Human Sexuality Continuing Education Course
(10 hours/units)

Course Objectives: In addition to the course objectives listed in the course description, please see additional course content areas related to human sexuality listed below:

- ✓ Social and cultural foundations
- ✓ Counseling theory and practice
- ✓ Assessment
- ✓ Professional practice issues
- ✓ Wellness and prevention
- ✓ Human growth and development

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1. Introduction and Definitions

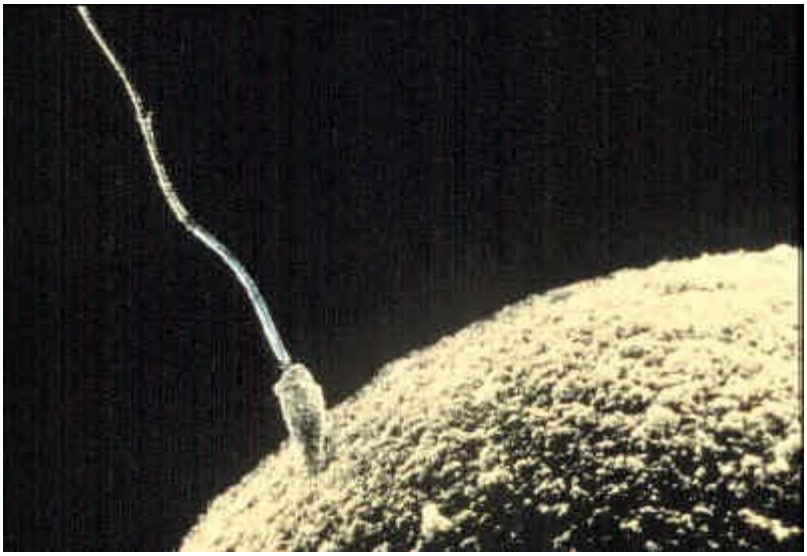
Sexual health today is widely understood as a state of physical, emotional, mental and social wellbeing in relation to sexuality. It encompasses not only certain aspects of reproductive health – such as being able to control one's fertility and being free from sexually transmitted infections (STIs), sexual dysfunction and sequelae related to sexual violence or female genital mutilation – but also, the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. Indeed, it has become clear that human sexuality includes many different forms of behavior and expression, and that the recognition of the diversity of sexual behavior and expression contributes to people's overall sense of well-being

and health.

Developments over the past three decades, particularly in the wake of the HIV pandemic, have brought an understanding that discrimination and inequality also play a key role in whether or not people can attain and maintain sexual health. For example, those who are perceived as having socially unacceptable sexual practices or characteristics, such as being HIV-positive, being an unmarried sexually active adolescent, a sex worker, a migrant, a transgender or intersex person, or engaging in same-sex sexual behavior, suffer both marginalization and stigma, which take a huge toll on people's health. Those who are deprived of, or unable to access, information and services related to sexuality and sexual health, are also vulnerable to sexual ill health. Indeed, the ability of individuals to achieve sexual health and well-being depends on their access to comprehensive information about sexuality, knowledge about the risks they face, vulnerability to the adverse consequences of sexual activity, access to good quality sexual health care, and access to an environment that affirms and promotes sexual health. As well as being detrimental to their sexual health, discrimination and inequalities may also constitute a violation of human rights. The achievement of the highest attainable standard of sexual health is therefore closely linked to the extent to which people's human rights – such as the rights to non-discrimination, to privacy and confidentiality, to be free from violence and coercion, as well as the rights to education, information and access to health services – are respected, protected and fulfilled. In the past two decades, an important body of human rights standards pertaining to sexuality and sexual health has been developed.

Human sexuality is described as the manner in which people experience and express themselves as sexual beings. There are many facets in the study of human sexuality including but not limited to:

- Biological
- Emotional
- Physical
- Sociological
- Philosophical



From a biological perspective, sexuality is defined as “the reproductive mechanism as well as the basic biological drive that exists in all species and can encompass sexual intercourse and sexual contact in all its forms”. There are also emotional or physical perspectives of sexuality, which refers to the “bond that exists between individuals, which may be expressed through profound feelings or emotions, and which may be manifested in physical or medical concerns about the physiological or even psychological aspects of sexual behavior”. Sociologically, it includes the cultural, political, and legal aspects of sexual behavior. Philosophically, it emphasizes the moral, ethical, theological, spiritual or religious aspects of sexual behavior *(Ellen Ross, Rayna Rapp Sex and Society: A Research Note from Social History and Anthropology Comparative Studies in Society and History).*

Human sexuality research has revealed that sexual variables are significant in developing one’s identity and to social evolution of individuals: “Human sexuality is not simply imposed by instinct or stereotypical conducts, as it happens in animals, but it is influenced both by superior mental activity and by social, cultural, educational and normative characteristics of those places where the subjects grow up and their personality develops. Consequently, the analysis of sexual sphere must be based on the convergence of several lines of development such as affectivity, emotions and relations” *(Ellen Ross, Rayna Rapp Sex and Society: A Research Note from Social History and Anthropology Comparative Studies in Society and History).*

The biological aspects of human sexuality include human reproduction and other aspects such as organic and neurological responses, heredity, hormonal issues, gender issues and sexual dysfunction *(Ellen Ross, Rayna Rapp Sex and Society: A Research Note from Social History and Anthropology Comparative Studies in Society and History).*

Additionally, human sexuality can be conceptualized as inclusive of the social life of humans, governed by implied rules of behavior. Of course, this involves cultural and

societal influences including media such as politics and the mass media. Historically, media has caused significant changes in sexual social norms such as the sexual revolution *(Ellen Ross, Rayna Rapp Sex and Society: A Research Note from Social History and Anthropology Comparative Studies in Society and History).*

2. Sexual Diversity

In 2015, a cross-sectional, Internet-based, U.S. nationally representative probability survey of 2,021 adults (975 men, 1,046 women) focused on a broad range of sexual behaviors was completed. The survey was titled the 2015 Sexual Exploration in America Study and survey completion took about 12 to 15 minutes. The survey was confidential and the researchers never had access to respondents' identifiers. Respondents reported on demographic items, lifetime and recent sexual behaviors, and the appeal of 50+ sexual behaviors. Most (>80%) reported lifetime masturbation, vaginal sex, and oral sex. Lifetime anal sex was reported by 43% of men (insertive) and 37% of women (receptive). Common lifetime sexual behaviors included wearing sexy lingerie/underwear (75% women, 26% men), sending/receiving digital nude/semi-nude photos (54% women, 65% men), reading erotic stories (57% of participants), public sex (≥43%), role-playing (≥22%), tying/being tied up (≥20%), spanking (≥30%), and watching sexually explicit videos/DVDs (60% women, 82% men). Having engaged in threesomes (10% women, 18% men) and playful whipping (≥13%) were less common. Lifetime group sex, sex parties, taking a sexuality class/workshop, and going to BDSM parties were uncommon (each <8%). More Americans identified behaviors as "appealing" than had engaged in them. Romantic/affectionate behaviors were among those most commonly identified as appealing for both men and women. The appeal of particular behaviors was associated with greater odds that the individual had ever engaged in the behavior. This study contributes to our understanding of more diverse adult sexual behaviors than has previously been captured in U.S. nationally representative probability surveys. Implications for sexuality educators, clinicians, and individuals in the general population are discussed.

Introduction

Alfred Kinsey and colleagues documented sexual diversity in the United States (U.S.) in large convenience samples of thousands of women and men in the 1930s – 1950s [1, 2]. The great interest with which their team's findings were met by the American population and scientific community emphasize the value of studying sexual behavior and its many expressions. Because sexual behaviors are often private, and because sexuality topics are often shrouded in secrecy and taboo, sexuality remains a particularly important topic to highlight in scientific research in order to expand knowledge and understanding of this important aspect of human life.

Although Kinsey's team asked about a broad range of sexual behaviors, few adults older than age 50 were interviewed and U.S. probability sampling was not then feasible. Thus, although human sexual behaviors were established as diverse, the population-based prevalence of such behaviors was unknown. Consequently, while sexual health

professionals have long been able to utilize Kinsey's data to reassure or inform clients, patients, policy makers, and one another that, indeed, humans express their sexual desires and interests through diverse sexual behaviors, just how rare or how common many sexual behaviors are has been unknown. All too often, when asked how common certain sexual expressions are, sexuality professionals have had to respond, "We don't know."

The National Health and Social Life Survey (NHSLS), conducted in 1991, was the first nationally representative survey of U.S. sexual behavior, providing population estimates of a limited range of sexual behaviors. The NHSLS answered some of these important questions (particularly those related to the prevalence of masturbation, vaginal intercourse, anal intercourse, oral sex, and the appeal of a range of sexual experiences), yet the survey was also limited to younger adults.

In addition to the NSHLS, there have been several important U.S. national studies that have addressed sexual behavior, though each has focused on a narrow range of ages and/or sexual behaviors. The National Survey of Family Growth (NSFG) and Youth Risk Behavior Survey (YRBS) survey younger age groups and have mostly asked about sexual behaviors related to risk of pregnancy and sexually transmitted infections (STI). Also, YRBS items pertaining to sexual behavior are not uniformly adopted by all U.S. states. The National Social Life, Health, and Aging Project (NSHAP) addresses a limited scope of relational and sexual issues of older Americans.

The National Surveys of Sexual Health and Behavior (NSSHB) are the most recent U.S. probability surveys focused specifically on human sexual expression and have sampled a broad spectrum of Americans including adolescents as young as age 14 and adults in their 80s and 90s. Although the NSSHB assesses a fairly broad range of sexual behaviors among a range of ages, the focus has still largely been on solo and partnered masturbation, oral sex, vaginal sex, anal sex, digital penetration of the vagina and anus, and the use of condoms, lubricants, and sex toys. NSSHB items are broader in behavioral scope than the United Kingdom's National Surveys of Sexual Attitudes and Lifestyles (NASTAL) and somewhat more limited in behavioral scope than the Australian Survey of Health and Relationships which has—among Australians ages 16 to 69—also asked respondents about fisting, rimming, role play or dressing up, and group sex.

U.S. data on diverse sexual behaviors are needed to improve clinicians', educators', policymakers' and the general public's understanding of human sexual expression. Consequently, human sexual expression can be more richly and accurately described which may also help people to feel "seen" or better represented in terms of their sexualities. Occasional population-based benchmarks of sexual behaviors are also helpful in understanding whether certain cultural moments influence sexual behavior. For example, the popularity of the book Fifty Shades of Grey prompted journalists to ask how many people may feel aroused by, or participate in, bondage, domination, submission/sadism, and masochism (BDSM)—also referred to as "kink" behaviors—and whether reading the book changed population-level sexual behavior. In fact, the book series and 2015 film release have been linked to increases in rope sales in hardware stores, sex toy

sales, as well as BDSM sex toy-related injuries. However, since there had been no earlier national benchmarks of BDSM-related behaviors in the U.S., it was impossible to assess whether sexual practices had indeed changed at the population level.

That said, there have been a number of other societal level changes relevant to Americans' sexual practices such as greater acceptance of same-sex partnerships and marriage and more representations in mainstream media of open relationships and marriages. Technological innovations have resulted in greater access to sexually explicit material and greater ease of taking and sharing sexually explicit photographs and videos. [We note that these innovations are available in many countries globally; however, because the present research is limited to Americans' sexual behaviors, we focus our discussion of influencing factors mostly on those likely to be experienced by individuals living in the U.S. at the time of the study.] Although humans have engaged in a wide range of sexual behaviors throughout historical time and place, researchers have yet to document such diverse behaviors in a U.S. population-based sample. Using data from the 2015 Sexual Exploration in America Study, a nationally representative probability sample of U.S. adults ages 18 and over, we sought to estimate the prevalence of a broad and diverse range of sexual behaviors of American women and men as well as to understand more about the appeal of such behaviors.

The Institutional Review Board (IRB) of the Human Subjects Office at Indiana University-Bloomington reviewed and approved all study protocols (#141211166). Data were collected in late December 2014 and January 2015 through the KnowledgePanel® of GfK Research (GfK) (Menlo Park, CA, USA). Research panels accessed through GfK are based on a U.S. nationally representative probability sample established using both random digit dialing and an address-based sampling (ABS) frame that covers about 97% of U.S. households including unlisted telephone numbers, those without landlines, those that are cell phone only, and those without Internet access. Non-Internet households selected into the sample are provided hardware (i.e., a web-enabled computer) and Internet service to facilitate participation. The GfK KnowledgePanel® has been utilized in numerous nationally representative probability surveys, including those related to sexual behaviors and health, as well as other topics. GfK panel members are invited to take a small number of surveys per month (often just one or two) and can earn points for completing surveys that they can then accumulate and exchange for products. No additional incentives were offered for completing of the present survey.

Once the sample frame of adults 18+ was established, 4532 individuals were sent an email from GfK informing them that a new survey was available. Those who clicked on the link to learn more about the survey were provided with a brief description of the survey topic and the IRB-approved Study Information Sheet; a total of 2021 individuals (47% of those invited) consented to participate and completed the survey. The Study Information Sheet described the research study as being "about the romantic relationships and sexual behaviors of adults in the United States", noted that people were being asked to participate even if they had never had sex or even if it had been a long time since they last had sex, described the confidentiality of the survey, and noted that participants could

skip any questions they did not wish to answer. In order to normalize a range of responses, we also noted in the Study Information Sheet (as we often do in related research) that while some people find it "embarrassing or uncomfortable" to be asked about their sexual behaviors, others "find it interesting to think about their romantic and sexual experiences".

Measures

Panel members are asked by GfK to complete demographic items on an annual basis for sampling stratification and post-sampling weighting purposes; thus items related to age, gender, race/ethnicity, education, marital status, household income, and employment status were provided by GfK and not asked again by the research team. In addition, questions regarding perceived happiness and health status (from the General Social Survey) were asked.

Relationship structure

We asked respondents to indicate their relationship status; those who were in a relationship were asked whether that relationship was—during the past year—entirely monogamous (partners agreed to have sex only with each other and indeed only being sexual with each other to the respondent's knowledge), monogamous but sexless (partners agreed to be "exclusive" with each other but did not have sex together in the past year), supposedly monogamous (had agreed to be sexual only with each other and one or both partners had engaged in sex with others), in an open relationship (had agreed that one or both partners would engage in sexual activities with others); or had not discussed their relationship structure. Another option was to describe it some other way, with a text box offered.

Sexual orientation

Consistent with the NSSHB item about sexual orientation, respondents were asked, "Which of the following best describes your sexual orientation?" (heterosexual/straight, gay or lesbian, bisexual, asexual (not sexually attracted to others), other/please describe).

Sexual behaviors

Respondents were also asked how recently they had engaged in 32 sexual behaviors using a response scale common to the NSSHB (past month, past year, more than a year ago, never) for the purposes of context and, where applicable, comparison. The sexual behavior items were developed by the first author with feedback from four American masters- and doctoral-level individuals who have engaged extensively with and/or identify with communities related to BDSM, swinging, sex parties, group sex, and other forms of sexual diversity and/or kink. Item order within this section was randomized. Prior to asking these items, participants read a screen that said: "In this next section we will ask you questions about many different things that people do in their sexual lives. Some are common and many people do them. Others may be less common. Your responses will help us to better understand Americans' sexual lives. Remember: your answers are completely confidential."

In measuring the appeal of more than 50 sexual behaviors, the response options used in the NHSLS were presented to participants (very appealing, somewhat appealing, not appealing, not at all appealing) to facilitate comparison for the few parallel items. Item order within this section was randomized.

The sample included 975 men and 1046 women (see Table 1 for demographic information and presentations of both unweighted and weighted total sample) with a mean age of 47.1 (SD = 17.3; range = 18–91). About 91% identified as heterosexual, with more women identifying as bisexual (3.6%) compared to lesbian (1.5%) and more men identifying as gay (5.8%) compared to bisexual (1.9%). Most respondents reported being generally "very happy" or "pretty happy" (88%), and nearly 86% reported "good", "very good", or "excellent" general health. Of those in relationships, most were in male-female romantic relationships (95.2% men, 96.8% women). About half were married.

In thinking about the past year, most of the 1421 respondents who were in relationships reported being entirely monogamous (77.8%, n = 1106). More than 1 in 10 partnered respondents were currently in monogamous but sexless relationships (11.7%, n = 166). Additionally, 4.1% (n = 58) were supposedly monogamous, 1.6% (n = 23) reported being in an open relationship, 2.5% (n = 36) had not discussed their relationship structure, and the remaining 1.4% (n = 20) identified their relationship in some other way.

Solo and partnered sexual behaviors

About 64% of men and 40.8% of women had masturbated in the last month and 8.2% of men and 21.8% of women reported having never masturbated in their lifetime. Vaginal intercourse and giving/receiving oral sex were the most common partnered behaviors followed by partnered masturbation. The next most prevalent partnered lifetime behaviors differed by gender; for men it was having sex with someone in a public place (>45%) and for women it was wearing sexy underwear or lingerie for a partner (>75%). Significantly more women reported having engaged in lifetime vaginal sex (but not recent vaginal sex), receptive anal sex, and having worn sexy underwear for a partner. Significantly more men than women (25.6% vs. 10.9%) reported having ever engaged in sucking/licking of toes or feet. There were no statistically significant differences by gender in terms of spanking, whipping, partnered masturbation, role playing, tying up a partner or being tied up, giving or receiving oral sex, or having sex in public.

Sexual behaviors involving enhancement products and/or media

The most prevalent lifetime behaviors in this section were watching sexually explicit videos or DVDs (>70% overall; see Table 3) followed by reading erotic stories (57% for both women and men) and, for men, looking at sexually explicit magazines (79.0%). Significantly more women than men reported having used a vibrator or dildo (50.2% vs. 32.9%). Significantly more men reported having used a phone app related to sex, looked at a sexually explicit magazine, watched a sexually explicit video or DVD, used over the counter enhancement herbs or pills, and having received nude or semi-nude photos of someone.

Appeal of sexual behaviors

For more than 20 sexual behavior items, there were no statistically significant gender differences in terms of ratings of appeal. These included having sex in a hotel room, giving/receiving massage, role playing, playful biting, spanking, whipping, tying up, reading erotic stories, dirty talk, and blindfolding. The most appealing behaviors were those commonly associated with romance and/or affection (e.g., saying sweet, romantic things during sex, kissing more often during sex, cuddling more often, making the room feel more romantic). Additionally, large proportions of Americans found the following to be somewhat or very appealing: having sex in other parts of the house, having sex more often, and vaginal intercourse.

However, there were more than 25 behavioral items that significantly more men rated as appealing compared to women. Among others, these included all anal sexual behaviors (anal sex, anal toys, anal fingering), giving and receiving oral sex, most uses of media related to sex (watching explicit videos/DVDs, phone sex, sex over FaceTime or Skype, sending or receiving nude photos, etc.), having sex where one might be seen or heard by others, watching others (e.g., watching a partner undress, watching a partner masturbate, watching others do sexual things), and group sexual experiences (e.g., threesomes, group sex, sex parties). However, it is important to note that just because men rated these items as more appealing than women does not mean that they were generally appealing. Some behaviors, such as anal intercourse and group sex, were rated as "not appealing" or "not at all appealing" by most men and women.

There were 5 sexual behaviors rated as significantly more appealing by women as compared to men. These were watching a romantic movie, getting a couple's massage, using a vibrator or dildo, wearing sexy underwear/lingerie, and experiencing pain as part of sex.

Relationships between appeal and behaviors

After adjusting for age, relationship status, relationship duration, and perceived health status, the appeal of a behavior significantly increased the odds of having recently engaged in the behavior for both men and women for all of the behaviors analyzed.

This study contributes to our understanding of more diverse adult sexual behaviors than has previously been captured in U.S. nationally representative probability surveys. Sexuality educators and clinicians are often faced with questions from students or patients who want to know whether their sexual interests or behaviors are common or rare and these data will facilitate the answering of such questions (though certainly the prevalence of a behavior is not an indication of whether said behavior is a "good", "bad", healthy, or enjoyable behavior for a particular person, dyad, or group). To our knowledge, this paper also includes the first data from a U.S. nationally representative probability sample that describes Americans' relationships structures (e.g., monogamous, open, etc.).

In comparison to the 2009 NSSHB, the most common lifetime behaviors were the same —solo masturbation for men and vaginal intercourse for women. For masturbation with a

partner, we found higher rates for both men and women in the last month and over the lifetime. This may have been influenced by how the questions were asked as the NSSHB asked about “masturbation with a partner” and we asked about “masturbation with someone else” and “masturbation in front of a partner”, which may imply a performer and an observer (emphases added).

The NSHLS found that vaginal sex was one of the behaviors that both men and women found very appealing. In their study, 76% of women and 84% of men reported vaginal sex to be “very appealing” but we found slightly lower rates with 70% of women and 73% of men reporting the same. The reason for this is unclear. It may reflect our study’s inclusion of Americans ages 60s-90s, more of whom may experience vaginal sex as uncomfortable (e.g., due to postmenopausal vaginal dryness) or difficult (e.g., due to erectile dysfunction or, again, vaginal dryness) and thus less appealing. However, our participants rated many more behaviors as appealing compared to vaginal sex. This may be because we included more behaviors that were less genital-focused or less influenced by gender or sexual orientation (e.g. cuddling). Another notable difference is that, in the NHSLS, using a dildo or vibrator was rated as very appealing by only about 4% of participants whereas we found 12.2% of men and 22.7% of women reported the same. This finding is consistent with an increased reporting of sex toy use in the U.S. in at least the past decade.

The most appealing behaviors for all participants, regardless of gender, were those commonly associated with romance and affection. Similarly, Joyal, Cossette, and Lapierre included over 1,500 Canadian adults in a non-representative sample study of 55 fantasy themes and found some of the most common fantasies for both men and women included romantic elements. Although fantasies and the appeal of behaviors are similar, they are different in the perceived potential of the behavior—e.g., limiting a behavior to a dream/fantasy versus something one might actually engage in. In addition, other researchers have found a significant and strong relationship between affectionate behaviors and sexual satisfaction.

As some individuals who engage in kink behaviors may experience shame or stigma, these data may help to contextualize diverse behaviors as normative in contemporary America, albeit infrequent. As the reported recency of several light kink behaviors (e.g., spanking, tying up, etc.) were not significantly different in their reported prevalence between men and women, this suggests perhaps that at least some of these behaviors are not gendered. We do note, however, the large gaps between many of the sexual behaviors we asked about in terms of their recency; that is, about one-third of the sexual behaviors were reported by 1–2% of Americans as having occurred in the previous month even though many more reported having engaged in these same behaviors in their lifetime. Behaviors that more often occurred in Americans’ more distant pasts included sex in public, tying up, foot/toe sucking or licking, role playing, whipping, sex via video, going to a strip club, having a threesome, having group sex, viewing sexually explicit magazines, and reading books about sex. Even anal intercourse was reported by few respondents as having occurred in the past month, though about 10 times as many

Americans reported ever having tried it in their lifetime. In contrast, the gap between past month and lifetime behaviors was considerably smaller for vaginal intercourse, oral sex, and masturbation, underscoring these behaviors as some of the most common and characteristic behaviors of Americans' sex lives. Spanking and vibrator use were also somewhat closer in terms of their recent and lifetime prevalence.

The often sizable differences between recent versus lifetime behaviors indicate some of the more regularly practiced sexual behaviors compared to those that may more often be part of sexual exploration, experimentation, or particular to certain past partners or life stages. Subsequent research might investigate developmental stages in individuals', couples' or groups' sexual lives that may be more or less likely to include varied exploration. For example, it may be that the early months of a couple's sex life may be marked by experimentation or exploration as sexual partners seek to impress, surprise, seduce, or learn about one another in terms of their emotional and physical responses. It may also be that some individuals engage in more diverse sexual behaviors over time as they become more comfortable exploring together or in response to sexual boredom.

Given that nearly one-third of women and nearly one-quarter of men had not engaged in sexual activity with anyone in the last year (consistent with NSSHB data)–and about 1 in 10 partnered Americans considered themselves monogamous but sexless—it is important to acknowledge that sizable proportions of Americans do not engage in partnered sexual activities during certain periods of their lives. Subsequent research might attend to reasons why people abstain from sex, even when they have romantic relationship partners, as well as the positive and/or negative impacts on their lives and relationships when this occurs.

This study adds to our understanding of diverse human sexual expression. Findings may inform mental and physical health clinicians in ways that improve their practices. Stereotypes that suggest men are uninterested in kissing, cuddling, or other forms of romance may also be challenged by these and other data that demonstrate the value of romantic and affection behaviors to both women and men. Clinicians in various settings working with adults in the U.S. can better meet the needs of their clients by being more aware of the diversity of sexual practices across the lifespan.

Strengths and limitations

Because we aimed to make population estimates, we utilized U.S. nationally representative probability sampling and worked with one of the few companies equipped to carry out such surveys in the United States. The present survey occurred via the Internet, which may have enhanced the valid reporting of sensitive and/or stigmatizing sexual behaviors. Even so, American culture continues to be marked by stigma, shame, and taboo around certain aspects of sexuality and thus a limitation is that some people may have felt this stigma and thus chosen to not participate in our study or to not provide accurate reports. Then again, it is possible that some people—in response to stigma or shape—felt encouraged by a chance to report openly about their sexual lives in a confidential survey.

Additional strengths are that KnowledgePanel® members are practiced at taking Internet-based surveys and thus familiar with how to respond to online questionnaires and that panel members also tend to complete most items with low per-item refusal rates. The reported prevalence of oral sex, vaginal intercourse, and anal intercourse was remarkably consistent with other recent U.S. nationally representative probability surveys (i.e., the various waves of the NSSHB), which suggest that respondents to the present survey were not likely to have been particularly different from those participating in other similar surveys of sexual behavior. Similarly, the distribution of sexual orientation categories is similar to that of the NSSHB.

As happens with most studies, we were limited by time and funding and thus had to make difficult choices about which items to include. We asked about a far greater of sexual behaviors than other national probability surveys (whether in the U.S., U.K., Australia, or Finland), but still could not ask about every sexual behavior of interest to our research team or stakeholders. We also did not differentiate between whether people had been the giver or receiver of certain behaviors (for example, whether they had spanked or been spanked; these were combined in a single item) and we left some descriptions open to subjective interpretation. For example, people may have varying ideas about what constitutes “rough sex” or “gentle sex” or saying “dirty things” or “sweet, romantic things” during sex. Although this is a limitation of our current research, it is similarly a limitation of most research that assesses seemingly banal behaviors such as vaginal intercourse or masturbation, given the many different ways each can be enacted and interpreted. Further, because we did not require information about the specific kinds of phone apps related to sex that respondents may have used, we simply inquired about their use of “phone apps related to sex”. Had we asked specifically about the kinds of phone apps related to sex (e.g., Grindr, Tinder, or other apps for dating or meeting for sexual encounters; sex education apps; or apps featuring erotica) we would have had a more detailed understanding about respondents’ use of technology related to sexualities.

The inability to clarify meaning to respondents or to ask them for their interpretation of items is a limitation of survey research. However, our data provide insights for subsequent research to approach with greater detail. Similarly—and consistent with the Australian Survey of Health and Relationships—we were not able to take a detailed look at, for example, the gender make-ups of respondents’ threesomes or group sex experiences, or what proportion of respondents’ experiences of specific behaviors were wanted, desired, or consensual. Our research is also limited to American women and men and to adults; thus, we make no claims about sexual behaviors among individuals in other cultures or even among younger U.S. adolescents. As with most U.S. probability surveys, our sample was also limited to non-institutionalized individuals and to those who can read and respond to questions written in English.

We feel that this study makes an important contribution to the literature by extending the sexual behaviors most commonly assessed. Although we asked about sexual behaviors associated with risk of pregnancy and infection we mostly asked about sexual behaviors that may be considered as being about exploration, recreation, affection, or novelty (e.g.,

spanking, whipping, kissing, saying romantic or “dirty” things during sex). Given the large amount of data presented in the current paper, analyses are presented only by gender and age and not, for example, by self-identified sexual orientation or other background characteristics such as education, race/ethnicity, relationship status, or sexual experience. Future manuscripts will be able to address the existing data in a more detailed manner.

Conclusions

Overall, findings add to our understanding of more diverse U.S. adult sexual behaviors and the appeal of a range of sexual behaviors. Findings provide baseline rates for a wide array of sexual behaviors among adults in the general populations in the United States for which such estimates have been previously absent. For practitioners and providers, this information may assist in meeting the needs of diverse populations including improved information exchange and educational efforts.

3. Sexual Violence and Abuse

All forms of sexual and sexuality-related violence have multiple negative effects on health and well-being. People living in violent relationships, for example, may be unable to make sexual and reproductive choices, either through direct exposure to forced or coerced sex or because they are unable to control or negotiate regular use of contraception and condoms. This puts them at risk of unwanted pregnancy (for women), and STIs including HIV. Intimate partner violence in pregnancy increases the likelihood of abortion, miscarriage, stillbirth, preterm delivery and low birth weight. An example of the way in which the law has an impact on sexual health is the legal understanding of rape, which has historically been understood as sexual intercourse by a man with a woman who is not his wife, through force and against her will, involving vaginal penetration by a penis. Under such a definition, women who have been raped by their husbands, women who have been raped anally, men and transgender individuals cannot claim, legitimately, to have been raped. International criminal law has evolved to define rape in much broader terms, covering different invasive acts perpetrated by and against people of any sex or gender, and recognizing that rape within marriage is a crime in all circumstances. Many national laws have been amended over the past decade in line with these human rights standards. This accommodates access to needed health services for all (unmarried girls and women, men, boys and transgender persons) as well as recourse to due process and redress, which plays a role in health.

