

A Brief Overview of Transgender Identity: Historical and Mental Health Perspectives

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Transgender is a term used to describe individuals who have persistent and significant discomfort with their assigned gender (White & Townsend, 1998). Transgender individuals were born biologically male or female, but live their lives to varying degrees as the opposite gender. Gender identity refers to an individual's self-identification as male, female, or other. Male and female are extremes on the gender continuum and many transgender people identify as somewhere in the middle, or gender variant. A transexual is a transgender individual who seeks genital reassignment surgery. Not all transgender individuals are seeking to "transition" through hormone therapy, aesthetic surgery, or genital surgery; in fact, many do not. Transgender people are referred to as male-to-female (MTF) or female-to-male (FTM).

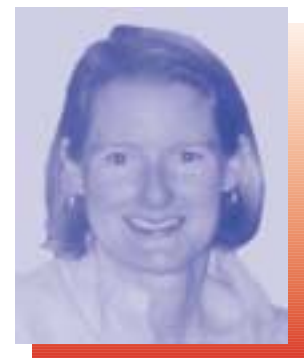
It is also important to distinguish between gender identity and sexual orientation. It is a myth that all MTF transgender individuals are attracted to men, or that they are really homosexuals. Many MTFs are happily married and have no desire to leave their wives. MTFs and FTMs may be attracted to men, women, or both and may identify as homosexual, bisexual, or heterosexual. It is important not to confuse these issues.



Dallas Denny, M.A.

Variant expressions of gender—what we today call transgender and transsexualism—have been present throughout human history (Taylor, 1996). Gender roles outside the binary male/female were recognized members of a variety of tribal cultures (Herdt, 1994), but until recently have been

repressed in Western societies (Bullough & Bullough, 1993). Historical documents suggest that many women lived socially as men (Dekker & van de Pol, 1989; Hall, 1996) from the Middle Ages on. Legal documents showing that men lived as women are less common, but this may be artifactual, due at least partly to the fact that until recently women were largely excluded from activities which would have generated legal documents. Nonetheless, there are many reports of men who lived as women (Bullough & Bullough, 1993).



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This edition of the *Psychology and AIDS Exchange* is certainly the longest one to date and I personally think it is also the best. Not only does this newsletter have a new look thanks to the efforts of Jim Harlow and the Public Communications staff at APA, it has lots of cutting-edge content including a feature series on transgender issues and an overview of exciting work coming out of the AIDS Prevention Center at the University of Miami School of Medicine.

Special acknowledgment and a hearty thank-you are due members of the Transgender Task Force of APA Division 44, the Society for the Psychological Study of Lesbian and Gay Issues, who organized the series of articles on transgender issues. I am particularly pleased to see these articles in print because information about the transgender community seldom if ever appears in the mainstream psychology literature.

It is clear that without professional education, widespread misconceptions about transgender individuals are likely to continue in the mental health community.

The damage that can result from misconceptions about the transgender community was first made clear to me when I worked as an intern on the psychiatric unit of a well-known and respected medical school. I was assigned to a new admission who I will call Rose. Rose was an African-American, male-to-female transgender individual who presented with complaints of depression and vague suicidal ideation. My initial interview revealed that Rose's depression stemmed from the break-up of a long-standing relationship with a married man who ended the relationship when he moved out-of-town for a new job.

Rose was very upset about the relationship but she was not upset about her identity. Long before her admission to the hospital, Rose received hormone therapy, electrolysis, and surgery for breast augmentation. She was quite pleased with the results and expressed no interest in pursuing genital reassignment surgery. Basically, Rose had been living contentedly with her identity for many years. Despite Rose's longstanding pattern of dressing and behaving as a woman, the nursing staff insisted that she dress as a man, use the men's bathroom, and reside on the male wing of the unit. When I questioned these decisions, the nursing staff sought and obtained the backing of attending physicians. These decisions and the harsh manner in which they were implemented substantially exacerbated Rose's depression and her suicidal ideation. Although Rose was stabilized on a regimen of anti-depressant medication while in the hospital, I have no doubt that her hospital stay did her more harm than good. She was deeply shamed by the experience and I worried that she was unlikely to seek help again. Although I don't know what happened to Rose, I do know that mental health professionals can do much better than was done to Rose. It is my hope that the articles in this volume move our profession along in the right direction.

It is important to note that the Transgender Task Force of APA Division 44 provides networking and information sharing through its online discussion group. To join the online discussion group, send e-mail to transtaskforce-subscribe@yahoogroups.com. For more information about the Division 44 Transgender Task Force, send an email to Nick Embaye, PhD, at nickembaye@earthlink.net.

I hope to see many of you in August in San Francisco at the APA Convention. As in years past, the HIV/AIDS-related events at convention have been compiled and printed in a special program that can be obtained at the Public Interest Directorate Information Booth located at the convention center.

John R. Anderson, PhD
Director, APA Office on AIDS

A Personal Story of Transition

Meredith Morgan

In the spring of last year I unburdened myself of a secret I'd kept for fifty years when I revealed my transsexuality to a few carefully chosen friends. It was stunning news for them, coming as it was from a person who'd never before given any indication of such a thing. My friends knew me as a man who had been married, fathered children, been a Vietnam combat veteran. They looked at me and saw someone who had followed his father into the building trades and earned a living working with his hands, outdoors, in all weathers.

During the year that has passed since then I've come out to my parents, my children, my sister and her family, and my former wife. I've been blessed with their understanding and encouragement and undiminished love as I've begun the transition from male to female.

Shortly after coming out I began corresponding with a friend on the East Coast. Our ongoing conversation has been an important and sustaining component of transition for me. At one time or another she and I have talked about the entire range of issues facing transsexuals and their families, but what has always been at the core of the conversation for me is my struggle with the question

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Clinical Issues in Work with Transgender Individuals

Michael L. Hendricks, PhD

Clinical work with transgender individuals requires a sensitivity for the full range of transgender experiences as well as an understanding of the kinds of services that transgender individuals may seek. Much of what has been written has addressed the provision of clinical services to transsexuals, transgenderists, and androgynes who ultimately seek medical services to “transition” to a desired physical gender appearance that approximates their internal, psychological experience of gender. While clinicians who work with transgender individuals may be called upon to provide these services, many others will not seek medical procedures to transition for a variety of reasons.



Michael L. Hendricks, PhD

In 1979, the Harry Benjamin International Gender Dysphoria Association (HBIGDA) published the first version of its standards of care for the treatment of individuals with gender dysphoria. While the standards of care (SOC) have evolved over the course of its five editions, its primary focus has been on ensuring competent and ethical treatment for transsexuals and other transgender individuals who request hormone treatment and/or surgery to alter their gender appearance. Designed as an interdisciplinary guide, the current SOC (Levine, et al., 1998) articulate specific roles for mental health professionals in working with individuals who wish to transition to their desired gender appearance.

In describing the roles for mental health professionals, the SOC differentiate between mental health assessment and treatment in the larger, multi-disciplinary spectrum of services provided to transgender individuals. The SOC stipulate that individuals who request hormones or surgery be evaluated by a mental health professional prior to either type of procedure to assess the individual's appropriateness and readiness for medical treatment.

Assessment

Medical procedure options for transitioning may be viewed in three broad groups: hormone therapy, aesthetic surgery, and genital reassignment surgery. It is important that the clinician be well-versed in these options, as well as the possibility for side-effects and reversibility of each. Hormone therapy involves administration of feminizing or masculinizing hormones that alter the individual's physical appearance. Aesthetic surgery typically refers to non-genital surgical procedures designed to enhance the desired sex characteristics, such as breast reduction or augmentation, or facial cosmetic surgery. Genital reassignment surgery is done specifically to

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An increasingly popular focus driving the formulation of health care policy at the federal level is remedying disparities in access of health care. Such disparities arise from socioeconomic factors such as race, class, gender and associated cultural norms. 'Gender' is commonly taken to mean women's issues, but disparities created by gender *variance* also can affect sizeable populations, placing them at higher risk to various diseases and causing high morbidity and mortality rates. By *gender variant*, I mean those who cannot or choose not to conform to societal gender norms based upon their physical sex status.

Transgendered people are overtly gender variant, and in recent needs assessment studies, have been found to face multiple barriers when accessing all forms of health care, regardless of their *gender vector* (Male-to-Female, or MTF, and Female-to-Male, or FTM).

In ten year cycles, the US Public Health Service (PHS) conducts a lengthy planning process that results in a Healthy People document for the next decade. The Health People documents are essentially blueprints for funding and research priorities for federal government health care agencies, and they also heavily influence state and local health care planning. In Healthy People 2010, sexual orientation was barely included and transgender appears just once, in the

HIV/AIDS in Transgender Populations

Jessica Xavier

Overview

Until recently, transgendered people have not been identified as a population uniquely at risk for HIV/AIDS, probably due in equal parts to the lack of research, their social stigmatization, their smaller numbers (in comparison with gay and bisexual men) and their invisibility through inclusion in other at risk groups. In its HIV/AIDS surveillance and prevention efforts, the Centers for Disease Control and Prevention (CDC) has taken an approach that includes all transgendered people, regardless of their gender vector, within the MSM (Men who have Sex with Men) category. Gender vector describes the direction of gender and/or physical sex change transpeople make (i.e., from female-to-male or from male-to-female). Transgender is a term taken to mean only male-to-female (MTF) by most public health officials aware of the term. However, female-to-male (FTM) transgendered people, who must depend mainly on injectable testosterone for hormonal therapy, and many of whom also have sex with non-transgendered men, represent a wholly unmeasured, unconsidered population at risk for HIV/AIDS and other STDs.



Jessica Xavier

An April 2000 CDC *Morbidity and Mortality Weekly Report* (MMWR) identified transgender persons who contracted TB as "men who have sex with men" (MSM). The MMWR acknowledges the possibility that "transmission may be occurring beyond the transgender community" which its authors describe as a "social network" composed only of "houses". Yet clearly observable urban and suburban transgender communities existing outside of these houses have been evident for the past ten years. There are now eleven national transgender organizations that provide support, social activities, and educational materials; convene public conferences; interact with professional medical, behavioral health, and gay, lesbian and bisexual organizations; and engage in various forms of public advocacy for transgendered people. Every major city in the United States has one or more support/social groups for transgendered people (IFGE, 2000) and many of these groups also engage in educational and advocacy activities.

The decision of CDC to categorize MTF and FTM transgendered people as MSM means the unique HIV prevention needs of the transgender community and the role of transgenders in HIV transmission to other populations are not being considered in a systematic and comprehensive way. Unfortunately, this approach has the potential for undermining national (and by extension, local) HIV/AIDS prevention efforts in significant ways. Many studies of other

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Transgender Resources

FTM International, Inc.
1360 Mission St., Suite 200
San Francisco, CA 94103
415/553-5987 Voice Mail
TSTGMen@aol.com e-mail
www.ftm-intl.org URL

Gender Education & Advocacy, Inc.
P.O. Box 65
Kensington, MD 20895
301/949-3822 Voice Mail
info@gender.org e-mail
www.gender.org URL

International Foundation for Gender Education, Inc.
P.O. Box 540229
Waltham, MA 02254-0229
781/899-2212 Voice Mail
info@ifge.org e-mail
www.ifge.org URL

National Transgender Advocacy Coalition, Inc.
P.O. Box 123
Free Union, VA 22940
info@ntac.org e-mail
www.ntac.org URL

A Brief Overview of Transgender Identity...

Gender-variant expression came to the attention of the early sexologists Hirschfeld (1910, 1991) and Ellis (1906), who differentiated it from homosexuality. As the twentieth century progressed, gender variance became increasingly medicalized, especially after Christine Jorgensen's sex reassignment in Denmark (Hamburger et al., 1953). Following Jorgensen's sex reassignment, increasing numbers of men and women began demanding similar treatment (Hamburger, 1953). This eventually resulted in the formation of the first U.S. gender clinic at Johns Hopkins University (Money & Schwartz, 1969). A textbook by Benjamin (1966) defined the syndrome of transsexualism and another by Green & Money (1969) described Johns Hopkins' interdisciplinary approach to sex reassignment.

