The word “transgender” is an umbrella term that encompasses a range of different people, including transsexuals, transvestites or cross-dressers, and intersexed people. What they have in common is that their gender identity—the psychological sense a person has as a man or a woman—or their gender presentation differs partly or completely from their biological sex, which is determined by a person’s genitals, chromosomes, and hormones.1

At one end of the transgender continuum is crossdressing, also known as transvestism, drag, or male or female impersonation, which refers to the practice of dressing as the opposite of one’s biological sex. There are heterosexual, gay, lesbian, and bisexual people who crossdress. People “dress” for a variety of reasons, including personal satisfaction, sexual gratification, and performance. Crossdressing may be an occasional activity that is not a defining characteristic of a person’s identity. “Crossdressing” is often used to describe heterosexual men who engage in this activity, while “drag” more often applies specifically to gay or lesbian participants, and “impersonation” describes entertainers.1

Transsexuals are people who identify with and desire to be the sex opposite of their biological sex.1 Some transsexuals undergo gender-confirmation surgery or hormone therapy to achieve primary and secondary sexual characteristics associated with their gender identity. Depending on the gender, these characteristics may include genitals, breasts, facial hair, and changes in vocal pitch. Gender confirmation surgery may include “top surgery” to reduce or enlarge breasts and “bottom surgery” to remove existing genitals and create genitals appropriate for the individual’s gender identity. Transgendered people may choose not to undergo surgery, to have only one procedure, or to have both.2

The word “transgender” is often used instead of “transsexual,” in part because people may identify as transgendered without having gender-confirmation surgery. A transgendered woman is someone who began life biologically male but has a female gender identity. Her gender identity might also be called male-to-female transgender, often referred to as MTF. A transgendered man began life biologically female but has a male gender identity. His gender identity may also be called female-to-male transgender, or FTM. Transgender status does not imply sexual orientation; there are gay, lesbian, bisexual, heterosexual, and asexual transgendered people.

Gender and Transgender

“Gender” has historically been used as a linguistic term to designate nouns as masculine, feminine, or neuter. In 1955, sociologist John Money adopted the term to distinguish masculinity and femininity from biological sex. “Gender identity” is a person’s perception of his or her gender. “Gender role” refers to the characteristics a culture assigns to men and women and influences how other people perceive.
a person’s gender. Clothing and body decoration are the major symbols of gender. Other symbols include mannerisms, gait, occupational choice, and sexual orientation.

It is important to remember that each of these components of gender occurs within a cultural context and is dynamic. What is “gender-appropriate” in one culture may lie outside the norm in another. Ideas about men and women—and their roles and appearance—change over time.

Most people are “gender congruent,” meaning that their gender identity is consistent with their biological sex, gender role, and other related symbolic manifestations of gender. Transgendered people do not fit neatly into the male or female categories. According to one conceptual model, people can generally be categorized across four gender-related characteristics: biological sex, gender role, psychological gender, and legal-institutional sex.

Biological sex is usually determined by a person’s genitals as well as other biological factors, including chromosomes, hormonal makeup, secondary sexual characteristics, and other physiological variations. However, some children are born “intersexed,” that is, with ambiguous genitalia or with both a penis and vagina, and this may cause difficulty in categorizing an infant as male or female. Many of these children undergo surgical interventions that alter their genitals to resemble those found on traditionally male or female children. These children are often reared as girls and develop breasts, but they never begin to menstruate.

Social gender refers to the way people present themselves in public. Many aspects of personal appearance are associated with gender. For example, the way a person dresses, wears his or her hair, talks, and acts may all affect his or her gender presentation. For some people, medical interventions that alter appearance to reflect a particular gender may play a significant role in social gender. Other people have a variable social gender, such as those who occasionally dress as the opposite gender for performance, fun, or sexual arousal. Medical procedures are expensive and are not simply a matter of personal choice; access to financial resources also plays an important role.

Psychological gender is the way people define themselves: as male, female, transgender, or intersex. The way people identify their own gender may be influenced by other factors, such as race, ethnicity, culture, subculture, and geographic location. Legal-institutional sex is the designation people cite on their identification cards, forms, and other official documents. It is sometimes possible for people to change their legal-institutional sex, depending on local laws.

