemic of the 1990s. First, it reviews recent HIV surveillance data about the shape of the drug use epidemic in the United States. Second, it offers an overview of the stimulant epidemic in particular. Finally, it describes two cases that offer insights into the lives of seropositive individuals who use stimulants.

The Epidemiology of Drug Use and HIV

A great deal of HIV transmission in the United States is attributable to the role substance use plays in unsafe sexual behavior. This is especially likely to be the case with stimulants such as methamphetamine and cocaine. While nearly 60 percent of the adults with AIDS and injection drug use histories are heterosexual men and 21 percent are women, 20 percent are men who have sex with men. Among people with AIDS younger than 25 years old, these proportions are even more dramatic: nearly one-third of those cases are among young women, one-third among heterosexual men, and almost another third among men who have sex with men.

Analyses of drug use have generally ignored drug-specific patterns and subcultures of drug use—for example, among methamphetamine, cocaine, crack cocaine, and heroin—regional differences in these drug use patterns, and a whole range of demographic data. In the eastern and upper middle western United States, and in parts of the U.S. South, the typical drug use-related AIDS case is likely to be a heterosexual individual—increasingly a woman or a person of color or both—who has used heroin, crack, or cocaine.

In the western United States, the profile is significantly different. In California, Oregon, and Washington, for example, a near majority of people with AIDS who have injection drug use histories have been gay and bisexual men (although this proportion appears to be decreasing). In the West, the drugs of choice associated with HIV disease appear to be stimulants, especially methamphetamines, but also cocaine, with heroin being less common in this population. Seroprevalence among people entering methadone maintenance in western Washington, for example, hovers at about 2 percent, versus 60 percent in comparable populations in New York City.*

The Class of Stimulants

The class of drugs called stimulants refers to widely disparate kinds of substances, which have in common the ability to increase activity in the central and autonomic nervous systems. The primary stimulant drugs associated with HIV disease in the United States are cocaine, crack cocaine, and methamphetamines.

Cocaine probably represents the oldest drug in this class, having been used by South American Indians for more than 1300 years. Cocaine is derived from the leaf of the coca plant (Erythroxylon coca) and was originally chewed to deliver its effect. Cocaine induces a general state of euphoria, depresses appetite, and increases endurance. Crack is a free base form of cocaine. Cocaine can be ingested, snorted,
Editorial: The Individual Described
Robert Marks, Editor

The speed and crack epidemics are not new, nor is their connection to HIV. Stimulants lead to “dissociation,” a stiff and formal word that describes actions that are anything but controlled and often risky. While this effect may be inherent to stimulant abuse, the profiles of people who use stimulants vary across a broad array of populations. This issue of FOCUS concentrates on methamphetamine use, one of the key areas of discourse at a conference on HIV and substance among men who have sex with men last September in Seattle. Michael Gorman, one of the conference’s organizers, describes the range of demographic characteristics of people who use methamphetamine and highlights geographical differences among these user populations. Two articles abstracted in the Recent Reports—one by Gorman and one by Cathy Reback—relying on ethnographic methods also detail the traits of specific subpopulations of speed users in Seattle and Los Angeles.

A Mantra for a Complex World
All of these reports help to flesh out the speed epidemic and the challenges of delivering HIV prevention messages to groups that seem to be similar but are, in reality, vastly different. Most compelling, is the fact that there are so many distinct groups of users and that what may appear to be subtle differences among these groups are so significant for HIV prevention. Michael Siever adds to this complexity by discussing in his article the effects of individual differences on a culturally competent, client-centered clinical approach.

For providers, all of this information is crucial to approach some of the most stereotyped groups in our society. The articles here clarify not only the extent and severity of the intertwined epidemics of HIV and stimulant use, but also the magnitude of difference among clients who may look the same.

This perspective, like the two epidemics, is not news. But perhaps, in the face of so many pressures to homogenize our perceptions, it must be repeated over and over; a mantra necessary to overcome the natural impulse, even among the most skilled therapist, to simplify a too, too complex world.