The psychomedical literature of the second half of the 1950's treated transsexualism and crossdressing as forms of mental illness. In 1980, transsexualism found its way into the Diagnostic and Statistical Manual of Mental Disorders (DSM) of the American Psychiatric Association, and remains in the current DSM-IVTR as "Gender Identity Disorder." Crossdressing is present in DSM-IVTR as "Transvestic Fetishism."

In the early 1990s, the term "transgender" arose as an umbrella to describe all sorts of gender-variant people, including crossdressers and transsexuals, and a category which had previously been ignored, transgenderists—those who choose to live as members of the other sex with no desire for genital surgery and sometimes with no hormonal therapy or other body modifications (see Bolin, 1994, for an anthropological perspective on the social change within the transgender community). The newly formed transgender community looked at gender variance not as mental illness, but as an inevitable and important social role toward which some human beings were predisposed. Cross-cultural support to support this interpretation was becoming available (Dragoin, 1997; Herdt, 1994; Roscoe, 1990; Williams, 1986).

This transgender paradigm shift has had a significant impact on the mental health community. However, many would say it has not had enough of an impact. Some mental health professionals continue to pathologize transgender people and lack the understanding and training to effectively provide mental health services to transgender individuals (Cole, Denny, Eyler, & Samons, 2000). Clinical work with transgender individuals requires an understanding and sensitivity to a broad range of transgender experiences as well as various transgender resources. The transgender community has pointed out that few people are entirely comfortable within rigid bipolar gender norms (Boswell, 1991, 1998), and that most people violate these norms to a greater or lesser degree in terms of their sexual orientation, manner of dress, choice of occupation, hobbies, gestures, and speech patterns (Wilchins, 1997).

Today a large community exists, consisting of crossdressers, transsexuals, and transgenderists, most of whom are from the middle and upper classes,

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The American Psychological Association

invites applications for the 2002–2003

William A. Bailey AIDS Policy Congressional Fellowship

Program

The American Psychological Association (APA) and the American Psychological Foundation (APF) established the William A. Bailey Congressional Fellowship in 1995 in tribute to Bill Bailey's tireless advocacy on behalf of psychological research, training, and services related to AIDS. Fellows spend one year working as a special legislative assistant on the staff of a member of Congress or congressional committee. Activities may involve conducting legislative or oversight work, assisting in congressional hearings and debates, and preparing briefs and writing speeches. Fellows also attend an orientation program on congressional and executive branch operations, which includes guidance in the congressional placement process, and a year-long seminar series on science and public policy issues. These aspects of the program are administered by the American Association for the Advancement of Science for the APA Fellows and those sponsored by over two dozen other professional societies.

Purpose

To provide psychologists with interests in HIV/AIDS policy, lesbian and gay issues, or related health and behavior issues with an invaluable public policy learning experience, to contribute to the more effective use of psychological knowledge in government, and to broaden awareness about the value of psychology-government interaction among psychologists and within the federal government.

Criteria

A prospective Fellow must demonstrate competence in scientific and/or professional psychology and an interest in HIV/AIDS, gay and lesbian concerns, or related health and behavior issues. Fellows must also demonstrate sensitivity toward policy issues and have a strong interest in applying psychological knowledge to the solution of societal problems. Fellows must be able to work quickly and communicate effectively on a wide variety of topics, and be able to work cooperatively with individuals having diverse viewpoints. An applicant must be a Member of APA (or an applicant for membership) and have a doctorate in psychology at the time of application, with a minimum of two years post-doctoral experience preferred.

Award

APA will sponsor one Fellow for a one-year appointment beginning September 3, 2002. The Fellowship stipend ranges from \$48,500 to \$61,200 depending upon years of postdoctoral experience. Up to \$3,000 is allocated for relocation to the Washington, DC area and for travel expenses during the year. Final selection of the Fellow will be made in early 2002.

Application

Interested psychologists should submit the following materials by December 7, 2001: (1) a detailed vita providing information about educational background, professional employment and activities, professional publications and presentations, public policy and legislative experience, and committee and advisory group appointments; (2) a statement of approximately 1000 words addressing the applicant's interests in the Fellowship, career goals, contributions the applicant believes he or she can make as a psychologist to the legislative process, and what the applicant wants to learn from the experience; and (3) three letters of reference specifically addressing the applicant's ability to work on Capitol Hill as a special legislative assistant.

Applications should be sent to: William A. Bailey AIDS Policy Congressional Fellowship, Public Policy Office, American Psychological Association, 750 First Street, NE, Washington, DC 20002-4242. For additional information about the application process, please contact the APA Public Policy Office at (202) 336-6062 or ppo@apa.org.

William A. (Bill) Bailey, a dedicated champion of AIDS policy issues for the APA and a staffer in the Public Policy Office died April 23, 1994, after finally losing his long personal battle with AIDS; he was 34. Among his many accomplishments, Bailey oversaw the development of a major report on behavioral and social sciences and the HIV/AIDS epidemic for the National Commission on AIDS; participated in the planning of an APA training program for psychologists who serve HIV-infected clients; facilitated the development of the AIDS community prevention programs supported by the Centers for Disease Control and Prevention; and forged collaboration between several government agencies to support the HIV/AIDS mental health services demonstration program.

Tamara Jackson, PhD

Dr. Jackson, the new William A. Bailey AIDS Policy Congressional Fellow, is currently completing a postdoctoral research fellowship at Yale University School of Medicine, where she is conducting community research on health behaviors of ethnic minority individuals. Her primary interests are in community and health psychology, with a focus on health promotion and disease prevention. Dr. Jackson's experience with HIV/AIDS includes research at Kent State University and a research assistantship at the Centers for Disease Control and Prevention. Dr. Jackson received her PhD in Clinical Psychology at Kent State University.



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APA William Bailey AIDS Policy Congressional Fellow Organizes Hearing

The current APA William Bailey AIDS Policy Congressional Fellow, Leonard Bates, was the driving force in conceptualizing and implementing an HIV/AIDS special hearing, in conjunction with the Congressional Black Caucus, the Congressional Hispanic Caucus, and the Congressional Asian Pacific American Caucus to call attention to an epidemic that continues to devastate communities of color.

This was the first time that all three caucuses have come together to call attention to the fact that people of color constitute 57% of the total number of AIDS cases since the beginning of the epidemic and to ask the Congressional Appropriations Committees for the highest possible level of funding for the state AIDS drugs program. As a result of the budget shortfall, states now face the possibility of waiting lists to treat HIV-positive people. Without such medication, HIV-positive individuals may not survive.

Secretary of Health and Human Services Tommy Thompson testified before the standing-room only hearing on June 12, 2001. He and other Bush administration officials had been asked to discuss the priorities that they have developed to strengthen the federal response to the epidemic within communities of color, with a special focus on the Minority AIDS Initiative. In addition, federal officials and representatives from community-based organizations funded by the Minority HIV/AIDS

Initiative were asked to provide information in response to the following requests:

- 1) Specify the amount of money received from the Minority HIV/AIDS Initiative,
- 2) Describe the organizations and initiatives supported through funds from the Minority HIV/AIDS Initiative, including U.S. territories and areas along the U.S.-Mexico Border,
- 3) Indicate whether organizations funded through the Minority HIV/AIDS Initiative were minority-managed and/or serving community-based organizations,
- 4) Specify the percentage of the client population and management of each funded community organization that was of color,
- 5) Define how the term community capacity is used within DHHS,
- 6) Indicate the extent to which the funds provided to community-based organizations were actually successful in increasing the capacity of minority communities to address issues related to HIV/AIDS,
- 7) Describe proposed future initiatives and desired funds

for HIV/AIDS efforts among communities of color, and

- 8) Explain how DHHS ensured that funded programs are culturally competent, linguistically specific and sensitive.

The Administration promised to provide written responses to the above questions. Members of the various caucuses have taken assignments to follow up either with the administration or community-based organizations to ensure that funding designated for minority HIV/AIDS community-based organizations

As a result of the budget shortfall, states now face the possibility of waiting lists to treat HIV-positive people.

reaches those organizations. Congresswoman Donna Christian-Christensen, chair of the Health Braintrust of the Congressional Black Caucus, along with Congressman Ciro Rodriguez, chair of the Congressional Hispanic Caucus Health Task Force and Congressman Robert Underwood of the Congressional Asian Pacific American Caucus promised that they “will continue to demand that the dollars for prevention, diagnosis, and treatment follow the epidemic and reach those most affected.”

For more information on the hearing, contact Leonard Bates with the office of Congresswoman Donna Christian-Christensen at (202) 226-7974. ■

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and most of whom are Caucasian. There is a second and largely underground group of transgendered people with incomes below the poverty level. This group does not enjoy the same access to health care as the first, and faces a variety of health risks, including HIV.

Some mental health professionals continue to pathologize transgender people and lack the understanding and training to effectively provide mental health services to transgender individuals.

In all but a few U.S. municipalities, transgender and transsexual people face employment discrimination (see Currah & Minter, 2000, for a list of cities and states with nondiscrimination laws). They are often rejected by their families, and are at high risk for attack on the street simply because of the way they look (Wilchins, et al. 1997). A study of transgender individuals in the U.S. indicated that approximately 60% had experienced some form of harassment or violence and that 37% had experienced some form of economic discrimination (Lombardi, Wilchins, Priesing & Malouf, in press). Inability to find a job can force them to turn to sex work; inability to procure legal hormones can lead to sharing needles; and, among MTF's, a desire to achieve instant curves via silicone can lead to injection by backroom "practitioners" (Tobin, 2001).

All these activities subject them to risk of HIV infection. This risk has translated into high rates of actual infections. Studies of MTF sex workers in the U.S. report prevalence rates ranging from 20% up to 68% (Clements-Nolle, Marx, Guzman, & Katz, 2001). Fortunately, data are accumulating that document the aforementioned risks and rates of infections; unfortunately, little has been done to reduce risks.

It is difficult to assess accurately the impact HIV has had on the transgender community. Transgenders are rendered invisible by the CDC's policy of classifying them under the MSM (Men who have Sex with Men) category. Additionally, there are very few studies on rates of HIV infection among transgender individuals who do not work in the sex industry. Finally, there is very little in the way of research addressing HIV and FTM individuals. ■

References and Recommended Reading

- Benjamin, H. (1966). The transsexual phenomenon: A scientific report on transsexualism and sex conversion in the human male and female. New York: Julian Press.
- Bolin, A.E. (1994). Transcending and transgendering: Male-to-female transsexuals, dichotomy, and diversity. In G. Herdt (Ed.), *Third Sex, Third Gender: Essays from Anthropology and Social History*, pp. 447-485. New York: Zone Publishing.
- Boswell, H. (1991). The transgender alternative. *Chrysalis Quarterly*, 1(2), 29-31.
- Boswell, H. (1998). The transgender paradigm shift toward free expression. In D. Denny (Ed.), *Current Concepts in Transgender Identity*, pp. 55-61. New York: Garland Publishing.
- Bullough, V.L., & Bullough, B. (1993). *Cross-dressing, Sex, and Gender*. Philadelphia: University of Pennsylvania Press.

Clements-Nolle, K., Marx, R., Guzman, R., & Katz, M. (2001). HIV prevalence, risk behaviors, health care use, and mental health status of transgender persons: implications for public health intervention. *American Journal of Public Health*, 91(6), 915-921.

Cole, S.S., Denny, D., Eyler, A.E., & Samons, S. (2000). Diversity in gender identity: Issues of transgender. In L. Szuchman & F. Muscarella (Eds.), *The Psychological Science of Sexuality*, pp. 149-195. New York: John Wiley & Sons, Inc.

Currah, P., & Minter, S. (2000). *Transgender Equality: A Handbook for Activists and Policymakers*. Washington, DC: National Gay and Lesbian Task Force.

Dekker, R.J., & van de Pol, L.C. (1989). The Tradition of Female Transvestism in Early Modern Europe. New York: St. Martin's Press.

Denny, D. (1995). The paradigm shift is here! *AEGIS News*, 1(4), 1, 4-5.

Dr. Walker arrested because of male garb. *Atlanta Constitution*, 2 February, 1913, 10B.