Gender identity does not necessarily determine sexual attraction. A study of 523 transgendered people found that after their transition, male-to-female participants were more likely than female-to-male participants to be attracted to the opposite sex and to self-identify as heterosexual. Among male-to-female participants, 75 percent had sex with male partners, 6 percent had sex with female partners, and 6 percent had sex with transgendered partners. Among female-to-male participants: 58 percent had sex with female partners, 18 percent had sex with male partners, and 15 percent had sex with transgendered partners.

Some transgendered people change the gender to which they are attracted after undergoing the gender reassignment process. In a qualitative study of 20 transsexuals, six male-to-female respondents reported that their sexual orientation had changed from being attracted to women before the transition to being attracted to men after the transition. Four of the participants were post-operative, and two were pre-operative. None considered themselves to be “gay” or reported homosexual behavior prior to gender reassignment, and five had been married. Five of the six participants believed their attraction to women before gender reassignment was related to their attempts to conform to traditional gender role expectations. After becoming women, the same traditional gender roles facilitated the development of sexual orientations toward men. Thus, they effectively remained heterosexual.

Stigma and Discrimination

Several common cultural attitudes and beliefs about gender may serve as a basis for stigma and discrimination against transgendered people: that there are only two genders; that gender is a biological fact independent of perception; that a person’s gender can never change; and that genitals are the defining feature of gender. Further, not knowing a person’s gender makes many people feel uncomfortable.

Research suggests that transgendered people experience severe employment, housing, and health care discrimination. Transgendered people are often victims of harassment and violence because of their physical appearance, and they tend to receive little or no protection from the legal system. Most transgendered people experience some form of discrimination or violence at some time in their lives. One study showed that about 60 percent of transgendered people had experienced some form of violence or harassment, and 37 percent had experienced some form of economic discrimination.

While transgendered people are at high risk for HIV, their fear of discrimination makes it difficult to target them for interventions, and they may avoid seeking HIV education, testing, and other health care services. Research has documented insensitive behavior by health care providers toward transgendered clients.
clients, for example, failing to respect transgendered women’s identity and referring to them as “he” or “him.” In addition, research suggests that many doctors have a negative opinion of transsexual women. A transgendered person’s awareness of this kind of insensitivity can make him or her less likely to access services.4

Transgendered sex workers may be at particularly high risk of both HIV and transgender-related discrimination. The social networks for many transgendered sex workers center around bars, where substance use is common, and transgendered sex workers often do not have alternative networks. Some transgender programs sponsor events such as beauty pageants to offer alternative support networks. Support groups may also help transgendered people increase their self-esteem by instilling pride in their transgender identity, which may motivate them to protect themselves from substance abuse and HIV.8

HIV Risk Factors

A qualitative study comparing HIV risk behaviors among transgendered women with gay or bisexual men and heterosexual women in San Francisco found that transgendered women were at greater HIV risk, because they had more sex partners, and were more likely to inject drugs, to have sex partners who inject drugs, and to exchange sex for money and drugs than the study’s other participants. Another factor that may contribute to risky behaviors among transgendered women is socioeconomic condition, such as low income, high unemployment, low education levels, temporary living conditions and discrimination.

Transphobia makes it hard to target transgendered people for HIV prevention.

The two-part study consisted of interviews with six program directors, one counselor, and one consultant at programs that provide HIV-related services to transgendered clients, as well as interviews with 173 clients of these agencies.8 In their interviews, providers offered opinions based on experiences; these observations may not be representative of all transgendered people. Providers reported that large numbers of transgendered clients engage in sex work, but they did not cite percentages. The interviews also described the following beliefs among the providers: many transgendered sex workers do not earn as much as other sex workers and compensate by having sex with more clients; speed (amphetamine) is the preferred drug among transgendered sex workers, and taking speed helps them work longer hours and cope with the related stress; and some transgendered people inject hormones smuggled from Mexico because they believe injections are more effective than pills. The needles for injecting hormones are longer than those for injecting drugs and are not available at most needle exchange services.8

While the provider interviews in this study focused primarily on transgendered sex workers, the interviews with clients compared the HIV risks of transgendered women, non-transgendered gay or bisexual men, and non-transgendered heterosexual women. In this aspect of the study, 28 percent of transgendered women and 27 percent of heterosexual women had injected drugs, compared with 13 percent of gay or bisexual men. In addition, 22 percent of transgendered women reported having sex partners who injected drugs, compared with 7 percent of heterosexual women and none of the gay or bisexual men.8