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smoked (as is often the case with crack), and injected. Cocaine mixed with heroin is called “speedball.” In addition to stimulant properties, cocaine has local anesthetic properties that can lead to convulsions as well as respiratory distress.

Amphetamines were first synthesized by a German pharmacologist in 1887. The related compound methamphetamine, currently referred to as “speed,” “crank,” or “ice” was synthesized in 1919. Amphetamines, including methamphetamines, are currently the most widely abused synthetic drugs in the United States and the Pacific Rim. Amphetamines and methampethamines—which may be drunk, eaten, smoked, injected, or absorbed through the rectum—cause the release of the neurotransmitters norepinephrine, dopamine, and serotonin. With a half-life of approximately 24 hours, the action of these drugs may be quite prolonged. Their therapeutic effects include treatment of narcolepsy (a sleep disorder), attention deficit disorder (ADD), and in some cases, depression.

The toxic effects of amphetamines and methamphetamines may include headache, hypertension, pallor, palpitation, and the constriction of veins (vaso-constriction). In low to moderate doses, these drugs may lead to signs of central nervous system intoxication, including anorexia, hyperreflexia (over-responsive reflexes), restlessness, talkativeness, and insomnia. At high dosages or prolonged continuous use, effects may also include hypervigilance and paranoia with hallucinations, with tendencies to violence.

While not a new problem, methamphetamine use has undergone a recent resurgence and continues to attract considerable national attention. Methamphetamines currently rank among the most widely used synthetic drugs in the United States, according to the Drug Abuse Warning Network, the CDC, the Drug Enforcement Agency, and the Office of National Drug Control Policy.

Between 1991 and 1996, methamphetamine-related deaths in the United States tripled, and almost all involved methamphetamines in combination with at least one other drug. Emergency room-related methamphetamine episodes also tripled since the early 1990s, with the largest increases occurring in the western United States, especially in Phoenix, San Diego, San Francisco, Los Angeles, Denver, and Seattle. By the mid-1990s, the methamphetamine epidemic had penetrated the Midwest and parts of the southern United States.

In all western and many midwestern states, methamphetamine has similarly
In Washington, admissions for treatment for speed use have increased sixfold, in some places even exceeding the number treated for heroin use.

The rise of methamphetamines notwithstanding, cocaine still remains a tremendously popular drug. Since it shares with methamphetamines some of the same pharmacological attributes, cocaine puts people at risk for HIV disease in similar ways: through needle sharing, sharing of other drug paraphernalia, or sexual disinhibition. It may be helpful to consider the cases of two seropositive individuals who use stimulants. Both individuals were identified through the Seattle Methamphetamine Study at the University of Washington.

Robert: Burning Out

Robert is a 28-year-old, gay White man who is staying with a friend while looking for a job and a new apartment. He is unsure of his HIV status; he tested negative three years ago, but occasionally engages in unsafe sex. Robert “water-injects” crystal methamphetamine (shooting a crystal solution into the anus). He says he has never shot crystal intravenously. Robert says he initially used crystal to increase sexual pleasure and energy for dancing. Today, he says he uses it as an escape from homelessness and unemployment.

Raised a Mormon in Utah, he moved to Seattle at age 21 to take a job for which he’d been recruited. He also began a law office internship and continued his undergraduate studies. He held a 3.9 grade point average and maintained a focus on his career goals. Robert says he first experienced crystal while in San Francisco when he was 23. “It wasn’t all that pleasant,” he says. “It was way too intense, lasted way too long.”

Two years later, burnt-out with his grueling school and work schedule, Robert decided to “live a little and do drugs all summer.” After two months of water-injecting crystal, he lost his job, quit his internship, and dropped out of college. He was evicted from his apartment, losing all of his personal belongings. Robert considers himself a crystal addict: “I mean, crystal is the type of drug that you’re doing around the clock.” Today, reflecting on his losses, he says, “I wish I’d never done crystal.”