Dragoin, W. (1997). The gynemimetic shaman: Evolutionary origins of male sexual inversion and associated talent? In B. Bullough, V. Bullough, & J. Elias (Eds.), *Gender Blending*, pp. 227-247. Amherst, NY: Prometheus Press.

Ellis, H.H. (1906). *Studies in the Psychology of Sex: Erotic Symbolism, Mechanism of Detumescence, the Psychic State in Pregnancy*. Philadelphia: F.A. Davis Co.

Green, R., & Money, J. (Eds.). (1969). *Trans-sexualism and Sex Reassignment*. Baltimore: The Johns Hopkins University Press.

Hall, R. (1996). *Patriots in Disguise: Women Warriors of the Civil War*. New York: Marlowe & Company.

Hamburger, C. (1953). The desire for change of sex as shown by personal letters from 465 men and women. *Acta Endocrinologica*, 14, 361-375.

Hamburger, C., St_rup, G.K., & Dahl-Iversen, E. (1953). Transvestism: hormonal, psychiatric, and surgical treatment. *Journal of the American Medical Association*, 12(6), 391-396.

Clinical Issues...

change the individual's genital appearance. Each of these types of procedures requires varying levels of psychological readiness. Israel and Tarver (1997) have written a very good synopsis of these issues.

One level of assessment involves determining whether the individual requesting hormones or surgery is experiencing psychopathology. The clinician must ascertain the presence of any psychiatric disorders that could cast doubt over, or seriously impact, the individual's appropriateness for medical procedures. For example, if the individual is experiencing an acute episode of a psychotic or mood disorder, he or she may not be competent to make major medical decisions at that time. Some individuals may be well advised to obtain mental health treatment before they are really able to make such decisions.

On the other hand, the clinician must keep in mind that the individual may be experiencing an anxiety or mood disorder that is strongly exacerbated by either the dissonance between internal sense of self and external appearance or the discrimination that transgender individuals often experience. In some cases, what may otherwise appear to be rather severe psychopathology may be entirely caused by the experience of being transgender in an intolerant environment. It is not unusual for transgender clients to report having been abused by parents, siblings, peers and others in the course of growing up. Not unlike any other abuse situation, there is often a profound impact on the individual's psychological functioning.

TRANSGENDER newsflash

Unsterilized Hormone Needles, Unsafe Sex Spread HIV Through Transgender Community

HIV rates in the transgender community are "staggeringly high," and "black market" sex hormones delivered through unsterilized needles could be to blame for at least part of the problem, *Salon* reports. Although hormone needle sharing "has not been identified as a major risk factor for HIV transmission among transsexuals," very little research exists on how the virus has affected the transgender community. Jason Farrell, executive director of the Positive Health Project, said, "Due to the lack of tracking, there might be an epidemic out of control and we don't know about it, nor do we have the resources to address it if we need to." However, transsexuals do face several risk factors for HIV, including unsterilized needle use, a lack of outreach and education programs and unsafe sex. A study of male-to-female transsexuals conducted by Dr. Paul Simon, a medical epidemiologist with the Los Angeles County Department of Health Services, found that 22% were HIV-positive and many respondents had engaged in unprotected anal sex. Sixty-nine percent of study participants had injected hormones "at some point in their lives," and of those who had injected hormones in the past six months, 72% said they "got their needles off the streets." However, since unsafe sex and intravenous drug use were also noted among study participants, Simon determined that it is "unclear what role black market needles played" in infecting the group.

Black Market Needles

Transsexuals obtain black market sex hormone injections from a number of sources, and an "underground economy

of fake doctors and self-appointed medical gurus" helps supply the shots, *Salon* reports. Transgender individuals often "prefer" injections to other forms of hormones, including pills, patches and liquid, because the injected hormones "supposedly take effect faster." Some of the shots are given in bar bathrooms or in the backs of vans, with "possibly hundreds" of individuals receiving injections by a single needle. A "growing number" of physicians and AIDS outreach workers feel that these shared needles "may be the cause of hundreds of [HIV] cases in the United States and abroad," and are "particularly concerned" about the high rates of HIV infection among the transgender population. Some states have started to look at needle deregulation as one possible way to reduce the risk of needle sharing. In San Francisco, for example, several health clinics provide free hormone syringes and free and low-cost hormone therapy in a "safe, medical setting," with time allotted specifically for transsexuals. On Jan. 1, New York state launched a new needle deregulation policy, under which it will make syringes available to adults without a prescription through licensed pharmacies, health care facilities and "certain health care practitioners who voluntarily register with the state" (Siegal, *Salon*, 3/28).

The foregoing information comes from the Kaiser Family Foundation. For access to the Foundation's policy research, analyses, reports and fact sheets, and media partnerships, visit the Foundation's main website at www.kf.org.

The other level of assessment involves the question of "readiness, which involves a sense of congruence with the changes to be effected by the medical procedures. Among the issues that need to be assessed is the extent to which the individual has considered the impact of transitioning on various components of his or her life and has adequately prepared for a transition. An examination of the individual's support network, interpersonal relationships, and disclosure skills, are helpful in the assessment.

The SOC recommend that each individual undergo a "real life experience" or RLE, in which that person lives full-time in the role of the desired gender for a specified period of time. The RLE gives the clinician an in vivo measure of the individual's readiness to transition.

However, while the RLE has proven invaluable to many individuals and is recommended for many, the clinician must also keep in mind that an RLE may not be practical or even possible for certain individuals.

For some, the task of assessment creates a sense that the clinician's role is to act as a "gatekeeper" to medical services. A less adversarial way to view the role is as a facilitator: in completing an assessment, the clinician helps the individual to determine the extent to which he or she is ready for medical procedures and helps the client to find ways to address those areas in which work still needs to be done. Ultimately, it is the transgender individual's decision whether to proceed with transitioning.

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Clinical Issues...

Treatment

Treatment of transgender individuals involves working with a broad spectrum of transgender individuals (not just those wishing to transition) and at a variety of points in their lives. Treatment typically involves psychotherapy to address clinical issues that the individual may present, just as it does for other clients. However, sensitivity and understanding of particular issues that impact transgender individuals' lives are essential to being able to offer the most competent treatment services. It is vitally important that the clinician treat any existing psychopathology while not pathologizing the individual's gender identity experience. Maintaining this distinction will ultimately best serve the client, while also building a therapeutic alliance that will enhance the clinician's effectiveness. In particular, it is important to allow the transgender individual to explore his or her own gender identity free of exterior labels and to explore its ramifications for emotional, cognitive, interpersonal, and social functioning.

Similar to working with lesbian, gay and bisexual clients, working with transgender clients requires an understanding of the process of coming out—of disclosing one's gender identity to self and others and becoming comfortable with that identity. A significant part of the coming out process involves defining one's own gender. This step is often hindered by culturally rigid definitions of sex as being either male or female. Transgender persons frequently report that these traditional definitions are constraining and do not fit their own internal experience of gender. Some transgender individuals ultimately define themselves as somewhere between the artificial male and female positions; others identify as gender variant.

The process of stepping outside of social norms may create for the individual feelings of loneliness, stigma, and shame, and may lead to denial of important aspects of gender. While there are now several visible role models for individuals struggling with non-heterosexual orientations, there are almost no transgender role models visible in American mainstream culture. This makes the task of coming out more difficult not only for the transgender individual, but also for family members and friends who may try to find an anchor for their understanding of the transgender person.

How and when to disclose a transgender identity is often the subject of psychotherapy sessions. Treatment needs to include providing the client with disclosure tools that address the timing, setting, and method of disclosure. Particular attention must be paid to disclosure to the client's spouse or partner, and children, for whom the impact can be expected to be greater. Some individuals may also want to come out at work; others will prefer to seek employment where coming out will be less of an issue, especially if the individual plans to transition to the congruent gender between jobs.

Transgender Youth

Adolescent transgender clients present some unique challenges. On the one hand, the clinician should be concerned with ensuring that the adolescent has every opportunity to experience his or her gender identity as normal and to explore ways of developing a lifestyle that is congruent with that identity. On the other hand, it is not unusual for adolescents to experience some amount of gender confusion as part of their identity formation. Hence, the task of the clinician is more difficult, because it involves providing treatment while navigating the minefield of common adolescent issues. It is especially important to be attentive to the issue of suicide risk when working with transgender youth.

While adults typically live independently enough to effect decisions they may make about their lives, adolescents often do not. Therapy with transgender youth often involves addressing their functioning at home and school, situations that they are less likely than adults to be able to escape. Sometimes it is necessary to involve school personnel in the treatment process to ensure an educated response to the youth's gender identity; sometimes it may be necessary for the youth to simply change schools.

BSSV

Behavioral and Social Science Volunteer Program

BSSV Program Update

Duane Wilkerson, MPH
Program Director

Since 1996, the Behavioral and Social Science Volunteer (BSSV) Program has been providing technical assistance (TA) associated with the behavioral and social science aspects of HIV prevention. TA has been offered to community-based organizations (CBOs), state and local health departments (HDs), and HIV prevention community planning groups (CPGs) through a national network of volunteer scientists. In the beginning, most of the volunteer scientists recruited for the program were psychologists. However, recruitment during the past 3 years has concentrated on other disciplines. Currently, the BSSV Program's cadre of volunteers include scientists from the disciplines of psychology, sociology, anthropology, public health, social work, education, and nursing.

The BSSV Program has worked hard to recruit a diverse group of volunteers. Over 30% of the program's volunteers are people of color and the male-female ratio is nearly 50-50.

Latinos/as, African Americans, Chinese Americans, Japanese Americans, Filipinos/as, Indian Americans, Caucasians, Native Americans, and Arab Americans are all represented in the program's pool of volunteer providers. Of the 56 volunteers who have participated in the last two BSSV trainings, exactly half are people of color.

The types of TA provided by this diverse group of volunteers include: developing evaluation models for prevention programs and planning; designing needs assessment tools; developing pre-and post-intervention questionnaires; identifying effective interventions; and adapting effective interventions for new settings and populations. Volunteers have provided this service to over 90 agencies, in 40 states, Puerto Rico, and The Virgin Islands.

The sixth BSSV Program training for volunteers was conducted in New



Duane Wilkerson

Orleans in June. Since December 1998, a total of 137 scientists have participated in these highly interactive, three-day trainings. Like the five trainings before it, the most recent training was a wonderful showcase for the experience, skill, wisdom and commitment to HIV prevention displayed by BSSV Program volunteers. This display was both inspirational and hopeful. Inspirational, because of their willingness to give of their time without being paid; hopeful because of what they could accomplish in providing the technical assistance needed to implement interventions more effectively.

BSSV Program staff estimate that in the past two years, volunteer scientists have provided over 1500 hours of highly skilled technical assistance, with only an occasional reimbursement request for travel expenses incurred. That is cost effectiveness! In an era of tightening budget concerns and an increased need to use limited resources in an efficient and effective manner, we are very proud of the work of our volunteers, the BSSVs!

In recognition of the quality of the volunteers (which is the quality of the program), CDC is increasing and extending the opportunities for the volunteers to work in additional ways with CDC. This new collaboration will involve the dissemination of effective HIV interventions identified by CDC.

Partly in response to this new scope of work, the BSSV Program is developing an advanced training scheduled to be piloted in early 2002. In addition to the advanced training, BSSVs participating in this dissemination



BSSV Training, New Orleans, Louisiana, June 2001

Orleans in June. Since December 1998, a total of 137 scientists have participated in these highly interactive, three-day trainings. Like the five train-

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A Personal Story...

of what it means to me to be a woman, of how to honor that woman, and how to finally present her to the world.

What follows is one of those early letters to my friend, Ann. Perhaps it will be instructive.

Dear Annie:

Thanks for the heartfelt affirmation. I knew I should expect no less from you. I'll try to answer your questions as best I can, in the order you asked them.

Yes, I'm seeing a therapist. I've been working with a very good one since last summer. He's not someone with a great deal of transgender experience but neither of us seems terribly anxious about that. I sense that he trusts in who he is as a person as much as in the things he knows. Though he's a superbly trained and sensitive practitioner—I wouldn't see someone who wasn't—he brings something to our relationship that's much more important to me than technical expertise. He brings humility. It's clear to me that he approaches human beings as mysteries to be celebrated rather than puzzles to be figured out. So when I look him in the eye and say, "This is who I am and who I've always known myself to be," he looks right back at me and answers, "I believe you." And I know he means it.