States have obligations to bring their laws and regulations that affect sexual health into alignment with human rights laws and standards. Removing barriers in access to sexual health information and services, and putting in place laws and regulations that aim to support and promote sexual health, are actions that are also in line with the World Health Organization’s global reproductive health strategy.

Sexual and sexuality related violence

Over the past three decades, extensive research in all regions of the world has brought to light the extent of sexual violence and sexuality-related violence. Sexual violence has a profound impact on physical and mental health. As well as causing physical injury, it is associated with an increased risk of a range of sexual and reproductive health problems, with both immediate and long-term consequences. People living in violent relationships, for example, may be unable to make sexual and reproductive choices, either due to being directly subjected to forced or coerced sex, or because they are unable to control or negotiate the use of contraception and condoms. This puts them at risk of unwanted pregnancy and sexually transmitted infections (STIs), including HIV.

Intimate partner violence in pregnancy increases the likelihood of abortion, miscarriage, stillbirth, preterm delivery and low birth weight. People subjected to violence, including sexual and sexuality-related violence, have been found to be at increased risk of depression, post-traumatic stress disorder, sleep difficulties, eating disorders and emotional distress.

Recent global prevalence figures indicate that, overall, 35% of women worldwide have experienced either intimate partner violence or non-partner sexual violence in their lifetime. On average, 30% of women who have been in a relationship report that they have experienced some form of physical or sexual violence by their partner. Globally, as many as 38% of murders of women are committed by an intimate partner. Data indicate that there is a higher incidence of sexual violence directed against women and girls. However, sexual violence and sexuality-related violence can be, and is, directed against anyone – women, men, girls, boys, transgender people and intersex people – and particularly against people in positions of vulnerability, such as people engaged in sex work, migrants, internally displaced persons and refugees, and people with disabilities. For example, increasing attention is being paid to sexual violence against men in conflict situations. In the last decade, sexualized violence against men and boys – including rape, sexual torture, mutilation of the genitals, sexual humiliation, sexual enslavement, forced incest and forced rape – has been reported in 25 armed conflicts across the world. Sexual and sexuality-related violence serve as a form of punishment and control, which may be committed by both non-state actors such as family members, neighbors or co-workers, as well as by agents of the state such as police, with the intention of inducing shame and diminishing the reputation of the victim of violence. These forms of violence stem from other forms of inequality, and serve to reinforce hierarchies of power based on gender, class, race, ethnicity, caste, sexual orientation, gender identity and expression, or other important social divisions. Victims of sexual violence may perceive themselves to be responsible, or may actually be held responsible by others, for the violence. They feel shame, dishonor, humiliation, guilt and stigmatization, all of which contribute to making it difficult to report incidents of violence, as well as to seek treatment and care for related physical and psychological injuries, thus compounding the health problems. Sexual violence is thus responsible for a significant disease burden.

Violence, including sexual violence and sexuality related violence, is a violation of fundamental human rights, most notably the rights to life, to be free from torture and inhuman and degrading treatment, to the highest attainable standard of health, and to bodily integrity, dignity and self-determination. Addressing violence against women in particular, international and regional human rights standards have made clear that the elimination of violence against women is essential for women's individual and social development and their full and equal participation in all sectors and spheres of society. Human rights bodies have specifically condemned traditional attitudes that regard women as subordinate to men, particularly because they perpetuate practices involving violence or coercion, the effect of which is to deprive women of the enjoyment of many of their human rights. Under international and regional human rights law, states have a responsibility to protect all individuals from all forms of violence. In line with the human rights concept of "due diligence", which applies to all persons, states must adopt legislative, administrative, social and economic measures necessary to prevent, investigate and punish acts of violence including rape, sexual violence, homophobic violence, female genital mutilation and trafficking into forced prostitution, whether perpetrated by the state or by private persons. States should also provide effective remedies, compensation and a mechanism for seeking redress.

Many states have adopted national legislation to address the issue of domestic and intimate partner violence, including sexual violence. Yet there are still national laws that do not recognize the diversity of forms or contexts of sexual violence, often leading to serious negative consequences for health and rights. On the other hand, international and regional human rights standards now define the diversity of forms of violence, perpetrators and victims, and a growing number of national laws and jurisprudence reflect this, as highlighted in this chapter. This section focuses on those forms of violence that are directly sexual or related to sexuality, including rape, child sexual abuse, forced marriage, trafficking into forced prostitution, regardless of the gender or sex of the victim. It also addresses other forms of violence affecting bodily and sexual integrity such as female genital mutilation, coercive practices within health services that directly affect people's sexual and reproductive health, and violence committed against persons because of their real or perceived sexual practices, behavior and expression, including hate crimes and so-called honor killings.

Health, human rights and legal implications of different forms of sexual and sexuality-related violence

Sexual assault including rape

Someone who is sexually assaulted, including someone who is raped or coerced into unwanted sexual intercourse, has little or no control over the situation, and the sexual health consequences are serious: possible unwanted pregnancy, and the need for abortion, which might be unsafe; exposure to STIs including HIV; and other reproductive and gynaecological morbidities. Cases are often unreported or undocumented because people who are sexually assaulted often suffer feelings of shame, blame or psychological

distress, and because the responses they get from formal institutions (police, judiciary, health), as well as from community members, are frequently unsympathetic, discriminatory and traumatizing. Very few cases of rape, for example, are actually reported to the police, making it almost impossible to estimate the actual extent of rape worldwide, but it occurs in all countries of the world, both within and outside marriage and intimate partnerships. It is also widespread in times of conflict. The legal understanding of sexual assault and rape has been historically narrow in scope. Rape, for example, has traditionally been understood as "unlawful" sexual intercourse by a man with a woman who is not his wife, through force and against her will, and involving vaginal penetration by a penis. Under such a definition, women who have been raped by their husbands, women who have been raped anally, men and transgender individuals cannot legitimately claim to have been raped. In 2010, international criminal law elaborated the elements of the crime of rape, radically changing this traditional understanding, and these elements have been affirmed by a number of national laws. The consideration of these elements requires, for example, a broader definition of what constitutes rape, which should cover coercive "invasion" or "conduct resulting in penetration, however slight, of any part of the body of the victim ... with a sexual organ, or of the anal or genital opening of the victim with any object or any other part of the body". The definition of rape should also be broad enough to be gender-neutral, meaning that it can apply to any person of whatever sex or gender. In addition, international and regional human rights laws now recognizes that rape can take place within marriage and is a crime in all circumstances. At the regional level, the language of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa clearly indicates that immunity cannot be granted to husbands, as states are enjoined to adopt laws that prohibit "all forms of violence against women, including unwanted or forced sex whether the violence take*s* place in private or in public". In a similar vein, the European Court of Human Rights has ruled unacceptable the idea of a husband being immune to prosecution for raping his wife, in line with what the Court termed a civilized concept of marriage but also with the fundamental right of respect for human dignity. Many national laws have been amended over the past decade in line with these human rights standards. For example, laws have been changed to recognize that marital rape is a crime; that rape can be committed by a person of any gender against another person of any gender; that any act of penetration can be considered as rape; and that evidence of physical force is not required as proof of rape (e.g. South Africa, Thailand). According to international human rights standards, the definition of rape should no longer require corroboration of a victim's testimony by third parties. In this way, it can no longer be implied that women's testimony cannot be relied upon. Several national courts and legislatures have removed the requirement for corroboration of a third party to "prove" that rape has taken place. The South African Supreme Court, for example, specifically stated that such a requirement was "based on an irrational and out-dated perception and unjust stereotyping against women as unreliable victims", and the Kenyan Court of Appeal found that such requirement constitutes discrimination against women and is contrary to the concept of equality. People held in detention, such as prisoners, can be

particularly at risk of sexual violence, and those who are sex workers, homosexuals or transgender, as well as sex offenders, may be at increased risk of sexual violence from other inmates and sometimes also directly from prison guards. Prison authorities' discriminatory attitudes towards these populations can create a climate in which such violations can easily proliferate. Rape in custodial situations has been regarded as a form of torture and cruel, inhuman and degrading treatment, and rape of a detainee by an official of the state is considered to be an especially grave and abhorrent form of ill treatment, given the ease with which the offender can exploit the vulnerability of his victim. Based on human rights standards, states are called upon to design and implement appropriate measures to prevent all sexual violence in all detention centers, ensure that all allegations of violence in detention centers are investigated promptly and independently, that perpetrators are prosecuted and appropriately sentenced, and that victims can seek redress including appropriate compensation. Some countries have established specific legal protections against prison rape. In the USA, for example, following data collection that confirmed that sexual abuse was a significant problem in prisons, jails and immigrant detention centers, and even more likely in juvenile facilities, a number of standards have been put in place, including prohibition of the hiring or promotion of staff who have been engaged in coercive sex, and limits on body searches by opposite-sex staff.

Sexual abuse of children

Sexual abuse of children (i.e. people under the age of 18) occurs in all regions of the world and is part of a broader phenomenon of child maltreatment. It is a serious violation of a child's rights to health and protection. Evidence from different parts of the world indicates that up to 20% of women and 5–10% of men report having been sexually abused as children. Sexual abuse of children has not been well documented at a population level, but clinic-based studies have shown severe effects on health, including sexual health, such as injuries, STIs (including HIV), trauma, depression, anxiety and even death. In older female children, it may result in unwanted pregnancy and unsafe abortion with potential complications. Sexually abused children are at increased risk for behavioral, physical and mental health problems including depression, smoking, obesity, high-risk sexual behaviors, harmful use of alcohol and drugs, and perpetrating or being a victim of violence. Children are understood to be at risk of sexual harm in part because they lack the ability to claim their rights, and also in part because of the power imbalances between younger and older persons. International and regional human rights standards provide the framework for states' obligations to take all appropriate legislative, administrative, social and educational measures to protect children from all forms of physical or mental violence, injury or abuse, including sexual abuse and to punish the perpetrators of such acts and protect the rights and interests of child victims. Regional standards also encourage children's participation, according to their evolving capacity,

in the design and implementation of relevant state policies, stressing that assistance to victims shall take due account of the child's views, needs and concerns, and always take into account the best interests of the child. Importantly, the Convention and mental health problems including depression, smoking, obesity, high-risk sexual behaviors, harmful use

of alcohol and drugs, and perpetrating or being a victim of violence. Children are understood to be at risk of sexual harm in part because they lack the ability to claim their rights, and also in part because of the power imbalances between younger and older persons. International and regional human rights standards provide the framework for states' obligations to take all appropriate legislative, administrative, social and educational measures to protect children from all forms of physical or mental violence, injury or abuse, including sexual abuse and to punish the perpetrators of such acts and protect the rights and interests of child victims. Regional standards also encourage children's participation, according to their evolving capacity, in the design and implementation of relevant state policies, stressing that assistance to victims shall take due account of the child's views, needs and concerns, and always take into account the best interests of the child. Importantly, the Convention should closely reflect the recognition of the status of people under 18 years of age as rights holders, in accordance with their evolving capacity, age and maturity.

Forced marriage and sexual and sexuality related violence

In a number of countries, children and adults – particularly women – may not be able to freely enter into marriage with their full consent for reasons linked to historical subordination, lack of economic independence, sociocultural tradition or family interest. Practices related to forced marriage include child or early marriage, forced marriage in war, conflict and post-conflict situations, widow inheritance, and forced marriage with an abductor or rapist. All such practices have a detrimental effect on the health and well-being of the people involved, and violate fundamental human rights. International human rights standards are unequivocal: "marriage shall be entered into only with the free and full consent of the intending spouses". Human rights bodies have frequently condemned both early and forced marriage as a violation of women's rights and have affirmed that a woman's right to choose when, if and whom she will marry must be protected and enforced by the law.

Child or early marriage

The practice of child or early marriage is widespread and occurs in all regions of the world. It prevents individuals from living their lives free from all forms of violence and it has adverse consequences on the enjoyment of human rights, such as the right to education, and the right to the highest attainable standard of health, including sexual and reproductive health. Within marriage, young women and girls in particular are at risk of sexual abuse, rape, premature motherhood and domestic violence, with all associated physiological and psychological trauma. Adolescent and child wives are less able than their adult counterparts to negotiate sex, or to make free and informed decisions affecting their sexual and reproductive health, including access to health services for contraception and the prevention and treatment of STIs.

Early marriage is very often linked to early childbearing as in many countries there is considerable pressure on girls to become pregnant soon after they are married. The health risks of early pregnancy for adolescent girls are considerable. Early childbirth is nearly

always associated with lower socioeconomic status, reduced access to antenatal care, and poor nutritional status, all of which can lead to poor maternal and child health outcomes. These include increased risks of: anaemia, premature labor, complications during delivery (including obstetric fistula), maternal death, low birth weight, and neonatal death. International and regional human rights standards and consensus documents call for the elimination of early and forced marriage. They call for the recognition of a minimum age of marriage, which should be 18 years for both men and women, and for the official registration of all marriages to be compulsory. They recognize the necessity of collective efforts of governments, lawmakers, judicial authorities, law enforcement officials, traditional and religious leaders, civil society, media, the private sector and other relevant stakeholders to address the root causes of this practice. In order to protect children and eliminate early marriage, most countries have put in place an enabling legal framework, setting the minimum age of marriage at 18 years in accordance with these human rights standards. Even in those countries, however, compliance is often poor for a variety of reasons, such as the lack of accurate registration of all births, which is necessary for establishing the age of those marrying, or the fact that many families remain financially and otherwise materially invested in early marriage practices. National courts are increasingly responding to this practice, upholding the fundamental rights of women to consent to marriage. For example, a Sharia Court in Nigeria ruled that a marriage of a teenage girl conducted without her consent constituted a violation of the rights to liberty and dignity under the Nigerian Constitution and that it was against their understanding of Sharia Law.Forced marriage in conflict settings. Forced marriages arise in war, conflict and post-conflict settings where women, sometimes very young, are captured by fighters and forced to live as their “wives” (i.e. as sexual and/or domestic partners), essentially in slavery. Human rights bodies are calling for the elimination of such practices. In Sierra Leone, for example, forced marriage has been judged a crime against humanity, and is recognized as “resulting in severe suffering, or physical, mental or psychological injury to the victim”.

Widow inheritance

Women’s free and full consent to marriage is also infringed by the practice of widow inheritance in some places. Drawn from local customary law and religious practices, such marriages still occurs in some parts of Asia and Africa, although it is diminishing. A surviving widow, whether a minor or an adult, is “inherited” by a male relative (often the brother) of the deceased spouse, along with other goods and property of the estate, such that she becomes his wife. Often this is the condition imposed on the widow for being able to remain in her house, or to receive support from her husband’s kin. Thus, she must enter a sexual relationship with a spouse not chosen by her, which is a form of coerced sex, with many potential negative sexual and reproductive health consequences. Under human rights laws, states have an obligation to end any practice whereby a widow is liable to be inherited by another person, and states must ensure that “widows are not subjected to inhuman, humiliating or degrading treatment” and that a “widow shall have the right to remarry, and in that event, to marry the person of her choice”.

Marriage with an abductor or rapist

Women may also be forced to marry against their will or without free and full consent in places where there are laws that allow mitigation (or complete annulment) of punishment for an abductor or rapist if he agrees to marry the woman he has abducted or raped. Such laws are discriminatory as well as being harmful to the well-being of the abducted or raped woman, as she is then pressured to take as her husband a person who has assaulted her. While a number of countries have such laws, there have been some positive reforms in line with international human rights protections, as, for example, in Ethiopia, which reformed its 1957 Penal Code in 2005 to remove the exculpation of an alleged rapist in light of a subsequent marriage to a victim.

Violence based on real or perceived sexual behavior or expression

Violence committed against persons because of their real or perceived sexual behaviour or expression has been recorded in all regions of the world. Among these sexual behaviors or forms of sexual expression are: having same-sex sexual partner(s), having extramarital sex, engaging in sex work, perceived effeminate behavior by men, sexual contact with those viewed as being social inferiors or members of enemy groups, behavior deemed to dishonor the kin group, and sexual disobedience. These behaviors are perceived as being nonconformist, transgressing societal or moral codes or norms, and violence is used to punish people for such conduct. The violent punishment may be physical or psychological, and the effects include: injury, reduced ability to access treatment for these injuries, humiliation, disempowerment and increased disease burden. Violence based on sexual orientation or gender identity. There is increasing documentation of targeted violence against people who have (or are suspected to have) same-sex sexual relationships, and against transgender people. The extent of such violence is currently impossible to estimate as few states have systems in place for monitoring, recording and reporting these incidents. Even where systems exist, incidents may go unreported or are misreported because victims distrust the police, are afraid of reprisals or threats to privacy, or are stigmatized. Homophobic and transphobic violence can take many forms, including harassment and bullying in schools, so-called street violence and other spontaneous attacks in public settings. Homophobic and transphobic violence can involve a high degree of cruelty and brutality, including beatings, murder, torture, rape and other types of sexual assault. Violent acts may be committed by family members and friends, peers at school, health-care providers, co-workers, the police or others.

Severe violence and torture occurring in healthcare settings has been documented, including denial of medical treatment, use of verbal abuse and public humiliation, and a variety of forced procedures such as psychiatric evaluation and sterilization. Other types of violence perpetrated by health personnel and other state officials include forcible anal examination for the prosecution of suspected homosexual activities, invasive virginity examination, hormone therapy, and so-called sex normalizing surgery and reparative

therapy. These procedures are rarely medically necessary, can cause serious injury, scarring, loss of sexual sensation, pain, incontinence and lifelong depression, and have also been criticized as being unscientific, potentially harmful and contributing to stigma.

Lesbian, gay and transgender people may be subject to aggravated violence and abuse by inmates and prison guards when they are in detention or under state care. Incidents have been reported in which individuals were subjected to victimization by police and prison guards, and authorities failed to take reasonable measures to prevent violence against detainees perceived as being lesbian, gay or transgender.

Criminalization of same-sex sexual behavior and non-gender-conforming behavior, and discriminatory laws and regulations, can create and intensify stigma, discrimination and violence, all of which have direct effects on lesbian, gay, transgender, gender variant and intersex people's health far beyond immediate injury. Criminal laws, public decency regulations and policing surveillance systems have all been used to harass, arrest, torture, rape and abuse people perceived as belonging to these groups. International and regional human rights bodies increasingly call for the respect and protection of lesbian, gay, transgender, gender variant and intersex people's human rights, including respect for their rights to life, liberty and security of person, to be free from torture or inhuman and degrading treatment and discrimination, the rights to privacy, freedom of expression, association and peaceful assembly, and the right to the highest attainable standard of health. They have also recognized that stigma, discrimination, marginalization and violence related to sexual orientation and gender identity and expression are often exacerbated by other personal characteristics and factors, such as race, ethnicity, religion, socioeconomic status, being a migrant or residing in conflict settings, and so they have called for the elimination of multiple discrimination. International and regional human rights bodies have clearly condemned violent crime perpetrated against persons because of their sexual orientation and/or gender identity and expression, including by law enforcement officials, as well as the failure of states to address such crime in their legislation. They have urged states to ensure that these acts of violence and human rights violations are investigated and their perpetrators brought to justice. Human rights bodies call on states to adopt legislation and public policies against discrimination and violence by reason of gender identity and expression. They have also called for the implementation of special measures – including appropriate training of law enforcement and judicial officials – to protect persons in prison against bias-motivated crimes related to their sexual orientation or gender identity. A number of countries in all regions address discrimination and violence on the basis of sexual orientation and gender identity in their legislation. Some have included provisions in their laws for addressing crimes committed on the basis of sexual orientation and gender identity, and included hate crimes and bias-motivated crimes related to sexual orientation and gender identity and expression in the hate crimes statute (e.g. Australia, USA). The anti-discrimination law in Serbia, for example, establishes the fundamental principle of equality of people of different sexes and genders, and includes sexual orientation and gender identity among the grounds for non-discrimination. It specifies that rights pertaining to gender or gender Honor crimes

and honor killings. In some regions, people may be killed because they are seen by family or community members as having brought shame or dishonor on a family, often for transgressing gender norms or for sexual behavior, including actual or assumed same-sex sexual activity. Documented crimes committed in the name of honor are most often perpetrated against women because of relations with a male partner who is viewed as an unacceptable match, or because of actual or assumed sex before marriage; one estimate suggests that at least 5000 women around the world are murdered by family members each year in these so-called honor killings. However, such crimes may also be committed against men and transgender people. Very often, these crimes remain unpunished and at times are even sanctioned by the law. International human rights bodies have stated that these crimes violate the rights to life, to equality before the law, and to equal protection in the law, and have strongly recommend that states pass legislation "to remove the defense of honor in regard to the assault or murder of a female family member". At the national level, some countries have changed their laws to reflect these human rights standards. In Turkey, for instance, where so-called honor killings were previously tolerated or even condoned by the state, a change in the Penal Code now takes the "honor" element of a killing as an aggravating instead of a mitigating factor in a criminal trial, signalling that such notions are a violation of human rights.

Sexual violence and sexuality-related violence occur in all parts of the world. Some people may be especially vulnerable to such violence, including women, children, people in custodial situations, people with disabilities, and/or people whose real or perceived sexual orientation or gender identity is deemed unacceptable. Violence in any form is detrimental to mental and physical health and other aspects of well-being.

Sexual and sexuality-related violence includes, but is not limited to, sexual assault and rape, forced and early marriage, trafficking into forced prostitution, harmful traditional practices such as FGM, and honor killings. Such violence takes place in intimate personal environments, such as marriage and domestic settings, and is also used as a weapon of war in conflict settings. Often it is committed by people in positions of authority and responsibility for the safety and well-being of others, for example in detention facilities. In health-care settings, violence that has an impact on sexual health includes forced sterilization and forced virginity testing. Health-care providers may inflict violence on their patients because of their real or perceived sexual orientation or gender identity.

Different forms of sexual and sexuality-related violence are violations of human rights. In accordance with human rights standards, states must adopt legislative, administrative, social, economic and other measures necessary to prevent, investigate and punish acts of violence including all forms of sexual violence, whether perpetrated by the state or by private persons, and they must provide support and assistance to the victims of violence, including access to health services. States should also provide effective remedies, compensation and mechanisms for seeking redress. This obligation applies with respect to all persons, regardless of their sex, gender, age, sexual orientation, gender identity, marital or other status, and irrespective of who it was that committed violence against them, in whatever context. Laws can play an important role in fostering the recognition of

all forms of violence as a human rights violation and a crime. They can be crucial in setting guarantees and frameworks for government actions to prevent, eliminate and deal with the consequences of violence, and a number of countries in different regions have developed laws in line with these human rights standards.

4. Services for the Promotion and Protection of Sexual Health

Ill health related to sexuality represents a significant disease burden throughout the world. This includes: morbidity and mortality related to HIV and other STIs; morbidity and mortality linked to lack of access to contraception; erectile dysfunction; the sequelae of sexual violence and female genital mutilation; and sexual and reproductive cancers (1). For example, sexually transmitted infections (STIs) are a significant cause of acute illness, infertility, long-term disability and death, with serious medical and psychological consequences for millions of men, women and adolescents. For people aged 15–49 years, an estimated 448 million new cases of four curable STIs (chlamydia, gonorrhoea, syphilis and trichomoniasis) occurred in 2005, and these numbers are not diminishing. An estimated 35 million people in 2013 were living with HIV, a largely sexually transmitted infection, and while the incidence of HIV continues to fall, this is still a huge burden related to sexual health. Globally, the proportion of women living with HIV has remained stable at 50% of all those living with HIV, although women are more affected in sub-Saharan Africa and the Caribbean. Since the beginning of the HIV epidemic in the 1980s, men who have sex with men and transgender people have been disproportionately affected by HIV. The few existing epidemiological studies among transgender people have shown disproportionately high HIV prevalence, ranging from 8% to 68% depending on the context and the type of study carried out. The continuing increase in the use of contraception since the 1960s has contributed to a reduction in maternal mortality, and it is estimated that one in three deaths related to pregnancy and childbirth could be avoided if all women had access to contraceptive services. The increased use of modern contraceptive methods could not have been possible without the provision of services, whether public or private, through dedicated services or primary health care. Evidence shows that for adolescents, increased access to modern contraception, and particularly emergency contraception, protects them from negative health outcomes, and does not lead to unwanted sexual intercourse, unprotected intercourse, decreases in condom use, increased STIs or increased pregnancy rates. It has been estimated that a doubling of the current global investments in contraceptive and fertility regulation services – so that more women have better access to needed services – would reduce unintended pregnancies by more than two thirds, from 75 million to 22 million. But it would also reduce unsafe abortions by almost three quarters, from 20 million to 5.5 million. Being able to be screened, counseled, diagnosed and treated appropriately for aspects of sexual health such as erectile dysfunction, the sequelae of sexual violence, female genital mutilation, reproductive tract infections that are not sexually transmitted, and sexual and reproductive cancers, is also critical for the protection and promotion of sexual health, as is having access to information and counseling related to sexuality. In addition, other health conditions such as cardiovascular disease, diabetes and cancer, all have a

detrimental effect on the sexual and reproductive health of both men and women. For example, testicular cancer can threaten a young man's sexual and reproductive future, and prostate cancer can affect a man's mid- and later-life chances for a sexual life. Sexual dysfunction resulting from such conditions can be ameliorated through different approaches, usually requiring an interaction with the Thus, the kinds of health services needed to promote and protect sexual health include: sexual health education and prevention information; sexuality counseling; identification and referral for victims of sexual violence and female genital mutilation; voluntary counseling, testing, treatment and follow-up for STIs, including HIV; screening, diagnosis, treatment and follow-up for reproductive tract infections, cancers and associated infertility; diagnosis and referral for sexual dysfunction and associated problems related to sexuality and intimate relationships. Such services may be integrated as part of primary health care or provided as standalone services, to address the most significant sexual health problems and concerns of the particular country, district or region.

Disability

People with disabilities have been found to face multiple barriers in access to health services. A world health survey found that people with disabilities were twice as likely to find health-care provider skills and equipment inadequate to meet their needs, three times as likely to be denied care, and four times as likely to be treated badly as non-disabled people. They were also 50% more likely to experience catastrophic health expenditure. Health-care providers may consider that people with intellectual disabilities or other disabilities should not have a sexual life, reproduce or look after children, and therefore should not need sexual and reproductive health services. Furthermore, healthcare settings may be physically inaccessible and health information may be unavailable in different formats.International human rights standards state that people with disabilities are entitled to health services, including those for sexual and reproductive health, on an equal basis with others, and to have control over their fertility. In particular, sexual health information and education should be made available in accessible formats. People with disabilities are entitled to the support and time they require to make informed decisions about matters of sexual and reproductive health. People with disabilities should not be subject to involuntary and/ or forced interventions such as sterilization.

The Law and Sex

In several countries there are common civil and religious laws including the following types.

- **Partner laws** regulate the choice of the partner on the following attributes: species, state, sex, age, number, group, time.
- **Species (human/non-human)**: Permitted: a human partner. Not permitted: a non-human partner. e. g. sex with animals is not permitted.

- **State (living/dead)**: Permitted: a living human. Not permitted: a dead one e. g. sex with the dead (necrophilia) is not permitted.
- **Sex (opposite/same)**: Permitted: a living human of the opposite sex. Not permitted: a living human of the same sex e. g. sex with the members of one's own sex Homosexual sex) is not permitted.
- **Age**: Permitted: a partner with a certain age. Not permitted: a partner with an age less than a certain age. These restrictions are of two types.
    - **Absolute age**: Permitted: a partner with the age greater than or equal to the age of consent as determined by the applicable law. Not permitted: a partner with the age less than the age of consent. The value of Age of consent ranges from 9 to 21.
    - **Relative age**: Permitted: a partner with the age greater (or less) than one's own age. Not permitted: a partner with the age less (or greater) than one's own age. E. g. a law that prohibits the woman being elder to the man.
- **Number (one/many)**: Number of partners for sexual activity.
    - **At a single sexual encounter**: e. g. monogamy and polygamy
    - **At any given time in life**: e. g. monogamy and polygamy
    - **At different times in life**: Permitted: only one partner at a time e. g. serial monogamy. Not permitted: polygamy.
- **Group**: Permitted: a partner from one's own race, religion, caste, creed, community and/or group. Not permitted: a partner outside one's own race, religion, caste, creed, community and/or group. These are of two types.
    - **Same**: Permitted: a partner from the same group. Not permitted: a partner from a different group.
    - **Different**: Permitted: a partner from a different group. Not permitted: a partner from the same group. E. g. sex with one's blood-relatives, sex with the members of one's own sex are prohibited.
- **Time**: The time in the life of the partner e. g. a law that prohibits the woman from engaging in sexual activity while she menstruates.
- **Activity laws** regulate the choice of the sexual activity e. g. a law that prohibits genital-genital intercourse. Activity laws are of the following types.

The laws sorted in the decreasing order of perceived severity for a **single** (*number*) **living** (*state*) **adult** (*absolute age*) **human** (*species*) being:

Legend

AT = Attribute Type = [A: Absolute | R: Relative]
A relative attribute takes its value relative to a **single living human** being.
PT = Permission Type = [Same | Opposite]

A permission type takes the value 'Same' if and only if the permitted matches with a single living adult human being in either the *species* or the *state* or the *absolute age* or the *number*.