Transgendered women reported an average of 31.2 sex partners in the prior six months, compared with an average of 5.7 partners for gay or bisexual men and 1.4 partners for heterosexual women. Among HIV-positive participants, transgendered women reported an average of 66.2 sex partners in the prior six months, compared with 4.79 for gay or bisexual men and 1.3 for heterosexual women. In the prior six months, 28 percent of transgendered women had exchanged sex for money or drugs, compared with 17 percent of heterosexual women and 8 percent of gay or bisexual men. Also, 17 percent of transgendered women had paid for sex, compared with 3 percent of gay or bisexual men and 4 percent of het-

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**Transgender Terminology**

**Transgender:** A broad term describing a variety of people whose gender identity or gender presentation differs from their biological sex; includes transsexuals, transvestites or crossdressers, and intersexed people.

**Biological Sex:** The genitals, chromosomes, hormones, and other physiological characteristics that make a person male, female, or intersexed.

**Intersexed People:** People born with sex chromosomes, external genitalia, or an internal reproductive system not typical for either male or female.

**Gender Identity:** The way people define themselves as male, female, transgender, or intersex, and how they present their gender to the world.

**Transsexuals:** People who identify with the sex opposite of their biological sex. Some desire or undergo gender-confirmation surgery or hormone therapy to achieve sexual characteristics congruent with their gender identity.

**Crossdressing, Transvestism, Drag, Male or Female Impersonation:** The activity of dressing up as a member of the opposite of one’s biological sex. There are heterosexual, gay, lesbian, and bisexual people in this category.
erosexual women. Overall, transgendered participants were more likely to engage in HIV risk behaviors than other participants.

Another San Francisco study of 523 transgendered men and women found higher rates of HIV infection among male-to-female participants (35 percent) than among female-to-male participants (2 percent). Among HIV-positive male-to-female participants, 65 percent knew they were infected, and only half of these were receiving HIV-related medical care. Transgendered women were also more likely to engage in receptive anal sex (63 percent) than insertive anal sex (30 percent). Some researchers suggest that receptive anal sex is more common among transgendered women because hormone use makes it difficult to maintain an erection, and adopting the receptive role in sex is viewed as the more feminine behavior. Only 7 percent of male-to-female participants had undergone vaginal reconstruction surgery, and 2 percent reported unprotected receptive vaginal sex.

Although the transgendered men in the study reported histories of HIV risk behaviors, recent risk behaviors were relatively uncommon. In the prior six months, only five female-to-male participants had engaged in non-hormonal injection drug use, four of whom had shared needles. In the prior six months, 20 percent had not had anal, vaginal, or oral sex, while 46 percent had only one sex partner, 32 percent had between two and 10 partners, and 2 percent had more than 10 partners. Both of the study’s HIV-positive female-to-male participants knew that they were infected.

A large proportion of all study participants lacked health insurance (52 percent of transgendered women and 41 percent of transgendered men). Many transgendered people enter the medical system in pursuit of hormones, and this provides an opportunity for health care workers to counsel and refer transgendered clients in need of HIV, substance use, or mental health services.

Transgendered women tended to be more socioeconomically disadvantaged and had higher HIV infection rates than transgendered men. The study’s HIV infection rates were also higher among transgendered women than estimates from studies of gay men and injection drug users of the same age in San Francisco. Needle sharing among participants who engaged in injection drug use was also higher than in studies with out-of-treatment injection drug users in San Francisco.

In a 2002 study of HIV status and risk factors among 49 transgendered women and 32 transgendered men, 19 percent reported being HIV-positive, 77 percent reported being HIV-negative, and 4 percent said they did not know their infection status or did not respond. Fifty-six percent of HIV-positive transgendered women were taking HIV antiviral medication. All female-to-male participants reported being HIV-negative.

Of the 12 participants with a history of injection drug use, 83 percent were male-to-female, and the 67 percent who reported needle sharing were all male-to-female. Only transgendered women reported having injected hormones and silicone, and more than 90 percent of these said the needles they used were clean.