Yes, my emotions do seem to be all over the place these days. I find myself inexpressibly happy,

HOPE

HIV OFFICE FOR PSYCHOLOGY EDUCATION

Hope Program Update

Christopher Rowe, HOPE Program Training Director

Funded originally in October of 1991, the HIV Office for Psychology Education (HOPE) Program has employed a train-the-trainer model to educate over 370 Regional Psychologist Trainers who have, in turn, provided HIV/AIDS-related mental health training programs for over 14,000 psychologists and other mental health professionals around the country.

In September 1998, the HOPE Program began its third, three-year contract with the Center for Mental Health Services (CMHS) to expand and further develop the capabilities of the existing network of regional psychologist HIV/AIDS trainers. That contract will expire at the end of August this year and thus this is a time for reflection and planning for the future.



Christopher Rowe

During the soon-to-expire contract, standard curricula were phased out. Regional Trainers expressed a desire for less structured materials indicating, among other things, that the old curricula were too long and inflexible. Standard curricula were replaced with a Training Resource Package comprised of six major sections, each with an abundance of didactic information, discussion points, and interactive exercises that could be selected and tailored as trainers saw fit. The six sections of the Training Resource Package are entitled: 1) An Introduction to the Epidemiology, Clinical Course, and Medical Treatment of HIV Disease; 2) The Mental Health Care Provider's Role in HIV Primary Care; 3) Assessment of Psychotherapeutic and Psychosocial Needs of People Living With HIV/AIDS; 4) Mental Health Intervention Strategies; 5) HIV Prevention Interventions for Mental Health Care Providers; 6) Issues for Mental Health Care Providers Caring for People Living With HIV/AIDS.

At the National Training Conference held in New Orleans in January 2000, HOPE trainers expressed interest in obtaining more specific information about HIV and its relationship to families. According to our trainers, the issues related to families and HIV is so specific that it warranted a stand-alone training section. Work began on the *HIV and Families* training section late last year, and it should be completed by the beginning of August. Like all sections of the new HOPE Training Resource Package, the HIV and Families section will include state-of-the-science didactic information as well as discussion topics and experiential/skills-building exercises.

A Personal Story...

for the most part, and at other times angry or scared to death for my kids or almost overwhelmed by the complexity of what's to come. But that constant euphoria I felt in the days immediately after coming out is wearing off and I seem to be occupied more with finding the proper balance between my gut level urge to rush headlong into this thing and the more rational part of me that realizes a little caution may be the wiser path.

I worry almost constantly about my daughters and how this will affect them. Our unerring trust in each other has been the common thread that has always run through the fabric of our lives and considering what it may do to them, and to that trust, when I finally tell them the truth terrifies me. I guess these are the things that carry with them the greatest risk of pain and heartbreak, for me and for the people I love. It may be the most telling measure of the hunger for authenticity and the resilience of the human spirit that these risks seem worth taking.

And yes, everyone wonders, but no one wants to come right out and ask, how sure I am that this is the right path for me to follow. I'm sure, Annie. Here's why. Long before I was even capable of reason I was marked, in whatever biological or psychological or mystical way that thing is done, as female. I believe completely that something like that happens, that there is such a thing as a purely female archetype and that at the core of every woman lies a fundamentally feminine way of being that has nothing to do with

acceptable gender roles or socialized behaviors or societal norms, something that may not be measurable or quantifiable or scientifically observable. Call it soul, call it life force, call it vital principle, but whatever you call it, I know that at the deepest center of whatever it is that makes me who I am as a human being, I've always been unalterably female in this way.

By the time I was five or six years old I knew there was something about me that wasn't as it was supposed to be and by the time I was seven or eight I began to understand exactly what it was. Not only had the genital package I was equipped with been sent to the wrong address, but the essential characteristics that defined me as a person were completely at odds with who and what I was expected to be.

I remember as a kid, lying in bed at night and praying fervently for God to change me into the girl I knew I really was. When the prayers didn't work, I felt betrayed and swung back and forth between anger and despair. I couldn't believe that any God worthy of the name would play such a cruel trick and some nights I'd ball up my fists and pound my pillow in my rage at whoever or whatever it was that had done this thing to me. On other nights I'd just give in to the consuming loneliness and cry myself to sleep.

But I always knew I had to try to be the boy and then the man that the people I loved expected me to be. God, Annie, I worked so hard at it. I tried every way I could think of to prove to myself and to everybody else that I was a man. I volunteered

for Special Forces and went to Vietnam, I followed my father into the heavy construction business, I married, I fathered children. But not once did I ever dare risk saying a word to anyone about the way I felt inside. It would have felt like a betrayal because I was convinced it would break the hearts of everyone I loved. So I buried it all inside, and I kept it there, until just about eight weeks ago.

As far as where I'm headed is concerned, that remains to be discovered. If you buy the notion that some kind of continuum exists with Gender Reassignment Surgery at one end and the closet at the other, then it would be fair to say I'm in the process of seeing where I land on that line. It seems to me that certain ineluctable truths must be admitted when a transsexual person begins this journey. I know, for example, that living in the world as a man for fifty years has left an indelible mark on me that isn't suddenly going to be erased. I also know that there is no miraculous way for me to distill all the millions of experiences that define and shape a woman's life and then breathe them in as if they were some healing vapor.

I wish these things weren't true but they are. I can never be the woman I would have been if I'd lived all those years as I so desperately wanted to or experienced all those things I longed so much to know. But it becomes more certain each day that everything about me that's genuine and that matters for anything at all is female, entirely and

A Personal Story...

completely and it's time to begin celebrating that fact instead of working so hard to conceal it.

If my wishes were the only consideration, I'd start changing my anatomical sex tomorrow. But troublesome things like family realities do have a way of complicating the equation, don't they? Though I still think it's important that surgery be an ultimate goal, I recognize that the road that gets me there may not be a direct one. I guess all we transpeople have our eyes on a prize of one kind or another but the prize for me isn't only a vagina. I don't hate my male anatomy and never have; it's simply been a matter of total indifference to me. What matters much more is finally achieving a sense of completeness.

Still, a congruent anatomy is an important part of it and I know I won't feel whole until all the tenses are in agreement. So surgery seems an entirely logical and reasonable thing to plan for. If I settle for anything less it will be because I have to, not because I want to.

You're right about the sexuality component; it seems to have only a peripheral connection here and I'm still trying to puzzle it out. I've always thought of myself as being about as heterosexual as you can get and I imagine I'll likely stay that way. On the other hand, I may not. Either way, though, it isn't something I stay up nights worrying about. It'll be what it'll be and I'll experiment with it until I find something that fits. But don't worry about me too much, dear. I'm painfully aware that I've moved from membership in one of the lowest at risk groups for HIV/AIDS to one of the highest, so anything I do in that regard I'll do with care.

*At the end of the day it comes down to this. There are some passages near the beginning of the book *Women Who Run With The Wolves* where the author talks about the legend of La Loba, the Wolf Woman. She speaks of this archetypal wild woman who wanders the desert places gathering up the bones of the long dead and then assembling them and singing over the skeletons, breathing into them until flesh and sinew and muscle start to appear and the creatures themselves begin to breathe and are reborn.*

These are images that resonate deeply with me. I feel as if I've spent my life as a wanderer, gathering up the bones of the woman I was supposed to have been, hiding them away in secret places, protecting them. My wandering has stopped now, Annie, and I've spread the bones out on the ground before me. Over the past few months I've been carefully connecting them together and now it's time to begin singing over them so that this woman, whoever she is, can finally breathe and come to life. It's a frightening, exhilarating, humbling, awe-inspiring experience. I'm glad you're along for the ride.

Love,
Meredith

Clinical Issues...

In all cases, the clinician must pay special attention to the possibility that the transgender individual will be subjected to violence or harassment, or that the individual may become suicidal. The clinician must be prepared to engage in crisis intervention should the need arise. This is best discussed openly with the client near the beginning of treatment. By adequately addressing the individual's need for an active support network that includes (but is not limited to) the clinician and developing effective methods for coping with stress, the likelihood that the individual will handle the negative actions of others will be greatly enhanced.

HIV and AIDS

Recent studies (e.g., Nemoto, Luke, Mamo, Ching, & Patria, 1999) have pointed out that the prevalence of HIV and AIDS among transgender individuals is at least as high as it is among gay and bisexual men. This due in part to the effects of shame and isolation that transgender individuals experience before and during their coming out process, which may include a lack of attention to self-protection and an increased rate of drug use. There is also a relatively high incidence of commercial sex work among male-to-female transgender individuals who have difficulty finding other employment or who may seek to supplement their income in order to fund medical treatments that are not covered by insurance. As is the case with all clients, the clinician needs to inquire about behavioral practices that may place the individual at risk for HIV infection and provide information (and referrals if necessary) on safer sex and needle use.

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COPA

AD HOC COMMITTEE ON PSYCHOLOGY AND AIDS

2001 Call for Nominations

The American Psychological Association (APA) Ad Hoc Committee on Psychology and AIDS (COPA) is seeking nominations for two new members whose terms will begin on January 1, 2002 and end on December 31, 2004.

The overall mission of COPA, a seven-member committee that reports directly to the APA Board of Directors, is to guide the development and implementation of APA's organizational response to the HIV/AIDS epidemic. Consistent with this mission, COPA is committed to the ongoing pursuit of the following objectives:

- Educate psychologists and society at large on the various and unique roles psychology can contribute to the fight against the HIV/AIDS epidemic;
- Encourage and support psychologists in their efforts toward eliminating this epidemic through effective strategies of preventive education and intervention;
- Stimulate behavioral research in a variety of areas associated with HIV prevention and mental health services for persons affected by HIV/AIDS;
- Facilitate linkages between APA, behavioral researchers, medical researchers and community-based organizations for the purpose of coordinating and improving HIV-related research and mental health services;
- Create educational resources about HIV/AIDS for APA members and the public;
- Provide guidance and direction for APA HIV/AIDS advocacy activities at federal, state and local levels; and,
- Serve as an oversight committee for APA Office on AIDS activities.

COPA members are required to attend two committee meetings per year in Washington, DC, with expenses reimbursed by APA, and to participate in monthly conference calls. Between meetings, members are expected to devote a substantial portion of time to COPA projects, provide consultation to APA Office on AIDS staff, and participate in advocacy activities as needed.

Candidates should have demonstrated expertise in dealing with HIV/AIDS issues as a researcher, practitioner, educator, and/or policy advocate. COPA seeks to involve a diverse group of psychologists, including persons of color and individuals who are living with HIV. COPA is particularly interested in candidates with expertise in the following areas: (1) HIV/AIDS public policy; (2) treatment and prevention for persons with substance use disorders who are living with HIV; and, (3) treatment and prevention for children and families who are living with HIV.

Nomination materials should include the nominee's qualifications, a letter from the nominee indicating willingness to serve on COPA, and a curriculum vita. **Self-nominations are encouraged.** Materials should be sent to Robert Beverly, Office on AIDS, 750 First Street, NE, Washington, DC 20002-4242. All material must be received by September 12, 2001.

Community Member Sought

COPA is also seeking applications for a community member whose term will begin on January 1, 2002 and end on December 31, 2004. Community members of COPA are typically not psychologists. They must be individuals who are openly living with HIV/AIDS and who have demonstrated interest and/or expertise in the application of behavioral and social science to the HIV/AIDS epidemic.

COPA is particularly interested in community member applicants of color with expertise in the following areas: (1) HIV/AIDS public policy; (2) community-based HIV/AIDS treatment and prevention; and, (3) treatment and prevention for children and families who are living with HIV.

A letter outlining the applicant's qualifications and a resume or curriculum vita should be sent to Robert Beverly, Office on AIDS, 750 First Street, NE, Washington, DC 20002-4242. All material must be received by September 12, 2001.

A Brief Overview of Transgender Identity...