Roxy: Going to Heaven

Roxy, a 36-year-old, seropositive, Black, transgendered female began shooting speed when she was 19. She remembers her first time fondly: “It was like dying and going to heaven.” Her primary motivation was for energy to dance. In 1983, Roxy was living in San Francisco and beginning hormone replacement therapy. When doctors told her that crystal would interfere with her male-to-female process, she stopped for two years, choosing to inject cocaine instead. After almost dying of a cocaine overdose, she went back to crystal.

After she completed her transition from male to female, Roxy began sex work in San Francisco’s Tenderloin District. She regularly engaged in unsafe sex. She eventually began stealing money to support her habit and going on crystal binges that sometimes lasted as long as 18 days.

Ultimately she decided that she had to stop prostituting and using crystal, so she moved to Seattle with one of her “johns.” She remained clean from crystal for two years. During a trip to San Francisco to visit friends, the reality of her HIV status hit her, and she began shooting crystal again. Roxy states, “HIV will really depress the shit out of you. Especially when you know somebody that’s really sick.”

Roxy still uses crystal—alone while masturbating to pornographic videos. She is well-connected to medical and social services in Seattle and regularly volunteers time at local AIDS organizations.

Conclusion

Robert and Roxy represent two points on the spectrum of people who use stimulants. Each began using speed for one reason and saw these reasons change over time; nonetheless, the fact of addiction remained prominent. The epidemiological data discussed in this article offer a perspective on the surprising number of different stimulant epidemics; stories like those of Robert and Roxy suggest the texture of each of these epidemics.
Stimulant Abuse Treatment and HIV
Michael D. Siever, PhD

The use of mind-altering substances is commonplace in our society. We use alcohol and other drugs for many reasons: to ease tension, to relax, to deal with unpleasant emotions, to escape the difficult realities of life, to seek thrills. Unfortunately, for many people, the recreational use of alcohol and other drugs becomes problematic and, for some, leads to addiction. In the last two decades, the potential negative consequences of substance use have increased significantly due to HIV disease. This article discusses HIV and stimulants, specifically cocaine and amphetamine, the context of stimulant use, and clinical approaches that can help clients.

Effects of Drug Use
Both cocaine and amphetamine can elevate mood, induce euphoria, increase alertness, reduce fatigue, increase energy, decrease appetite, increase motor and speech activity, and provide a sense of increased personal power and prowess. These positive effects often lead, either slowly or swiftly, to addiction. Both can be ingested in a variety of ways including snorting, smoking, and injecting. Cocaine today is most commonly taken in the form of “crack” which is smoked. Methamphetamine, known as “crystal,” “crank,” “meth,” or “speed,” is most often snorted, but increasingly is either smoked or injected.1

Side effects for both cocaine and amphetamine include increased blood pressure and heart rate, sweating, anxiety, irritability, insomnia, and paranoia. At high doses or with prolonged use, the irritability and anxiety can become heightened and there may emerge frankly paranoid delusions and visual and auditory hallucinations that closely resemble paranoid schizophrenia. With continued use, amphetamine users often develop a pattern of confused and disorganized behavior, including compulsive repetition of meaningless acts sometimes referred to as “tweaking.” Other negative effects include profound physical and emotional depression as the drug is metabolized and the positive effects wear off. Although not a direct effect of the drug, amphetamine users often suffer the consequences of going for days without eating, drinking, or sleeping.1

There is mounting evidence that methamphetamine in high doses or with prolonged use can produce long-term changes in brain chemistry.2 This may explain the persistence for months, even years after drug cessation of drug craving, paranoia, and sometimes even psychotic behavior, including hallucinations. In addition, many speed users, upon relapse, resume the often elaborate paranoid delusions at what seems to be exact point where they left off the last time they used.

The most important difference between crack and speed is the cost and duration of the high: speed is less expensive and produces a much longer lasting high with a half-life that is 12 to 13 times that of cocaine.2 Although crack is relatively cheap, around $10 per “rock,” and the effect is intense, the brief high necessitates frequent purchases. Methamphetamine, on the other hand, is relatively cheap with a high that lasts for four to six hours at a minimum; costing about $30, a quarter-gram of crystal may keep the low frequency user high for several days.