**Commercial Sex Work**

Gender confirmation surgery is expensive, and discrimination in the workplace makes it difficult for transgendered people to make a living through traditional employment. For some, commercial sex work may provide a way of obtaining the money required for gender confirmation surgery. Research comparing male-to-female transgendered sex workers with male and female sex workers in the same neighborhoods has consistently found higher HIV infection rates among the transgendered samples.

Although research has shown that many transgendered sex workers have high rates of condom use with clients, they tend to occupy the bottom of the sex-work hierarchy and to work in the least desirable locations, to earn the least amount of money, and to be stigmatized by male and female sex workers. As a result, transgendered sex workers may be more willing to engage in unprotected sex with clients who refuse to wear condoms or offer more money to do so. There are also reports of male-to-female transgendered sex workers engaging in unprotected sex with heterosexual men because of the belief that the HIV risk is low with these men.

In a study of 209 male-to-female transgender clients of an HIV harm reduction program in Hollywood, California, 36 percent of participants reported exchanging sex for money or drugs during the previous 30 days. These participants were more likely than others to have used alcohol and other drugs, including injection drugs, within the previous 30 days.

There were also differences between participants who engaged in sex work and those who did not in terms of sexual activity with “non-exchange” male sex partners, that is, partners who did not exchange payment for sex. In the prior 30 days, sex-working participants reported an average of 21 sex partners in total, while other participants reported an average of three partners. However, sex workers demonstrated a greater understanding of HIV risk and a high rate of condom use with clients (95 percent). They were also more likely to use condoms with non-exchange male sex partners than participants who had not engaged in sex work (94 percent versus 56 percent). Because of high rates of condom use, sex workers in this sample may be at lower risk for sexually transmitted HIV than participants who did not report sex work, despite having more sex partners, higher rates of substance use, and other risk factors.
Implications for Counseling

HIV test counselors may feel ill-prepared to work with transgendered clients because they have little or no experience with this population. Counselors may not know which questions are appropriate to ask, particularly related to a client’s sexual risks. They may even find themselves unsure of a client’s gender or suspect that a client is transgendered but be unsure about how to proceed. Societal assumptions and misconceptions about transgendered people may also cause counselors, despite their best intentions, to feel uncomfortable working with these clients.

Most of the challenges of working with transgendered clients, however, are the same as with other clients: examining and being aware of a counselor’s own issues, assumptions, and judgements; addressing clients in a respectful way that acknowledges their stage in the behavior change continuum; and actively listening and relating to each client as an individual. It is essential to apply the tenets of client-centered counseling because transgendered clients, like other clients, are the experts on their own lives, their own risk, and where they can best make changes to reduce that risk.

Learning more about transgendered people, the terms they use to describe their experience, and the social factors that shape that experience, gives counselors a head start in working with transgendered clients.

Of particular importance is “transphobia,” the societal marginalization and stigmatization of transgendered people. It can include isolation from family and friends, employment and housing discrimination, and insensitivity of healthcare providers. Extreme forms of transphobia involve violence, for example, the well-publicized cases of rape and murder of young transgendered man Brandon Teena in 1993 and the 2002 murder of transgendered female teenager Gwen Araujo.

Transgendered people are at varying degrees of transition and maintaining their gender identity, risk-related knowledge, and sexual practices. These psychosocial factors can act as co-factors for HIV risk and impede adopting safer behaviors.

HIV Risks

Though the biology of HIV risk is the same for everyone regardless of gender identity, there are particular psychosocial factors among transgendered people that influence risk-taking behavior.

Economic marginalization is an important HIV co-factor among transgendered people, particularly transgendered women. Many transgendered people face discrimination when seeking employment, and limited economic opportunities lead many transgendered women to engage in sex work.

Many transgendered people experience low self-esteem. Low self-esteem can lead to a lack of regard for personal safety, which makes negotiating safer sex more difficult and can be a factor in precipitating substance abuse. Transgendered people may also fear that it will be difficult to find a sex partner who will accept their transgender status. If they find such a partner, they may feel such gratitude for being validated as “real” that concerns about HIV risk may seem to matter. In addition, belonging to a population with disproportionately high rates of HIV infection can lead to a sense of fatalism or apathy, which in turn may cause transgendered people to believe that they, too, will eventually become infected because it has happened to so many people they know.

Transgendered people who seek counseling or social support often find that few therapists are knowledgeable about transgender experience, and limited social support further deepens a feeling of isolation.