Herdt, G. (Ed.). (1994). *Third Sex, Third Gender: Essays from Anthropology and Social History*. New York: Zone Books.

Hirschfeld, M. (1910). *Die transvestiten: Eine untersuchung uber den erotischen verkleidungstrieh*. Berlin: Medicinischer Verlag Alfred Pulvermacher & Co.

Hirschfeld, M. (1991). *Transvestites: The Erotic Drive to Cross Dress*. (Michael A. Lombardi-Nash, translator). Buffalo, NY: Prometheus Books.

Lombardi, E.L., Wilchins, R.A., Priesing, D., & Malouf, D. (In Press). Gender violence: transgender experiences with violence and discrimination. *The Journal of Homosexuality*.

Money, J., & Schwartz, F. (1969). Public opinion and social issues in transsexualism. In R. Green & J. Money (Eds.), *Transsexualism and Sex Reassignment*, pp. 253-269. Baltimore: The Johns Hopkins University Press.

Roscoe, W. (1990). *The Zuni Man-Woman*. University of New Mexico Press.

Taylor, T. (1996). *The Prehistory of Sex: Four Million Years of Human Sexual Culture*. New York: Bantam Books.

Tobin, T. (2001, 18 April). "Tis' food, drink, and injections." *St. Petersburg Times* (FL).

White, J.C. & Townsend, M.H. (1998). Transgender medicine: issues and definitions. *Journal of the Gay and Lesbian Medical Association*, 2, 1-3.

Wilchins, R.A. (1997). *Read My Lips: Sexual Subversion and the End of Gender*. Ithaca, NY: Firebrand Books.

Wilchins, R.A., Lombardi, L., Priesing, D., & Malouf, D. (1997, 13 April). *Genderpac First National Survey of Transgender Violence*. New York: Gender Public Advocacy Coalition.

Williams, W.L. (1986). *The Spirit and the Flesh: Sexual Diversity in American Indian Culture*. Boston: Beacon Press.

HIV/AIDS in Transgender Populations...

at risk populations have repeatedly demonstrated that a clear understanding of the cultural complexities of a given population is a key factor in developing effective, targeted HIV education and prevention materials. A recent policy statement by the American Public Health Association (APHA) urges recognition of both MTF and FTM transgendered people as separate and distinct from gay men and lesbians with regard to both research and their health care (APHA, 1999). In June 2001, the CDC released a Program Announcement focusing on Young Men of Color Who Have Sex with Men, which specifically mentions transgendered people by name—a CDC first.

Transgender Populations and HIV Risk

The lack of understanding of transgendered people is due, in part, to their underground status, which has, until recently, contributed to the lack of research. The 'invisibility' of transgendered people in this country becomes easily understood in light of their intense, pervasive stigmatization, since they are largely viewed as the cultural gendered stereotypes of gay men and lesbians (Xavier, 1999). Since disclosure of transgender status results

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Clinical Issues...

The Issue of Competency

True stories abound among transgender individuals of healthcare services that either did no discernible good or, worse, caused significant harm. One of the most common complaints about mental healthcare professionals is that those transgender individuals seeking services are tired of having to educate their therapists in order to receive anything close to competent services. There is a great unmet need for transgender mental health services, but too often clinicians rush in to fill that need without proper preparation. Clinicians must ensure that they receive the necessary education and training that will make them both sensitive to the phenomenological experiences of their clients and knowledgeable about effective assessment and treatment approaches.

To date, psychologists wishing to provide these services have no comprehensive set of guidelines to direct their efforts. The HBGDA SOC address some of the need for competency of health care professionals providing services to transgender individuals. However, the treatment of competency in the SOC takes a necessarily broad-brush approach because of the multidisciplinary application of the SOC. While they do state that mental health clinicians need to be knowledgeable, they do not address the need for sensitivity. Other authors have proposed more detailed guidelines to address sensitivity and competence of mental health providers (see Israel and Tarver, 1997, and Lombardi, 2001), but none of them carries the authority of a professional association.

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Transgendered People...

substance abuse chapter. After its release, a group of Gay, Lesbian, Bisexual and Transgendered (GLBT) health care activists, led by the Gay and Lesbian Medical Association (GLMA), protested this lack of inclusion, and their advocacy eventually resulted in the release of a Companion Document to Health People 2010. The Companion Document is an first important step towards putting transgender health care issues, as well as those of gay, lesbian and bisexual people, on the radar screens of health care providers.

Transgender Care is an umbrella term for various procedures that allow transgender people to achieve some measure of physical congruency with their internal gender identities—their sense of being male, female, or something else. Transgender Care includes psychotherapy, hormonal and surgical sex reassignment, and various cosmetic procedures to achieve the primary and secondary sexual characteristics of chosen genders. Transgender Care procedures are not commonly recognized as medically necessary by most health care providers or insurers, making them difficult and expensive to access.

There are some areas of mutual concerns for all the sexual minorities (HIV/AIDS, the chilling effects of homophobia on health care access, ATOD use, etc.) but until recently, the health care needs and concerns of transgendered people have gone largely unaddressed by both health care providers and researchers. In 1999, the American Public Health

HIV/AIDS in Transgender Populations...

in discrimination, harassment and violence, most transgendered people seek to blend into non-transgendered populations and maintain a self-protective secrecy—itself a major barrier to research.

The AIDS epidemic, however, has prompted public health departments of various cities and a few states to conduct research of many stigmatized, at risk populations—including transgendered. At these local levels, public health workers have noted significant numbers of MTF transgendered people in the sex industry, where they not only become at high risk for HIV/AIDS and other STDs, but also transmission vectors. Transgender-specific qualitative and quantitative needs assessments performed over the past six years have yielded a wealth of information, not only about sexual risk behaviors, but also psychosocial and physical medical needs, access of and barriers to health care, and other data.

HIV seroprevalence in MTF transgendered people has been reported as ranging from 14% (Rodríguez-Madera, 2000 and Kenagy et al, 2001) 22% (Simon & Reback, 1999) 21% to 30% (McGowan, 1999) 32% (Xavier, 2000) 35% (Clements, 1999) and 47% (Nemoto, 1999). Seroprevalence studies restricted to sex worker populations have shown rates as high as 70% (Elifson, 1993). Other studies have shown that transgender sex workers are often induced to engage in barrier-free sex (Nemoto et al, 1999; McGowan, 1999).

Significant rates of high risk sexual behaviors were reported by many studies. Unprotected receptive anal intercourse amongst MTFs was found as high as 54% (Clements, 1999) and 42% (Xavier, 2000). However, many of these studies found that transgender participants perceived themselves to be at low risk for HIV (ActionAIDS, 1997; THAC, 1997; Rodríguez-Madera, 2000) and not all those who engaged in unsafe sex behaviors get tested for HIV (Rodríguez-Madera, 2000; Xavier, 2000).

Substance abuse has been repeatedly cited in studies as a co-factor in HIV transmission, and high rates of substance abuse amongst transgender samples were found in many studies (Elifson, 1993; Mason et al, 1995; Reback and Lombardi, 1997; McGowan, 1999; Clements, 1999; Xavier, 2000). However, needle sharing for injection of hormones, especially for FTM populations, remains a largely non-addressed risk (Nemoto, 1999; McGowan, 1999). Unfortunately, clean needle usage is included in transgender-specific HIV prevention materials produced only in a few areas, principally from the San Francisco Bay area.

Lack of sensitivity and awareness by providers were mentioned as barriers to care and access of HIV prevention services (McGowan, 1999; JRI, 2000; Xavier, 2000) as well as fear of transgender status being revealed (McGowan, 1999; Xavier, 2000). For those being treated for HIV and AIDS, there is sufficient anecdotal evidence to suggest that adverse experiences

HIV/AIDS in Transgender Populations...

arising from simultaneous administration of HIV/AIDS medications and hormonal sex reassignment warrant immediate, additional study, if not specific medical and perhaps psychological strategies, in provision of care. Administration of anti-retroviral drugs like AZT, DDI and 3TC has been found to lower serum hormonal levels in non-transgendered persons living with AIDS (GMHC, 1996).

Needs Assessment Findings

An analysis of a dozen transgender needs assessment studies to date reveals the following factors that distinguish transgendered populations from the traditional MSM category:

1. The Impact of Per Capita Rates of Discrimination and Violence on Educational, Employment and Housing Opportunities. Due to the overt, unconcealable nature of gender variance, transgendered people may be more likely to incur discrimination at per capita rates higher than many gay men or lesbians who may be able to conceal their sexual orientation. The resulting lack of health insurance from unemployment and under-employment, or insufficient coverage from underinsurance, is associated with a lesser ability or willingness to access necessary health care services (JRI, 2000; Xavier, 2000). The lack of employment opportunities significantly reduces housing opportunities as well, and likely explains why some MTF transgendered people chose sex work to survive (Mason, 1995; Reback and Lombardi, 1997; Clements, 1998; Xavier, 2000).

2. The Impact of Transphobia and Trans-ignorance in Health Care.

Frequent anecdotal reports of transphobic bias of many health care institutions are reported on the Internet. Hostile or insensitive caregivers reduce the willingness of transgendered people to access care, and fear of discovery of transgender status keeps many away from the health care system altogether (Xavier, 2000).

3. The Urgent Need of Transgendered People for Access to Transgender Care.

It is common for transgendered people, especially transsexuals, to place a higher priority on successful access to the transformative medical technologies of transgender care, quite often to the neglect of other health care priorities. Transsexual people will take all sorts of risks—financial and health-related—to accumulate the money required for the various cosmetic, hormonal and surgical sex reassignment procedures (Israel and Traver, 1997).

4. The Impact of Negative Body Issues.

Transgendered people who encounter barriers to accessing transgender-related care may be less likely to take care of their bodies, to access other health care services when necessary, to practice safer sex and may be more likely engage in substance abuse. (Clements, 1998; Namaste, 1999)

5. The Invisibility of Transsexual Men (FTMs).

Transgendered people are often thought to be only MTF, and thus transsexual and transgendered men are usually completely ignored in education and prevention efforts. Yet many transsexual

men identify themselves as gay or bisexual and actively engage in unprotected sex with other men (Namaste, 1999; Clements, 1999).

6. The Impact of Gender Identity Issues on Education and Prevention.

Since gender does not equal genitalia for transgendered people, non-transgender gender-specific education and prevention efforts targeted at male and female populations may have less of an impact than prevention efforts that are more clearly tailored to the realities of the transgender community. For example, some transgender people refer to their existing genitalia or anatomy in terms congruent with their gender identity. A transgendered man can view his enlarged clitoris as a penis, or a transgendered woman can view her rectum as a vagina. A pre-operative transsexual woman (with an intact penis) can be in a relationship with a non-transgender woman and still identify herself as a lesbian. In a relationship with a man, the same person may identify herself as a heterosexual woman. Accordingly, genitalia-specific reduction methods are likely to be less effective with these transgender individuals. (Xavier, 2000).

7. The Impact of Changing Sexual Anatomy Over Time.

The process for surgical sex reassignment can have many stages, with multiple procedures conducted over many years. In the interim, transsexual people can also refer to their existing genitalia in terms congruent with their gender identity. Upon completion of genital sex reassignment, post-operative transsexual people need to be

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Association (APHA) passed a resolution calling for the National Institutes of Health (NIH), the Centers for Disease Control and Prevention (CDC), and others to recognize the health care needs of transgendered people as distinct from those of from gay men and lesbians. It also urges that health care providers be sensitive and respectful when treating transgendered people, and recommends funding for more research to increase understanding of their health risks and the barriers they encounter when accessing health care.

Separation from gay men has become a key concern for transgendered HIV/AIDS advocates. In its HIV surveillance and prevention efforts, CDC has insisted on including transgendered people of either gender vector in the 'Men who have Sex with Men' (MSM) category.

However, there are more than enough factors to warrant their separation and recognition as a cultural group distinct from MSMs. These factors include the impact of higher per capita rates of discrimination and violence on the educational, employment and housing opportunities of transgendered people; transphobia and trans-ignorance as barriers to health care access; the urgent need to access Transgender Care; the impact of negative body issues on safer sex practices, increased substance abuse rates and overall mental health; the invisibility of FTMs and female-bodied transgendered people; and the effect of gender identity issues on HIV prevention and education.