Differences in the cultural context of crack and speed use are particularly

Clearinghouse: Stimulants and HIV

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Many crystal addicts are self-medicating an undiagnosed attention deficit hyperactivity disorder.

The Context of Use

Working successfully with drug users requires taking into account the type and extent of drug use and its cultural context. And while substance abuse treatment may be a necessary adjunct to HIV prevention and care, it is important to realize that not all drug use constitutes abuse or addiction, but may nonetheless affect HIV risk.

To provide culturally competent services to drug users, a client-centered approach is essential. The clinician must seek to understand each client as an individual, including the social context in which the client uses, his or her pattern of drug use and reasons for using, and the relationship between sex and drugs. When dealing with such highly stigmatized behaviors, it is especially important that health care workers create a safe, non-judgmental environment. Acknowledging the positive as well as the negative aspects of drug use is crucial in developing an effective relationship with clients.

A good illustration of a culturally competent approach is the treatment of methamphetamine abuse in gay and bisexual men. Since pharmacological treatments for methamphetamine dependency have not yet been developed, care must focus on psychosocial and behavioral treatment. The context of drug use in this population is influenced by the centrality of sexuality to a gay or bisexual identity, the emotional impact of AIDS on the gay and bisexual communities, and the marginalization of gay and bisexual men.

For many gay and bisexual men, drug use and sexuality are closely intertwined. Many report never having had sex while not under the influence of some substance. Consequently, feeling “horny” becomes a trigger for drug use and is the most frequent reason for relapse. In addition, in a community that celebrates casual sex, many gay and bisexual men have unresolved issues around sexual versus emotional intimacy. Finally, in a community in which beauty is highly prized and sexual objectification common, many use speed as a method of weight control.

Within gay and bisexual communities, substance use occurs in the context of massive loss and grief. Regardless of a person’s serostatus, the illness and death of so many loved ones has complicated bereavement and produced widespread depression. In addition to its reputation as the most effective antidepressant available on the street, methamphetamine is known to combat the physical effects of HIV disease such as fatigue.

One of the most frequent reasons given for substance abuse among gay and bisexual men is the desire to numb oneself, to not

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See also references cited in articles in this issue.
feel, to not think. This desire for escape combined with the current “safe sex fatigue” felt by some gay and bisexual men, enables them to engage in unsafe sexual activity without acknowledging the consequences. Additionally, in the gay community, recreational substance use is considered normative, not deviant. Ironically, despite this, gay and bisexual injection drug users may still experience significant stigmatization from within their community.

As is true in other stigmatized communities, many gay and bisexual men, having experienced insensitivity, homophobia, and even outright discrimination from health care providers, may therefore distrust the health care system. Many also resist Twelve Step groups in which the focus is on commonality and on minimizing difference, a perspective that may counter a gay or bisexual man’s experience of feeling “different” because of his sexual orientation. Similarly, many gay and bisexual men may have difficulty with the Twelve Step emphasis on spirituality, given the condemnation most religions express toward homosexuality.

All of these issues are magnified for gay and bisexual men of color. Many of these clients have experienced not only societal stigmatization, but also homophobia from their ethnic communities and racism from the gay and bisexual communities.

Treatment Considerations

In addition to cultural context, it is important to understand the individual histories of stimulant abusing gay and bisexual men whose past may include sexual abuse and exploitation, physical and emotional abuse, and other factors that may contribute to pre-existing mental health issues and predispose them to substance use and other high-risk behaviors. One common clinical observation is that many who are addicted to methamphetamine are self-medicating an undiagnosed attention deficit hyperactivity disorder, while others were diagnosed and prescribed Ritalin as children and became addicted to this amphetamine analog.

When working with gay and bisexual methamphetamine users, as with any other substance users, it is essential to gauge the client’s motivation for change. Many clients may have no desire to cease their speed use or are ambivalent at best about making any changes. For these clients, harm reduction approaches, especially in terms of HIV risk, may be more useful than trying to impose abstinence. Reducing frequency and amount of use, switching from injecting to snorting or smoking, or using safer sex techniques while high are among the initial goals to which clients might agree.