For transgendered people of color, feelings of isolation may be especially acute. Already forced to cope with racism and economic marginalization, as well as discrimination because of their gender identity, they may not consider HIV prevention to be a priority. Experiences with the health care system may reflect their marginalization in the larger society, resulting in a mistrust of health care providers and prevention messages.

Substance abuse plays a major role in HIV risk among transgendered people both by creating an environment that makes safe choices more difficult or less important, and directly as a risk factor, through needle sharing. Transgendered people also often face barriers to substance abuse treatment because many programs are ill-equipped to meet their needs. For example, residential substance abuse treatment facilities may not be open to or appropriate for transgendered clients because of the
way these programs divide clients by gender for housing.

For both transgendered men and transgendered women, the excitement of using new body parts or exploring new identities can be a powerful force that overwhelms caution about unprotected sex. For transgendered men receiving testosterone therapy, one of the side-effects may be a sharp increase in sex drive, which may increase willingness to engage in risky sexual behavior. In addition, constructed vaginas (sometimes called neo-vaginas) may be less flexible and not as well lubricated than “organic” vaginas and, thus, may be more likely to tear during sex and increase chances of HIV transmission.

A Transgender-Friendly Atmosphere

Few positive portrayals of transgendered people exist in the popular media, and many misconceptions still endure. These include the notion that transgendered people are simply gay men or lesbians who cannot accept their sexual orientation, that they are confused, and that they cannot function as healthy members of society. It is essential for counselors working with transgendered clients to be aware of their reactions and not allow these responses to distract the focus from the client-centered risk assessment and risk reduction.

A simple but effective way to begin to create a transgender-friendly atmosphere is to create forms and procedures that acknowledge transgender existence. At some sites, demographic forms include “transgender” among the possible options to describe a client’s gender, but others limit the categories to “male” and “female.” It is appropriate to ask a client “Do you identify as male, female, or transgendered?” Keep in mind, however, that not all transgendered people refer to themselves as transgendered. For example, a transgendered woman may simply refer to herself as a woman. One of the most important things to remember is the principle of self-determination: use the same label the client uses rather than assuming that a client prefers a certain label. It is client-centered—and simply respectful—to always address transgendered people as the gender with which they identify, and refer to them in that way whether they are in your presence or not.

It is important for counselors to ask open-ended questions that may reveal information about client physiology, for example, “What kind of sex do you have?” After establishing rapport with clients, counselors may ask more specific questions about their anatomy to better understand their HIV risks. However, the best place to begin is with the same questions counselors ask all clients: “What brings you in to test?” and “What has put you at risk for HIV?” These types of open-ended questions may prompt clients to disclose their gender and other relevant information.

Do not assume that transgendered clients are unwilling to discuss private sexual matters. Do not be afraid to ask clarifying questions, if necessary. For example, a transgendered woman may refer to her anus or penis as “my pussy,” or she may, in fact, have had surgery to construct a vagina. It is important to clarify what she means, for example, by asking, “What do you mean when you say your ‘pussy’?”

On the other hand, always follow the client’s lead. For example, if a woman appears transgendered but she identifies as “female” and not “transgendered,” and she offers no information that she might be transgendered in response to open-ended questions, do not ask her if she has insertive anal sex.

Remember not to confuse gender identity with sexual orientation. Also be careful not to make assumptions about sexual activities—for example, that transgendered men do not have vaginal sex or that transgendered women are not insertive partners in anal sex—or generalize about groups—for example, that all transgendered women engage in sex work or use substances.

When working with transgendered clients, it is important to cover certain topics, in particular, sharing needles to inject hormones, tearing tissues in the neo-vagina, libido levels, healing after surgery, douching, and sex toys. One way to ask if the client is undergoing the gender confirmation surgery process and, if so, which phase, is by saying, “Have you chosen to have gender confirmation surgery?” Another option is simply saying something like, “You may be aware that any type of cuts on our bodies can serve as portals for infec-

References

Case Study

Robin is a 38-year-old, transgendered (male-to-female), heterosexual woman. She tests for HIV about once a year at an anonymous site. She says that she only has “real sex” with her primary partner and that he refuses to use condoms. Robin says she sometimes douches after sex because of her concerns about HIV.