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targeted for HIV and STD prevention efforts specific to their new genitalia. Many transsexual women may be completely unaware of their increased susceptibility to hard to see STDs (Xavier, 2000).

8. The Unmeasured Impact of Men Who Have Sex with Transgender Sex Workers. A single MTF transgender sex worker can have sex with many non-transgendered men in a single evening, and many (if not most) clients of transgendered sex workers do not regard themselves as having sex with men, but with women (personal communication with a Washington, DC sex worker and anecdotal interviews with clients). Clients of transgender sex workers are rarely captured by surveys, nor are safer sex messages specifically targeted towards them. As such, they represent a largely unmeasured HIV vector for others with whom they have sex (wives, girlfriends, other men) (APAIT, 2000).

Conclusion

Given that many if not most state, county and city health departments follow the lead of the CDC in HIV/AIDS Surveillance methodology (AHA, 1999), it is therefore critical that CDC reexamine its traditional approach of simply conflating not only transgender people of either gender vector together but moreover, of including both gender vectors within MSM populations. ■

References

- ActionAIDS of Philadelphia et al, *Needs Assessment of Transgendered People in Philadelphia for HIV/AIDS and other Health and Social Services*. 1997: ActionAIDS Inc., Unity Inc. and University of Pennsylvania, School of Social Work, Philadelphia, PA.
- American Public Health Association, "Policy Statements Adopted by the Governing Council of the American Public Health Association, November 10, 1999."
- Asian Pacific AIDS Intervention Team (APAIT), "Men Who Have Sex with Transgendered (MSTGs), Poster presented at the United States Conference on AIDS, 2000.
- Bockting WO, Rosser S. and Coleman E. *Transgender HIV/AIDS Prevention Program Manual*. 1993: Program in Human Sexuality, Department of Family Practice and Community Health, Medical School, University of Minnesota, Minneapolis, MN.
- Centers for Disease Control and Prevention (CDC). HIV-related Tuberculosis in a Transgender Network—Baltimore, Maryland, and New York City Area, 1998-2000. *Morbidity and Mortality Weekly Report* 49(15): 317-320. 2000.
- Centers for Disease Control and Prevention (CDC) Update, Program Announcement 01163 Released. June 21, 2001.
- Clements K. et al, *The Transgender Community Health Project: Descriptive Results*. 1999. San Francisco Department of Public Health.
- Clements K, Wilkinson W, Kitano K, Marx R. *HIV Prevention and Health Service Needs of the Transgender Community in San Francisco*. 1998: AIDS Office, San Francisco Department of Public Health, San Francisco, CA.
- Elifson K, Boles J, Posey E, Sweat M, Darrow W, Elsea, W. Male Transvestite Prostitutes and HIV Risk. 1993: *American Journal of Public Health*, 83 (2) 260-262.
- Gay Men's Health Crisis, GMHC Fact Sheet, *Menstrual Problems in HIV Infection*. 1996: GMHC Department of Treatment Education and Advocacy, New York, NY.
- Kenagy G, Bostwick W. *Health and Social Service Needs of Transgendered People in Chicago*. 2001: Jane Addams College of Social Work, University of Illinois at Chicago.

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Margie Hunter v. District of Columbia, 1999. Superior Court of the District of Columbia, Civil Division.

International Foundation for Gender Education, "International and National Organizations" listing, *Transgender Tapestry*, Issue #91, Fall, 2000, 77-84.

Israel G and Tarver, D. *Transgender Care: Recommended Guidelines, Practical Information & Personal Accounts*. 1997: Philadelphia, Temple University Press.

JSI Research and Training Institute, Inc. *Access to Health Care for Transgendered Persons in Greater Boston*. July 2000.

Mason T, Connors M, Kammerer C. *Transgendered and HIV Risks: Needs Assessment*. 1995: Prepared for the Massachusetts Department of Health, HIV/AIDS Bureau. Gender Identity Support Services for Transgendered (GISST)

McGowan CK. *Transgender Needs Assessment*. 1999: The HIV Prevention Planning Unit of The New York City Department of Health, New York, NY.

Namaste VK. HIV/AIDS and Female to Male Transsexuals and Transvestites: Results from a Needs Assessment in Quebec. 1999: *International Journal of Transgenderism* 3, 1+2, http://www.Symposion.com/ijthiv_risk/namaste.htm

Nemoto T, Luke D, Mamo L, Ching A, Patria J. HIV Risk Behaviors Among Male-to-Female Transgendered in Comparison with Homosexual or Bisexual Males and Heterosexual Females. *AIDS Care* (1999), Vol.1, No.3, 297-312.

Reback CJ and Lombardi EL. *HIV Risk Behaviors of Male-to-Female Transgendered in a Community-based Harm Reduction Program*. 1997.

Reback, CJ, Simon P, Gatson B, Bemis, C. *The Los Angeles Transgender Health Study: Baseline Findings*. 1999.

Rodríguez-Madera, S and Toro-Alfonso, J. Transgendered, HIV and Puerto Rico. Abstract presented at the United States Conference on AIDS, 2000.

Transgender Health Action Coalition, Final Report by the Transgender Health Coalition (THAC) to the Philadelphia Foundation Legacy Fund (for the) Needs Assessment Survey Project (A.K.A. the Delaware Valley Transgender Survey). 1997: THAC, Philadelphia, PA.

Xavier, JM. "Transphobia Rooted in Intolerance of Difference", *The Washington Blade*, April 23, 1999.

Xavier JM, Simmons R. The Needs of Black and Latino Transgendered. Abstract and Poster presented at the United States Conference on AIDS, 2000.

Xavier JM, Final Report of the Washington Transgender Needs Assessment Survey. 2000: Administration for HIV and AIDS, Government of the District of Columbia, Washington, DC.

Transgendered People...

The Health Resources and Services Administration, which administers the Ryan Act CARE Act, is just beginning to recognize the high HIV risks faced by transgendered people, but like the CDC, has yet to specifically count them. In this case, invisibility, not silence, equals death.

Transgender Care itself might provide an effective means of harm reduction in transgender populations at risk or living with HIV/AIDS. Providing wider access to hormonal therapy should improve the self-care and regard of transgendered people for their bodies, resulting in less likelihood to engage in unsafe sex and substance abuse, or to resort to dangerous extra-medical practices like silicone injections. However, Medicaid coverage for hormonal therapy is problematic and varies from state to state. Medicaid's governing federal agency, the Health Care Finance Administration, still persists in classifying Sex Reassignment Surgery as "experimental" thus facilitating its exclusion by private health insurance

providers. Hormonal therapy itself is "off-label" use, since clinical research trials of estrogen in natal males and testosterone in natal females for the purpose of sex reassignment have never been conducted in the U.S. If Transgender Care was recognized by the US PHS as medically necessary for the health of transgendered persons, then NIH could license the trials and upon their completion, the FDA could label hormones for appropriate usage. Yet the agony of mis-assigned sex is not understood by the federal government, let alone the general public. Hence it becomes an "orphan" concern for a tiny, stigmatized sexual minority.

Besides government agencies, several professional organizations also play key roles in governing the access of Transgender Care. The Harry Benjamin International Gender Dysphoria Association (HBI-GDA) publishes its commonly used *Standards of Care* (SOC) for hormonal and surgical sex reassignment. However, the SOC assume an equal ability by all transgendered people to simultaneously access and pay for the required psychotherapy, endocrinology and surgery—an impossibility for many economically dispossessed transgendered people, especially those of color. Treatment under the SOC is usually preceded by a diagnosis of Gender Identity Disorder, a classification contained in the *Diagnostic and Statistical Manual* published by the American Psychiatric Association. It should be noted that most transgendered people regard their condition as physical and thus do not consider themselves to have a mental disorder.'

HOPE Program Update...

In August of this year, it is anticipated that CMHS will provide APA with another three-year contract to fund the HOPE Program. The new contract will enable the HOPE Program to build on its well-established track record of offering high quality HIV/AIDS training to psychologists and other mental health providers. As with any effective program, building wisely for the future requires understanding and responding to lessons learned from past performance.

One lesson learned from past performance is the need for ongoing recruitment and training of HOPE Program Trainers. Experience has shown that during any three-year period of performance since the inception of the HOPE Program in 1991, only about one third of the HOPE Trainers actually organize and deliver HOPE Program workshops. At the outset, it is clear that all HOPE Trainers demonstrate substantial interest in conducting training as evidenced by their willingness to submit application materials, their written agreement to train at least 30 mental health providers, and their attendance at a three-day, train-the-trainer conference to which they travel and stay at their own expense. However, despite their best intentions, about two thirds of the psychologists fail to set up workshops. The reasons for the failure of two thirds of the HOPE Program Trainers to set up workshops vary. Some trainers conclude that the work involved in setting up a training event is too time-consuming to do on a volunteer basis. Others are willing to put in the effort but find that they don't really have the time. Others simply drop out and don't communicate with HOPE Program staff for whatever reasons. Attrition seems to be a recurring part of the process so ongoing trainer recruitment and training must be a part of the continuation effort.

A second lesson learned from past performance is the need to update the HOPE Program training materials on an ongoing basis. Given the fact that the effects of the illness and the physical and psychological ramifications of medical treatment are constantly changing, frequent updates are crucial.

A third lesson learned from past performance is the increased use of the internet for HIV/AIDS-related information and education. The growing number of mental health providers with internet access combined with improved technology for internet-based education and the increased reliance on distance learning by rural providers suggest the need for the HOPE Program to develop a comprehensive program of internet-based, at-home, HIV/AIDS education for mental health providers.

A fourth lesson learned comes from experiences associated with the HOPE Program NTCs. At the NTCs, HOPE Trainers are required to conduct an HIV/AIDS training sessions based on HOPE Program training materials and then receive feedback from peers about the session they conducted. During these sessions, it became clear that not all HOPE Program Trainers had a fluid and facile understanding of key elements of HIV/AIDS prevention and care. The need to develop some mechanism to ensure that all trainers are well-grounded in the basics of HIV/AIDS mental health care was equally clear. Thus, in the

new contract, HOPE Program staff intend to develop an internet-based, at-home, basic HIV/AIDS knowledge education program that all trainers must take and then pass with a high level of accuracy.

In anticipation of the new contract, HOPE Program staff are now beginning their determined effort to recruit 100 new HOPE Trainers. Application to become a HOPE Trainer involves the submission of a curriculum vitae, a completed application form, and a letter describing one's HIV-related work. To request an application to become a HOPE Regional Trainer or for additional information about any aspect of the HOPE Program, please contact me directly at CRowe@apa.org or (202) 216-7603. ■

BSSV...

program will participate in a training on a specific selected intervention and then become a resource for local agencies who wish to replicate proven interventions.

Let me conclude by saying that the BSSV Program is beginning an effort to inform agencies who receive funding from their health departments (local or state) that our TA services are available to them as well, free of charge. If you know of such agencies that could use TA in the areas described above, please contact the BSSV Program office! We would be happy to contact the agency and discuss a possible TA effort.

If you want to know more about the BSSV Program yourself, please contact the BSSV office at 202.218.3993, or email us at bssv@apa.org. ■

Organizational Resources

National Organizations

Gender Education & Advocacy
P.O. Box 65
Kensington, MD 20895
(301) 949-3822, Voice Mail Box #8

LLEGO (the National Latina/o Lesbian, Gay, Bisexual & Transgender Organization)
1612 K Street, NW Suite 500
Washington, DC 20006
(202) 466-8240

National Youth Advocacy Organization
1638 R Street NW
Washington, DC 20009
(202) 319-7596

Community-Based Organizations

Asian Pacific AIDS Intervention Team
605 West Olympic Blvd., #610
Los Angeles, CA 90015
(213) 553-1845

Asian & Pacific Islander Wellness Center
730 Polk Street, 4th Floor
San Francisco, CA 94109
(415) 292-4320, x 351

Bienestar
1169 N. Vermont Avenue
Los Angeles, CA 90029-1701
(213) 660-9680

Camden Area Health Education Center
514 Cooper Street
Camden, NJ 08102
(856) 963-2432

Gender Identity Project
Lesbian & Gay Community Services Center
One Little West 12th Street
New York, NY 10014
(212) 620-7310

Transgendered People...