Type	Attribute	Sub-attribute	AT	PT	Permitted	Not Permitted
Partner	Species		R	Same	Human	Non-human. Sex with animals i. e. Zoophilia
	__State		R	Same	Living	Dead. Sex with the dead i. e. necrophilia
	____Group	Sex	R	**Opposite**	A partner with a sex different from one's own. Sex with a partner with a sex different from one's own i. e. heterosexual sex.	A partner from one's own sex. Sex with a partner from one's own sex i. e. homosexual sex
	____Group	Family	R	**Opposite**		A partner from one's own family. Sex with a partner from one's own family i. e. incest
	____Age	Adulthood with respect to the age of consent	R	Same	A partner with age >= the age of consent	A partner with age < the age of consent. Sex with a partner with age < the age of consent i. e. pedophilia

	____Group	Race, religion, caste, creed, community, etc.	R	Same	A partner from a group same as one's own	A partner from a group different from one's own
	____Number	At a single sexual encounter	R	Same	One	Opposite i. e. many
	____Number	In a particular period in life	R	Same	One i. e. monogamy or many i. e. polygamy	Many i. e. polygamy
	____Number	In different periods in life	R	Same	One i. e. serial monogamy or many i. e. polygamy	Many polygamy
	____Age	Relative	R			E. g. a woman elder than a man.
	____Time					E. g. a menstruating woman
Activity					Genital-genital intercourse	

5. Sexually Transmitted Diseases

Classification

Sexually transmitted diseases (STDs) are also referred to as sexually transmitted infections (STIs) or venereal diseases (VDs). It is defined as “an illness that has a significant probability of transmission between humans or animals by means of sexual contact, including vaginal intercourse, oral sex, and anal sex”. More recently, the term sexually transmitted infection (STI) has been preferred due to several reasons including that it has a broader range of meaning; a person may be *infected*, and may potentially infect others, without showing signs of *disease*. Until the 1990s, STDs were mostly referred to as *venereal diseases*. Public health officials originally introduced the term *sexually transmitted infection*, which clinicians are increasingly using alongside the term *sexually transmitted disease* in order to distinguish it from the former. According to the

Ethiopian Aids Resource Center FAQ, "Sometimes the terms STI and STD are used interchangeably. This can be confusing and not always accurate, so it helps first to understand the difference between infection and disease. Infection simply means that a germ — virus, bacteria, or parasite — that can cause disease or sickness is present inside a person's body. An infected person does not necessarily have any symptoms or signs that the virus or bacteria is actually hurting his or her body; they do not necessarily feel sick. A disease means that the infection is actually causing the infected person to feel sick, or to notice something is wrong. For this reason, the term STI — which refers to infection with any germ that can cause an STD, even if the infected person has no symptoms — is a much broader term than STD." *(Source: Aids Resource Center).*

Pathology

Several different STDs are more easily transmitted through the mucous membranes of the penis, vulva, rectum, urinary tract and less often through the mouth, throat, respiratory tract and eyes. Mucous membranes allow certain pathogens to permeate into the body. Pathogens are also able to pass through breaks or abrasions of the skin, even minute ones. The shaft of the penis is particularly susceptible due to the friction caused during penetrative sex. The primary sources of infection in ascending order are venereal fluids, saliva, mucosal or skin (particularly the penis), infections may also be transmitted from feces, urine and sweat. The amount required to cause infection varies with each pathogen *(Mary-Ann Shafer, Anna-Barbara Moscicki, Sexually Transmitted Infections).*

The probability of sexual infection transmission is higher from sex than by more casual means such as touching and hugging. Mucous membranes exist in the mouth and genitals. However, many STIs are more easily transmitted through oral sex than through deep kissing. With HIV, genital fluids contain higher pathogen content than saliva. However, certain STI infections can be transmitted by direct skin contact such as herpes simplex and HPV. Some infections are still transmittable even when no symptoms exist. For example, herpes is more transmittable when blisters are present than when they are absent. However, HIV is transmittable at any time, even if symptoms are not present *(Mary-Ann Shafer, Anna-Barbara Moscicki, Sexually Transmitted Infections).*

Sexually transmitted diseases are *transmitted* from one person to another by certain sexual activities rather than being actually *caused by* those sexual activities. Bacteria, fungi, protozoa or viruses are the causative agents. Some STDs such as HIV can be transmitted from mother to child either during pregnancy or breastfeeding. Sexual activities between partners are considered a route for the transmission of STDs, "Giving" or "receiving" are both risky although receiving carries a higher risk *(Mary-Ann Shafer, Anna-Barbara Moscicki, Sexually Transmitted Infections).* Safer sex, such as the use of condoms, is the most effective method to decrease the risk of contracting sexually transmitted diseases. The transfer of and exposure to bodily fluids, such as blood transfusions, sharing injection needles, and childbirth are other means of transmission. This puts certain groups, such as medical workers, hemophiliacs, and drug user at risk *(Mary-Ann Shafer, Anna-Barbara Moscicki, Sexually Transmitted Infections).*

Prevalence

The incidence of sexually transmitted disease is high in most parts of the world. Shifting sexual beliefs and oral contraceptive use have changed traditional sexual restraints, especially for women. The spread of drug-resistant bacteria (e.g., penicillin-resistant gonococci) makes some STDs more difficult to treat *(Mary-Ann Shafer, Anna-Barbara Moscicki, Sexually Transmitted Infections)*.

Prevention

Some vaccines protect against certain viral STIs, such as Hepatitis B and some types of HPV. The most effective way to prevent the contraction of an STI is to avoid bodily parts or fluids which can lead to transfer. Of course, no contact at all minimizes risk the most. Not all sexual activities involve contact and proper use of condoms reduces contact and risk *(Mary-Ann Shafer, Anna-Barbara Moscicki, Sexually Transmitted Infections)*.

Partners should receive testing/screening for STIs prior to sexual contact. Several infections are not able to be detected immediately after exposure. Therefore, adequate time must pass between possible exposure and consequent screening *(Mary-Ann Shafer, Anna-Barbara Moscicki, Sexually Transmitted Infections)*.

Types

The diseases listed below are usually sexually transmitted. Some diseases are transmitted in other ways such as HIV/AIDS which may be transmitted through the sharing of infected needles by drug users.

Bacterial

- Bacterial Vaginosis (BV) - not officially an STD but affected by sexual activity.
- Chancroid
- Donovanosis
- Gonorrhea
- Lymphogranuloma venereum (LGV) (*Chlamydia trachomatis* serotypes L_1, L_2, L_3. See Chlamydia)
- Non-gonococcal urethritis (NGU)
- Staphylococcal infection (Staphylococcus aureus, MRSA) - Sexually transmissible.
- Syphilis

Fungal

- Tinea curis "Jock Itch"- Sexually transmissible.
- Yeast Infection

Viral

- Adenoviruses thought to contribute to obesity - venereal fluids (also fecal & respiratory fluids)
- Viral hepatitis (Hepatitis B virus) - saliva, venereal fluids.
  (Note: Hepatitis A and Hepatitis E are transmitted via the fecal-oral route; Hepatitis C (liver cancer) is rarely sexually transmittable, and the route of transmission of Hepatitis D (only if infected with B) is uncertain, but may include sexual transmission.
- Herpes Simplex skin and mucosal, transmissible with or without visible blisters
  - Herpes simplex virus 1 may be linked to Alzheimer's disease.[15]
- HIV/ AIDS (Human Immunodeficiency Virus) - venereal fluids
- HTLV 1, 2 - venereal fluids
- Genital warts - ("low risk" types of Human papillomavirus HPV) - skin and mucosal, transmissible with or without visible warts
- Cervical cancer, anal cancer - ("high risk" types of Human papillomavirus HPV) - skin and mucosal
- Molluscum contagiosum
- mononucleosis
  - (Cytomegalovirus CMV - Herpes 5) - saliva, sweat, urine, feces and venereal fluids.
  - (Epstein-Barr virus EBV - Herpes 4) - saliva
- Kaposi's sarcoma

Parasites

- Pubic lice, colloquially known as "crabs"
- Scabies

Protozoal

- Trichomoniasis

Bacterial Vaginosis

Bacterial Vaginosis (BV) is a condition in women where the normal balance of bacteria in the vagina is disrupted and replaced by an overgrowth of certain bacteria. It is sometimes accompanied by discharge, odor, pain, itching, or burning.

Bacterial vaginosis (BV) is the most common vaginal infection in women of childbearing age. In the United States, BV is common in pregnant women. The cause of BV is not fully understood. BV is associated with an imbalance in the bacteria that are normally found in a woman's vagina. The vagina normally contains mostly "good" bacteria, and

fewer "harmful" bacteria. BV develops when there is an increase in harmful bacteria. Not much is known about how women get BV. There are many unanswered questions about the role that harmful bacteria play in causing BV. Any woman can get BV. However, some activities or behaviors can upset the normal balance of bacteria in the vagina and put women at increased risk including:

- Having a new sex partner or multiple sex partners,
- Douching

It is not clear what role sexual activity plays in the development of BV. Women do not get BV from toilet seats, bedding, swimming pools, or from touching objects around them. Women who have never had sexual intercourse may also be affected.

Women with BV may have an abnormal vaginal discharge with an unpleasant odor. Some women report a strong fish-like odor, especially after intercourse. Discharge, if present, is usually white or gray; it can be thin. Women with BV may also have burning during urination or itching around the outside of the vagina, or both. However, most women with BV report no signs or symptoms at all.

In most cases, BV causes no complications. But there are some serious risks from BV including:

- Having BV can increase a woman's susceptibility to HIV infection if she is exposed to the HIV virus.
- Having BV increases the chances that an HIV-infected woman can pass HIV to her sex partner.
- Having BV has been associated with an increase in the development of an infection following surgical procedures such as a hysterectomy or an abortion.
- Having BV while pregnant may put a woman at increased risk for some complications of pregnancy, such as preterm delivery.
- BV can increase a woman's susceptibility to other STDs, such as herpes simplex virus (HSV) and gonorrhea.

Pregnant women with BV more often have premature births or babies with a low birth weight (low birth weight is less than 5.5 pounds).

The bacteria that cause BV can sometimes infect the uterus and fallopian tubes. This type of infection is called pelvic inflammatory disease (PID). PID can cause infertility or damage the fallopian tubes enough to increase the future risk of ectopic pregnancy and infertility. Ectopic pregnancy is a life-threatening condition in which a fertilized egg grows outside the uterus, usually in a fallopian tube which can rupture.

A health care provider must examine the vagina for signs of BV and perform laboratory tests on a sample of vaginal fluid to look for bacteria associated with BV.

Although BV will sometimes clear up without treatment, all women with symptoms of BV should be treated to avoid complications. Male partners generally do not need to be treated. However, BV may spread between female sex partners.

Treatment is especially important for pregnant women. All pregnant women who have ever had a premature delivery or low birth weight baby should be considered for a BV examination, regardless of symptoms, and should be treated if they have BV. All pregnant women who have symptoms of BV should be checked and treated.

Some physicians recommend that all women undergoing a hysterectomy or abortion be treated for BV prior to the procedure, regardless of symptoms, to reduce their risk of developing an infection.

BV is treatable with antibiotics prescribed by a health care provider. Two different antibiotics are recommended as treatment for BV: metronidazole or clindamycin. Either can be used with non-pregnant or pregnant women, but the recommended dosages differ. Women with BV who are HIV-positive should receive the same treatment as those who are HIV-negative.

BV can recur after treatment. BV is not completely understood by scientists, and the best ways to prevent it are unknown. However, it is known that BV is associated with having a new sex partner or having multiple sex partners.

The following basic prevention steps can help reduce the risk of upsetting the natural balance of bacteria in the vagina and developing BV:

- Be abstinent.
- Limit the number of sex partners.
- Do not douche.
- Use all of the medicine prescribed for treatment of BV, even if the signs and symptoms go away.

Chlamydia

Chlamydia is a common sexually transmitted disease (STD) caused by the bacterium, *Chlamydia trachomatis*, which can damage a woman's reproductive organs. Even though symptoms of Chlamydia are usually mild or absent, serious complications that cause irreversible damage, including infertility, can occur "silently" before a woman ever recognizes a problem. Chlamydia also can cause discharge from the penis of an infected man.

Chlamydia is the most frequently reported bacterial sexually transmitted disease in the United States. Women are frequently re-infected if their sex partners are not treated. Chlamydia can be transmitted during vaginal, anal, or oral sex. Chlamydia can also be passed from an infected mother to her baby during vaginal childbirth.

Any sexually active person can be infected with Chlamydia. The greater the number of sex partners, the greater the risk of infection. Because the cervix (opening to the uterus) of teenage girls and young women is not fully matured and is probably more susceptible to infection, they are at particularly high risk for infection if sexually active. Since Chlamydia can be transmitted by oral or anal sex, men who have sex with men are also at risk for Chlamydia infection.

Chlamydia is known as a "silent" disease because about three quarters of infected women and about half of infected men have no symptoms. If symptoms do occur, they usually appear within 1 to 3 weeks after exposure.

In women, the bacteria initially infect the cervix and the urethra (urine canal). Women who have symptoms might have an abnormal vaginal discharge or a burning sensation when urinating. When the infection spreads from the cervix to the fallopian tubes (tubes that carry fertilized eggs from the ovaries to the uterus), some women still have no signs or symptoms; others have lower abdominal pain, low back pain, nausea, fever, pain during intercourse, or bleeding between menstrual periods. Chlamydia infection of the cervix can spread to the rectum.

Men with signs or symptoms might have a discharge from their penis or a burning sensation when urinating. Men might also have burning and itching around the opening of the penis. Pain and swelling in the testicles are uncommon.

Men or women who have receptive anal intercourse may acquire Chlamydia infection in the rectum, which can cause rectal pain, discharge, or bleeding. Chlamydia can also be found in the throats of women and men having oral sex with an infected partner. If untreated, Chlamydia infections can progress to serious reproductive and other health problems with both short-term and long-term consequences. Like the disease itself, the damage that Chlamydia causes is often "silent."

In women, untreated infection can spread into the uterus or fallopian tubes and cause pelvic inflammatory disease (PID). This happens in up to 40 percent of women with untreated Chlamydia. PID can cause permanent damage to the fallopian tubes, uterus, and surrounding tissues. The damage can lead to chronic pelvic pain, infertility, and potentially fatal ectopic pregnancy (pregnancy outside the uterus). Women infected with Chlamydia are up to five times more likely to become infected with HIV, if exposed.

To help prevent the serious consequences of Chlamydia, screening at least annually for Chlamydia is recommended for all sexually active women age 25 years and younger. An annual screening test also is recommended for older women with risk factors for Chlamydia (a new sex partner or multiple sex partners). All pregnant women should have a screening test for Chlamydia.

Complications among men are rare. Infection sometimes spreads to the epididymis (the tube that carries sperm from the testis), causing pain, fever, and, rarely, sterility.

Rarely, genital Chlamydia infection can cause arthritis that can be accompanied by skin lesions and inflammation of the eye and urethra (Reiter's syndrome).

Chancroid

Chancroid is caused by a bacterial infection that produces genital ulcers. It is difficult to diagnose without a specific laboratory test, which most health care providers and laboratories do not have the capability to perform. Large outbreaks may go unrecognized despite a large burden of disease in the community. The disease causes genital ulcers and is of concern because it may contribute to increased HIV transmission in some communities *(Source: CDC Center for Disease Control)*.

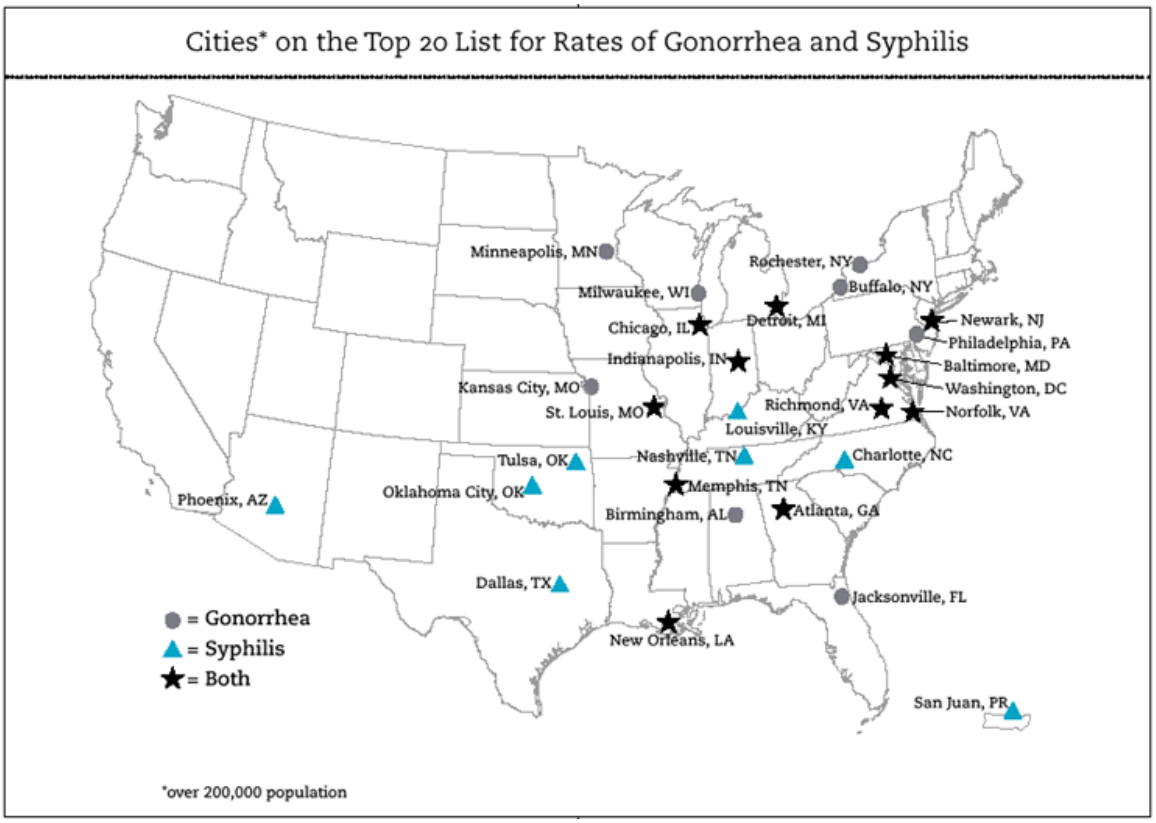
Gonorrhea

Gonorrhea is caused by *Neisseria gonorrhoeae*, a bacterium that can grow and multiply easily in the warm, moist areas of the reproductive tract, including the cervix (opening to the womb), uterus (womb), and fallopian tubes (egg canals) in women, and in the urethra (urine canal) in women and men. The bacterium can also grow in the mouth, throat, eyes, and anus.

Detailed national data by city and state are only available for nationally notifiable STDs. And while Chlamydia became nationally notifiable in 1995, the data are currently more representative of trends in screening than of trends in disease. Because Chlamydia often has no symptoms, cases are frequently identified only through screening. Therefore, high rates of Chlamydia and gonorrhea may indicate more effective screening programs and the introduction of more sensitive tests, rather than higher incidence of disease. This section will therefore present the status of gonorrhea and syphilis by city and state. To provide an indication where Chlamydia is currently the most common, data on the percentage of women who tested positive for Chlamydia in family planning clinics also are provided on the overview maps. Other STDs, like genital herpes and HPV are known to be wide-spread across all states and communities.

Gonorrhea			Syphilis		
City	Cases	Rate per 100,000 Population	City	Cases	Rate per 100,000 Population
1. Baltimore, MD	6,124	948.6	1. Indianapolis, IN	407	50.0
2. Richmond, VA	1,827	940.9	2. Nashville, TN	250	46.8
3. St. Louis, MO	2,876	847.6	3. Baltimore, MD	246	38.1
4. Rochester, NY	2,037	846.6	4. Memphis, TN	258	29.7
5. Atlanta, GA	5,631	761.6	5. Atlanta, GA	213	28.8
6. Washington, DC	3,536	675.9	6. Oklahoma City, OK	114	28.0
7. Detroit, MI	7,900	626.8	7. Detroit, MI	189	15.0
8. Newark, NJ	1,741	612.3	8. St. Louis, MO	51	15.0
9. Norfolk, VA	1,291	599.9	9. Tulsa, OK	45	11.8
10. Memphis, TN	5,038	579.9	10. New Orleans, LA	51	11.0
11. New Orleans, LA	2,687	577.2	11. Louisville, KY	67	10.0
12. Philadelphia, PA	7,775	541.3	12. Chicago, IL	282	9.5
13. Milwaukee, WI	4,884	535.7	13. Norfolk, VA	20	9.3
14. Chicago, IL	14,488	486.4	14. Washington, DC	45	8.6
15. Kansas City, MO	1,956	432.8	15. Charlotte, NC	53	8.4
16. Minneapolis, MN	1,558	427.4	16. Newark, NJ	22	7.7
17. Jacksonville, FL	2,981	405.2	17. Dallas, TX	151	7.4
18. Buffalo, NY	1,233	389.2	18. Phoenix, AZ	195	7.0
19. Birmingham, AL	2,492	377.8	19. Richmond, VA	13	6.7
20. Indianapolis, IN	3,045	374.4	20. San Juan, PR	61	5.8
Rate for United States: 133.2			**Rate for United States: 2.5**		

Areas Currently Facing the Greatest Rates of Curable STDs



Many of these communities also face a significant threat from Chlamydia, which remains widespread across much of the United States. The highest levels of Chlamydia remain in states where screening and treatment have not been widely implemented.

States with the Highest Rates of Gonorrhea and Syphilis

Twenty-four states now have rates of gonorrhea that exceed the Healthy People 2000 goals for the nation, including the following states in order by rates per 100,000 people: *South Carolina* (392), *Mississippi* (378.3), *Louisiana* (301.9), *Georgia* (278), *North Carolina* (257.4), Alabama (250.2), *Delaware* (223.5), *Tennessee* (209.3), Maryland (203.1), *Illinois* (193.1), *Texas* (166.6), *Michigan* (162), *Ohio* (161.8), *Florida* (153.8), *Missouri* (150.5), *Virginia* (138.4), *Wisconsin* (127.5), Arkansas (127.1), Oklahoma (120.1), *Pennsylvania* (110.8), New York (109.1), Indiana (103.3), *Connecticut* (101.4) and *Kansas* (101.4).

Gonorrhea is spread through contact with the penis, vagina, mouth, or anus. Ejaculation does not have to occur for gonorrhea to be transmitted or acquired. Gonorrhea can also be spread from mother to baby during delivery. People who have had gonorrhea and received treatment may get infected again if they have sexual contact with a person infected with gonorrhea. Any sexually active person can be infected with gonorrhea. In the United States, the highest reported rates of infection are among sexually active teenagers, young adults, and African Americans. Some men with gonorrhea may have no symptoms at all. However, some men have signs or symptoms that appear two to five

days after infection; symptoms can take as long as 30 days to appear. Symptoms and signs include a burning sensation when urinating, or a white, yellow, or green discharge from the penis. Sometimes men with gonorrhea get painful or swollen testicles. In women, the symptoms of gonorrhea are often mild, but most women who are infected have no symptoms. Even when a woman has symptoms, they can be so non-specific as to be mistaken for a bladder or vaginal infection. The initial symptoms and signs in women include a painful or burning sensation when urinating, increased vaginal discharge, or vaginal bleeding between periods. Women with gonorrhea are at risk of developing serious complications from the infection, regardless of the presence or severity of symptoms.

In women, gonorrhea is a common cause of pelvic inflammatory disease (PID). About one million women each year in the United States develop PID. The symptoms may be quite mild or can be very severe and can include abdominal pain and fever. PID can lead to internal abscesses (pus-filled "pockets" that are hard to cure) and long-lasting, chronic pelvic pain. PID can damage the fallopian tubes enough to cause infertility or increase the risk of ectopic pregnancy. Ectopic pregnancy is a life-threatening condition in which a fertilized egg grows outside the uterus, usually in a fallopian tube. In men, gonorrhea can cause epididymitis, a painful condition of the ducts attached to the testicles that may lead to infertility if left untreated.

Gonorrhea can spread to the blood or joints. This condition can be life threatening. In addition, people with gonorrhea can more easily contract HIV, the virus that causes AIDS. HIV-infected people with gonorrhea can transmit HIV more easily to someone else than if they did not have gonorrhea.

If a pregnant woman has gonorrhea, she may give the infection to her baby as the baby passes through the birth canal during delivery. This can cause blindness, joint infection, or a life-threatening blood infection in the baby. Treatment of gonorrhea as soon as it is detected in pregnant women will reduce the risk of these complications. Pregnant women should consult a health care provider for appropriate examination, testing, and treatment, as necessary.

Several antibiotics can successfully cure gonorrhea in adolescents and adults. However, drug-resistant strains of gonorrhea are increasing in many areas of the world, including the United States, and successful treatment of gonorrhea is becoming more difficult. Because many people with gonorrhea also have Chlamydia, another STD, antibiotics for both infections are usually given together. Persons with gonorrhea should be tested for other STDs.

It is important to take all of the medication prescribed to cure gonorrhea. Although medication will stop the infection, it will not repair any permanent damage done by the disease. People who have had gonorrhea and have been treated can get the disease again if they have sexual contact with persons infected with gonorrhea. If a person's symptoms

continue even after receiving treatment, he or she should return to a doctor to be reevaluated.

Increases in gonorrhea rates in eight western states from 2000 to 2005 have been described among a wide variety of populations in the affected states. Increases in quinolone-resistant *Neisseria gonorrhoeae* (QRNG) in 2006 led to changes in national guidelines that now limit the recommended treatment of gonorrhea to a single class of drug, the cephalosporins. The combination of increases in gonorrhea morbidity in some populations with increases in resistance and decreased treatment options have reinforced the need for better understanding of the epidemiology of gonorrhea.

Although gonorrhea case reporting is useful for monitoring trends in gonorrhea, true increases or decreases in disease burden may be masked by changes in screening practices (affected by concomitant testing for Chlamydia and broader use of urine-based testing), use of diagnostic tests with differing test performance, and changes in reporting practices.

For most areas, the number of gonorrhea cases reported to CDC is affected by many factors, in addition to the occurrence of the infection within the population. As with reporting of other STDs, reporting of gonorrhea cases to CDC is incomplete. For these reasons, supplemental data on gonorrhea prevalence in persons screened in a variety of different settings are useful in assessing disease burden in selected populations.

An evaluation of increases in gonorrhea in eight western states from 2000 to 2005 suggested that increases were likely due to a variety of factors such as changes in testing practices (increased volume and use of more sensitive tests) as well as real increases in disease.

Genital Herpes

Genital herpes is a sexually transmitted disease (STD) caused by the herpes simplex viruses type 1 (HSV-1) or type 2 (HSV-2). Most genital herpes is caused by HSV-2. Most individuals have no or only minimal signs or symptoms from HSV-1 or HSV-2 infection. When signs do occur, they typically appear as one or more blisters on or around the genitals or rectum. The blisters break, leaving tender ulcers (sores) that may take two to four weeks to heal the first time they occur. Typically, another outbreak can appear weeks or months after the first, but it almost always is less severe and shorter than the first outbreak. Although the infection can stay in the body indefinitely, the number of outbreaks tends to decrease over a period of years.

Results of a nationally representative study show that genital herpes infection is common in the United States. Nationwide, at least 45 million people ages 12 and older, or one out of five adolescents and adults, have had genital HSV infection. Over the past decade, the percent of Americans with genital herpes infection in the U.S. has decreased.

Genital HSV-2 infection is more common in women (approximately one out of four women) than in men (almost one out of eight). This may be due to male-to-female transmission being more likely than female-to-male transmission.

HSV-1 and HSV-2 can be found in and released from the sores that the viruses cause, but they also are released between outbreaks from skin that does not appear to have a sore. Generally, a person can only get HSV-2 infection during sexual contact with someone who has a genital HSV-2 infection. Transmission can occur from an infected partner who does not have a visible sore and may not know that he or she is infected.

HSV-1 can cause genital herpes, but it more commonly causes infections of the mouth and lips, so-called “fever blisters.” HSV-1 infection of the genitals can be caused by oral-genital or genital-genital contact with a person who has HSV-1 infection. Genital HSV-1 outbreaks recur less regularly than genital HSV-2 outbreaks.

Most people infected with HSV-2 are not aware of their infection. However, if signs and symptoms occur during the first outbreak, they can be quite pronounced. The first outbreak usually occurs within two weeks after the virus is transmitted, and the sores typically heal within two to four weeks. Other signs and symptoms during the primary episode may include a second crop of sores, and flu-like symptoms, including fever and swollen glands. However, most individuals with HSV-2 infection never have sores, or they have very mild signs that they do not even notice or that they mistake for insect bites or another skin condition.

Genital herpes can cause recurrent painful genital sores in many adults, and herpes infection can be severe in people with suppressed immune systems. Regardless of severity of symptoms, genital herpes frequently causes psychological distress in people who know they are infected.

In addition, genital HSV can lead to potentially fatal infections in babies. It is important that women avoid contracting herpes during pregnancy because a newly acquired infection during late pregnancy poses a greater risk of transmission to the baby. If a woman has active genital herpes at delivery, a cesarean delivery is usually performed. Fortunately, infection of a baby from a woman with herpes infection is rare.

