

MODULE TEN

Transgender and HIV/AIDS

The information for this module was excerpted from the following sources:

Hendricks, M. (2001). Clinical issues in work with transgender individuals. *Psychology and AIDS Exchange Newsletter*, 30, pp. 3, 9, 10, 14, 16, 27.

Center for AIDS Prevention Studies at the University of California–San Francisco (2001, September). *Fact Sheet #41E*. Prepared by Joanne Keatly, MSW and Kristen Clements-Nolle, MPH

A. Transgenders and HIV Prevention

- The use of “club drugs”—methamphetamine, Ecstasy (MDMA), gamma hydroxybutyrate (GHB), ketamine, and poppers (amyl nitrites)—has increased dramatically since the early 1990s with the spread of circuit parties and raves, and the re-emergence of sex clubs. The use of these substances in sexually charged environments creates a psychological, sociological, and biological environment that threatens individual and public health.
- Male-to-female transgender individuals (MTFs) have higher rates of HIV-related risks and HIV than female-to-male transgender persons. MTFs have high rates of HIV infection, with overall rates of 35% in San Francisco in 1997 and 22% in Los Angeles in 1998. (Clements-Nolle, et al., 2001; Simon, Reback & Bemis, 2000). A study of MTF sex workers in Atlanta found that 68% tested positive for HIV (Elifson, et al., 1993). Infections among MTFs continue to rise, with an estimated rate of new infections of 3-8% per year (Kellogg, et al. in press; Simon, Reback & Bemis, 2000). African American MTFs have higher rates of HIV than other racial/ethnic groups (Clements-Nolle, et al., 2001; Elifson, et al., 1993; Kellogg, et al., in press; Simon, Reback & Bemis, 2000).
- Injection drug use is also common among MTFs, putting them at high risk for HIV. In a San Francisco study, 18% of the respondents reported non-hormonal injection drug use in the past six months and half of this group shared syringes (Clements-Nolle, et al., 2001). MTFs may inject female hormones as well, in order to feminize their bodies. HIV risk through hormone injection varies regionally, with New York reporting more risk than in San Francisco, due to differences in availability of hormones and hormone syringes (Clements-Nolle, et al., 2001; McGowan, 1999). In San Francisco, the needle exchange programs offer hormone syringes and a number of public health clinics offer free or low-cost hormone therapy.
- Transphobia, or the pervasive social stigmatization of MTFs, greatly exacerbates their HIV risk. This intense stigmatization results in their social marginalization, which includes the denial of educational, employment and housing opportunities

(Green, 1994; Nemoto, et al., 1999). It also creates multiple barriers to accessing health care. Such marginalization lowers MTFs' self esteem, increases the likelihood of survival sex work and lessens the likelihood of safer sex practices (Bockting, Robinson & Rosser, 1994). All of this leads to high rates of HIV, STDs, drug use and attempted suicide.

- MTFs primarily have sex with men and are likely to engage in receptive anal sex, which puts them at increased risk (Clements-Nolle, et al., 2001; Simon, Reback & Bemis, 2000; Boles & Elifson, 1994). Some MTF sex workers are willing to not use condoms with their paying partners if they are offered more money (Nemoto, et al., 1999). However, some studies show that most unprotected sex occurs with primary partners, not paying partners (Simon, Reback & Bemis, 2000).

B. Barriers to HIV Prevention

- Psychosocial factors such as poverty, low self-esteem, depression, feelings of isolation, rejection, and powerlessness are cited by MTFs as barriers to sexual and drug risk reduction. For example, many MTFs state that they engage in unprotected sex because it validates their female gender identity and boosts their self-esteem (Boles & Elifson, 1994; Clements-Nolle, Wilkinson & Kitano, 2001). For many MTFs, securing employment and housing are more pressing issues than HIV and must be addressed before HIV prevention efforts can be effective (Clements-Nolle, Wilkinson & Kitano, 2001).
- Many transgender individuals do not access HIV prevention or health services due to the insensitivity of service providers and health care staff (Clements-Nolle, Wilkinson & Kitano, 2001; Feinberg, 2001), or fear of being revealed as transgender (Xavier, 2000). Some HIV prevention programs for MTFs face challenges renting space due to transphobia.

C. HIV Prevention Interventions

- The U.S. Office of National Drug Control Policy (ONDCP, 2004a) identifies four specific club drugs: MDMA (methylenedioxymethamphetamine, “Ecstasy”), GHB (gamma-hydroxybutyrate), ketamine, and Rohypnol (flunitrazepam). Although an argument could be made to include substances such as methamphetamine and LSD, these were not included for a couple of reasons. For one, they are inconsistently included in the category of club drugs. In addition, they have a longer history of misuse and a correspondingly larger literature.

- The Transgender Resources and Neighborhood Space (TRANS) Project, at the Center for AIDS Prevention Studies (CAPS) in San Francisco, CA, provides workshops addressing substance abuse, HIV, commercial sex work, self care and general life skills. It also hosts an informal drop-in center where clients can relax, shower and socialize. MTF outreach workers facilitate all activities. The Project collaborates with Walden House Transgender Recovery Program, which provides expanded therapy, counseling, mentorship programs and life training skills that address the unique needs of MTFs (University of San Francisco Center for AIDS Prevention Studies, 2001).
- The Program in Human Sexuality (PHS) at the University of Minnesota developed and evaluated a community-based program for MTFs based on the health belief model and eroticizing safer sex. Although the program was well received, feedback from participants stressed the need for a comprehensive health-based approach because clients' concerns around gender overrode their HIV concerns. PHS now offers All Gender Health seminars based on a sexual health model that address HIV risk in the context of participants' lives and cover topics such as stigmatization, dating, sexual functioning, substance abuse, and violence. They combine education with entertainment, featuring MTF celebrities and MTF health professionals (Bockting, Rosser & Coleman, 2000).
- The Transgender Harm Reduction Program in West Hollywood, CA, conducts outreach to MTFs at risk—both those living on the streets and in the suburbs. The program consists of outreach, community skills building workshops, mentoring and job training. Workshop topics include grooming and hygiene, legalization and documentation, health care and hormone therapy, as well as explicit HIV risk reduction. Implicit in the program is the importance of increasing self esteem in order to adopt safer behavior (Reback & Lombardi, 1999).
- Gender Identity Support Services for Transgenders (GISST) in Boston, MA, has been serving HIV- and HIV+ individuals since 1993. GISST provides AIDS education, HIV testing, alcohol and drug rehabilitation, counseling, job training, social skills, social acceptance, and gender identity counseling. They host luncheons on topics such as surgery and hormones, featuring speakers, videos, and clients sharing experiences (Hope-Mason, Connors & Kammerer, 1995).

D. Clinical Treatment Issues

- The Transgender Harm Reduction Program in West Hollywood, CA, conducts outreach to MTFs at risk—both those living on the streets and in

the suburbs. The program consists of outreach, community skills building workshops, mentoring and job training. Workshop topics include grooming and hygiene, legalization and documentation, health care and hormone therapy, as well as explicit HIV risk reduction. Implicit in the program is the importance of increasing self esteem in order to adopt safer behavior (Reback & Lombardi, 1999).

- 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.
- 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.
- 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 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. Ultimately, it is the transgender individual’s decision whether to proceed with transitioning.
- 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.

- 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. 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.