Ultimately, the most important strategy in changing public policy—and attitudes—regarding Transgender Care is yet more professional and public education. The importance of changing hearts and minds in what has been called a “cultural war” cannot be overstated. However, public educational efforts are quite problematic for transgendered people themselves, due to intense social stigmatization. Transgendered people are commonly regarded as the cultural arch-stereotypes of gay men and lesbians, or as sexually perverted freaks wholly undeserving of their human dignity or civil rights. Transphobic discrimination, harassment and violence drives the majority of transgendered people to assimilate into the nontransgendered population, leaving the remainder at society’s fringe, living Hobbesian existences, vulnerable to “social cleansing” through malevolent neglect.

Hence the important role to play for the national professional organizations—the American Psychological Association (APA); the American Association of Sexologists, Educators, Counselors and Therapists (AASECT); the Society for the Scientific Study of Sex (SSSS); and the National Association of Social Workers (NASW); and others. All can have an enormous impact, should they make and act upon resolutions similar to that of the APHA’s. In 2000, the APA issued its *Guidelines for Psychotherapy with Gay, Lesbian and Bisexual Clients* to assist psychologists in seeking and utilizing appropriate education and training in their treatment. Should sufficient research from both US and international sources be identified, similar guidelines could be drafted for transgendered clients, with the same goals of providing practitioners with a frame of reference for treatment, along with basic information and further references in the areas of assessment, intervention, identity, relationships, and the education and training of psychologists. Beyond education and de-stigmatization, APA and other national professional associations could champion research to better meet the health care needs of transgendered populations. Without such advocacy and assistance, improving the health and well-being of transgendered people will remain very problematic. ■



Hispanic AIDS Forum Files Suit After Being ‘Forced’ to Relocate

The New York-based Hispanic AIDS Forum on Tuesday filed a discrimination lawsuit against a former landlord, arguing that the landlord refused to renew the group’s lease when it rejected the “ultimatum” that transgendered women clients use a men’s bathroom. The suit... contends that the “force[d]” move caused the group to spend money for relocation and new equipment that otherwise could have been used for client services. The Hispanic AIDS Forum counsels HIV-positive patients and transgendered people who do not have HIV/AIDS. New York Association of Gender Rights Advocacy Coordinator Pauline Park said that forcing transgendered women to use the men’s bathroom during counseling sessions is a safety threat, as these women face harassment and physical and sexual assault in men’s bath-

rooms. “It happens all the time in homeless shelters where transgendered women are forced to locate in men’s shelters and are harassed and assaulted by the other residents and in some cases even by staff,” she added. ACLU Attorney Tamara Lange said, “The impact that we’re seeking is that everyone will realize that they need to accommodate transgendered people and not draw strict gender boundaries that require people to go into a situation that’s unsafe for them...” (Lowe, *Newsday*, 6/27).

The foregoing information comes from the Kaiser Family Foundation. For access to the Foundation’s policy research, analyses, reports and fact sheets, and media partnerships, visit the Foundation’s main website at www.kf.org.

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A Cognitive-Behavioral Intervention for HIV+ Recovering Drug Abusers

The 2000–05 NIDA-Funded AIDS Prevention Center Study

*Robert Malow, PhD; Jessy Dévieux, PhD;
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Neil Schneiderman, PhD*

Introduction

The UNAIDS June 2000 Report on the Global HIV/AIDS Epidemic characterizes developed countries such as the United States as having “longer survival but more risk behavior.” This is a commentary on the availability of antiretroviral drug therapy combined with the high prevalence of alcohol and drug abuse. In 1999, the director of the National Institute on Drug Abuse (NIDA), Dr. Alan Leshner, highlighted the prominent role of drug abuse as a ‘major vector’ in the transmission of HIV, critically linked to crime and losses in productivity and human capital. Most central to public health and future disparities in care, those with a history of alcohol and drug abuse are not only at higher risk for HIV infection and its transmission to others, but they are also at risk for failure in adhering to antiretroviral regimens. Thus, they are likely to remain marginal to



Robert Malow, PhD and Jessy Dévieux, PhD

innovations, particularly when their share of potential public health costs loom large in terms of resistant strains of HIV because of adherence failure, and treatment losses because of relapse.

Therapeutic Adherence and Relapse Management at the AIDS Prevention Center (APC)

To address the marginality of this very significant high risk group, NIDA has funded five projects in response to the RFA entitled “HIV Therapy for Drug Users: Access, Adherence, Effectiveness.” One of the projects funded will be undertaken by the AIDS Prevention Center (APC) at the University of Miami School of Medicine. This project is called “Cognitive Behavioral Treatment of HIV+ Drug Abusers.”

The goal of this 5-year study is to extend an intervention model developed from over a decade of NIH-funded research at the University of Miami to a low income, ethnically diverse target population of HIV+ drug abusers in recovery. This model is the Cognitive Behavioral Stress Management (CBSM) intervention, based on cognitive social learning and relapse prevention theory. Its antecedents can also be found in stress and coping, social support, and skills training theoretical approaches to primary and secondary HIV prevention. CBSM has shown effectiveness with non-drug abusing subgroups in research con-

ducted by the project’s investigators, including Antoni, Fletcher, Ironson, Klimas, and Schneiderman. Pilot research has demonstrated the feasibility and potential promise of using this model for recovering drug abusers (RDAs). The newly funded CBSM-RDA study (Robert Malow, P.I.) takes this investigation to the next level with a randomized experiment comparing the effects of CBSM-RDA with a standard of care control group. The principal aims are to understand the effects on

...those with a history of alcohol and drug abuse are not only at higher risk for HIV infection and its transmission to others, but they are also at risk for failure in adhering to antiretroviral regimens.

adherence to Highly Active Antiretroviral Therapy (HAART), safe sexual activity, and relapse patterns in recovery from drug abuse. It is the first NIH-funded project to specifically evaluate an intervention to improve HAART adherence and other health behaviors among a sample of male and female RDAs who have predominantly abused crack cocaine.

A large and growing number of HIV+ drug dependent or recovering individuals, including nearly 80% of the

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The CBSM-RDA Modality

Group process is at the core of CBSM-RDA designs. This is not only to attend to practice-based cost effectiveness constraints but also to allow an experiential basis to both the intervention and the research knowledge gained. It carries an incentive for interventionists to not merely deliver risk reduction skills and social networks to participants, but more fundamentally to build upon the contextual realities and incipient structures that these individuals bring to the process. The CBSM-RDA group has developed into an approach that distinctively focuses on contextual-community factors, with strategies that draw upon the target population's oral and visual traditions, linguistic culture, dominant participatory learning style, and the collective consciousness of their ethnic/racial and socioeconomic communities. Moreover, it integrates participants' own experience with HIV, drug abuse and recovery, and the problems in negotiating safe sexual activity.

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proposed target sample, are non-injection drug users who primarily smoke/freebase crack cocaine. In a sense, the rise of non-injection drug abuse has refocused attention on the nonmaterial, psychological interplay of sex and addiction. Fundamental to the effort in this study is the identification of mediators and moderators of effects, such as psychopathology, gender, ethnicity and dyadic relational factors, utilizing hierarchical linear and structural equations modeling to explore how study variables interrelate to predict outcome. Study outcomes will be followed at 3, 6, and 12 months in 160 male and 160 female HIV+ RDAs with respect to the following endpoints: distress (i.e., depressive symptoms and mood state), quality of life, drug abuse relapse, unsafe sex, HAART adherence, and health status indicators (e.g., viral load, CD4 count, physical symptoms).

Development of the CBSM-RDA Intervention

In addition to their numeric importance and the problems related to poverty (e.g., housing, child care, transportation, employment, medical care, violence) and the drug lifestyle that may take precedence over efforts to medically manage HIV infection, crack cocaine abusers present a number of other complications. First, crack abusers engaging in higher levels of unsafe sexual behavior demonstrate distinctive treatment needs and patterns of psychopathology. Second, crack use has been associated with increases in sexual behaviors (e.g., sexual arousal, disinhibition, and multiple contacts) that are related to an enhanced risk of transmitting HIV/STD. Third, crack use may reduce immune functioning directly and indirectly through circumstances associated with the crack using lifestyle, (e.g., inadequate medical care, poor nutrition, and increased frequency of STD). Fourth, smoking crack often results in lesions to the lips, tongue, and esophagus, which may enhance the likelihood of STD/HIV transmission during oral sex. Finally, with habitual crack use, it often becomes increasingly difficult for men to ejaculate. The extended and rough oral, anal, or vaginal sex necessary for the male crack-using partner to ejaculate increases the likelihood of developing mucosal lesions and transmitting or acquiring STDs. Given these differences, HIV+ crack abusers may require even more tailored interventions than intravenous drug users.

The CBSM-RDA is designed for 2-member facilitator teams, consisting of a professionally trained therapist (defined as having at least a masters degree in psychology, counseling, social work or the equivalent with at least three years of experience conducting group psychotherapy with the target population) and a recovering addict paraprofessional with a well-established record of uninterrupted abstinence. In stage 1 pilot experience, paraprofessionals emerged as excellent role models, lending credibility to the study and demonstrating greater sensitivity to the nuances of addictive behavior than other types of staff. They also frequently engendered greater trust and rapport with participants, such as those in the CBSM-RDA study who have likely experienced multiple instances of social deprivation, devaluation, and stigma.

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Based on an assessment of the literature and our experience in prior studies, pointing to a number of advantages in using a mixed gender team, each facilitator team includes a male and female co-facilitator. Such a team is likely to enhance the effects of modeling, role playing, and safer sex messages. Our pilot work showed that almost all male participants and most female participants preferred to have an opposite-gender facilitator for the many role-play and safer sex exercises. Although a small number of women and even fewer men initially experienced mild discomfort in discussing sensitive issues in the presence of an opposite-gender facilitator, this uneasiness appeared to dissipate quickly as the groups proceeded. Moreover, almost all of these individuals later volunteered for role playing and reported feeling comfortable with the opposite-gender facilitator, openly expressing their thoughts and feelings in a relaxed manner. A mixed gender team also takes full advantage of the differential impact that gender is likely to have on participant understanding and acceptance of certain types of information (e.g., more responsiveness in women to training in the use of female condoms when led by female facilitators).

Though there are advantages (e.g., ecological validity) to discussing safer sex and other HIV/AIDS topics in the presence of the opposite sex, pilot testing and other considerations led us to utilize separate male and female groups. Pilot participants were more comfortable asking important questions and participating in a same-sex

group format, which also permitted the intervention to be more tailored to gender-specific, culturally sensitive issues critical to this population during safe sex negotiation. Further, the same-sex format deepens the content of the group sessions, by fostering personal role-playing examples and freer disclosure and interaction among participants. In designing the group sessions, we proceeded without any assumptions regarding the sexual orientation of participants, training facilitators to use gender neutral terms that do not preference heterosexual relationships, such as: a) “partners” or “persons we date” rather than “boyfriend” or “girlfriend”; b) “when a couple has sex” rather than “when a man and woman have sex”; and c) “when a person removes his penis from the other partner” rather than “when a man removes his penis from the woman.”

In a sense, the rise of non-injection drug abuse has refocused attention on the nonmaterial, psychological interplay of sex and addiction.