Herpes may play a role in the spread of HIV, the virus that causes AIDS. Herpes can make people more susceptible to HIV infection, and it can make HIV-infected individuals more infectious.

The signs and symptoms associated with HSV-2 can vary greatly. Health care providers can diagnose genital herpes by visual inspection if the outbreak is typical, and by taking a sample from the sore(s) and testing it in a laboratory. HSV infections can be diagnosed between outbreaks by the use of a blood test. Blood tests, which detect antibodies to HSV-1 or HSV-2 infection, can be helpful, although the results are not always clear-cut.

There is no treatment that can cure herpes, but antiviral medications can shorten and prevent outbreaks during the period of time the person takes the medication. In addition, daily suppressive therapy for symptomatic herpes can reduce transmission to partners.

The surest way to avoid transmission of sexually transmitted diseases, including genital herpes, is to abstain from sexual contact, or to be in a long-term mutually monogamous relationship with a partner who has been tested and is known to be uninfected.

Genital ulcer diseases can occur in both male and female genital areas that are covered or protected by a latex condom, as well as in areas that are not covered. Correct and consistent use of latex condoms can reduce the risk of genital herpes.

Persons with herpes should abstain from sexual activity with uninfected partners when lesions or other symptoms of herpes are present. It is important to know that even if a person does not have any symptoms he or she can still infect sex partners. Sex partners of infected persons should be advised that they may become infected and they should use condoms to reduce the risk. Sex partners can seek testing to determine if they are infected with HSV. A positive HSV-2 blood test most likely indicates a genital herpes infection.

Genital human papillomavirus (HPV) is the most common sexually transmitted infection (STI). The virus infects the skin and mucous membranes. There are more than 40 HPV types that can infect the genital areas of men and women, including the skin of the penis, vulva (area outside the vagina), and anus, and the linings of the vagina, cervix, and rectum. You cannot see HPV. Most people who become infected with HPV do not even know they have it.

HPV

Most people with HPV do not develop symptoms or health problems. But sometimes, certain types of HPV can cause genital warts in men and women. Other HPV types can cause cervical cancer and other less common cancers, such as cancers of the vulva, vagina, anus, and penis. The types of HPV that can cause genital warts are not the same as the types that can cause cancer.

HPV types are often referred to as “low-risk” (wart-causing) or “high-risk” (cancer-causing), based on whether they put a person at risk for cancer. In 90% of cases, the body’s immune system clears the HPV infection naturally within two years. This is true of both high-risk and low-risk types.

Genital warts usually appear as small bumps or groups of bumps, usually in the genital area. They can be raised or flat, single or multiple, small or large, and sometimes cauliflower shaped. They can appear on the vulva, in or around the vagina or anus, on the cervix, and on the penis, scrotum, groin, or thigh. Warts may appear within weeks or months after sexual contact with an infected person. Or, they may not appear at all. If left untreated, genital warts may go away, remain unchanged, or increase in size or number. They will not turn into cancer.

Cervical cancer does not have symptoms until it is quite advanced. For this reason, it is important for women to get screened regularly for cervical cancer.

Other less common HPV-related cancers, such as cancers of the vulva, vagina, anus and penis, also may not have signs or symptoms until they are advanced.

Genital HPV is passed on through genital contact, most often during vaginal and anal sex. A person can have HPV even if years have passed since he or she had sex. Most infected persons do not realize they are infected or that they are passing the virus to a sex partner.

Very rarely, a pregnant woman with genital HPV can pass HPV to her baby during vaginal delivery. In these cases, the child may develop warts in the throat or voice box – a condition called recurrent respiratory papillomatosis (RRP).

HPV can cause normal cells on infected skin or mucous membranes to turn abnormal. Most of the time, you cannot see or feel these cell changes. In most cases, the body fights off HPV naturally and the infected cells then go back to normal.

- Sometimes, low-risk types of HPV can cause visible changes that take the form of genital warts.
- If a high-risk HPV infection is *not* cleared by the immune system, it can linger for many years and turn abnormal cells into cancer over time. About 10% of women with high-risk HPV on their cervix will develop long-lasting HPV infections that put them at risk for cervical cancer. Similarly, when high-risk HPV lingers and infects the cells of the penis, anus, vulva, or vagina, it can cause cancer in those areas. But these cancers are much less common than cervical cancer.

HPV infection. Approximately 20 million Americans are currently infected with HPV, and another 6.2 million people become newly infected each year. At least 50% of sexually active men and women acquire genital HPV infection at some point in their lives.

Genital warts. About 1% of sexually active adults in the U.S. have genital warts at any one time.

Cervical cancer. The American Cancer Society estimates that in 2008, 11,070 women will be diagnosed with cervical cancer in the U.S.

Other HPV-related cancers are much less common than cervical cancer. The American Cancer Society estimates that in 2008, there will be:

- 3,460 women diagnosed with vulvar cancer;
- 2,210 women diagnosed with vaginal and other female genital cancers;
- 1,250 men diagnosed with penile and other male genital cancers; and
- 3,050 women and 2,020 men diagnosed with anal cancer.

Certain populations may be at higher risk for HPV-related cancers, such as gay and bisexual men, and individuals with weak immune systems (including those who have HIV/AIDS).

RRP is very rare. It is estimated that less than 2,000 children get RRP every year.

A vaccine can now protect females from the four types of HPV that cause most cervical cancers and genital warts. The vaccine is recommended for 11 and 12 year-old girls. It is also recommended for girls and women age 13 through 26 who have not yet been vaccinated or completed the vaccine series.

For those who choose to be sexually active, condoms may lower the risk of HPV, if used all the time and the right way. Condoms may also lower the risk of developing HPV-related diseases, such as genital warts and cervical cancer. But HPV can infect areas that are not covered by a condom—so condoms may not *fully* protect against HPV. So the only sure way to prevent HPV is to avoid all sexual activity.

Individuals can also lower their chances of getting HPV by being in a mutually faithful relationship with someone who has had no or few sex partners. However, even people with only one lifetime sex partner can get HPV, if their partner was infected with HPV. For those who are not in long-term mutually monogamous relationships, limiting the number of sex partners and choosing a partner less likely to be infected may lower the risk of HPV. Partners less likely to be infected include those who have had no or few prior sex partners. But it may not be possible to determine if a partner who has been sexually active in the past is currently infected.

There are important steps girls and women can take to prevent cervical cancer. The HPV vaccine can protect against most cervical cancers (see above). Cervical cancer can also be prevented with routine cervical cancer screening and follow-up of abnormal results. The Pap test can identify abnormal or pre-cancerous changes in the cervix so that they can be removed before cancer develops. An HPV DNA test, which can find high-risk HPV on a woman's cervix, may also be used with a Pap test in certain cases. The HPV test can help healthcare professionals decide if more tests or treatment are needed. Even women who got the vaccine when they were younger need regular cervical cancer screening because the vaccine does not protect against all cervical cancers.

There is currently no vaccine licensed to prevent HPV-related diseases in men. Studies are now being done to find out if the vaccine is also safe in men, and if it can protect them against HPV and related conditions. The FDA will consider licensing the vaccine for boys and men if there is proof that it is safe and effective for them. There is also no approved screening test to find early signs of penile or anal cancer. Some experts recommend yearly anal Pap tests for gay and bisexual men and for HIV-positive persons because anal cancer is more common in these populations. Scientists are still studying

how best to screen for penile and anal cancers in those who may be at highest risk for those diseases.

Generally, cesarean delivery is not recommended for women with genital warts to prevent RRP in their babies. This is because it is unclear whether cesarean delivery actually prevents RRP in infants and children.

The HPV test on the market is only used as part of cervical cancer screening. There is no general test for men or women to check one's overall "HPV status." HPV usually goes away on its own, without causing health problems. So an HPV infection that is found today will most likely not be there a year or two from now. For this reason, there is no need to be tested just to find out if you have HPV *now*. However, you should get tested for signs of disease that HPV can cause, such as cervical cancer *(source: CDC Center for Disease Control)*.

- **Genital warts** are diagnosed by visual inspection. Some health care providers may use acetic acid, a vinegar solution, to help identify flat warts. But this is not a sensitive test so it may wrongly identify normal skin as a wart.
- **Cervical cell changes** (early signs of cervical cancer) can be identified by routine Pap tests. The HPV test can identify high-risk HPV types on a woman's cervix, which can cause cervical cell changes and cancer.
- As noted above, there is currently no approved test to find HPV or related cancers in men. But HPV is very common and HPV-related cancers are very rare in men.

There is no treatment for the virus itself, but a healthy immune system can usually fight off HPV naturally. There *are* treatments for the diseases that HPV can cause:

Visible genital warts can be removed by patient-applied medications, or by treatments performed by a health care provider. Some individuals choose to forego treatment to see if the warts will disappear on their own. No one treatment is better than another.

Cervical cancer is most treatable when it is diagnosed and treated early. There are new forms of surgery, radiation therapy, and chemotherapy available for patients [see www.cancer.org]. But women who get routine Pap testing and follow up as needed can identify problems *before* cancer develops. Prevention is always better than treatment.

Other HPV-related cancers are also more treatable when diagnosed and treated early. There are new forms of surgery, radiation therapy, and chemotherapy available for patients *(source: CDC Center for Disease Control)*.

Pelvic Inflammatory Disease (PID)

Pelvic inflammatory disease (PID) is a general term that refers to infection of the uterus (womb), fallopian tubes (tubes that carry eggs from the ovaries to the uterus) and other reproductive organs. It is a common and serious complication of some sexually transmitted diseases (STDs), especially Chlamydia and gonorrhea. PID can damage the fallopian tubes and tissues in and near the uterus and ovaries. PID can lead to serious

consequences including infertility, ectopic pregnancy (a pregnancy in the fallopian tube or elsewhere outside of the womb), abscess formation, and chronic pelvic pain *(source: CDC Center for Disease Control)*.

Each year in the United States, it is estimated that more than 1 million women experience an episode of acute PID. More than 100,000 women become infertile each year as a result of PID, and a large proportion of the ectopic pregnancies occurring every year are due to the consequences of PID.

PID occurs when bacteria move upward from a woman's vagina or cervix (opening to the uterus) into her reproductive organs. Many different organisms can cause PID, but many cases are associated with gonorrhea and clamydia, two very common bacterial STDs. A prior episode of PID increases the risk of another episode because the reproductive organs may be damaged during the initial bout of infection.

Sexually active women in their childbearing years are most at risk, and those under age 25 are more likely to develop PID than those older than 25. This is partly because the cervix of teenage girls and young women is not fully matured, increasing their susceptibility to the STDs that are linked to PID.

The more sex partners a woman has, the greater her risk of developing PID. Also, a woman whose partner has more than one sex partner is at greater risk of developing PID, because of the potential for more exposure to infectious agents.

Women who douche may have a higher risk of developing PID compared with women who do not douche. Research has shown that douching changes the vaginal flora (organisms that live in the vagina) in harmful ways, and can force bacteria into the upper reproductive organs from the vagina.

Women who have an intrauterine device (IUD) inserted may have a slightly increased risk of PID near the time of insertion compared with women using other contraceptives or no contraceptive at all. However, this risk is greatly reduced if a woman is tested and, if necessary, treated for STDs before an IUD is inserted.

Symptoms of PID vary from none to severe. When PID is caused by Chlamydia infection, a woman may experience mild symptoms or no symptoms at all, while serious damage is being done to her reproductive organs. Because of vague symptoms, PID goes unrecognized by women and their health care providers about two thirds of the time. Women who have symptoms of PID most commonly have lower abdominal pain. Other signs and symptoms include fever, unusual vaginal discharge that may have a foul odor, painful intercourse, painful urination, irregular menstrual bleeding, and pain in the right upper abdomen (rare).

Prompt and appropriate treatment can help prevent complications of PID. Without treatment, PID can cause permanent damage to the female reproductive organs. Infection-causing bacteria can silently invade the fallopian tubes, causing normal tissue to turn into scar tissue. This scar tissue blocks or interrupts the normal movement of eggs into the

uterus. If the fallopian tubes are totally blocked by scar tissue, sperm cannot fertilize an egg, and the woman becomes infertile. Infertility also can occur if the fallopian tubes are partially blocked or even slightly damaged. About one in ten women with PID becomes infertile, and if a woman has multiple episodes of PID, her chances of becoming infertile increase.

In addition, a partially blocked or slightly damaged fallopian tube may cause a fertilized egg to remain in the fallopian tube. If this fertilized egg begins to grow in the tube as if it were in the uterus, it is called an ectopic pregnancy. As it grows, an ectopic pregnancy can rupture the fallopian tube causing severe pain, internal bleeding, and even death.

Scarring in the fallopian tubes and other pelvic structures can also cause chronic pelvic pain (pain that lasts for months or even years). Women with repeated episodes of PID are more likely to suffer infertility, ectopic pregnancy, or chronic pelvic pain.

PID can be cured with several types of antibiotics. A health care provider will determine and prescribe the best therapy. However, antibiotic treatment does not reverse any damage that has already occurred to the reproductive organs. If a woman has pelvic pain and other symptoms of PID, it is critical that she seek care immediately. Prompt antibiotic treatment can prevent severe damage to reproductive organs. The longer a woman delays treatment for PID, the more likely she is to become infertile or to have a future ectopic pregnancy because of damage to the fallopian tubes.

Hospitalization to treat PID may be recommended if the woman (1) is severely ill (e.g., nausea, vomiting, and high fever); (2) is pregnant; (3) does not respond to or cannot take oral medication and needs intravenous antibiotics; (4) has an abscess in the fallopian tube or ovary (tubo-ovarian abscess); or (5) needs to be monitored to be sure that her symptoms are not due to another condition that would require emergency surgery (e.g., appendicitis). If symptoms continue or if an abscess does not go away, surgery may be needed. Complications of PID, such as chronic pelvic pain and scarring are difficult to treat, but sometimes they improve with surgery.

Women can protect themselves from PID by taking action to prevent STDs or by getting early treatment if they do get an STD. The surest way to avoid transmission of STDs is to abstain from sexual intercourse, or to be in a long-term mutually monogamous relationship with a partner who has been tested and is known to be uninfected.

CDC recommends yearly Chlamydia testing of all sexually active women age 25 or younger, older women with risk factors for Chlamydia infections (those who have a new sex partner or multiple sex partners), and all pregnant women. An appropriate sexual risk assessment by a health care provider should always be conducted and may indicate more frequent screening for some women.

Any genital symptoms such as an unusual sore, discharge with odor, burning during urination, or bleeding between menstrual cycles could mean an STD infection. If a woman has any of these symptoms, she should stop having sex and consult a health care

provider immediately. Treating STDs early can prevent PID. Women who are told they have an STD and are treated for it should notify all of their recent sex partners so they can see a health care provider and be evaluated for STDs. Sexual activity should not resume until all sex partners have been examined and, if necessary, treated.

Syphilis

Syphilis is a sexually transmitted disease (STD) caused by the bacterium *Treponema pallidum*. It has often been called "the great imitator" because so many of the signs and symptoms are indistinguishable from those of other diseases.

Syphilis is transmitted from person to person through direct contact with a syphilis sore. Sores occur mainly on the external genitals, vagina, anus, or in the rectum. Sores also can occur on the lips and in the mouth. Transmission of the organism occurs during vaginal, anal, or oral sex. Pregnant women with the disease can pass it to the babies they are carrying. Syphilis cannot be spread through contact with toilet seats, doorknobs, swimming pools, hot tubs, bathtubs, shared clothing, or eating utensils.

Many people infected with syphilis do not have any symptoms for years, yet remain at risk for late complications if they are not treated. Although transmission occurs from persons with sores who are in the primary or secondary stage, many of these sores are unrecognized. Thus, transmission may occur from persons who are unaware of their infection.

Primary Stage

The primary stage of syphilis is usually marked by the appearance of a single sore (called a chancre), but there may be multiple sores. The time between infection with syphilis and the start of the first symptom can range from 10 to 90 days (average 21 days). The chancre is usually firm, round, small, and painless. It appears at the spot where syphilis entered the body. The chancre lasts 3 to 6 weeks, and it heals without treatment. However, if adequate treatment is not administered, the infection progresses to the secondary stage.

Secondary Stage

Skin rash and mucous membrane lesions characterize the secondary stage. This stage typically starts with the development of a rash on one or more areas of the body. The rash usually does not cause itching. Rashes associated with secondary syphilis can appear as the chancre is healing or several weeks after the chancre has healed. The characteristic rash of secondary syphilis may appear as rough, red, or reddish brown spots both on the palms of the hands and the bottoms of the feet. However, rashes with a different appearance may occur on other parts of the body, sometimes resembling rashes caused by other diseases. Sometimes rashes associated with secondary syphilis are so faint that they

are not noticed. In addition to rashes, symptoms of secondary syphilis may include fever, swollen lymph glands, sore throat, patchy hair loss, headaches, weight loss, muscle aches, and fatigue. The signs and symptoms of secondary syphilis will resolve with or without treatment, but without treatment, the infection will progress to the latent and possibly late stages of disease.

Late and Latent Stages

The latent (hidden) stage of syphilis begins when primary and secondary symptoms disappear. Without treatment, the infected person will continue to have syphilis even though there are no signs or symptoms; infection remains in the body. This latent stage can last for years. The late stages of syphilis can develop in about 15% of people who have not been treated for syphilis, and can appear 10 – 20 years after infection was first acquired. In the late stages of syphilis, the disease may subsequently damage the internal organs, including the brain, nerves, eyes, heart, blood vessels, liver, bones, and joints. Signs and symptoms of the late stage of syphilis include difficulty coordinating muscle movements, paralysis, numbness, gradual blindness, and dementia. This damage may be serious enough to cause death.

The syphilis bacterium can infect the baby of a woman during her pregnancy. Depending on how long a pregnant woman has been infected, she may have a high risk of having a stillbirth (a baby born dead) or of giving birth to a baby who dies shortly after birth. An infected baby may be born without signs or symptoms of disease. However, if not treated immediately, the baby may develop serious problems within a few weeks. Untreated babies may become developmentally delayed, have seizures, or die.

Some health care providers can diagnose syphilis by examining material from a chancre (infectious sore) using a special microscope called a dark-field microscope. If syphilis bacteria are present in the sore, they will show up when observed through the microscope.

A blood test is another way to determine whether someone has syphilis. Shortly after infection occurs, the body produces syphilis antibodies that can be detected by an accurate, safe, and inexpensive blood test. A low level of antibodies will likely stay in the blood for months or years even after the disease has been successfully treated. Because untreated syphilis in a pregnant woman can infect and possibly kill her developing baby, every pregnant woman should have a blood test for syphilis.

Genital sores (chancres) caused by syphilis make it easier to transmit and acquire HIV infection sexually. There is an estimated 2- to 5-fold increased risk of acquiring HIV if exposed to that infection when syphilis is present.

Ulcerative STDs that cause sores, ulcers, or breaks in the skin or mucous membranes, such as syphilis, disrupt barriers that provide protection against infections. The genital

ulcers caused by syphilis can bleed easily, and when they come into contact with oral and rectal mucosa during sex, increase the infectiousness of and susceptibility to HIV. Having other STDs is also an important predictor for becoming HIV infected because STDs are a marker for behaviors associated with HIV transmission.

Syphilis is easy to cure in its early stages. A single intramuscular injection of penicillin, an antibiotic, will cure a person who has had syphilis for less than a year. Additional doses are needed to treat someone who has had syphilis for longer than a year. For people who are allergic to penicillin, other antibiotics are available to treat syphilis. There are no home remedies or over-the-counter drugs that will cure syphilis. Treatment will kill the syphilis bacterium and prevent further damage, but it will not repair damage already done.

Because effective treatment is available, it is important that persons be screened for syphilis on an on-going basis if their sexual behaviors put them at risk for STDs. Persons who receive syphilis treatment must abstain from sexual contact with new partners until the syphilis sores are completely healed. Persons with syphilis must notify their sex partners so that they also can be tested and receive treatment if necessary.

The surest way to avoid transmission of sexually transmitted diseases, including syphilis, is to abstain from sexual contact or to be in a long-term mutually monogamous relationship with a partner who has been tested and is known to be uninfected. Avoiding alcohol and drug use may also help prevent transmission of syphilis because these activities may lead to risky sexual behavior. It is important that sex partners talk to each other about their HIV status and history of other STDs so that preventive action can be taken.

Genital ulcer diseases, like syphilis, can occur in both male and female genital areas that are covered or protected by a latex condom, as well as in areas that are not covered. Correct and consistent use of latex condoms can reduce the risk of syphilis, as well as genital herpes and chancroid, only when the infected area or site of potential exposure is protected.

Condoms lubricated with spermicides (especially Nonoxynol-9 or N-9) are no more effective than other lubricated condoms in protecting against the transmission of STDs. Use of condoms lubricated with N-9 is not recommended for STD/HIV prevention. Transmission of an STD, including syphilis cannot be prevented by washing the genitals, urinating, and/or douching after sex. Any unusual discharge, sore, or rash, particularly in the groin area, should be a signal to refrain from having sex and to see a doctor immediately.

Trichomonias

Trichomonias is a common sexually transmitted disease (STD) that affects both women and men, although symptoms are more common in women. Trichomoniasis is the most common curable STD in young, sexually active women. An estimated 7.4 million new cases occur each year in women and men.

Trichomoniasis, which affects both men and women, is caused by a microscopic parasite. While bacterial vaginosis is caused by an imbalance in the bacteria normally found in the vagina, and as such only affects women. Currently, there are no national surveillance data on trichomoniasis, bacterial vaginosis, and related vaginal infections, but these infections are among the most common conditions found in women in health care settings. While these diseases are treatable, untreated bacterial vaginosis is associated with pelvic inflammatory disease, and both trichomoniasis and bacterial vaginosis may increase the risk of HIV infection. In pregnant women, these diseases may also cause babies to be born prematurely or with low birth weights. However, the biomedical mechanisms for these outcomes are just beginning to be understood.

An estimated five million cases of trichomoniasis occur each year in the United States Scientific studies suggest bacterial vaginosis is common in women of reproductive age. In the United States, as many as 16 percent of pregnant women have BV. This varies by race and ethnicity from six percent in Asians and nine percent in whites to 16 percent in Hispanics and 23 percent in African Americans.

Diagnoses of other vaginal infections-of which bacterial vaginosis is the most common cause-increased dramatically over the decade, but now have begun to decline. In 1997, more than three million women were diagnosed with vaginitis in private doctors' offices. Because these cases do not include women diagnosed in public health care settings or who are not diagnosed at all, these are minimum numbers of infection.

Trichomoniasis is caused by the single-celled protozoan parasite, *Trichomonas vaginalis*. The vagina is the most common site of infection in women, and the urethra (urine canal) is the most common site of infection in men. The parasite is sexually transmitted through penis-to-vagina intercourse or vulva-to-vulva (the genital area outside the vagina) contact with an infected partner. Women can acquire the disease from infected men or women, but men usually contract it only from infected women.

Most men with trichomoniasis do not have signs or symptoms; however, some men may temporarily have an irritation inside the penis, mild discharge, or slight burning after urination or ejaculation.

Some women have signs or symptoms of infection which include a frothy, yellow-green vaginal discharge with a strong odor. The infection also may cause discomfort during intercourse and urination, as well as irritation and itching of the female genital area. In rare cases, lower abdominal pain can occur. Symptoms usually appear in women within 5 to 28 days of exposure.

The genital inflammation caused by trichomoniasis can increase a woman's susceptibility to HIV infection if she is exposed to the virus. Having trichomoniasis may increase the chance that an HIV-infected woman passes HIV to her sex partner(s). Pregnant women with trichomoniasis may have babies who are born early or with low birth weight (low birth weight is less than 5.5 pounds). For both men and women, a health care provider must perform a physical examination and laboratory test to diagnose trichomoniasis. The parasite is harder to detect in men than in women. In women, a pelvic examination can reveal small red ulcerations (sores) on the vaginal wall or cervix.

Trichomoniasis can usually be cured with prescription drugs, either metronidazole or tinidazole, given by mouth in a single dose. The symptoms of trichomoniasis in infected men may disappear within a few weeks without treatment. However, an infected man, even a man who has never had symptoms or whose symptoms have stopped, can continue to infect or re-infect a female partner until he has been treated. Therefore, both partners should be treated at the same time to eliminate the parasite. Persons being treated for trichomoniasis should avoid sex until they and their sex partners complete treatment and have no symptoms. Metronidazole can be used by pregnant women. Having trichomoniasis once does not protect a person from getting it again. Following successful treatment, people can still be susceptible to re-infection.

The surest way to avoid transmission of sexually transmitted diseases is to abstain from sexual contact, or to be in a long-term mutually monogamous relationship with a partner who has been tested and is known to be uninfected. Latex male condoms, when used consistently and correctly, can reduce the risk of transmission of trichomoniasis.

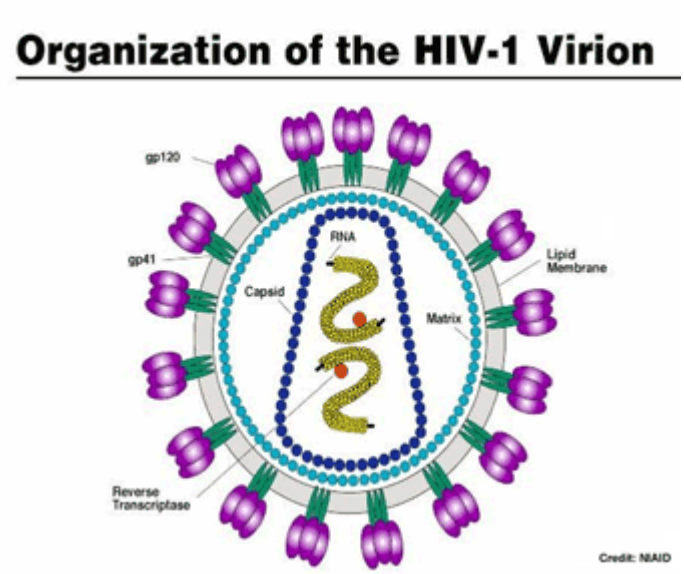
Any genital symptom such as discharge or burning during urination or an unusual sore or rash should be a signal to stop having sex and to consult a health care provider immediately. A person diagnosed with trichomoniasis (or any other STD) should receive treatment and should notify all recent sex partners so that they can see a health care provider and be treated. This reduces the risk that the sex partners will develop complications from trichomoniasis and reduces the risk that the person with trichomoniasis will become re-infected. Sex should be stopped until the person with trichomoniasis and all of his or her recent partners complete treatment for trichomoniasis and have no symptoms.

HIV and AIDS

HIV

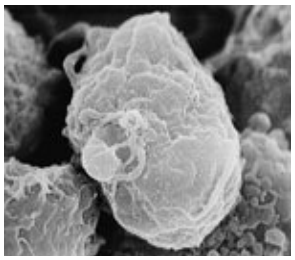
HIV stands for human immunodeficiency virus. This is the virus that causes AIDS. HIV is different from most other viruses because it attacks the immune system. The immune system gives our bodies the ability to fight infections. HIV finds and destroys a type of white blood cell (T cells or CD4 cells) that the immune system must have to fight

disease.



Structure of the Human Immunodeficiency Virus

AIDS stands for acquired immunodeficiency syndrome. AIDS is the final stage of HIV infection. It can take years for a person infected with HIV, even without treatment, to reach this stage. Having AIDS means that the virus has weakened the immune system to the point at which the body has a difficult time fighting infection. When someone has one or more specific infections, certain cancers, or a very low number of T cells, he or she is considered to have AIDS *(source: CDC Center for Disease Control).*



Electron microscope image of HIV, seen as small spheres on the surface of white blood cells.

Scientists identified a type of chimpanzee in West Africa as the source of HIV infection in humans. The virus most likely jumped to humans when humans hunted these chimpanzees for meat and came into contact with their infected blood. Over several years, the virus slowly spread across Africa and later into other parts of the world. For more information view our question and answer on the origin of HIV *(source: CDC Center for Disease Control).*

HIV was first identified in the United States in 1981 after a number of gay men started getting sick with a rare type of cancer. It took several years for scientists to develop a test for the virus, to understand

how HIV was transmitted between humans, and to determine what people could do to protect themselves.

AIDS cases began to fall dramatically when new drugs became available. Today, more people than ever before are living with HIV/AIDS. CDC estimates that about 1 million people in the United States are living with HIV or AIDS. About one quarter of these people do not know that they are infected: not knowing puts them and others at risk.

HIV is a fragile virus. It cannot live for very long outside the body. As a result, the virus is not transmitted through day-to-day activities such as shaking hands, hugging, or a casual kiss. You cannot become infected from a toilet seat, drinking fountain, doorknob, dishes, drinking glasses, food, or pets. You also cannot get HIV from mosquitoes.