Motivational interviewing is especially useful in ascertaining a client’s desire for change and for reinforcing whatever desire for change exists. For the client who wants to quit, cognitive-behavioral techniques such as relapse prevention may be helpful. Using relapse prevention, counselors and clients identify the environmental and psychological cues that trigger the desire to use and develop effective coping skills to minimize these triggers. In addition, in order to avoid relapse, providers and clients may need to manage difficult emotional issues that the client had successfully avoided through drug use. For some, a substance abuse treatment program is appropriate; for others, peer support such as Crystal Meth Anonymous, a rapidly growing, West Coast, Twelve Step group may be sufficient. It is also important to remember that many people deal effectively with their substance abuse problems without any professional help.

Conclusion

Overcoming methamphetamine abuse and addiction is an arduous and lengthy process. Patience is required both of the counselor and the client. Relapse is often part of the recovery process and should not be viewed by the counselor or client as failure. This is especially true in terms of methamphetamine addiction because drug craving and negative side effects may persist long after drug use cessation.

The very nature of addiction is that the immediate payoff of using seems to outweigh the long-term benefits of abstaining. The clinician’s most important role may be in helping the client at each step to cope with the length of this process, continually assisting him or her in remembering the long-term benefits of recovery.

Authors

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Recent Reports

**Speed and Risky Sex among Non-Injectors**

A study of clients tested at about 850 state-funded antibody test sites in California found that snorting and smoking methamphetamines is associated with risky sexual behaviors and HIV infection. Researchers gathered data from 370,000 clients tested between July 1, 1994 and December 31, 1995. They excluded data from injection drug users, people who reported no sexual relations, and women who only had sex with women, and divided the remaining 250,000 clients into four categories—gay men, bisexual men, heterosexual men, and heterosexual women—and each category into methamphetamine users and nonusers.

About 4 percent of the 250,000 subjects reported using methamphetamines during sex. Methamphetamine use during sex was related to risky behavior regardless of sex, age, race or ethnicity, or sexual orientation, and was independent of other drug use (alcohol, cocaine, and marijuana). Those reporting methamphetamine use had significantly more sexual partners than nonusers—and were more likely than non-users to have engaged in anal intercourse. Regardless of type of intercourse—vaginal, anal-receptive, or anal-insertive—methamphetamine users were less likely than nonusers to use condoms and were more likely than nonusers to have acquired a sexually transmitted disease. Users were more than twice as likely to have had sex with a sex worker or to have exchanged money or drugs for sex; they were more than four times as likely to have had sex with an injection drug user.

Gay men who reported methamphetamine use were almost twice as likely to be HIV-infected as nonusing gay men. According to the researchers, there are several explanations for this association, which was independent of the use of other drugs. First, users were more than twice as likely as nonusers to have exchanged money or drugs for sex. Second, people who use methamphetamines may be risk takers by nature. Third, because methamphetamines reduce social inhibitions and heighten sexual pleasure, users may be more likely to seek sexual gratification from numerous partners. Fourth, methamphetamines can cloud a user’s judgment about unsafe sexual practices.

The researchers advise health educators to address the perceived positive aspects of methamphetamine use, for example, elevated sexual experience and performance, when formulating HIV-prevention messages.

**Methamphetamine Use and Gay Identity**

Methamphetamine use in the gay community has increased so dramatically in recent years that for many men, it has become an integral part of their gay identity—a surprising result suggested by an ethnographic survey of gay and bisexual men in Los Angeles. Interventions for substance use must therefore address gay identity and the meaning of gay sex.

Researchers interviewed 63 methamphetamine users who used the drug at least once a month during the previous six months and at least once in the previous 30 days. Participants self-identified as gay or bisexual men, heterosexual men who have sex with men, or male-to-female transgendered individuals. Research methods included observational fieldwork, unstructured interviews, and focus group discussions in five populations: former methamphetamine users, youth, men of color, predominantly street-using HIV-positive men, and predominantly middle-class and upper-middle-class seropositive professionals.