Praise Robin for testing, and acknowledge that as a repeat tester, much of the testing process is probably familiar to her. Confirm this, and ask her why she tests once a year. Does she feel as if she is at high risk for HIV simply because she is transgendered? Does she believe it is inevitable that she will become infected?

Ask Robin what kinds of sex she has, and listen for cues in her responses to inform follow-up questions. Is she at risk for HIV from vaginal intercourse? Is she the insertive or receptive partner, or both, in anal intercourse? What about oral sex? The answers to these questions can lead to asking what Robin means by the “real sex” she has with her primary partner. Does that mean anal sex, or unprotected sex, or something else?

Explore if she is sexually active with non-primary partners in ways that are risky, and if so, ask about their gender. If she uses condoms in some situations, assess how she implements condom use into these sexual activities, and ask how she might apply these approaches to her relationship with her primary partner. Also explore Robin’s feelings about using condoms and the meaning of having unprotected sex in her primary relationship. Ask if there are barriers that prevent her from making risk-reduction changes.

Ask which, if any, sexual activities Robin believes her partner practices outside their relationship, and whether or not he has been tested for HIV. In which ways does she believe she is at risk for HIV with her primary partner? Discuss ways Robin might negotiate condom use with him, including such options as the female condom. Does she feel she has enough power in the relationship to insist on condom use?

Try to build on the discrepancy between Robin’s concern for her health and having unprotected sex with her partner. For example, the counselor might say, “On the one hand, you are concerned about your health, and you try to protect yourself by douching and testing regularly. But there are more effective ways to protect yourself, like using condoms. How can you better protect yourself and your partner?”

Remaining neutral and non-judgmental, explain to Robin that douching, whether anally or vaginally, is not effective protection from HIV and may even increase risk by irritating internal tissues. Explore ideas Robin has for more effective strategies such as condom use or switching from anal or vaginal sex to oral sex.

Assess risks Robin may face from sharing needles to inject street drugs or hormones. Find out if she has a reliable source for new hormone injection needles. If not, refer her appropriately. (It is preferable to take any medication under a physician’s care, and public or private clinics that offer hormone therapy and other services to transgendered people would be an important referral. If there is a local needle exchange program, find out if it offers needles appropriate for injecting hormones; if so, offer this as a referral.)

Summarize Robin’s risk factors, and reiterate the steps she is willing to take in her plan to reduce risk.
**Test Yourself**

**Review Questions**

1. Biological sex is determined by which of the following factors? a) genitals; b) hormonal makeup; c) secondary sexual characteristics; d) all of the above.

2. True or False: Gender identification determines a person’s sexual orientation.

3. True or False: Crossdressing may be an occasional activity that is not a defining characteristic of a person’s identity.

4. Which of the following attitudes and beliefs about gender may serve as a basis for stigma and discrimination against transgendered people? a) that there are only two genders; b) that gender exists as a biological fact independent of perception; c) that a person’s gender can never change; d) all of the above.

5. True or False: Most transgendered people experience some form of discrimination or violence at some time in their lives.

6. True or False: Workplace discrimination and economic pressures may lead transgendered people to engage in sex work.

7. Research has found which of the following behaviors among transgendered sex workers? a) injection drug use; b) engaging in unprotected sex with clients willing to pay more for this service; c) high rates of condom use with clients; d) all of the above.

8. True or False: A San Francisco study found that the estimated HIV infection rate among transgendered women was higher than estimates from studies of gay men and injection drug users of the same age.

**Discussion Questions**

1. What are some of the social factors transgendered people may experience that may increase their risk for HIV?

2. What are some thoughts and feelings counselors may have about transgendered clients that could interfere with providing client-centered counseling?

3. What are some of the similarities and differences between transgendered women (MTF) and transgendered men (FTM) in terms of possible risk factors for HIV?

4. What are some ways for a test counselor to begin to discuss HIV risks with a client who appears to be transgendered?

5. How can counselors familiarize themselves with appropriate referrals that transgendered clients may access locally or on the Internet?

6. What should a counselor do if he or she is unable to determine a client’s gender?

**Answers**

1. d.

2. False. The sexual orientation of transgendered people can vary, and some people change their sexual orientation after transitioning to another gender.

3. True.

4. d.

5. True.

6. True.

7. d.

8. True.
DID YOU KNOW?

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