HIV is primarily found in the blood, semen, or vaginal fluid of an infected person. HIV is transmitted in 3 main ways:

- Having sex (anal, vaginal, or oral) with someone infected with HIV
- Sharing needles and syringes with someone infected with HIV
- Being exposed (fetus or infant) to HIV before or during birth or through breast feeding

HIV also can be transmitted through blood infected with HIV. However, since 1985, all donated blood in the United States has been tested for HIV. Therefore, the risk for HIV infection through the transfusion of blood or blood products is extremely low. The U.S. blood supply is considered among the safest in the world.
Increased risk for infection includes:

- injected drugs or steroids, during which equipment (such as needles, syringes, cotton, water) and blood were shared with others
- had unprotected vaginal, anal, or oral sex (that is, sex without using condoms) with men who have sex with men, multiple partners, or anonymous partners
- exchanged sex for drugs or money
- been given a diagnosis of, or been treated for, hepatitis, tuberculosis (TB), or a sexually transmitted disease (STD) such as syphilis
- received a blood transfusion or clotting factor during 1978–1985
- had unprotected sex with someone who has any of the risk factors listed above

Prevention

Your risk of getting HIV or passing it to someone else depends on several things. Do you know what they are? You might want to talk to someone who knows about HIV. You can also do the following:

- Abstain from sex (do not have oral, anal, or vaginal sex) until you are in a relationship with only one person, are having sex with only each other, and each of you knows the other's HIV status.
    - If both you and your partner have HIV, use condoms to prevent other sexually transmitted diseases (STDs) and possible infection with a different strain of HIV.
    - If only one of you has HIV, use a latex condom and lubricant every time you have sex.
- If you have, or plan to have, more than one sex partner, consider the following:
    - Get tested for HIV
        - If you are a man who has had sex with other men, get tested at least once a year.
        - If you are a woman who is planning to get pregnant or who is pregnant, get tested as soon as possible, before you have your baby.
    - Talk about HIV and other STDs with each partner before you have sex.
    - Learn as much as you can about each partner's past behavior (sex and drug use), and consider the risks to your health before you have sex.
    - Ask your partners if they have recently been tested for HIV; encourage those who have not been tested to do so.
    - Use a latex condom and lubricant every time you have sex.
    - If you think you may have been exposed to another STD such as gonorrhea, syphilis, or *Chlamydia trachomatis* infection, get treatment. These diseases can increase your risk of getting HIV.
    - Get vaccinated against hepatitis B virus.
- Even if you think you have low risk for HIV infection, get tested whenever you have a regular medical check-up.
- Do not inject illicit drugs (drugs not prescribed by your doctor). You can get HIV through needles, syringes, and other works if they are contaminated with the blood of someone who has HIV. Drugs also cloud your mind, which may result in riskier sex.
- If you do inject drugs, do the following:
    - Use only clean needles, syringes, and other works.
    - Never share needles, syringes, or other works.

    - Be careful not to expose yourself to another person's blood.
    - Get tested for HIV test at least once a year.
    - Consider getting counseling and treatment for your drug use.
    - Get vaccinated against hepatitis A and B viruses.
- Do not have sex when you are taking drugs or drinking alcohol because being high can make you more likely to take risks.

Symptoms

The only way to know whether you are infected is to be tested for HIV. You cannot rely on symptoms alone because many people who are infected with HIV do not have symptoms for many years. Someone can look and feel healthy but can still be infected. In fact, one quarter of the HIV-infected persons in the United States do not know that they are infected. For more information view our question and answer on symptoms.

Once HIV enters the body, the body starts to produce antibodies—substances the immune system creates after infection. Most HIV tests look for these antibodies rather than the virus itself. There are many different kinds of HIV tests, including rapid tests and home test kits. All HIV tests approved by the US government are very good at finding HIV.

Of all racial and ethnic groups in the United States, HIV and AIDS have hit African Americans the hardest. The reasons are not directly related to race or ethnicity, but rather to some of the barriers faced by many African Americans. These barriers can include poverty (being poor), sexually transmitted diseases, and stigma (negative attitudes, beliefs, and actions directed at people living with HIV/AIDS or directed at people who do things that might put them at risk for HIV).

When we look at HIV/AIDS by race and ethnicity, we see that African Americans have

- **More illness.** Even though blacks (including African Americans) account for about 13% of the US population, they account for about half (49%) of the people who get HIV and AIDS.
- **Shorter survival times.** Blacks with AIDS often don’t live as long as people of other races and ethnic groups with AIDS. This is due to the barriers mentioned above.
- **More deaths.** For African Americans and other blacks, HIV/AIDS is a leading cause of death.

Prevention Challenges

A number of cultural, socioeconomic, and health-related factors contribute to the HIV epidemic in the US Hispanic/Latino community.

- **Behavioral risk factors** for HIV infection differ by country of birth. For example, data suggest that Hispanics/Latinos born in Puerto Rico are more likely than other Hispanics/Latinos to contract HIV as a result of injection drug use or high-risk heterosexual contact. By contrast, sexual contact with other men is the primary cause of HIV infections among Hispanic/Latino men born in Central or South America, Cuba, Mexico, or the United States.
- Hispanic/Latino men and women are most likely to be infected with HIV as a result of **sexual contact with men**. Hispanic/Latina women may be unaware of their male partner's risk factors or incorrectly assess them . In five different studies of gay and bisexual men in the U.S., Hispanic/Latinos were reported to have the highest rates of unprotected male-to-male sexual contact, even when compared to men from other ethnic minority groups.
- **Injection drug use** continues to be a risk factor for Hispanics/Latinos, particularly those living in Puerto Rico. Both casual and chronic substance users may be more likely to engage in risky sexual behaviors, such as unprotected sex, when they are under the influence of drugs or alcohol.
- The presence of certain **sexually transmitted diseases** (STDs) can significantly increase one's chances of contracting HIV infection, and the rates of STDs are high for Hispanics/Latinos.
- Hispanics/Latinos confront several **cultural factors** that can affect one's risk of HIV infection. Some may avoid seeking testing, counseling, or treatment if infected, for fear of embarrassment, rejection, and stigma. Stigmatizing sexuality adds to the prevention challenges making it hard to reach a community that is ‘silent' (e.g., traditional rigid gender roles and norms such as “machismo” contribute to the sense of Latino gay men being “failed men”).
- Greater **acculturation into the US culture** has both negative effects (engaging in behaviors that increase the risk for HIV infection) and positive effects (communicating with partners about practicing safer sex) on the health behaviors of Hispanics/Latinos.
- **Socioeconomics factors** such as poverty, migration patterns, social structures or language barriers add to Hispanic/Latino infection numbers. Problems associated with socioeconomics factors—including unemployment, transience, a lack of formal education, immigration status, inadequate health insurance, and limited access to high-quality health care—can hinder access to HIV/AIDS prevention and care.

Trends

During the 1980s, AIDS cases alone provided an adequate picture of HIV trends because the time between infection with HIV and progression to AIDS was predictable. This predictability, however, has diminished since 1996, when highly active antiretroviral

therapy (HAART) became available. Access, adherence, and response to HAART affect whether or when HIV progresses to AIDS. Thus, trends in AIDS cases alone no longer accurately reflect trends in HIV infection. AIDS trends do, however, continue to provide important information about where care and treatment resources are most needed.

Psychological Considerations

Many individuals already have pre-existing psychological issues which make it even more challenging to cope with HIV. Being a victim of sexual abuse is very common among those with HIV. Further, some people may not only be coming out to their families about being HIV+, but also coming out about being homosexual as well. If diagnosed with HIV or AIDS, it is important for the individual to gain emotional and psychological support. Unfortunately, due to the perceived stigma of the disease, many people do not seek the services that they need. However, HIV *is treatable* and with medical and psychological treatment, people can live happy and productive lives in spite of having the disease *(Blechner MJ, Hope and mortality: psychodynamic approaches to AIDS and HIV)*.

Therapy can help clients become more proactive, re-engage in life and in relationships, learn to cope with symptoms, and take an active role in their health issues. Therapy can help those with HIV to develop greater self-awareness, especially with self-defeating behaviors, stronger coping skills, and the motivation to engage in meaningful and productive activities. Further, there are many promising studies that indicate a potential link between the HIV positive person's health, and taking care of their emotional health. If a person is diagnosed with HIV or AIDS, they should reach out to trusted friends and family members. Individuals can also seek a support group for those with HIV, contact their local AIDS Service Organization for information on available psychosocial support, and seek therapy with a competent and licensed therapist who is practiced in working with those who have HIV or AIDS *(Blechner MJ, Hope and mortality: psychodynamic approaches to AIDS and HIV)*.

Anxiety

Anxiety is a common symptom in HIV-infected patients. When anxiety symptoms are severe or persistent, patients may have an anxiety disorder. These disorders include panic disorder, generalized anxiety disorder, obsessive-compulsive disorder, and post-traumatic stress disorder (PTSD) Among HIV-infected patients receiving medical care, 20.3% have been found to have an anxiety disorder, with 12.3% meeting the criteria for panic disorder, 10.4% for PTSD, and 2.8% having generalized anxiety disorder. Patients with other psychiatric disorders, such as adjustment disorders, major depression, psychosis, or substance use disorders, can also present with significant anxiety. To help patients receive optimal care, clinicians need to be aware of the differences among these specific disorders. Furthermore, patients with histories of anxiety or mood disorders are susceptible to recurrence of anxiety symptoms during the course of HIV illness. Anxiety can manifest in many ways, such as shortness of breath, chest pain, racing/pounding

heart, dizziness, diaphoresis, numbness or tingling, nausea, or the sensation of choking. When clients present with these somatic symptoms, for which no underlying medical etiology can be established, clinicians should consider an anxiety disorder as the cause. In addition to somatic complaints, clients with anxiety disorders often present with fear, worry, insomnia, impaired concentration and memory, diminished appetite, ruminations, compulsive rituals, and avoidance of situations that make them anxious *(Kranzler HR, Rounsavill BJ, eds. Dual Diagnosis and Treatment: Substance Abuse and Comorbid Medical and Psychiatric Disorders).*

Anxiety symptoms such as worry, nervousness, fear, and tension are commonly experienced by people with HIV during periods of their illness and may be a response to stressful situations. An anxiety disorder occurs when symptoms:

- Interfere with a patient's daily function (e.g., the patient is unable to work, leave home, attend to medical care)
- Interfere with personal relationships
- Cause marked subjective distress

Even brief episodes of anxiety, such as those occurring during a panic attack, may interfere markedly in a patient's life and may warrant a diagnosis of an anxiety disorder. Anxiety-like symptoms may also be caused by mental health disorders other than anxiety disorders. For example, it may be difficult to distinguish depression with agitation from an adjustment disorder with anxious mood. In general, adjustment reactions follow a stressful event, which is often not true in clinical depression, and are less likely to present with the entire vegetative symptom complex seen in depression, which is characterized by insomnia, diminished appetite, diurnal variation in mood, loss of pleasure/interest, feelings of guilt, fatigue, and attention and concentration problems *(Kranzler HR, Rounsavill BJ, eds. Dual Diagnosis and Treatment: Substance Abuse and Comorbid Medical and Psychiatric Disorders).*

Certain anxiety symptoms can be effectively managed without the use of medication. There are also patients who prefer to avoid the use of psychotropic medication. Patients with mild anxiety symptoms that do not interfere with function may respond to supportive or behavioral interventions. Clinicians may find the following strategies helpful in such situations:

- Expressing empathy
- Educating patients about anxiety
- Reassuring patients that anxiety is the cause of somatic symptoms experienced during panic attacks
- Identifying the psychological factors that contribute to anxiety
- Preparing patients for stressful situations and assisting in development of coping mechanisms

- Teaching patient's simple relaxation exercises. Slow, deep breathing with focus on inspiration and expiration of air can be helpful. Such exercises can be useful when patients practice for 1 minute three times a day, increasing to 5 minutes, if possible.

Depression

Clinical depression is the most commonly observed mental health disorder among HIV-infected patients, affecting up to 20% of patients. The prevalence may be even greater among substance users. Depressive symptoms have been associated with risk behavior, non-adherence to medications, and shortened survival. Although sadness and grief are normal responses to many of the consequences of HIV infection, clinical depression is not. Failure to recognize depression may endanger both the patient and others in the community. Patients with depression are at higher risk for co-morbid psychiatric, alcohol, and substance use-related disorders, particularly alcohol, cannabis, and cocaine use *(Kranzler HR, Rounsavill BJ, eds. Dual Diagnosis and Treatment: Substance Abuse and Comorbid Medical and Psychiatric Disorders).*

Although many of the somatic symptoms of depression may be attributed to HIV infection, opportunistic or other infections, or side effects of medications, the primary care clinician should recognize that the following symptoms can be caused by depression:

- Depressed mood
- Loss of interest or pleasure
- Feelings of guilt
- Suicidal thoughts
- Sleep disturbance
- Appetite/weight changes
- Attention/concentration problems
- Energy level changes/fatigue
- Psychomotor disturbance

Many HIV-infected patients may not recognize or report symptoms. They may present instead with behavioral changes that may indicate the presence of an underlying depressive disorder. Clinicians should recognize the following behavioral changes as possible indications of an underlying depressive disorder:

- A change in treatment adherence
- An inability to make life choices, including those related to medical care and adjustment to HIV disease
- A preoccupation with a particular problem, usually one that presents as minor
- A change in functioning, including an inability to perform activities of daily living, a return to substance use, or a self-imposed isolation

- Unexplained medical complaints, particularly pain or fatigue
- Interpersonal problems
- Presenting with difficult behaviors in the medical setting

HIV-infected patients do not become depressed simply because their disease progresses; however, it is particularly important to screen for depression during the crisis points noted in Table 1. Medically ill patients may experience normal sadness, grief, and discouragement or demoralization. However, the presence of hopelessness, anaerobia (the absence of pleasure from usually pleasurable activities), ruminative guilt, and suicidal ideation may indicate accompanying clinical depression requiring psychiatric intervention *(Kranzler HR, Rounsavill BJ, eds. Dual Diagnosis and Treatment: Substance Abuse and Comorbid Medical and Psychiatric Disorders)*.

Crisis Points for HIV-Infected Persons

- Learning of HIV-positive status
- Disclosure of HIV status to family and friends
- Introduction of medication
- Occurrence of any physical illness
- Recognition of new symptoms/progression of disease (e.g., major decrease in CD4 cells, increase in viral load)
- Necessity of hospitalization (particularly the first hospitalization)
- Death of a significant other
- Diagnosis of AIDS
- A return to a higher level of functioning (e.g., re-entry into job market/ school, giving up entitlements)
- Major life changes (e.g., childbirth, pregnancy, loss of job, end of relationship, relocation)
- Necessity of making end-of-life and permanency planning decisions

Data are from Duffy V. The 14 crisis points of AIDS. AIDS Patient Care STDs

Clinicians should use the diagnostic criteria in the *Diagnostic and Statistical Manual of Mental Disorders-V* to diagnose Depressive Disorders

In addition to Major Depressive Disorder, there are other kinds of Depression, such as Minor Depression and Dysthymic Disorder, which share symptoms with Major Depressive Disorder but differ in duration and severity. The clinician should refer to the *DSM-V* for more information on these subtypes of depression. The following psychiatric

disorders, which require a different treatment approach, may present with symptoms of depression and should be excluded as possible causes:

- Bipolar Disorder
- Post-Traumatic Stress Disorder
- HIV-associated dementia
- Alcohol and substance use

Suicidality

HIV-infected patients may be at higher risk for suicidal behavior, particularly after a diagnosis of HIV disease or during progression to AIDS, as patients' health and quality of life decline. Other patients, such as those with certain personality disorders, may be at increased risk for violent behavior. Although only a small number of HIV-infected patients attempt or commit suicide or violence, routine mental health assessment and procedures in the clinic setting for responding to mental health emergencies can ensure that the potential for such behavior is identified and appropriately addressed *(Coté TR, Biggar RJ, Dannenberg AL. Risk of suicide among persons with AIDS: A national assessment, JAMA)*.

Rates of suicidal behavior have been more widely studied in gay men than in other populations, although some studies have shown that HIV-infected women have higher rates of suicide attempts than HIV-infected men. Studies conducted before the introduction of HAART indicated an increased risk of completed suicide in patients with HIV/AIDS that was 7 to 36 times greater than in the non-HIV-infected population. Since the introduction of HAART, more recent evidence suggests that suicide among HIV-infected patients may be mediated more often by factors other than HIV, including depression, alcohol, or other substance-related disorders. Because patients with suicidal behavior often present with co-morbid depression, screening for and timely treatment of depression may reduce a patient's risk for suicide. Suicide risk in HIV-infected patients may be higher than in populations with other chronic medical illnesses, such as cancer. Evidence suggests that risk for suicidal behavior increases during the initial weeks following a diagnosis of HIV disease and then declines as patients adjust to their HIV status. However, as patients' health and quality of life decline, risk of suicide may again increase, particularly among middle-aged and older patients, who frequently experience poorer health-related quality of life when progressing to AIDS. A comprehensive mental health assessment is essential for any patient who directly expresses suicidal or violent behavior or whose behavior and risk factors suggest potential for suicide or violence *(Bellini M, Bruschi C. HIV infection and suicidality. Affect Disorder)*.

PTSD

Exposure to a traumatic event is normally accompanied by distress. For most individuals such distress resolves spontaneously without the onset of any psychiatric illness. Among a subset of people, the type, severity, and duration of symptoms that develop following trauma will meet criteria for either acute stress disorder (ASD) or post-traumatic stress

disorder (PTSD). ASD is not as well studied as PTSD. Some trauma researchers feel ASD is on a continuum with PTSD and that the cut-off times for the two disorders are arbitrary *(Cooper J, Carty J, Creamer M. Pharmacotherapy for post-traumatic stress disorder: Empirical review and clinical recommendations)*.

The rate of PTSD following exposure to a particular trauma ranges from 12% to 70%, with the higher rates occurring in populations exposed to traumas that involve interpersonal violence (e.g., rape, sexual abuse, torture). Women have higher rates of PTSD than men. Among women, sexual assault is the most common precipitating trauma, whereas among men, the most common trauma is combat exposure. Although PTSD has a lifetime prevalence rate of approximately 1.3% to 7.8% in the general population, the rates of PTSD in the HIV-infected population are higher. The prevalence of PTSD in HIV-infected individuals may be as high as 42%. Although onset of a severe, life-threatening illness (such as HIV/AIDS) can sometimes in itself be a traumatic experience leading to PTSD, more often a history of physical or psychological trauma (and diagnosis of PTSD) co-occurs with an individual's HIV status. Among people with the most severe mental illnesses, specifically schizophrenia, schizoaffective disorder, and bipolar disorder, comorbid PTSD is an important predictor of HIV infection *(Cooper J, Carty J, Creamer M. Pharmacotherapy for post-traumatic stress disorder: Empirical review and clinical recommendations)*.

Many of the symptoms of ASD overlap with those of PTSD. ASD defines a severe stress response that follows shortly after a traumatic event, whereas PTSD cannot be diagnosed until symptoms have persisted for 30 days or longer. The presence of full or partial ASD is associated with an increased risk of developing PTSD. In various studies, the presence of numbing, depersonalization, a sense of reliving the trauma, motor restlessness, and peri-traumatic dissociation were found to predict progression to PTSD. These associations raise the possibility that effective early treatment of trauma symptoms can be a useful strategy in the prevention of PTSD. However, it should be noted that many trauma survivors who develop PTSD do not have initial ASD symptoms, and many individuals with ASD will not develop PTSD.

HIV Status and Discrimination

Although being HIV-positive is not itself indicative of sexual transmission of the infection, individuals are often discriminated against for their HIV-positive status based on a presumption of sexual activity that is often considered socially unacceptable. In addition, in response to the fact that most HIV infections are due to sexual transmission, a number of countries criminalized transmission of, or exposure to, HIV, fuelling stigma, discrimination and fear, and discouraging people from getting tested for HIV, thus undermining public health interventions to address the epidemic. Even where persons living with HIV/AIDS may be able, in principle, to access health services and information in the same way as others, fear of discrimination, stigma and

violence may prevent them from doing so. Discrimination against people living with HIV is widespread, and is associated with higher levels of stress, depression, suicidal ideation, low self-esteem and poorer quality of life, as well as a lower likelihood of seeking HIV services and a higher likelihood of reporting poor access to care. HIV transmission has been criminalized in various ways. In some countries criminal laws have been applied through a specific provision in the criminal code and/or a provision that allows for a charge of rape to be escalated to "aggravated rape" if the victim is thought to have been infected with HIV as a result. In some cases, HIV transmission is included under generic crimes related to public health, which punish the propagation of disease or epidemics, and/or the infliction of "personal injury" or "grievous bodily harm".

Contrary to the HIV-prevention rationale that such laws will act as a deterrent and provide retribution, there is no evidence to show that broad application of the criminal law to HIV transmission achieves either criminal justice or public health goals. On the contrary, such laws fuel stigma, discrimination and fear, discouraging people from being tested to find out their HIV status, and undermining public health interventions to address the epidemic. Thus, such laws may actually increase rather decrease HIV transmission. Women are particularly affected by these laws since they often learn that they are HIV-positive before their male partners do, since they are more likely to access health services. Furthermore, for many women it is either difficult or impossible to negotiate safer sex or to disclose their status to a partner for fear of violence, abandonment or other negative consequences, and they may therefore face prosecution as a result of their failure to disclose their status. Criminal laws have also been used against women who transmit HIV to their infants if they have not taken the necessary steps to prevent transmission. Such use of criminal law has been strongly condemned by human rights bodies.

Various human rights and political bodies have expressed concern about the harmful effects of broadly criminalizing the transmission of HIV. International policy guidance recommends against specific criminalization of HIV transmission. Human rights bodies as well as United Nations' specialized agencies, such as UNAIDS, have stated that the criminalization of HIV transmission in the instance of intentional, malicious transmission is the only circumstance in which the use of criminal law may be appropriate in relation to HIV. States are urged to limit criminalization to those rare cases of intentional transmission, where a person knows his or her HIV-positive status, acts with the intent to transmit HIV, and does in fact transmit it. Human rights bodies have called on states to ensure that a person's actual or perceived health status, including HIV status, is not a barrier to realizing human rights. When HIV status is used as the basis for differential treatment with regard to access to health care, education, employment, travel, social security, housing and asylum, this amounts to restricting human rights and it constitutes discrimination. International human rights standards affirm that the right to non-discrimination includes protection of children living with HIV and people with presumed same-sex conduct.

Human rights standards also disallow the restriction of movement or incarceration of people with transmissible diseases (e.g. HIV/AIDS) on grounds of national security or the preservation of public order, unless such serious measures can be justified. To protect the human rights of people living with HIV, states have been called on to implement laws that help to ensure that persons living with HIV/AIDS can access health services, including antiretroviral therapy. This might mean, as in the case of the Philippines, for example, explicitly prohibiting hospitals and health institutions from denying a person with HIV/AIDS access to health services or charging them more for those services than a person without HIV/AIDS. International guidance also suggests that such laws should be consistent with states' international human rights obligations and that instead governments should expand programs that have been proven to reduce HIV transmission while protecting the human rights both of people living with HIV and those who are HIV-negative.

National Overview of Sexually Transmitted Diseases (STDs)

All Americans should have the opportunity to make choices that lead to health and wellness. Working together, interested, committed public and private organizations, communities, and individuals can take action to prevent sexually transmitted diseases (STDs) and their related health consequences. In addition to federal, state, and local public support for STD prevention activities, local community leaders can promote STD prevention education. Health care providers can assess their patients' risks and talk to them about testing. Parents can better educate their children about STDs and sexual health. and openly discuss ways to protect their health with partners and providers. As noted in the Institute of Medicine report, The Hidden Epidemic: Confronting Sexually Transmitted Diseases, surveillance is a key component of all our efforts to prevent and control these diseases.

This overview summarizes national surveillance data for 2015 on the three notifiable diseases for which there are federally funded control programs: chlamydia, gonorrhea, and syphilis. As of 2018, this is the most current data available.

Chlamydia
In 2015, a total of 1,526,658 cases of Chlamydia trachomatis infection were reported to the CDC. This case count corresponds to a rate of 478.8 cases per 100,000 population, an increase of 5.9% compared with the rate in 2014. During 2014–2015, the rate of reported chlamydia cases among women increased 3.8% and the rate among men increased 10.5%. Following three years of decreases in rates during 2011–2014, the rate among women aged 15–19 years increased 1.5% during 2014–2015.

In 2015, the overall rate of chlamydial infection in the United States among women (645.5 cases per 100,000 females) based on reported cases was over two times the rate among men (305.2 cases per 100,000 males), reflecting the larger number of women

screened for this infection. However, with the increased availability of urine testing and extragenital testing, men, including gay, bisexual, and other men who have sex with men (collectively referred to as MSM) are increasingly being tested for chlamydial infection. During 2011–2015, the chlamydia rate in men increased 20.0%, compared with a 0.3% increase in women during this period.

The facilities reporting chlamydial infections have changed over the last 10 years. In 2015, over 75% of chlamydia cases were reported from venues outside of STD clinics. Among women, only 4.5% of chlamydia cases were reported through an STD clinic and about a third of cases were reported from private physicians/health maintenance organizations.

Rates of reported chlamydia varied among different racial and ethnic minority populations. In 2015, the rate of chlamydia among Blacks was 5.9 times the rate among Whites, and the rate among American Indians/Alaska Natives was 3.8 times the rate among Whites.

Gonorrhea
In 2009, the national rate of reported gonorrhea cases reached an historic low of 98.1 cases per 100,000 population. However, during 2009–2012, the rate increased slightly each year to 106.7 cases per 100,000 population in 2012 and then increased again during 2013–2015. In 2015, 395,216 gonorrhea cases were reported for a rate of 123.9 cases per 100,000 population, an increase of 12.8% from 2014.

During 2014–2015 the rate of reported gonorrhea increased 18.3% among men and 6.8% among women. Gonorrhea rates among both men and women increased in every region of the United States, with largest increases in the West and the South. The magnitude of the increase among males suggest either increased transmission or increased case ascertainment (e.g., through increased extra-genital screening) among MSM or both.

In 2015, the rate of reported gonorrhea cases remained highest among Blacks (424.9 cases per 100,000 population) and among American Indians/Alaska Natives (192.8 cases per 100,000 population). While rates of gonorrhea declined 4.0% among Blacks during 2011–2015, rates increased among all other racial and ethnic groups, including a 71.3% increase among American Indians/Alaska Natives.

Antimicrobial resistance remains an important consideration in the treatment of gonorrhea. With increased resistance to the fluoroquinolones and declining susceptibility to cefixime, dual therapy with ceftriaxone and azithromycin is now the only CDC recommended treatment for gonorrhea. In 2015, the percentage of isolates with elevated minimum inhibitory concentrations (MICs) of cefixime and ceftriaxone remained low (0.5% and 0.3%, respectively). During 2013–2015, the percentage of isolates with

reduced azithromycin susceptibility increased from 0.6% to 2.6%. Continued monitoring of susceptibility patterns to these antibiotics is critical.

Syphilis

In 2000 and 2001, the national rate of reported primary and secondary (P&S) syphilis cases was 2.1 cases per 100,000 population, the lowest rate since reporting began in 1941. However, the P&S syphilis rate has increased almost every year since 2001. In 2015, a total of 23,872 P&S syphilis cases were reported, and the national P&S syphilis rate increased to 7.5 cases per 100,000 population, a 19.0% increase from 2014.

During 2014–2015, the P&S syphilis rate increased both among men (18.1%) and women (27.3%) and rates increased among both sexes in every region of the country. Nationally, P&S syphilis rates increased in every 5-year age group among those aged 15–64 years and in every racial and ethnic group except for American Indians/Alaska Natives during 2014–2015.

During 2000–2015, the rise in the P&S syphilis rate was primarily attributable to increased cases among men and, specifically, among MSM. In 2015, men accounted for over 90% of all cases of P&S syphilis. Of those male cases for whom sex of sex partner was known, 81.7% were MSM. Reported cases of P&S syphilis continued to be characterized by a high rate of HIV co-infection, particularly among MSM. In the 31 states able to classify at least 70.0% of reported P&S syphilis cases as MSM, men who have sex with women (MSW), or women and at least 70.0% of reported cases as HIV-positive or HIV negative, 49.8% of MSM with P&S syphilis were also reported as HIV-positive compared with 10.0% of cases among MSW and 3.9% of cases among women.

The 2013 rate of congenital syphilis (9.2 cases per 100,000 live births) marked the first increase in congenital syphilis since 2008. During 2013–2014, the rate increased 27.2% and during 2014–2015 increased 6.0%, primarily attributable to an increase in the West. There were 487 cases of congenital syphilis reported in 2015 compared with 461 in 2014. Rates of congenital syphilis were highest among Blacks (35.2 cases per 100,000 live births), followed by Hispanics (15.5 cases per 100,000 live births) and American Indians/Alaska Natives (10.3 cases per 100,000 live births).

Other Sexually Transmitted Diseases

Chancroid

Chancroid is caused by infection with the bacterium Haemophilus ducreyi. Clinical manifestations include genital ulcers and inguinal lymphadenopathy or buboes.1 Reported cases of chancroid declined steadily between 1987 and 2001. Since then, the number of reported cases has fluctuated somewhat, while still appearing to decline

overall. In 2015, a total of 11 cases of chancroid were reported in the United States. Seven states reported one or more cases of chancroid in 2015.

Although the overall decline in reported chancroid cases most likely reflects a decline in the incidence of this disease, these data should be interpreted with caution because Haemophilus ducreyi is difficult to culture; as a result, this condition may be substantially underdiagnosed.

Human Papillomavirus

Human Papillomavirus (HPV) is the most common sexually transmitted infection in the United States. Over 40 distinct types can infect the genital tract; about 90% of infections are asymptomatic and resolve spontaneously within two years. However, persistent infection with some HPV types can cause cancer and genital warts. HPV types 16 and 18 account for approximately 70% of cervical cancers worldwide, while HPV types 6 and 11 are responsible for approximately 90% of genital warts.