Of the sample, 49 percent were White, 22 percent were Hispanic, 19 percent were African American, 7 percent were Native American and 3 percent were Asian/Pacific Islander. Participants’ ages ranged from 17 to 51 years. Nearly all had been tested for HIV and were aware of their HIV status; 42 percent were seropositive.

Participants identified themselves in terms of three primary characteristics, all of which are associated with social stigma: sexuality, methamphetamine use, and HIV.

**There was a strong relationship between gay identity and drug use: speed facilitated social and sexual interactions, interrupted negative internal messages about being gay, or became positively associated with sex and sexual identity.**
status. Many participants used methamphetamine as a positive coping mechanism for dealing with physical or emotional pain, negative internal messages arising from their sexual orientation, or fears of transmitting HIV. Most distanced themselves from the self-concept of drug user by considering themselves “functional” and therefore exceptional among users: 64 percent viewed their crystal use as controlled but often described the crystal use of friends as unmanageable. Crystal use also freed many subjects from guilt associated with their HIV status and unsafe sex.

Subjects indicated a strong relationship between gay identity and drug use: methamphetamines facilitated social interactions and sexual encounters, interrupted negative internal messages about being gay, or in some way had become positively associated with sex and sexual identity.

In terms of social interactions, crystal use was described as an “equalizer,” enabling clients to cross social boundaries. It also formed separate social groupings around injectors, who were afforded less social status by non-injectors, and “club kids,” youth for whom crystal use is associated with dancing rather than with sex. Youth who lived with a parent or guardian primarily used crystal for dancing; those who did not tended to support themselves through sex work and used crystal primarily for sex.

An Ethnographic View of Speed and Sex


The recent rise in methamphetamine use presents one of the most serious hazards for HIV seroconversion among men who have sex with men, according to preliminary data from a Seattle ethnographic study.

Researchers recruited 30 subjects using referrals from participating agencies and individuals. Approximately 80 percent were White, and a majority identified themselves as gay or bisexual. All participants were either still using methamphetamines or had recently stopped, and nearly half reported injection as their primary method of use. The study relied on ethnographic research methods such as unobtrusive community observations, focus group interviews with both service providers and community leaders, and a variety of types of individual interview.

A majority of those interviewed had extensive histories of polydrug use; all said that when they tried methamphetamines, they became hooked. Subgroups of methamphetamine users included: men involved in “circuit parties,” men whose activities focused on gay baths and sex clubs, transgendered or transsexual people, young adults connected with street scenes, HIV-infected men who used methamphetamines to self-medicate, middle class “weekend users,” and men who lived in the suburbs but socialized in the city.

Mental health providers reported that some people with HIV disease used methamphetamines to help manage symptoms of depression. Research subjects themselves reported they used the drugs for their aphrodisiac qualities and some transgendered individuals used them to assist in the transition to their feminine personae.

Other studies have found that the disinhibiting effect of speed can lead to increased number of sexual partners, unsafe sexual behaviors, condom breakage, and needle sharing. One study found that methamphetamine-using men who have sex with men engage in unprotected anal intercourse 2.9 times more often than nonusers; another found that the strongest relative hazard for HIV seroconversion was consistent methamphetamine use.

Next Month

HIV disease has always had a tremendous effect on interpersonal relationships, in particular, intimate ones and most dramatically in committed relationships. In couples—both mixed serostatus ones and couples where both partners have HIV—the unexpected recovery of one partner is bound to have an effect on the couple’s dynamic. In the April issue of _FOCUS_, Robert H. Remien, PhD, a Research Scientist/Clinical Psychologist at Columbia University, details the effects of successful antiviral treatment on a couple, discussing issues such as changes in roles, expectations, and sexual activity.

Also in the March issue, Norman M. Sohn, PhD, LCSW, a psychotherapist and a member of the clinical faculty of the University of California San Francisco Department of Psychiatry, reviews the theoretical underpinnings of couples counseling, applying a control-mastery approach.
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