Intervention design has proceeded by making cultural relevance a priority in targeting the study population of predominantly unemployed, low SES, Hispanics and African Americans. The key organizing framework has been meaningful and relevant examples and role-playing exercises or cognitive rehearsals, group discussion and interaction, and information, each directed at the critical issues of cultural context, RDA life experience, risk behavior reduction, and HAART adherence. Consequently,

examples and group exercises incorporate terminology and expressions familiar to local multicultural communities, reflecting practices of spirituality and religion, family and group relationships, and the oral tradition. Oral and group-centered approaches are designed for sensitivity to the learning styles, collective orientations, values, and educational levels of participants, with feedback loops to incorporate their “real life” examples and concerns. Also, adapted modules are geared for relevance to recovering drug abusers, incorporating “The Serenity Prayer” and a focus on relapse prevention and long-term maintenance. Information content is directed at reducing risk behaviors, such as risky sex and drug abuse. For example, STD testing/treatment is encouraged because the prevalence and incidence rates of STDs among the target population are high, and lesions and inflammations produced by many STDs facilitate HIV transmission and progression. Thus, the CBSM-RDA includes supplemental information about the ease of a) STD transmission; b) short and long-term consequences (e.g., sterility and pelvic inflammatory disease); c) the high prevalence of trichomoniasis, chlamydia and gonorrhea; and d) the availability of an inexpensive diagnostic test that is non-invasive and also an effective treatment that requires only one dose of antimicrobial medication. Additional content is aimed at promoting HAART adherence, conveying the clinical implications of recent scientific advances, and addressing beliefs

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regarding post-exposure prophylaxis, life expectancies, undetectable viral loads, and the negative role of substance use in adhering to new medical regimens.

Study Protocol

The CBSM-RDA protocol comprises two broad domains: risk reduction/health maintenance strategies and stress management techniques. It specifically targets activities to the interrelationships between HAART adherence, sexual risk behavior, and substance abuse. Thus, activities include: a) increasing participant awareness of prescription guidelines and the health consequences of inconsistent adherence, continued drug abuse, and high-risk sex; b) building self-efficacy in adopting health-promoting behaviors while raising self-awareness of vulnerability to the effects of negative health behaviors; c) instilling adaptive coping strategies (e.g., planning and scheduling medication and food intake within daily routines) and breaking through denial and misperceptions surrounding risk behaviors; d) improving awareness of triggers, like substance use, for unsafe sex and poor medication adherence; e) demonstrating how to calculate an internal cost/benefit analysis of choices and distinguish short and long-term consequences; and f) providing skills for interacting with physicians and resisting adverse peer influences. In addition, the intervention has been adapted to take account of the cultural factors that may mediate participants' explanatory models of medication and disease, including the external barriers (financial, proximity) that may impede access to health care.

Fidelity to the study protocol is ensured by several mechanisms. A detailed manual has been developed for both intervention and control conditions, with specific instructions for tailoring the condition to differences in gender, literacy, and ethnic/cultural background. In addition, both facilitators and participants will complete an integrity rating scale to assess the degree to which important aspects of the protocol have been administered. And, audiotapes will be made of all group sessions, which will then be randomly rated for treatment integrity.

The CBSM-RDA is comprised of 10 sessions administered over a 10-week period in groups of eight. This group size promotes interpersonal interactions and disclosures and affords the opportunity for cognitive rehearsal and role playing of risk reduction skills. Embedded in the group sessions are procedures to help comprehension and retention of presented material, since many pilot study participants encounter difficulties in this area. ■

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Correction of Previous Article Appearing in the *Psychology and AIDS Exchange*

An article in the Winter 2000 issue of *Psychology & AIDS Exchange* (i.e., Issue 28), "Translating Primary HIV Prevention Intervention in Diverse Groups: The AIDS Prevention Center (APC) in Miami," reported on the creation of the AIDS Prevention Center at the University of Miami School of Medicine. That report focused on the translational design issues in the future of HIV, introducing the concept of deep intervention and the adaptation of the Cognitive Behavioral (CB) model for targeting the contextual and cultural factors in HIV risk and primary prevention. Mistakenly, the names of authors did not appear with the article. The authors were Robert Malow, Jessy Devieux, and Rhonda Rosenberg, all from the AIDS Prevention Center. Further information about both the previous and the current article can be obtained from Dr. Robert Malow at rmalow@bellsouth.net

Upcoming Events

2001 National HIV Prevention Conference

**August 12-15, 2001
Hyatt Regency Atlanta Hotel
Atlanta, GA**

For nearly 20 years, HIV and AIDS have presented historic challenges to our nation's public health, scientific, and medical communities. This conference, following the 1999 National HIV Prevention Conference, is unique in its sole concentration on the ever-important science of HIV prevention.

Numerous governmental and non-governmental organizations have committed their support to the **2001 National HIV Prevention Conference**, because it offers opportunities to share effective prevention approaches and research findings among governmental, community, and academic partners in HIV prevention, as well as

strengthen collaborations between program practitioners and researchers in areas including behavioral interventions, vaccine development, and monitoring the epidemic.

The fee schedule is as follows:

Registrations received before July 18, 2001:
\$300.00

Registrations received after July 18, 2001:
\$350.00

After July 18, registration will be processed on-site only (dependent upon space availability.)

For more information, please visit the conference website at <http://www.2001hivprevconf.org/default.cfm>, or call the HIV Prevention Conference Hotline at (404) 233-6446.

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Organizational Resources

Community-Based Organizations, cont'd

Gender Identity Support Services for Transgenders
14 Beacon Street
Boston, MA 02108
(617) 720-3413

High Risk Project
449 East Hastings Street
Vancouver, BC V6A 1P5
(604) 255-6143

Ke Ola Mamo
1108 Fort Street Mall, Room 2
Honolulu, HI 96813
(808) 595-2089

Life Foundation
233 Keawe Street
Suite 226
Honolulu, HI 96813

Positive Health Project
301 West 37th Street, 2nd Floor
New York, NY 10018
(212) 465-8304

Program in Human Sexuality
University of Minnesota
1300 South Second Street
Suite 180
Minneapolis, MN 55454
(612) 625-1500

Proyecto ContraSIDA Por VIDA
2973 16th Street
San Francisco, CA 94103
(415) 864-7278

Safe Haven Outreach Ministry
805 Florida Avenue, NW
Washington, DC 20001
(202) 299-0701

Tenderloin AIDS Resource Center
187 Golden Gate Avenue
San Francisco, CA 94102
(415) 255-8272

TransHealth and Education
Development Program
100 Boylston Street
Suite 860
Boston, MA 02116
(617) 988-2605, ext. 211

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Clinical Issues...

Earlier this year, APA released its *Guidelines for Psychotherapy with Lesbian, Gay, and Bisexual Clients*. These guidelines address both the sensitivity and competence that psychologists need to possess in order to provide clinical services to LGB clients effectively and ethically. Using these guidelines as a standard, APA could be of great help both to transgender individuals and to the clinicians who serve them by developing guidelines for providing clinical services to transgender clients. ■

References

American Psychological Association. (2001). *Guidelines for psychotherapy with lesbian, gay, and bisexual clients*. Washington, DC: Author.

Israel, G. E., & Tarver, D. E., II (1997). *Transgender care: Recommended guidelines, practical information & personal accounts*. Philadelphia: Temple University Press.

Levine, S. B., Brown, G., Coleman, E., Cohen-Kettenis, P., Hage, J. J., VanMaasdam, J., Petersen, M., Pfaefflin, F., & Schaefer, L. C. (1998). The standards of care for gender identity disorders. *The International Journal of Transgenderism, 2*, <http://www.symposion.com/ijt/ijtc0405.htm>.

Lombardi, E. (2001). Enhancing transgender health care. *American Journal of Public Health, 91*, 869-872.

Nemoto, T., Luke, D., Mamo, L., Ching, A., & Patria, J. (1999). HIV risk behaviors among male-to-female transgenders in comparison with homosexual or bisexual males and heterosexual females. *AIDS Care, 11*, 297-312.

Note: Dr. Hendricks co-chairs Division 44's Transgender Task Force and is in private practice at the Washington Psychological Center, P.C., 4201 Connecticut Ave., NW, Suite 602, Washington, D.C. 20008. Email: psymichael@aol.com.

Upcoming Events

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United States Conference on AIDS (USCA) 2001

**September 13-16, 2001
Fountainbleau Hilton Resort and Towers
Miami Beach, FL**

The fifth annual United States Conference on AIDS (USCA) will take place September 13-16, 2001 in Miami Beach, Florida. In the past we have had over 3,100 service providers, people living with HIV/AIDS, policymakers, public officials, international delegates, funders, and other leaders attending USCA, making it the largest AIDS-related gathering in the U.S. Over 3,300 attendees are expected. Dr. David Ho will keynote.

Important USCA Deadlines

To register online:
<http://www.nmac.org/usca2001/registration.htm>

Hotel Registration: August 13, 2001. For hotel information:
<http://www.nmac.org/usca2001/hotelreservation.htm>

For specific questions and concerns regarding USCA 2001 please contact our Conference Registrar, Paul Woods at: pwoods@nmac.org or 202-483-6622.

Growing Up with HIV/AIDS: Issues

**Memphis, TN
October 4-5, 2001**

Sponsored by St. Jude Children's Research Hospital. University of Tennessee Boling Center for Developmental Disabilities. This conference will address issues affecting the community by the growing numbers of children, adolescents, and their families living with HIV/AIDS. It provides a forum for service systems and individuals to exchange information and current research results to develop collaborative efforts. Key topic areas are: Adolescents with HIV/AIDS, Children with HIV/AIDS, Community Health Planning, Cultural Factors, Ethical Issues, Family Support, HIV Prevention, Nutrition, Quality of Life.

Fees: \$175/registration. Continuing education credits are available for nurses, social workers, and dieticians.

To register or for more information contact the Training Coordinator, TEL: (901) 448-2660, FAX: (901) 448-7097, TTD: (901) 448-4677, E-MAIL: cgreenwald@utm.edu, WEB: www.utm.edu/bcdd

American Public Health Association: 129th Annual Meeting and Exposition

**Atlanta, GA
October 21-25, 2001**

The APHA's annual meeting provides participants with the opportunity to explore public health: science, practice, and policy; networking; professional development and education; and job possibilities. Major areas addressed include: Adolescents, Children, Disease Prevention, Diseases or Disorders, Drug Abuse Treatment, Epidemiology, Health Care Accessibility, Health Care Services, Health Promotion, HIV Prevention, Immunization, Mental Health, Minorities, Nutrition, School Health Education, Substance Abuse, Surveillance, Treatment, and Women.

Fees are dependent upon membership status, date of registration, and professional status, such as full-time student or retired APHA member. Continuing education credits are available.

To register or for more information contact Edward Shipley, TEL: (202) 777-2478, E-MAIL: edward.shipley@apha.org, WEB: www.apha.org

XIV International AIDS Conference

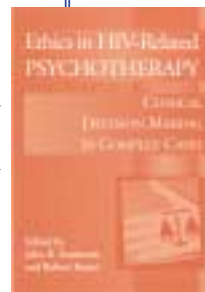
**Barcelona, Spain
July 2002**

Over the years the AIDS epidemic and its associated scientific, social and political needs have changed dramatically. The major purpose of the early international conferences was to share research and medical findings about a relatively new dis-

ease. Hence, the early emphasis was on clinical and biomedical aspects. More recently, as our understanding of the basic science and natural history of HIV infection has steadily increased, more attention has been devoted to creating opportunities for sharing our understanding in more social and community-related areas, including local and national experiences in response to the epidemic.

International AIDS Conferences, under the sponsorship of the International AIDS Society, have worked to adapt content and format in response to the special sensitivities of local conference organizers, collaborating with international organizers and developing science-into-action partnerships for the XIV International AIDS Conference to be held in Barcelona (Catalonia, Spain) in July 2002.

For more information visit the Conference Website at http://www.aids2002.com/IE_Home.asp or contact the Conference Program Secretariat, Edifici Apollo X, Balmes, 200 at. 9, 08006 Barcelona, Spain
Tel: +34 932 182 404
Fax: +34 932 170 188
E-mail: aids2002@aids2002.com



Ethics in HIV-Related Psychotherapy:

Clinical Decision-Making in Complex Cases

Edited by John R. Anderson, PhD, and Robert L. Barret, PhD

In this volume, Anderson and Barret provide a practical decision-making model and down-to-earth advice for clinicians with HIV-positive clients. They begin with an overview of common ethical

dilemmas, discuss the risk of legal malpractice, and offer guidance on reducing this risk. Ten diverse case studies are presented highlighting common ethical conflicts and including comments from an ethicist and an attorney. This volume is ideal not only for seasoned therapists but also for those taking graduate ethics courses in psychology, counseling, social work, and related mental health. 2001. 376 pages. Hardcover.

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