A quadrivalent HPV vaccine that protects against infection by HPV types 6, 11, 16 and 18 has been licensed in the United States for use in females since June 2006, and in males since October 2009. In October 2009, a bivalent HPV vaccine that protects against infection by HPV types 16 and 18 was licensed for use in females. In December 2014, a 9-valent vaccine that protects against infection by the HPV types included in the quadrivalent vaccine, as well as five additional cancer causing types (HPV types 31, 33, 45, 52, and 58), was licensed for use in the United States. For females, all three vaccines have been recommended for routine use in those aged 11 or 12 years, and through age 26 in those who have not been vaccinated previously. For males, the quadrivalent and 9-valent vaccines have been recommended for routine use in those aged 11 or 12 years, and through age 21 in those who have not been vaccinated previously. Vaccination of gay, bisexual, and other men who have sex with men (collectively referred to as MSM) through age 26 is also recommended; other males aged 22–26 years may be vaccinated. Vaccination is also recommended through age 26 years for immunocompromised persons (including those infected with HIV) who have not been vaccinated previously

HPV vaccine uptake in the United States remains lower than the Healthy People 2020 goal of 80% coverage. In 2015, a national survey found that 63% of girls aged 13–17 years had received at least 1 dose of the HPV vaccine, and 42% had received all 3 doses in the series. HPV vaccine uptake is lower among boys; 50% aged 13–17 years received at least 1 dose, but only 28% received all 3 doses.

HPV infection is not a nationally reportable condition. Cervicovaginal prevalence of quadrivalent HPV vaccine types 6, 11, 16, and/or 18 was estimated using data for females aged 14-34 years from the National Health and Nutrition Examination Survey. Prevalence decreased significantly from the pre-vaccine era (2003–2006) to the early post-vaccine

era (2009–2012) in specimens from females aged 14–19 and 20–24 years, the age groups most likely to benefit from HPV vaccination. Among those aged 25–34 years, vaccine-type HPV prevalence did not differ significantly between the two time periods, and no differences were observed in the prevalence of non- quadrivalent HPV vaccine types by time period for any age group. In a population-based study of female residents of four geographic catchment areas (Alameda County, California; New Haven County, Connecticut; Monroe County, New York; Washington and Multnomah Counties, Oregon), incidence of high-grade cervical intraepithelial neoplasia in 18–20 year olds, based on laboratory reports and medical record review, decreased during 2008–2012. However, cervical cancer screening, which was estimated using age-group-specific screening rates derived from a variety of data sources in three catchment areas, also declined in this age group during the same period. The larger observed decrease in cervical neoplasia, relative to the estimated decline in screening, suggests that HPV vaccination may be impacting the true burden of cervical neoplasia in young women.

Data from the National Disease and Therapeutic Index (NDTI) suggest that cases of genital warts, as measured by initial visits to physicians' offices, may have increased during the late 1990s through 2014. Although the number of visits appears to have decreased in 2012 and 2013, visits in 2014 (465,000) slightly exceeded those in 2011; more years of data are needed to better elucidate recent trends in initial genital wart visits from these data. The 2015 NDTI data were not obtained in time to include them in this report. NHANES data for 1999–2004 indicated that 5.6% of sexually active adults aged 18–59 years self-reported a history of a genital wart diagnosis.

Prevalence of genital warts during 2003–2010 was examined using health-care claims records from a large United States cohort of individuals with employer provided private health insurance. Prevalence among females aged 15–19 years was stable during 2003–2007, but then significantly declined during 2007–2010. Among females aged 20–24 years, genital wart prevalence significantly increased during 2003–2007, then was stable during 2007–2010; although prevalence in this age group appeared to decrease during 2009–2010, more years of data are needed to interpret this observation. Prevalence in females aged 25–39 years significantly increased throughout the time period, but among those aged 25–29 years a potential inflection in trend was observed in 2009, for which additional years of data are needed to appropriately assess. Genital wart prevalence significantly increased in males of all age groups during 2003–2010, although for those aged 20–24 years a potential inflection in trend again was observed in 2009.

Enhanced behavioral and demographic information on patients who presented for care in 2015 in 7 jurisdictions of the STD Surveillance Network (SSuN) was used. Only jurisdictions that contributed data for all of 2015 were included in the figure. Genital warts were identified by provider diagnosis or by documentation from the physical examination. MSM and men who have sex with women only (MSW) were defined by self-report or by sex of reported sex partners. The prevalence of genital warts in 2015 is

presented separately for MSM, MSW, and women by SSuN jurisdiction in the figure. Among women, the median prevalence of genital warts was 0.9% (range 0.7 to 2.2) across all sites, compared to 3.3% (range 1.9 to 4.6) for MSM and 4.3% (range 1.7 to 8.1) for MSW.

Herpes Simplex Virus

Herpes simplex virus (HSV) is among the most prevalent of sexually transmitted infections. Although most infections are subclinical, clinical manifestations are characterized by recurrent, painful genital and/or anal lesions. Most genital HSV infections in the United States are caused by HSV type 2 (HSV-2), while HSV type 1 (HSV-1) infections are typically orolabial and acquired during childhood.

HSV infection is not a nationally reportable condition. Data on initial visits to physicians' offices for genital HSV infection are available from the NDTI; however the 2015 NDTI data were not obtained in time to include them in this report. Visits have generally increased over time; the maximum number of initial visits (371,000) occurred in 2006, while 299,000 visits took place in 2014.

Most persons with genital HSV infection have not received a diagnosis. The overall percentage of HSV-2 seropositive NHANES participants aged 14–49 years who reported never being told by a doctor or health care professional that they had genital herpes did not change significantly between 1988–1994 and 2007–2010, and remained high (90.7% and 87.4%, respectively). However, an overall increase in the number of physician visits for genital HSV infection over time, as suggested by the NDTI data, may indicate increased recognition of infection.

NHANES data on the gender- and race/ethnicity-specific seroprevalence of HSV-2 among those aged 14–49 years were compared across survey years 1988–1994, 1999–2002, 2003–2006, and 2007–2010. Overall, HSV-2 seroprevalence decreased between 1988–1994 and 2007–2010, from 21.2% to 15.5%.25 Among non-Hispanic White females, HSV-2 seroprevalence significantly decreased from 19.5% in 1988–1994 to 15.3% in 2007–2010; HSV-2 seroprevalence remained stable among non-Hispanic Black females, from 52.5% in 1988–1994 to 49.9% in 2007–2010. Similar race/ethnicity differences were observed for males. These data, along with data from NHANES survey years 1976–1980,26 indicate that non-Hispanic Blacks had higher overall seroprevalence than non-Hispanic Whites in each survey period.

NHANES data also show that among adolescents aged 14–19 years HSV-1 seroprevalence has significantly decreased by almost 23%, from 39.0% in 1999–2004 to 30.1% in 2005–2010, indicating declining orolabial infection in this age group. HSV-2 seroprevalence in this age group was much lower, less than 2% in both time periods. Other studies have found that genital HSV-1 infections are increasing among young

adults. This has been attributed, in part, to the decline in orolabial HSV-1 infections, because those who lack HSV-1 antibodies at sexual debut are more susceptible to genital HSV-1 infection; increasingly common oral sex behavior among adolescents and young adults also has been suggested as a contributing factor. The absence of HSV-1 antibodies also increases the likelihood of developing symptomatic disease from newly-acquired (i.e., primary) genital HSV-2 infection. Young women may therefore be increasingly likely to first acquire HSV-1 infection genitally, or acquire a primary genital HSV-2 infection, during their child-bearing years, and first-episode primary HSV infection during pregnancy increases the risk of neonatal HSV transmission.

Trichomonas vaginalis

Trichomonas vaginalis is a common sexually transmitted protozoal infection associated with adverse health outcomes such as preterm birth and symptomatic vaginitis. It is not a nationally reportable condition, and trend data are limited to estimates of initial physician office visits from the NDTI. Visits appear to be fairly stable since the 1990's; the number of initial visits for Trichomonas vaginalis infection in 2014 was 155,000. The 2015 NDTI data were not obtained in time to include them in this report. NHANES data from 2001–2004 indicated an overall Trichomonas vaginalis infection prevalence of 3.1%, with the highest prevalence of 13.3% observed among non-Hispanic Blacks.

6. Sexually Transmitted Diseases and Substance Abuse

Infectious diseases are common among drug users. Throughout the past decade, drug use and the frequency of infectious diseases among this population have escalated. The acquired immunodeficiency syndrome (AIDS) epidemic and the resurgence of tuberculosis have magnified the need for the prompt recognition and treatment of these and other infectious diseases.

Individuals who are dependent on drugs are represented disproportionately in the population with human immunodeficiency virus (HIV) and AIDS; tuberculosis, including multi-drug resistant tuberculosis; syphilis; and hepatitis B and C. Patients who enter drug treatment programs are at risk of having one or more of these diseases. This section focuses on these particular infectious diseases because they occur frequently among treatment populations and have significant medical and socioeconomic consequences for infected persons and others if not recognized and treated. In addition, the trained staff of a drug treatment program can screen for and medically manage these diseases.

Included in this section are discussions of other infectious diseases common to treatment populations, including Chlamydia, gonorrhea, herpes simplex, chancroid, and hepatitis A and D. Information is provided about transmission, symptoms, and indications for screening. The section is intended for use in a broad variety of clinical settings - inpatient,

residential rehabilitation, and outpatient facilities, including methadone and drug-free modalities.

This section focuses on infectious diseases that are prevalent in and especially harmful to patients in drug treatment, and that can be medically managed by treatment staff or through referrals for primary care. The treatment recommendations in this TIP are largely, but not exclusively, based on guidelines from the Centers for Disease Control and Prevention (CDC). Trained medical staff are needed to diagnose and treat these diseases. Treatment providers who do not offer such medical resources are encouraged to refer their patients to community-based health care professionals. Follow up care of those patients referred initially to other health care professionals should be provided.

Infectious Diseases Linked With Drug Use

Using drugs is an important risk factor for disease. Drug use is associated with such risk behaviors as the sharing of contaminated needles and other drug paraphernalia, and unsafe sexual practices that contribute to transmission of certain infectious diseases. For example, research indicates

- There has been a steady increase in the incidence of hepatitis B, despite the availability of a vaccine since 1982. Most of the increase is attributed to injection drug use.The prevalence of hepatitis C in injection drug users is also high.
- Injection drug use is closely linked to the spread of HIV. Patients infected with HIV, because of their impaired immune systems, are at increased risk of developing numerous infections, the majority of which represent reactivation of prior infection. However, HIV-infected persons are far more likely to develop active TB after exposure to TB than HIV-negative persons.
- An increase in cases of tuberculosis appears to be related to HIV infection and is seen primarily in the 25- to 44-age group. Multi-drug resistant tuberculosis has been detected in a growing number of States and is seen especially in large cities with high rates of drug use, homelessness, and HIV infection.
- The association between syphilis and drug use has been substantiated by retrospective studies and is particularly strong among cocaine users).

Sexually transmitted diseases other than AIDS have the greatest impact on younger people under the age of 25, especially teenagers, and women. The Guttmacher Institute reports that one in five persons in the United States (56 million people) have a viral sexually transmitted disease (such as genital herpes, human papillomavirus). Women account for about half of all sexually transmitted infections that occur each year, but they suffer more frequent and severe long-term consequences than men.

Sexually transmitted diseases (STDs) affect women disproportionately, because women tend to show fewer symptoms and as a consequence they go untreated for longer periods of time. A bacterial STD can usually be cured if treated early. However, these diseases are often undetected. Many of the most serious problems from STDs come from undetected Chlamydia and gonorrhea; many of these cases lead to bacterial infection of the uterus, fallopian tubes, or lining of the pelvic organs, sometimes causing infertility. The transmission of an STD to an unborn child or during childbirth can have devastating effects.

The first part of this section addresses issues that affect and support the entire infectious disease screening and treatment process. The remaining chapters provide protocols for specific infectious diseases that are common in treatment populations. The protocols include information on prevalence and disease symptoms, screening procedures, and treatment regimens. Some sections include a list of sources.

- "Issues for Counselors" presents a discussion of counseling issues relevant to infectious disease screening for treatment populations. The chapter reviews the critical role of the counselor in providing pre- and post-test counseling and risk reduction interventions.
- "Legal and Ethical Issues" provides a discussion of legal and ethical issues such as confidentiality, record keeping, reporting, and the duty to warn.
- "Issues for Treatment Program Administrators" offers guidance for treatment program administrators concerning staff training and community development issues and environmental safety.
- "The Initial Patient Contact" discusses establishing a therapeutic relationship, assessing risk, and issues pertaining to taking a history.
- Protocols for the screening and treatment of tuberculosis and multi-drug resistant tuberculosis are presented.
- HIV/AIDS screening and referrals for continuing medical management are discussed.
- Hepatitis B, C, A, and D are discussed.
- The sexually transmitted diseases syphilis, gonorrhea, Chlamydia, herpes simplex, and chancroid are discussed.

A variety of other sexually transmitted diseases, prevalent in treatment populations including many that are common to women, are not addressed in this TIP. For more information, the reader is referred to the Centers for Disease Control, *Sexually Transmitted Diseases: Clinical Practice Guidelines*.

Substance use is common among people with HIV infection. Unfortunately, substance use can trigger and often complicate mental health problems. For many, mental health problems predate substance use activity. Substance use can increase levels of distress, interfere with treatment adherence, and lead to impairment in thinking and memory.

Diagnosis and treatment by a psychiatrist or other qualified physician is critical as symptoms can mimic psychiatric disorders and other mental health problems.

The Reference Group to the United Nations on HIV and Injecting Drug Use recently estimated that worldwide about three million injecting drug users might be infected with HIV. About 10% of HIV cases worldwide are attributable to injecting drug use (mostly with opioids, although the use of other substances, including stimulants, has been associated with unsafe injecting practices and sexual risk behaviors). Injecting drug users principally acquire HIV through sharing injection equipment, whereas non-injecting use of drugs, such as cocaine or amphetamine-type stimulants, is associated with transmission of HIV through high-risk sexual behaviors. Some drug users practice unsafe sex with multiple partners in exchange for drugs or money, providing a bridge for HIV to spread from populations with high HIV prevalence to the general population. Interventions that reduce the spread of HIV in injecting drug users include, among others, HIV testing and counseling, needle and syringe programs, opioid substitution therapy and other drug dependence treatment. Drug dependence is associated with particularly high-risk patterns of drug use and related risks of HIV transmission for the following reasons: drug users experience difficulties in controlling drug-taking behaviors and frequent episodes of intoxication and withdrawal (often accompanied by a strong desire to take drugs); furthermore, they persist with drug use despite clear evidence of harmful consequences or high risk of such consequences. Effective and ethical prevention and treatment at the early stages of drug use and dependence can reduce the drug-related risks of HIV transmission. A recent WHO collaborative study on drug dependence treatment and HIV/AIDS found that substitution therapy of opioid dependence significantly reduced risks of HIV transmission in opioid-dependent individuals in low- and middle-income countries, consistent with the findings in high-income countries.

The incidence of AIDS-defining illness in patients receiving highly active antiretroviral therapy has been reported to be especially high in injecting drug users. In a study conducted in HIV-positive women in the United States of America, chronic depressive symptoms were associated with increased AIDS-related mortality and rapid disease progression independent of treatment and co-morbid substance use.

Mental and substance-use disorders affect help-seeking behavior or uptake of diagnostic and treatment services for HIV/AIDS. Mental illnesses have been associated with lower likelihood of receiving antiretroviral medication. In a study of women who were medically eligible to receive highly active antiretroviral therapy, its non-receipt was associated with substance use and with a history of childhood sexual abuse. Among people with HIV/AIDS, those with drug-use disorders typically experience the greatest barriers in accessing treatment because of negative societal attitudes and reluctance to seek any kind of treatment. Injection drug use has consistently been shown to be associated with low uptake of highly active antiretroviral therapy.

Substance-use disorders affect both the progression of HIV disease and the response to treatment. In untreated co-morbid drug dependence, rates of adherence to highly active antiretroviral therapy are low, and rates of co-infection with hepatitis B and C viruses are high. Several randomized controlled trials have indicated that, with integrated treatment of both drug dependence and HIV/AIDS, rates of adherence approach the rate for the non-drug-dependent population. Recent research suggests that harmful patterns of alcohol use are associated with higher mortality in patients with HIV/AIDS. Several mechanisms appear to be responsible, including a direct effect of alcohol on HIV disease progression, probably mediated through the immune system, and the undermining of adherence to treatment. Even relatively low levels of alcohol consumption, such as one standard drink per day, have been associated with a reduction in adherence to treatment regimens.

The use of alcohol is known to be associated with an increased risk of unsafe sexual behavior. Given the widespread harmful use of alcohol in many countries with a high incidence and prevalence of HIV, levels and patterns of alcohol consumption may substantially influence HIV spread in populations. Several studies, including those conducted in African countries with high prevalence of HIV, have shown a positive association between HIV and alcohol consumption, with a prevalence of HIV infection among people with alcohol-use disorders higher than in the general population.

The National Institute on Alcohol Abuse and Alcoholism reports that the changing patterns of HIV transmission in the United States; the role of alcohol in the transmission of HIV within, and potentially beyond, high-risk populations; the potential influence of alcohol abuse on the progression and treatment of HIV-related illness; and the benefits of making alcoholism treatment an integral part of HIV prevention programs (*Sources: Health Resources and Services Administration; National Institute on Drug Abuse; Alcoholism: Clinical and Experimental Research).*

With 31 percent of all HIV cases among men, and 57 percent among women, attributed to injection drug use, it is obvious the shooting illegal drugs increases the risk of contracting the AIDS virus, but drinking alcohol can also contribute to the spread and progression of the disease. According to the *Health Resources and Services Administration*, non-injection drug use can also lead to contracting the HIV virus, because drug users may trade sex for drugs or money or engage in behaviors under the influence that put them at risk. Binge drinking is also risky. The same is true for people who drink to excess. People who are intoxicated loose their inhibitions and have their judgment impaired and can easily find themselves involved in behavior that would put them at risk for contracting HIV *(Kranzler HR, Rounsavill BJ, eds. Dual Diagnosis and Treatment: Substance Abuse and Comorbid Medical and Psychiatric Disorders. New York: Marcel Dekker).*

National Institute on Drug Abuse Research reports that most young people are not concerned about becoming infected with HIV, but they face a very real danger when they engage in risky behaviors, such as unprotected sex with multiple partners.

***Alcohol Increases HIV Susceptibility**:*

Risky behavior is not the only way drinking alcohol can increase the risk for becoming infected with HIV. A study by Gregory J. Bagby at the Louisiana State University Health Sciences Center found that alcohol consumption may increase host susceptibility to HIV infection. Bagby's student, conducted with rhesus monkeys infected with simian immunodeficiency virus (SIV), found that in the early stages of infection, monkeys who were given alcohol to drink had 64 times the amount of virus in their blood than the control monkeys. Bagby concluded that the alcohol increased infectivity of cells or increased the number of susceptible cells (*Sources: Health Resources and Services Administration; National Institute on Drug Abuse; Alcoholism: Clinical and Experimental Research).*

Virus Progresses Faster:

For people who have already been infected with HIV, drinking alcohol can also may accelerate their HIV disease progression, according to a study by Jeffrey H. Samet at Boston University. The reason for this is both HIV and alcohol suppress the body's immune system. Samet's research found that HIV patients who were receiving highly active antiretroviral therapy (HAART), and were currently drinking, have greater HIV progression than those who do not drink. They found that HIV patients who drank moderately or at at-risk levels had higher HIV RNA levels and lower CD4 cell counts, compared with those who did not drink (*Sources: Health Resources and Services Administration; National Institute on Drug Abuse; Alcoholism: Clinical and Experimental Research).*

Drinking Impacts Medication Compliance:

Patients with HIV who drink, especially those who drinking heavily, or less likely to adhere to their prescribed medication schedule. Both the Samet study and research at the Center for Research on Health Care at the University of Pittsburgh School of Medicine found that nearly half of their patients who drank heavily reported taking medication off schedule. The researchers reported that many of the heavy drinkers simply would forget to take their medications. This is potentially a big problem for healthcare providers due to the fact that alcohol dependence in those with HIV runs at rates twice as high as the general population (*Sources: Health Resources and Services Administration; National Institute on Drug Abuse; Alcoholism: Clinical and Experimental Research).*

7. Mental Health and Sexually Transmitted Diseases

Direct or indirect effects of the HIV virus can affect brain functioning. Some medications used to treat HIV infection can also cause similar complications. In people with HIV infection or AIDS, these complications can have significant impact on daily functioning and greatly diminish quality of life. Among the most common disorders are *HIV-associated minor cognitive motor disorder, HIV-associated dementia, delirium, and psychosis*. Signs of trouble may include forgetfulness, confusion, attention deficits, slurred or changed speech, sudden changes in mood or behavior, difficulty walking, muscle weakness, slowed thinking and difficulty finding words. People with HIV who have any of these problems should discuss their concerns with their physician immediately. New anti-HIV therapies in combination with psychiatric medication can reverse delirium and dementia and markedly improve cognition; however, special care must be taken to ensure that the drugs do not interact with HIV medications. Psychotherapy can also help patients understand their condition and adapt to their diminished level of functioning *(Gray F, Adle-Biassette H, Chrétien F, Lorin de la Grandmaison G, Force G, Keohane C).*

The prevalence of mental illnesses in HIV-infected individuals is substantially higher than in the general population. Furthermore, HIV tends to be concentrated in highly vulnerable, marginalized and stigmatized populations; in particular, sex workers, men who have sex with men, drug users and prisoners have higher levels of mental health disorders than the general population. Increased psychological distress among people with HIV infection is common. Studies in both low- and high income countries have reported higher rates of depression in HIV-positive people compared with HIV negative control groups. The level of distress often seems to be related to the severity of symptoms of HIV infection. Coping styles and learned resourcefulness may shape the experience of depressive symptoms and the ability to care for oneself. Family relationships and the support of a partner can also influence mental health consequences (*World Health Organization, Executive Board EB124/6, 124th Session).*

When faced with a diagnosis of HIV or AIDS, there are many emotional issues that a person may experience. Some of the common concerns or issues include anger, loss (health, job, relationships), stigma and fear of disclosure. There may also be a general fear, as well as anxiety, isolation, and depression. People with HIV must also cope with the psychological effects of fatigue, medication side effects, insomnia, irritability and difficulty with concentration. Substance abuse also frequently either co-occurs or develops after a diagnosis of HIV or AIDS *(Blechner MJ, Hope and mortality: psychodynamic approaches to AIDS and HIV. Hillsdale, NJ: Analytic Press.)*

HIV/AIDS imposes a significant psychological burden. People with HIV often suffer from depression and anxiety as they adjust to the impact of the diagnosis of being infected and face the difficulties of living with a chronic life-threatening illness, for

instance shortened life expectancy, complicated therapeutic regimens, stigmatization, and loss of social support, family or friends. HIV infection can be associated with high risk of suicide or attempted suicide. The psychological predictors of suicidal ideation in HIV-infected individuals include concurrent substance-use disorders, past history of depression and presence of hopelessness (*World Health Organization, Executive Board EB124/6, 124th Session).*

Studies have demonstrated a high prevalence of HIV infection in people with serious chronic mental illnesses. Prevalence rates in mentally ill inpatients and outpatients have been reported to be between 5% and 23%, compared with a range of 0.3% to 0.4% in the general population in the United States of America over comparable time periods. Some studies have reported behavioral risk factors for transmission of HIV in between 30% and 60% of people with severe mental illnesses. These risks include high rates of sexual contact with multiple partners, injecting drug use, sexual contact with injecting drug users, sexual abuse (in which women are particularly vulnerable to HIV infection), unprotected sex between men and low use of condoms. Besides these behavioral risks, mental disorders may also interfere with the ability to acquire and/or use information about HIV/AIDS and thus to practise safer behaviors or increase the likelihood of situations occurring in which risk behaviors are more common. Inadequate provision of integrated services for people with mental-health and substance-use disorders, HIV/AIDS and related physical, psychological and social problems creates an additional serious barrier to treatment and care for HIV/AIDS.

There is consistently strong evidence from high-income countries that adherence to highly active antiretroviral therapy is lowered by depression, cognitive impairment, alcohol use and substance-use disorders. Furthermore, such therapy, especially with efivarenz, can be associated with a range of sideeffects on the central nervous system, including depression, nervousness, euphoria, hallucination and psychosis. Mental disorders, including substance use disorders, are risk factors for contracting HIV, and the presence of HIV/AIDS increases the risk of development of mental disorders. The resulting comorbidity complicates help-seeking, diagnosis, quality of care provided, treatment and its outcomes, and adherence. The diagnosis of mental health problems in HIV-infected individuals faces several barriers. Patients often do not reveal their psychological state to health-care professionals for fear of being stigmatized further. Also, health-care professionals are often not skilled in detecting psychological symptoms and, even when they do, they often fail to take the necessary action for further assessment, management and referral.

Counseling Clients with STDs Such as HIV and Substance Abuse Disorders

The pandemics of substance abuse and HIV/AIDS are clearly moving along similar paths, and each continues to present unique, yet interrelated, challenges. First, both disorders are considered to be chronic--that is, lifelong diseases. Second, substance abuse

is a primary risk behavior for HIV infection. Third, a diagnosis of HIV infection or related conditions can be a stressor for an individual already in recovery from a substance abuse disorder. However, the diagnosis of HIV infection may motivate a client to enter substance abuse treatment. Injection drug users who test positive for HIV are more likely to enter treatment than those who test negative. Also, studies have noted a reduction in risk-taking behaviors among injection drug users who test positive for HIV. The diagnoses of a substance abuse disorder and HIV/AIDS require extensive physical and mental health care and counseling in conjunction with extensive social services. To deal with the myriad issues surrounding substance abusers who are HIV positive, substance abuse treatment professionals must continually update their skills and knowledge as well as reexamine their own attitudes and biases.

Staff Training, Attitudes, And Issues

Before conducting any screening, assessment, or treatment planning, counselors should reassess their personal attitudes and experiences in working with HIV-infected substance abusers. This section discusses several ways in which counselors can accomplish this, including formal training within counselors' programs, examining personal attitudes (e.g., countertransference and homophobia), examining fears of infection, and avoiding burnout. It is important to reassess comfort levels with each client because each client will vary in demographic and cultural background. For instance, a service provider may feel comfortable working with a young Asian American male with a history of alcohol use, yet the same provider may not be at all comfortable with a pregnant Hispanic woman who is an active injection drug user and wishes to have her baby.

Training

Clinicians must have the proper training to screen, assess, and counsel clients. Achieving staff competency is an ongoing process. The complexities related to people with HIV/AIDS and substance abuse disorders are constantly changing and do not allow staff members to defer learning or training or even to maintain a "status quo" attitude about their competency.
Examples of methods to help staff grow in the areas of assessment, screening, and treatment planning include the following (see also the section "Cultural Competency Issues" later in this chapter):

- *Model skills and competencies*. Less experienced staff can observe supervisors or more tenured staff who demonstrate desired qualities.
- *Peer training and feedback*. Peer teams can provide feedback through direct observation of staff members' interactions with clients, as well as review of staff members' client charts.

- *Case presentations*. Weekly or monthly group case presentations conducted by a different staff member each time can be effective for building skills and monitoring quality. Case simulation, in which each staff member has an opportunity to ask the "client" a question, is a highly useful training tool. At the end of the presentation, everyone attending can provide feedback about the activity.
- *Experiential skills-building exercises*. Many activities can be used to sensitize staff to the client's experiences. Activities can include encouraging staff members to go to a confidential and anonymous HIV/AIDS test site, or anonymously sit in the waiting room of the local food stamp office, HIV/AIDS clinic, or county jail. Staff must use different avenues to maintain a keen sensitivity to and awareness of the client's issues.
- *Assessment instruments*. Use specific assessment tools, such as substance abuse and sexual history questionnaires (e.g., the Addiction Severity Index [ASI]).
- *Formal conferences, training, consultations with clinicians*. Often agency budgets are tight, and the first expense to be cut is staff development. This is a major problem for many programs. Programs must establish that improvement and excellence are serious goals and that attending treatment-oriented conferences is a part of building staff competency and moving toward these goals.

Attitudes

It is important that counselors be aware of any of their own attitudes that might interfere with helping a client. By learning to put aside personal judgments and focus on client needs, staff members can build trust and rapport with the client. When a counselor can deal with a client in a sensitive, empathic manner, there is a much greater chance that both will have a positive and successful encounter.

Countertransference is a set of thoughts, feelings, and beliefs experienced by a service provider that occurs in response to the client. Although sometimes these beliefs and feelings are conscious, generally they are not. It is thus unrealistic to expect counselors, usually untrained in addressing unconscious mental processing, to be aware of countertransference. Regular clinical supervision, which should be integrated into the staffing of the program, can help raise their awareness. If such resources exist, counselors may, with caution, address this issue.

In order to deal with countertransference issues, counselors must be willing to examine their skills and attitudes. Working with clients who have HIV/AIDS and substance abuse disorders brings up issues for treatment staff that can be both physically and emotionally demanding. Counselors see a broad range of diverse clients from all walks of life. To work in both these fields, providers must learn to be comfortable in discussing topics they may never have talked about openly--sex, drug use, death, grief, and so on. To effect positive change, counselors also must be willing to seek additional specialized training and support.

Examining attitudes and skills

Countertransference can manifest itself in many different ways. The key to seeing countertransference issues is awareness and consciousness-raising. The commitment to "do no harm" to clients and their families, along with a desire to provide quality services, should be the driving forces for willingly examining these issues.
Following are some common countertransference issues for providers working with substance abusers who are HIV positive *(adapted from National Association of Social Workers, NASW)*:

- Fear of contagion
- Fear of the unknown
- Fear of death, dying, grief, and loss
- Stigmatization (e.g., of people with mental health problems, "addicts," people who are HIV positive, homosexuals)
- Powerlessness, helplessness, and loss of control
- Shame and guilt
- Homophobia
- Anger, rage, and hostility
- Frustration
- Overidentification
- Denial
- Differences in culture, race, class, and lifestyle
- Fantasies of professional omnipotence
- Burnout
- Measures of success and personal reward

Homophobia

To be aware of homophobic responses among treatment professionals and of their own countertransference issues, it is important that counselors understand how the client is handling his homosexuality. The counselor should understand the possible link between substance abuse and gay or lesbian identity formation. Substance abuse can be an easy relief, can provide acceptance, and, more important, can mirror the "comforting" dissociation developed in childhood. The "symptom-relieving" aspects of substance

abuse help fight the effects of homophobia; substance abuse can allow "forbidden" behavior, allow social comfort in bars or other unfamiliar social settings and provide comfort just from the dissociative state itself. For example, some men have their first homosexual sexual experience while drinking or being drunk. This connection is a very powerful behavioral link--the pleasure and release of substance abuse with the pleasure and release of sex--and is very difficult to change or "unlink" later in life.

In regard to the issue of homophobia, it is also critical to understand how stereotypes affect the treatment options offered. The professional should take an inventory of these stereotypes to assess her homophobia potential and should be aware of the roles countertransference can play. The short assessment tool provided below can be used to examine where providers and clients alike might rank on a continuum of homophobic reactions. This tool is also useful in group supervision sessions or discussions with both gay/lesbian and heterosexual colleagues.
It is important that counselors have a working knowledge of some of the terminology and definitions pertaining to homophobia. Following is a brief list of terms and definitions.

- *Overt homophobia* includes violence, verbal abuse, and name-calling.
- *Institutional homophobia* describes the way in which governments, businesses, schools, churches, and other institutions and organizations treat people differently and less favorably based on their sexual orientation.
- *Cultural homophobia* includes social standards and norms requiring heterosexuality.
- *Internalized homophobia* is acceptance and integration by lesbians and gays of the negative attitudes expressed by society toward them.
- *Heterosexism* is the system of advantages bestowed on heterosexuals. It is the institutional form of homophobia that assumes all people are or should be heterosexual and therefore excludes the needs, concerns, and life experiences of lesbians, gays, and bisexuals.
- *Coming out* may possibly be the most important part of gay and lesbian development. This is the process, often lifelong, in which a person acknowledges, accepts, and in many cases appreciates his or her own lesbian, gay, bisexual, or transgender identity. This often involves sharing this information with others. Family members of gay and lesbian individuals go through a similar process.
- *Oppression* is the systematic subjugation of a particular social group by another group with access to social and political power, by withholding access to that power.

- *Lesbian/gay baiting* involves actions or words that imply or state that the presence of a gay man or lesbian hurts or discredits a social system. The purpose is to hurt, demean, intimidate, or control, and to stop social change or acceptance of lesbians and gays within the social system.

These definitions can help the counselor become aware of the added layer of discrimination felt by gay men and lesbians in treatment for HIV/AIDS and a substance abuse disorder. Following is a list of some "Do's" to keep in mind when working with homosexual clients *(adapted from Storms)*.

- Identify the lesbian/gay client's strengths and accept them as you find them.
- Listen empathically and refrain from making judgments about the client's lifestyle.
- Remain aware of the client's sexual orientation and the possible effects of this orientation on the client's experience and world-view.
- Explore the client's sexual practices with an eye toward internalized homophobia.
- Be aware of your own preference and mindful of possible homophobia or confusion in your own sexual identity.
- Be knowledgeable about compulsive sexual behavior and sexual practices in the lesbian/gay community.
- Ask your lesbian/gay clients what terms they prefer when discussing their sexual orientation and those of others.
- Encourage self-empowerment, consciousness-raising, and participation in the lesbian and gay community.
- Encourage your program to hire openly lesbian and gay counselors/therapists.
- Educate others about internalized homophobia and heterosexism. Be gay- and lesbian-affirming rather than just gay- and lesbian-tolerant.
- Stay abreast of current information on resources and display this information in your office. Attend seminars and professional workshops about working with lesbian and gay clients.

Fear of infection

Fear of infection is one of the most challenging issues for counselors. It is essential that providers examine this issue without blaming or judging themselves and others. Most professionals who work with substance abusers and HIV-positive individuals have thought about becoming infected with HIV, hepatitis, or tuberculosis (TB) through their

jobs *(Sherman and Ouellette).* Some fear that scientists are not aware of modes of infection or transmission that might put service providers and their families at greater risk of infection *(Montgomery and Lewis).* The key to dealing with this fear is to discuss it and vent the feelings with someone who is safe, trusted, and informed, *and* to practice universal precautions at all times.

Beyond this, it is essential for providers to have regular and frequent inservice training with updates on the latest research and data about transmission and treatment of HIV/AIDS, hepatitis, and TB.

Special considerations for counselors who treat HIV-infected clients

The challenges and stresses related to working with people with HIV/AIDS are in some ways unique. The fact that providers often deal with multiple and serial losses and see clients suffering on a daily basis clearly affects the providers' psychological health. In recent years, therapists have begun to examine and assess these service providers for symptoms of post-traumatic stress disorder (PTSD).

Burnout often is referred to as "bereavement overload." One definition characterizes burnout as lowered energy, enthusiasm, and idealism for doing one's job, that is, as a loss of concern for the people served and for the work. Unlike fatigue, burnout does not resolve after a given amount of rest and recreation.

Burnout prevention and stress management techniques should be used both in the work setting and in counselors' personal lives. Working with HIV-infected substance abusers requires agencies and individuals to be more creative and flexible in finding new and different ways to support and nurture counselors to prevent burnout. Agencies that have taken on this challenge with integrity and commitment have seen highly effective staff function at optimal levels for many years.

Suggestions for ways in which agencies can take care of counselors at work include

- Assigning clearly specific duties
- Having clear boundaries on professional obligations
- Enlisting volunteer help from community organizations
- Allowing for "time out" activities
- Varying tasks and responsibilities
- Building in "mental health days"
- Providing for continuing education
- Holding staff retreats (with enjoyable activities planned)
- Holding discussion, process, and support groups
- Convening regular staff/team supervision meetings

In addition, it is important that agencies allocate time to discuss the deaths and losses faced by staff. This may mean supporting special memorial events at which those who have been lost to HIV/AIDS disease can be remembered. Agencies also can support staff through contracts with employee assistance program therapists and by providing an onsite therapeutic support group for staff members to attend as they wish.

Screening

Client-Specific Needs

A positive screen for HIV infection typically leads to a referral for formal assessment, usually to an HIV/AIDS case management service. Frequently, substance abuse treatment programs provide referrals to HIV/AIDS care services. Providers will want to identify substance abuse treatment programs and agencies with these networks. At a minimum, services should include the following client needs in priority order:

- Substance abuse treatment
- Medical care
- Housing
- Mental health care
- Nutritional care
- Dental care
- Ancillary services
- Support systems

Mental health care

A diagnosis of mental illness may reflect the client's affective and mood responses to this medical judgment, may be a consequence of self-medication, or may reflect neurological complications of HIV/AIDS, as well as an underlying mental health disorder. Mental health care should consist of both a neuropsychiatric workup and full mental health status examinations. Service providers should be alert to and notify clients and psychiatrists that complications may arise from the use of prescription medication for mental health problems and interactions between drug residue in the body and medications for HIV/AIDS and opportunistic infections.

Lipodystrophy syndrome

Lipodystrophy syndrome occurs in early end-stage AIDS and produces altered body composition and various hormonal and physiological changes. The cause of the syndrome and its relationship with HIV and protease inhibitors are unknown. Because of the disfiguring nature of some symptoms, lipodystrophy can be particularly distressing for women. Symptoms include

- Redistribution of body fat
- Increase in waist size

- Thinning of the arms and legs
- Increased facial wrinkling
- Weakness and muscle wasting
- Gastrointestinal symptoms
- Increased triglycerides and cholesterol
- Decreased testosterone levels
- Hypertension
- Diabetes

Disclosure Issues

Disclosure issues are difficult for all HIV-infected clients. For substance-abusing clients, these issues take on additional challenges. For example, disclosure of positive HIV status may lead to personal threats or harm to both client and family. A client's family may refuse to associate with him upon learning of his HIV/AIDS status. Particularly for clients whose culture reflects definition of self within a community or self in relation to a clan (as opposed to individual definition), separation from community can serve as a trigger for lapse or relapse into risky substance use and sex-related behaviors. Therefore, providers must use caution when notifying clients of test results and should comply with regulations to ensure that a client's confidentiality is preserved.

Also, during group therapy clients often feel an obligation to reveal their HIV status to the rest of the group. Counselors should caution clients about the impact of such disclosure and consider discouraging them from making it. Clients who wish to disclose their HIV status generally do so in response to treatment themes of honesty and openness and are not completely aware of the consequences. Of course, in treatment settings where all patients are HIV positive, there is no need for this concern.

HIV/AIDS-Specific Substance Abuse Counseling Issues

There are many counseling issues specific to HIV/AIDS that providers should be familiar with when treating HIV-infected, substance-abusing clients.

Cultural Competency Issues

Culture is the integrated pattern of human behavior that includes thoughts, speech, actions, and artifacts. Culture depends on the capacity of humans for learning and transmitting knowledge to succeeding generations. It takes into account the customs, beliefs, social norms, and material traits of a racial, religious, or social group. With this type of definition, it is easy to see that there is indeed a culture of addiction, a culture of poverty, a gay culture, and even a recovery culture.

Cross and colleagues present a comprehensive discussion of culturally competent systems of care. Five essential elements contribute to cultural competence *(Cross)*, which can briefly be described as follows:

1. **Valuing diversity.** Counselors value diversity when they accept that the people they serve come from very different backgrounds and may make different choices based on culture. Although all people share common basic needs, there are vast differences in how people go about meeting those needs. Accepting the fact that each culture finds some behaviors, actions, or values more important or desirable than others helps workers interact more successfully with different people.
2. **Cultural self-assessment.** When counselors understand how systems of care are shaped by dominant cultures, it may be easier for them to assess how these systems interface with other cultures. Care providers can then choose actions that minimize cross-cultural barriers.
3. **Dynamics of difference.** When cultural systems interact, both representatives (e.g., care provider and client) may misjudge the other's actions based on history and learned expectations. Both will bring dynamics of difference--culturally prescribed patterns of communication, etiquette, and problem-solving, as well as underlying feelings about serving or being served by someone who is different. Incorporating an understanding of these dynamics and their origins into the system enhances chances for productive cross-cultural interventions.
4. **Institutionalization of cultural knowledge.** Workers must have accurate cultural knowledge and information or access to such information. They also must have available to them community contacts and consultants to answer culturally related questions.
5. **Adaptations to diversity.** The previous four elements build a context for a cross-culturally competent system of care and service. Both workers' and systems' approaches can be adapted to create a better fit between needs of people and services available. For instance, members of certain ethnic groups repeatedly receive negative messages from the media about their culture. Programs can be developed that incorporate alternative culturally enhancing experiences, develop problem-solving skills, and teach about the origins of stereotypes and prejudice. By creating and implementing such programs, workers can begin to institutionalize cultural interventions as a legitimate helping approach.

Finally, becoming culturally competent is a developmental process for individual counselors. It is not something that happens because one reads a book, or attends a workshop, or happens to be a member of a minority group. It is a process born of a commitment to provide quality services to all and a willingness to risk.

Making culturally competent decisions

Treatment providers and counselors must examine two essential factors when working with culturally, racially, or ethnically different populations: the socioeconomic status of the client or group and the client's degree of acculturation. A distinction should be made when discussing a population as a whole and a particular segment of that population. For example, when treating an HIV-infected substance-abusing Hispanic woman, the counselor should focus on the woman as an individual and on the particular circumstances of this individual's life, rather than seeing her as an abstract representative of her culture or race. More often, poverty is the relevant issue to be discussed, rather than specific ethnic or racial factors.

The second factor, degree of acculturation, is important and should be part of the assessment process. How acculturated or assimilated are the family and client? What generation is this client? Assessing for this, and knowing that several generations with different values and levels of acculturation may all live in one household, can test the communication skills and counseling skills of the best service providers. When discussing acculturation/ assimilation and values, counselors should keep in mind that, in general, the more years a family has lived in the United States, the less traditional their values tend to be. Thus a fourth-generation Chinese-American client may not speak Chinese or hold traditional Chinese values. Knowing the values and beliefs of a client is crucial if treatment is to be effective.

Providers must also help develop culturally competent systems of care. A part of this is making services accessible to and often used by the target risk populations. Culturally competent systems also recognize the importance of culture, cross-cultural relationships, cultural differences, and the ability to meet culturally unique needs.

Aside from assessing cultural competence using the five elements discussed previously, it also is helpful to examine some ways in which providers can minimize cultural clashes and blocks that may exist when working with clients.

One concern in providing culturally competent care is how to discuss values and differences around sex and sexuality. In many cultures, people avoid discussing sex because they find such discussions disrespectful. This is one reason why so many cultures avoid discussing homosexuality. A counselor should consider using a less direct approach when initiating discussion about issues related to sex and sexual orientation. Many providers believe that some of the public health problems faced in communities of color

and the gay community are related to their inability to speak often and directly enough about safer sex practices, risky behaviors, and homosexuality. Even in the recovery culture and in many treatment settings, sex and sexuality are blatantly avoided. Service providers must acknowledge that they, too, in addition to their clients, are often uncomfortable talking about sexuality, sexual identity, and sexual orientation.

Providers also should be aware of the messages often given to communities of color and particularly women. The message, "stop having sex," often advocated by providers has been mixed with historical issues and fears of racial/ethnic genocide, thus making it difficult for most groups to give any credence to those expounding this method of reducing HIV/AIDS. The value of sex and procreation in many cultures makes it difficult for someone from outside the client's culture, especially someone of a different gender, to tell people to not have sex or to have sex only with a condom.

Finally, it is important that the counselor recognize that much of what is asked of clients and their families is personal and private. Questions related to sex, dying, and substance abuse are not usual topics of conversation, and when asking these questions, the counselor crosses many boundaries. It often is considered disrespectful (and offensive to certain cultural values) to ask questions about these specific areas. One wise way to broach these subjects with clients, especially clients who are significantly older than the provider or from a more traditional culture, is to simply apologize
The most practical advice is for providers to (1) maintain an open mind, (2) use cultural consultants for training and support, and (3) when in doubt, defer to the concepts of health and stability over pathology and dysfunction.

Special Populations

Gay, lesbian, bisexual, and transgender populations
Providers wishing to serve the needs of particular ethnic or cultural groups have learned that communities must be understood, respected, and consulted in order to make effective interventions; this also holds true when working with gay men, lesbians, and bisexual men and women. This population is defined not by traditionally understood cultural and ethnic minority criteria, but by having a sexual orientation that differs from that of the majority. Transgender people also form a unique population, often linked to gay men, lesbians, and bisexuals, although they differ from the majority by gender identification rather than sexual orientation.

Men who have sex with men (or MSMs--the CDC category used to report its data) may self-identify as gay (men with homosexual sexual orientations), bisexual (men who feel sexually drawn to both men and women), or heterosexual (men having sex with men as a purely physical act and not a reflection of innate sexual orientation). No matter what their sexual orientation, unprotected sexual contact puts MSMs at risk for HIV. In most reviews of gay men and safer sex practices, most men who were knowledgeable about

safer sex failed to practice it while under the influence of some substance. Many men from minority backgrounds who have sex with other men do not self-identify as gay or bisexual, so interventions should be based not on sexual orientation, but on sexual behavior.

Some women who have sex with women continue to have sex with men. A number of these women may be injection drug users and share syringes; consequently, they are prone to HIV infection. Although it is unlikely that female-to-female transmission of the virus will occur, lesbians have been urged to use safer sex precautions, such as using dental dams during oral sex.

Lesbians present some specific issues that must be highlighted. Compared with gay men, they are more likely to have lower incomes (as do women in general when compared with men); are more likely to be parents (about one-third of lesbians are biological parents); face prejudice as women as well as for being gay, including the stronger reaction against and willingness to ignore females with substance abuse disorders; are more likely to come out later in life (about 28 years of age versus 18 years of age in men); and are more likely to have bisexual feelings or experiences, so that they are still at sexual risk for HIV infection as well as possible IDU risk *(Banks and Gartrell, ; Bell et al.,; Bradford and Ryan, Mosbacher).*

Gay youth also present treatment challenges. Special sensitivity and understanding are needed to work with youth of any background, especially youth who are gay or lesbian or from an ethnic minority background. Young gay males in particular may be subjected to harassment at home or school, and they are prone to alcohol use, dropping out of school, running away, and getting involved in sex for drugs or money (*Ku et al.,; Rotheram-Borus et al.,; Savin-Williams)*. Many young gay male streetworkers abuse amphetamines, "tweaking" to have a sexual experience, and may exchange sex for drugs.

In general, gay men, lesbians, bisexuals, and transgender people are wary of the medical establishment and may resist seeking health care, distrust the advice given, or question the treatment plan suggested if the provider displays evidence of homophobia or heterosexism.

Gender identification is different from sexual orientation. *Gender identity* refers to a person's basic conviction of being male, female, or transgender. *Sexual orientation* refers to sexual attraction to others (men, women, or transgender persons). For example, many cross-dressers are heterosexual men who have active sexual relationships with women. Many homosexual men, although historically considered effeminate, identify strongly as men and appear very masculine.

Substance use plays a significant role in the high HIV prevalence in MTF transgender individuals. One study that investigated 519 transgender individuals in San Francisco

found high rates of substance abuse among both MTF and FTM individuals (*Clements et al.*). The study reported that 55 percent of the MTF sample indicated they had been in substance abuse treatment at some time during their lifetime. The study also found that HIV prevalence was significantly higher among MTF individuals (35 percent) than FTM individuals (2 percent), and among the MTF individuals, HIV prevalence for African Americans was 61 percent. Although the HIV prevalence rate was low in the FTM individuals, they commonly reported engaging in many of the same HIV risk behaviors as the MTF individuals (*Clements et al.)*

Counseling transgender individuals who are HIV positive and in substance abuse treatment can involve many different issues. Some of these issues are obvious: lack of family and social supports, isolation, low self-esteem, and internalized transphobia, to name a few. Some issues are not so obvious; for example, transgender clients currently undergoing hormone therapy often experience emotional and physical changes that can make treatment for substance abuse more difficult and relapse more likely. Although medically managed hormone treatment should not be interrupted, both the clinician and client must be aware that estrogen and testosterone therapies are mind and mood-altering substances, particularly when incorrectly taken. Improper administration of estrogen mimics the premenstrual symptoms of non-transsexual women, which can have a deleterious effect on recovery (CSAT, in press [b]). These premenstrual symptoms can trigger or exacerbate Post Acute Withdrawal Syndrome, which is believed to be the leading cause of relapse.

Additional relapse triggers or clinical issues may include the following: (1) inability to find, engage in, or maintain gainful employment due to employer prejudice against transgender individuals; (2) lack of formal education or training because the client was forced to leave school or home before completing his or her education; (3) the fact that HIV-positive transgender clients may be denied sex reassignment surgery due to their HIV status, even if they are asymptomatic and healthy; and (4) the general lack of substance-free role models and widespread social support for transgender individuals.

Figure 7-5: Guidelines for Working With Transgender Clients

Figure 7-5 Guidelines for Working With Transgender Clients	
Do	**Don't**
• Use the pronouns based on their *self-identity* when speaking to or about transgender individuals. • Obtain clinical supervision if you have reservations about working with transgender individuals. • Allow transgender clients to continue the use of hormones when prescribed; advocate for the transgender client who is using "street" or illegally prescribed hormones to receive immediate medical care and legally prescribed hormones. • Ensure that all clinic staff receive training on transgender issues. • Ascertain a transgender client's sexual orientation before treating him or her. • Allow transgender clients to use appropriate bathrooms and showers based on their *gender self-identity and gender role.* • Require all clients and staff to create and maintain a hospitable environment for all transgender clients. Post a nondiscrimination policy, including sexual orientation and gender identity, in the waiting room.	• Call someone who identifies as female "he" or "him," or someone who identifies as male "she" or "her." • Make transphobic comments to other staff or clients. • Ask the transgender client to choose between hormone therapy or substance abuse treatment. • Leave it to the transgender client to educate clinic staff. • Assume all transgender individuals are gay. • Force transgender clients identifying as male to use female facilities; likewise, don't force those identifying as female to use male facilities.

Clinicians, particularly those in rural areas, may have had little experience in treating transgender clients. Figure 7-5 lists some guidelines that clinicians may find helpful in working with this population. Some resources providers may also find helpful include the Lambda Center in Washington, D.C. (202-965-8434), which provides behavioral healthcare programs for transgender clients and others with HIV/AIDS and substance abuse problems, and the Center Gender Identity Project in New York City (212-620-7310), which provides HIV/AIDS and substance abuse counseling and referral services exclusively for transgender clients.

Women

The needs of women have always represented a unique challenge to health care and substance abuse treatment systems. Traditionally, these challenges have not been well met and are being exacerbated by the growing number of substance-abusing women infected with HIV. The diseases of substance abuse and HIV/AIDS present differently in women than in men and progress at different rates for a variety of reasons, including the fact that women usually present later in the HIV/AIDS disease process than men. Gender-specific services for women should include the following:

- Medical and substance abuse treatment that is accessible, available, and incorporates
    - ○General health (including reproductive health) and wellness across the life span
    - ○Mental health counseling (particularly for PTSD)
    - ○Parenting skills and support
    - ○Family-focused support
    - ○Relationship issues
    - ○Trauma/abuse support
    - ○Educational/vocational services
    - ○Legal services
    - ○Sexuality and sexual orientation issues
    - ○Eating disorder support
    - ○Women-only support groups
- Empowerment--that is, holistic programming that emphasizes the development of a partnership with a female service provider, one in which there are mutual respect and many opportunities for positive role modeling
- Transportation services
- Child care, both onsite and supervised
- Woman-sensitive women working with women
- Long-term case management services that extend to the client and her family

A woman's identity as caregiver/caretaker must be recognized as an extremely powerful factor in how she accesses care and treatment and how successful she is in her recovery and health maintenance. There is no question that this identity/role can explain why a woman seeks treatment ("for the kids") or why she leaves treatment ("to get home to my husband/partner/kids"). This is also a factor in a woman's sense of guilt and shame from becoming HIV infected--a societal stigma that only "bad girls" get HIV or are addicts or alcoholics, and the stigma of being an unfit mother if she has lost custody of her children.

Providers must be open and prepared to discuss safer sex and drug and alcohol abuse from a risk-reduction perspective. They must be well informed about and comfortable in discussing sexuality. Risk reduction is an ongoing type of intervention that goes beyond assertiveness training and teaching women how to put condoms on men. It recognizes the need to "start where the client is" and use appropriate interventions, which may help a woman reduce her risk of getting reinfected or of infecting a partner. This includes instructing female injection drug users about how to use bleach to "clean their works," how to use a female condom, or how to use a vaginal spermicide foam (not the safest risk-reduction method, however) to lower their risk of HIV infection when having intercourse. It also involves making referrals to substance abuse treatment and instruction for male partners on how to use a condom correctly.

Reproductive decision-making

Reproductive decision-making is an important area for providers to examine with both female and male clients. Providers must be prepared to discuss pregnancy and family planning with respect and without judgment. This is a difficult task for providers and clients; counselors may have many judgments about "right" and "wrong" and many opportunities for counter-transference. One way providers can interact with clients is to help them openly and honestly consider various factors when making reproductive decisions. Figure 7-6 is adapted from an article written by Rebecca Dennison, director of a women's health advocacy organization based in San Francisco, who is HIV positive and considered these issues with her husband in her own reproductive decision-making. The questions listed in Figure 7-6 are extremely helpful, but it is also important to remember that many clients have never made reproductive decisions. Their substance abuse problems have been at the forefront of their lives for so long that they may find it difficult, even in recovery, to "own" their decision-making responsibilities. One way to provide support in this area, and help build coping skills, is to encourage women to talk with other women--to become part of a support group that is based on empowerment and women helping women. Counselors should see reproductive decision-making as a very high priority and move toward this goal in small, incremental steps.

At present, no one knows exactly how to predict which mothers will transmit HIV to their infants. Although there is some speculation that a mother's viral load, measured through viral load assays, may indicate whether her infant becomes HIV infected. Much is still

unknown, and controversies abound, but providers must understand and respect the importance of self-determination and the right of women to make their own decisions. Ultimately, it is the woman's choice.

Today, HIV-positive women are looking at the prospect of pregnancy differently than they did in 1989. HIV-positive women who think about becoming pregnant have access to information about viral load testing and the possibility of artificial insemination. Also, HIV-positive women can consider a natural rhythm method, identifying fertile days and limiting unprotected intercourse to those times to decrease their partner's risk of HIV infection. There is no question that even today, facing pregnancy while HIV positive, examining the options related to terminating or continuing a pregnancy, deciding about medications, examining the woman's health and the infant's health, and addressing the long-term implications are all complex issues.

It is essential that providers examine these issues with clients within the context of a biopsychosocial framework. Counselors and health care providers must work together, along with the female client, to stay aware of the latest research and information regarding HIV/AIDS treatment. It is also important to remember that data and information on HIV/AIDS are constantly changing and that the "facts" provided to clients today may be very different tomorrow.

Parents who are HIV Positive

More and more resources have been developed for single- and two-parent households in which one or both parents are HIV positive and/or the children are HIV positive. There must be a continued awareness of the needs of these families.

These families experience the need for a variety of services, both child-centered and adult-centered. Concerns about guardianship for children after the parent is unable or unavailable to care for them must be a major focus for the parent and the service provider. Unfortunately, many clients who have long histories of substance abuse may have "burned many bridges," and the family support they need for permanency planning and establishing an appropriate guardian for their children is no longer available. All too often, there is only a tired, abused, and used grandparent who is dealing with chronic ailments, limited resources, and little emotional energy to raise more children.

If a child also is HIV positive, there will be special needs that the parent may not be able to address while facing her own issues. The already demanding dynamics of childhood, school, and growing up become more challenging for an HIV-infected child and parent. Even if the child is not HIV positive, the demands of parenting can prove rigorous for single parents with HIV/AIDS. Although the parent experiences the relief of knowing the

child is all right, the poignant realization that he may not live to see that child grow up can still be painful.

The HIV-infected single parent with a substance abuse disorder is at risk of losing custody of her minor children if convicted of drug possession or substance abuse. If family members disapprove of the single parent's lifestyle, they may seek custody of the active substance abuser's minor children. The counselor may facilitate a plan encouraging the single parent toward goals that support the parenting relationship. This enables the recovery process to take place while the parent and child are working out their own version of permanency planning.

It is difficult for a child to witness the effects of a substance abuse disorder on a parent; surely the difficulty increases enormously when the child is told that the parent has HIV/AIDS. Children whose parents are in recovery from substance abuse disorders or who are maintaining some stability despite periodic substance abuse may experience some changes in their relationships with their parents.

There are support groups and programs for children whose parents are affected by HIV. Although not available in all communities, these groups offer children a chance to talk about their fears regarding their parents' health, learn more about the disease, and socialize with others who are facing these problems. At the same time, the programs can provide the parent with some respite time. In addition, groups like Al-Anon and Alateen can provide children with support and education about the recovery process.
If service providers work in a large urban area, chances are there will be an AIDS Service Organization (ASO) listed in the phone book. This agency is likely to have lists of support groups of all kinds. Single parents with substance abuse disorders who are HIV positive should also have a support group.

Hispanics

The Hispanic population in the United States is diverse, composed of a wide range of racial, indigenous, and ethnic groups. The following are important statistics related to the U.S. Hispanic population that affect how outreach, prevention, and treatment planning should be conducted:

- Hispanics have the highest labor force participation rate of all groups.
- Hispanic men have the highest fertility rate of all groups across all ages.
- Hispanic men have the lowest divorce rate of all groups.
- Hispanic men are on average younger than other men in the United States (with median age of 26.2 years).

- Hispanic women seek detoxification and treatment for substance abuse disorders in lower numbers than women from any other ethnic/cultural group.
- 90 percent of Hispanics are Catholic.
- 36 percent of Hispanic children live below the poverty level.
- There is a clear increase in substance abuse as Hispanics become more acculturated (i.e., in second and third generations, and so on).
- Hispanics are overrepresented among HIV/AIDS cases for men, women, and children.
- Hispanics as a group may include aliens who are undocumented or carry immigrant visas (green cards) and who avoid contact with the health care system because they fear possible deportation.

Within the context of acculturation and socioeconomic status, providers should be aware of specific cultural issues that can support interventions and improve a provider's ability to engage Hispanic clients, such as the role of the family, the values of interdependence, respect, and "personalismo" (i.e., importance of personal contact). Understanding these concepts will help establish rapport and trust.

The Hispanic family is generally extended and has many members. A Hispanic client's support system may be composed of siblings, godparents, aunts, and uncles who are all very involved with the client. The family as a whole is of great importance, and often what is best for the family will override what is best for one of its members. Because the family is so important to most Hispanics, children are highly valued. This makes it easier to see how some Hispanic women who are HIV positive grieve deeply about the decision not to have children and may feel unfulfilled and inadequate as a result. This also sheds some light on the challenges of involving Hispanics in substance abuse treatment. Leaving their children behind while in treatment or turning guardianship over to a State agency may be unacceptable and create more conflict.

African Americans

Many African Americans have a deep-seated mistrust of the health system. This dates back to the pre-Civil War period when, because they were considered property and had no legal right to refuse, slaves were sometimes used in medical experiments *(source: Gamble).* A collective memory thus exists among the African American community of their exploitation by the medical establishment More recently *(source: Gamble)* the syphilis study performed at Tuskegee University from 1932 to 1972, during which 400 African American men infected with syphilis were deliberately denied life-saving treatment, has fostered in some African Americans the belief that contact with health care institutions will automatically expose them to racist administrators and policies. Several articles point to the Tuskegee study as a significant factor in the low participation of African Americans in clinical trials and organ donation efforts and in the reluctance of

many African Americans to seek routine preventive care. As one AIDS educator said, "so many African American people that I work with do not trust hospitals or any of the other community health care service providers because of that Tuskegee experiment. It is like _ if they did it once, then they will do it again" *(Source: AIDS Weekly Plus; Karkabi; Thomas and Quinn)*.

Counselors should be aware that the issues of slavery and institutional racism are constant and prevalent facts in the lives of many African Americans and should be addressed early in treatment so they are acknowledged, validated, and brought into the treatment process. In order to provide effective substance abuse treatment for African American clients, providers need to take into account the social, economic, political, and cultural contexts of their lives *(Pena and Koss-Chioino)*.

Spirituality is very important for many African Americans. The relationship between an individual and the faith community is a critical source of strength that can help prepare clients to succeed in substance abuse treatment. In addition, many African Americans have strong social networks. They may have friends or a pastor with whom they might share information they would not share with a substance abuse counselor. These confidants might act as "co-therapists" for the client. It can be helpful for clients if counselors can identify and integrate clients' co-therapists into their substance abuse treatment plans (keeping in mind clients' rights to confidentiality and the need for signed consent forms--see Chapter 9 for more information). Along these lines, for African Americans with substance use disorders and HIV/AIDS, support groups of friends may be more likely to be helpful and less undermining than support groups of families. This is perhaps due to the lingering stigma of the ways in which HIV/AIDS is acquired--both intravenous drug use and homosexual activity are still highly stigmatized acts within many African American communities. Thus, activating family supports may be difficult, and providers should encourage clients to participate in support groups composed of their peers.

Asian Americans

The increasing size and diversity of the Asian and Pacific Islander population make it difficult to discuss group norms regarding substance abuse. Norms for alcohol and tobacco use vary by culture and there appear to be no norms governing the consumption of narcotics or other substances.

Service providers also should shed the notion of the "model minority," which often typecasts Asians and Pacific Islanders and limits treatment access. Often, Asians and Pacific Islanders believe the model minority myth and feel isolated when they test positive or report substance abuse disorders. They may also feel they have let down their families and communities.

Despite differences in cultural norms and mores among Asians and Pacific Islanders, cross-cultural beliefs in the importance of group and collective identity, service, and responsibility suggest the use of treatment strategies that incorporate biological or constructed families and communities rather than a focus on individual behavior change. Moreover, treatments that emphasize nonverbal or indirect communication skills, not confrontation, may be more culturally appropriate and more effective. Most American treatment modalities rely heavily on verbal therapies that require direct verbal emotional expression and a high level of personal disclosure. Many substance abuse treatment programs favor a confrontational approach, and many HIV/AIDS programs favor support groups and psychotherapy. These treatment approaches, unless modified for Asian and Pacific Islander clients, are often unsuccessful because they violate Asian and Pacific Islander cultural norms. By American standards, Asians and Pacific Islanders tend to communicate more indirectly, often by telling stories and discussing what happened to themselves and others. Their feelings and opinions are implied rather than directly stated. Asians and Pacific Islanders are also less likely to provide direct verbal expression of their feelings by using "I" statements than are members of other groups. Providers should expect to reveal personal information about themselves if they want clients to disclose their own problems. Asians and Pacific Islanders may prefer to keep strong feelings under control so that they will not become disruptive. Caring is often demonstrated by physical support such as by giving money, cooking favorite foods, or giving advice rather than by verbal expression or physical affection.

A problem-solving approach rather than an intrapsychic one is more effective with Asian and Pacific Islander clients. Problem-solving enables a counselor to provide information, educational materials, and referrals without probing for more personal information and pushing a client to express feelings. For Asian and Pacific Islander clients with somatic complaints, suggest relaxation and breathing techniques, meditation, qigong, yoga, massage, acupuncture, tai chi, or biofeedback. It is generally not helpful to discuss underlying feelings because it is not only culturally unacceptable, but many Asian and Pacific Islander clients do not see the emotional-physical connection. In problemsolving, providers should actively give suggestions and if necessary, be directive rather than let Asian and Pacific Islander clients struggle to figure out what options are available to them.

Asking personal questions about substance abuse and sexual risk factors, especially early in the helping relationship, could be viewed as intrusive and disrespectful. Asian and Pacific Islander clients may not answer truthfully, if at all, and may not return. It is best to start with the least intrusive or nonthreatening questions during the intake and explain why the information is needed. If clients seem uncomfortable with certain questions, ask them at a later date.

Making an effort to connect with clients outside actual treatment appointments when they come to the agency for other activities or via follow-up calls is also helpful. Asian and

Pacific Islander clients may not initiate contact when they have a problem because of cultural tendencies to minimize problems to reduce stigma and because they do not want to be intrusive and bothersome. In all interactions, it is helpful to minimize the stigma Asian and Pacific Islander clients attach to their HIV/AIDS status and substance abuse disorders. Counselors should not refer to themselves as HIV/AIDS, mental health, or alcohol and drug counselors unless they know the client is comfortable with this. These titles imply the client has an unacceptable condition and can increase stigma. Clients may be more receptive to treatment for HIV/AIDS and substance abuse issues if they are combined with other, less stigmatized health issues.

Group interventions can be effective if everyone speaks the same language well enough and if the group is centered around an unstigmatized activity, social gathering, or education session. Providing refreshments also facilitates bonding. Asian and Pacific Islander participants will look to a facilitator to provide direction and guidance. Rather than be assertive in talking, Asian and Pacific Islander clients will more likely wait for a space to open up for them to speak and consequently will rarely have the opportunity to do so when in a group with predominately non-Asians and Pacific Islanders. Should this happen, the group leader needs to facilitate opportunities for Asian and Pacific Islander clients to participate.

Native Americans

The CDC found that Native Americans have high rates of STDs and substance abuse, which in turn raise their risk of HIV/AIDS. They also lack access to diagnosis and treatment. Gay men and substance abusers run the highest risk of HIV/AIDS among Native Americans and Alaskan Natives, just as they do among white Americans.

The combination of high rates of cofactors for HIV/AIDS, limited access to health care, lack of information and education about HIV/AIDS issues, substantial numbers of Native Americans who are already infected with HIV, and the flow of Native Americans between urban centers and reservations all lead to an HIV/AIDS crisis for Native American communities.

Limited treatment services for HIV-infected substance abusers exist on and outside tribal lands. In 1991, the American Indian Community House, which ministers to the health, social service, and cultural needs of Native Americans in the New York City area, created the HIV/AIDS Project, the first Native American program east of the Mississippi River to provide culturally sensitive legal services, HIV/AIDS treatment information, emergency assistance, and prevention education. The Friendship House Association of American Indians in San Francisco provides another example of treatment (drop-in centers). This program provides comprehensive treatment to Native Americans living with HIV/AIDS as well as treatment for substance dependency. Services target the gay, lesbian, and bisexual communities. HIV/AIDS is presently underreported for Native Americans and is

based on the high incidence of sexually transmitted diseases (STDs) in general, and thus substance abuse treatment centers will be faced with more and more HIV-infected Native Americans.

Clients involved with the criminal justice system

Many persons with substance abuse disorders receive treatment only after arrest and are offered treatment as a diversionary service or receive treatment while they are in jail or prison. The racial and class patterns characterizing arrest, adjudication, and sentencing in the United States skew more white Americans (regardless of social class or income) to treatment trajectories and more persons of color to jail or prison trajectories. Access to treatment within the criminal justice system is thus highly associated with ethnicity and social class. Only a handful of correctional facilities in the United States have instituted some type of therapeutic community treatment program in prison with a parallel transitional program for new parolees. Unfortunately, many HIV-infected individuals who are in treatment for HIV find it impossible to remain on their medication schedules after being arrested because their medications are often confiscated for days at a time.

Risky behaviors that lead to HIV infection are not eliminated when a person is imprisoned but may actually increase in frequency and availability. This occurs for several reasons. First, drug offenses count for the single largest number of Federal and State crimes for which people are arrested and incarcerated

Injection drug users face particular risk in prison settings as clean syringes are all but impossible to secure. Although syringes are not officially available, they can be acquired through illicit prison markets at exorbitant prices ($34 in one Canadian facility) or through risky exchange of syringes for unprotected sex. Syringes are typically not new or sterile. As a result, injection drug users have as their only recourse used or shared syringes, which increases their chances of HIV infection. Tattooing is also common practice among prisoners and is another source of HIV infection. To date, there have been at least two documented cases of HIV/AIDS related to tattooing with unsterile needles in a correctional facility.

Only six prison systems in the United States distribute condoms: Mississippi, New York City, Philadelphia, San Francisco, Vermont, and the District of Columbia. Distribution strategies range from receipt of a single condom per medical visit to receipt of multiple condoms during HIV/AIDS education workshops. Furthermore, condom distribution programs send mixed messages because sexual activity in some facilities is illegal and a punishable offense. In other facilities, correctional medical and social service staff may advocate condom availability while administration and security officers oppose it.

Sixteen prison systems mandate HIV testing, and although 77 percent make testing available to inmates on request, few inmates request it for several reasons. First,

confidentiality of results is not guaranteed. Second, mandatory testing may result in the segregation of those who test positive from those who test negative or who do not test. Third, prisoners do not wish to acknowledge activities that could subject them to further sanctions. Fourth, confidentiality on discharge is eliminated because the Federal Bureau of Prisons requires HIV testing for all inmates on their release. HIV-positive inmates are asked to directly notify sex partners and significant others of the results. However, the Bureau of Prisons handles only a small percentage of inmates, and its policy is not the norm.

Although there are large numbers of substance abusers within correctional facilities, less than 15 percent participate in treatment programs. This is partly because of lack of program availability and the common type of program offered (i.e., 12-Step, abstinence-based.) A 1991 study reported that only 1 percent of inmates with moderate to severe substance abuse disorders received appropriate treatment. Many of these treatment programs advocate sexual abstinence during recovery. Often, these programs offer no or little information about safer sex practices or advocacy around changing sexual behaviors. When persons with substance abuse disorders in treatment relapse, as is often the case, they may also engage in risky sexual behaviors. They are most likely to engage in risky sexual behaviors with sexual partners from similar treatment networks. These partners may include people who have used syringes, traded sex for money or drugs, or been victims of trauma. All of these populations are likely to have higher rates of HIV infection, making transmission likely.

Adolescents

Adolescents are another group that is experiencing an increase in incidence and prevalence of HIV. Findings from the Monitoring the Future surveys have revealed a dramatic and sustained increase in consumption of licit and illicit drugs among adolescents--this after nearly two decades of sustained decrease in drug consumption. Studies also note that teens are having sex earlier than ever before, often with multiple partners and inconsistent use of condoms, putting them at greater risk for HIV/AIDS. Beyond this, young people find themselves marginalized in U.S. society; this is especially true for young gay and bisexual youth, sexually active young women, and young people of color.

According to the CDC, AIDS is the fifth leading cause of death for Americans between the ages of 25 and 44 *(Source: CDC)*. At greatest risk are young, disadvantaged females, particularly African American females, who are being infected with HIV at younger ages and higher rates than their male counterparts *(Source: CDC)*. Because of the long and variable time between HIV infection and AIDS, surveillance of HIV infection provides a clearer picture of the pandemic in young people than surveillance of AIDS cases. From the States for which HIV is a reportable condition, young people ages 13 to 24 accounted for a much greater proportion of HIV than AIDS cases (17 percent versus 4 percent). Of

these HIV infections, 38 percent were reported among young females, and 56 percent were among African Americans *(Source: CDC)*.

Adolescents may benefit from treatment that is developmentally appropriate and peer oriented. Addressing educational needs may be particularly important as well as involving family members in the planning of treatment and therapy. Substance abuse among adolescents is frequently associated with depression, eating disorders, and sexual abuse history. Histories of familial sexual and substance abuse are predictive of serious adolescent substance involvement and subsequent treatment needs.

Older adults

The last few years have witnessed greater increases in the number of HIV/AIDS cases among middle-aged and older individuals than in those under 40 years of age. Through June 1999, people over the age of 50 account for 11 percent of cumulative AIDS cases and 5 percent of cumulative HIV cases in the United States. Women comprise a greater percentage of all AIDS cases as age increases, ranging from 13 percent of AIDS cases among people aged 50-59, 15 percent of AIDS cases among those aged 60-69, and 21 percent of those 65 and over. For women with HIV, 22 percent of this group is in the 50-59 age bracket; 24 percent is aged 60-64; and 31 percent aged 65 and older. The rate of HIV infection in older women reflects the greater incidence of surgeries (such as hysterectomy) that require blood transfusions.

Although many of these AIDS cases are the result of HIV infection at a younger age, many people become infected after age 50. Rates of HIV infection among older adults are difficult to ascertain because very few people over 50 years of age routinely test for HIV. Because older adults are diagnosed with HIV/AIDS at advanced stages, older adults are less amenable to treatment, become sicker, and die faster than their under-50 counterparts. In addition, retroviral treatments and opportunistic infection prophylaxis may interact with medications the older person is taking to treat other preexisting chronic illnesses and conditions. Also, the vast majority of medication studies are done on much younger subjects. There is little research on the metabolism of anti-HIV drugs in older adults.

There is, as well, little research on the substance-abusing behavior of older adults, and very few substance abuse treatment programs address the needs of older adult substance abusers. Unfortunately, many medical professionals do not consider older patients to be at risk for either substance abuse (with the exception of alcohol use) or HIV infection. A study in Texas found that most doctors never asked patients older than 50 years questions about substance abuse or HIV/AIDS or discussed risk factor reduction. Doctors were much more likely to rarely or never ask patients over 50 about HIV/AIDS risk factors (40 percent) than to rarely or never ask patients under 30 (7 percent). Older persons may not be comfortable disclosing their sexual behaviors or substance abuse to others, since their

generation or culture may not encourage such disclosures. This can make finding treatment programs and support programs especially difficult.

Certainly, there is a need to educate service providers about the sex- and substance-related behaviors of older persons. At the very least, service providers should conduct thorough sex and substance abuse risk assessments with their patients over 50, and challenge all assumptions that older people do not engage in these activities or will not discuss them.

Sex industry workers

Among sex workers, street prostitutes are the most vulnerable to HIV infection, given the coexisting features of poverty, homelessness, history of childhood sexual abuse, and alcohol and drug dependence. Comparatively, male and female sex workers who work in massage parlors, escort services, their own apartments, or brothels rather than on the street are far less likely to be at risk for infection, less likely to depend on substances, and more likely to control sexual transactions and insist on condom use.

Among female sex workers, IDU continues to be the major cause of HIV infection. Female injection drug users who trade sex for money or drugs are more likely to share syringes than injection drug users who do not exchange sex for money or drugs. Drug use also increases the likelihood of sex work and risky sex. Studies of crack cocaine abusers in three urban neighborhoods found that 68 percent of the women who were regular crack smokers exchanged sex for drugs or money. Of those, 30 percent had not used a condom in 30 days. Recent research has also demonstrated an association between HIV infection, heavy crack use, and unprotected fellatio. This is likely due to the combination of poor dental hygiene, damage to the mouth from hot crack stems or pipes, high frequency of fellatio, and inconsistent or marginal condom use. Street-based sex workers may agree to unprotected sex if clients offer more money, if workers themselves are desperate for money to buy drugs, or if activity has been slow.

HIV treatment challenges may occur given the sex workers' more immediate needs for drugs, food, and housing. These needs overshadow future concerns about living with HIV/AIDS. Beyond this, sex workers with HIV/AIDS may continue to work routinely for the purpose of exchanging sex for drugs or money. Sex workers thus run risks of spreading HIV/AIDS as well as reinfection of HIV and the acquisition and transmission of other diseases such as hepatitis and STDs.

There are many examples of effective treatment programs for sex workers with substance abuse disorders, including the California Prostitutes Education Project (CAL-PEP); Sisters Helping Each Other in Chicago, Illinois; Second Chance in Toledo, Ohio; the Threshold Project in Seattle, Washington; Alternatives for Girls in Detroit, Michigan; and the On the Streets Mobile Unit-Options Program in New York City. Most of these

programs use former sex workers as outreach staff, use a risk-reduction model of care, and establish linkages with organizations in the treatment continuum.

Homeless people

Homeless people suffer higher rates of many diseases, including HIV/AIDS and substance abuse disorders, than the general population. No national statistics exist, but studies within major U.S. cities are illustrative. In a 1990 survey of homeless adults in St. Louis, Missouri, 40 percent of men and 23 percent of women reported substance abuse, and 62 percent of men and 17 percent of women reported alcohol abuse. Another 1993 study of homeless adults in Mississippi revealed that 70 percent of respondents engaged in at least one of the following high-risk behaviors: unprotected sex with multiple partners, injection substance abuse, sex with an infected partner, and exchanging unprotected sex for drugs or money. Of these respondents, nearly half reported two risk factors, and 25 percent reported three or four risk factors. Homeless people--especially women and youth--may engage in risky behaviors for survival reasons.

Individual therapy strategies

Clients may raise several issues in therapy that then become clinical issues. Following are common issues that clients raise during the inpatient treatment process along with suggested responses from the counselor during individual therapy:

- Feeling the problem (of HIV infection or living with AIDS) has not "hit them" yet. The counselor can provide the client with education about risky behaviors, living with AIDS, and so on. Presenting the client with future scenarios and life trajectories if behaviors remain unchanged may be helpful. Sharing success stories about positive changes in peers may also be a helpful strategy.
- Expressing the need to make their own decisions and choices regarding care, treatment, and their lives. Counselors should underscore the fact that clients must decide what is in their best interests, taking care to define "their best interests" within the client's definition of self as either an individual, a provider, a parent or caregiver, a member of a family or community, or a combination thereof. Counselors should balance this by letting clients know that no one has all the answers to their problems, and reassure clients that their feelings are valid, not unusual, and realistic. Changing one's life is hard work.
- Knowing how to change behavior, yet not making these changes. The counselor should support client efforts to reduce risk behaviors but educate the client as to why risk remains. Exploring what the client is willing to consider changing provides an outline of possible actions. Working together with the client on strategies

to resolve barriers to change in small steps may be a useful tactic as well.

- Giving up hope for change or feeling overwhelmed by problems. Workers should reassure clients that their feelings are typical and that change is hard. Telling clients about positive role models who have successfully changed after facing many difficulties along the way is another useful approach.

Service providers should know that this initial phase of client change is the longest and most difficult for many clients. It is not uncommon for clients to spend a lot of time in inpatient treatment weighing the pros and cons of their behavior. Clients may have invested much energy in intentionally not thinking about the problem. Thinking about the problem may release painful issues (real or perceived) for clients that they have not allowed themselves to reflect on. Service providers should be acutely aware of the power of denial for many substance-abusing clients living with HIV/AIDS.

It is often difficult for the client to anticipate potential problems, interactions, and pitfalls, particularly those that will be faced in the external community. The counselor must help the client examine the barriers that may arise and develop strong responsive coping skills and activities. A weak plan of action can lead to quick lapses and relapses. This level of client activity (preparing for action) is characterized by switches in both personal external cues for behaviors and the ways in which clients perceive and cope with internal situations. This is a time for counselors to develop specific plans and identify individuals in a person's social environment who may provide support or information to the client upon discharge.

The idea of self-liberation can be used to influence a client to choose to act in a specific manner or believe in his ability to change. Clients can benefit from thinking about what may change once the new behavior(s) have begun so they can be prepared for those changes. Questions similar to the following can be used to facilitate self-liberation:

- Is this what you want to do? Are you prepared for the risks involved?
- What are your reasons for changing your behavior?
- When do you want to make your change?
- What problems do you think you may face in the future?
- Whom have you discussed this with?
- How do you feel the environment is going to affect your change?
- Are there any support groups you could join in the area? Would you like to join any?

Group therapy strategies

The gains made in individual treatment can be consolidated in well-designed and well-facilitated group therapy. Consciousness-raising techniques may help when talking with a client who seems to lack basic information about behaviors or topics, such as HIV transmission. Questions such as the following can determine how much consciousness raising is needed:

- What are your concerns about HIV/AIDS?
- What do you think about "cleaning your works" in order to protect yourself?

Dramatic relief strategies can be used when talking with a client who knows something about topics like HIV/AIDS but still engages in unsafe behavior. Questions such as the following are helpful in determining the level of dramatic relief strategies:

- Do you feel you are at risk for HIV/AIDS?
- Do you worry about getting an STD?

Group therapy also can be used to present role models (peers) who have successfully addressed many of the issues clients in inpatient treatment may face. Peer programs can provide support for substance recovery and other psychosocial services. There are many resources in the community for these interventions; all a program must provide is a meeting place. It is helpful if the peer group facilitator has some training, even if this consists solely of the orientation that all substance abuse treatment program volunteers receive. Because they are not led by professionals, peer groups may be limited in what they can achieve. However, the absence of professional involvement may give peer groups greater credibility with hard-to-reach clients.

Self-reevaluation (or self-reflection) and environmental reevaluation are good activities to use in group settings during inpatient treatment when clients might be motivated to change behavior. Self-reevaluation occurs when clients think about their behavior, and environmental reevaluation occurs when they think about the impact of their behavior on others. A counselor can initiate self-reevaluation by asking questions such as the following:

- How would you feel about bleaching all the time?
- Are there times you are willing to take risks by not using a condom? Why or why not?
- How often do you think about HIV/AIDS?
- Do you ever worry about getting something from your partner? What do you worry about? Why do you worry?
- Do you ever worry about giving something to your partner? What do you worry about? Why do you worry?

Environmental reevaluation can be facilitated with questions such as the following:

- How does your partner (partners) feel about using condoms?

- How would your partner (partners) feel if condoms were used?
- Do people close to you ever talk about your addiction? What do they say?
- Do people close to you ever talk about HIV/AIDS? What do they say?
- How does your addiction affect people who are close to you?

Group therapy in inpatient settings can be very helpful in setting the stage for actual behavior change. It is challenging for clients who have started to change behavior within a structured setting to continue the change when they return to the less structured environment from which they came. This environment may not necessarily support newly acquired lifestyle changes.

Stage of HIV infection

Segregating groups by stage of HIV infection presents difficulties, but not doing so can also be problematic. Clients who are HIV positive but asymptomatic and attending a support group for the first time may be uncomfortable when encountering clients in the late stages of AIDS. Such a meeting may force them to confront fears about their own mortality before they are ready to do so.
Because treatment programs have limited resources, separating groups by stage of HIV infection may be impractical. Programs able to support separate groups may wish to use the three-group model, with groups consisting of

- Clients newly aware of their positive HIV status
- Those who are asymptomatic or mildly symptomatic
- Those with more advanced disease

The interplay between substance abuse disorders and HIV infection in groups can be complicated. As clients move further into substance abuse recovery, they may be getting progressively more ill from HIV disease. In a mixed group, healthier clients may provide support to sicker ones.
In a group consisting solely of clients symptomatic with AIDS, members are vulnerable to becoming involved in a process of continual grieving. Sometimes groups have to discontinue for a period of time when too many members become sick or die. For this reason, it may be helpful to establish support groups for time-limited periods.

Outpatient treatment

Outpatient treatment consolidates the gains made in the detoxification and inpatient and residential treatment levels of care. Typically, clients may still need to think about change or begin to plan for change on their discharge from inpatient or residential treatment. On entering outpatient treatment, clients may have actually begun some behavior change, but

the novelty of the change can lead to relapse as the client moves away from the controlled and structured environment.

Clients in outpatient treatment usually need support from at least one other person who cares about them. This can be a time when clients are vulnerable because as they change, others around them may change in response. Friends and significant others may feel threatened, abandoned, jealous, or angry and may try to sabotage the client's efforts. This puts tremendous pressure on clients because they are experiencing new feelings and new, difficult ways of life. Although many of these life changes may be positive, they are also unfamiliar for many clients.

During outpatient treatment, group therapy could focus on the use of successful peers in modeling helpful but difficult strategies such as stimulus control and counter conditioning. Individual therapy will involve helping the client balance and coordinate recovery with other issues, such as assessing client responses and concerns with case management, care coordination, and child and family issues when relevant.
Stimulus control and counter conditioning are two strategies clients may find helpful. Stimulus control helps clients restructure their environment so they can avoid circumstances that elicit problem behaviors. There are three methods for managing tempting stimuli:

- Develop a plan for managing the situation.
- Manage the situation so the temptation does not occur. For instance, a person who knows alcohol puts her at risk for unsafe sex will not drink when sex may occur.
- Restructure the environment so that stimuli for more positive events occur and so clients remain aware of people, places, and things that cause relapse.

In developing stimulus control strategies, consider developing questions such as the following:

- What are the situations where you may be at risk of not using a condom?
- How can you avoid them?
- How do you stay safe when you have sex?
- Where do you keep your condoms?
- What are the situations in which you find yourself using substances?
- Do you keep your own "works" with you?
- When are you tempted not to bleach?

Counter conditioning involves exchanging risky behaviors with less risky alternatives in situations that are not amenable to stimulus control. To develop counter conditioning strategies, questions such as the following can be used:

- If you found yourself in a situation where you were tempted to have sex without a condom, how could you deal with it so that you could have safer sex?
- How would you deal with a situation where you insisted on having safer sex and your partner got angry?

A major risk during outpatient treatment is the involvement of the client in sexual networks and sexual mixing. Many clients in treatment may select sexual partners from similar networks (recovery programs, 12-Step meetings, and so on). These partners might include persons who have used syringes, traded sex for drugs or money, been victims of trauma, or been incarcerated. All of these populations may have higher rates of HIV infection, making transmission more likely, and clients should be counseled about these risks.

Drop-in centers

Drop-in centers are an excellent way to engage homeless people in treatment. These centers offer a needed service for substance-abusing individuals who are homeless. As individuals start dropping in, they begin to interact with staff and form trusting relationships, which builds a necessary foundation for beginning treatment. The use of maintenance strategies characterizes treatment in drop-in centers. At this phase, service providers must work to prevent relapse and bring together the gains achieved during inpatient and outpatient treatment. During this time, clients may have learned to adjust their new behavior to the environment in which they live, and the behavior has perhaps become habitual.

Also during this time, many clients relapse and may return to earlier treatment levels and milestones. As discussed elsewhere, there are many factors leading to client relapse. Situations such as breaking off relationships, starting new ones, severe temptation, or lack of environmental support may contribute to relapse. In addition, the client can easily choose not to try again due to the negative feelings associated with relapse such as shame, embarrassment, guilt, failure, regret, anger, or denial. Service providers may work with clients so that they can realize that their past successes indicate better chances of success in the future. They should underscore the fact that clients have learned new ways of coping with old behaviors and have developed supportive relationships. Service providers may find the use of reinforcement management a helpful strategy that can be facilitated in either individual or group level modes. Reinforcement management helps clients develop internal and external reinforcers and rewards that increase the chance of new behaviors continuing. Workers can also reassure clients that relapse encounters are part of an ongoing process. Helping clients determine what caused the slip can be useful in helping them develop strategies to avoid lapses in the future. Workers can also work with clients to help them learn more about themselves, their environment, and their addiction and risky behaviors.

Questions similar to the following can help determine if clients need better or more reinforcement management:

- Do you feel good about your new behavior?
- What kind of things do you tell yourself, knowing you are practicing safer sex?
- What kind of things do you tell yourself, knowing you are controlling your substance abuse?

Counseling Terminally Ill Clients

The counseling of ill and dying clients should be supportive and non-confrontational, addressing issues relevant to the client's illness at a pace determined by the client. However, clients are not the only ones to be affected by the approach of death; counselors too may need assistance in dealing with clients' deaths. This section addresses the issues of denial, planning for death, pain management, unfinished business, and bereavement. A five-stage bereavement and loss model, based on Elisabeth Kubler-Ross' book *On Death and Dying*, also is presented.

Denial

Denial about a client's HIV/AIDS diagnosis can be experienced by both clients and counselors. Denial is a natural response and should be confronted only if it causes harm; for example, when a client in denial about his illness delays in making arrangements for medical and nursing care or procuring assistance with daily living activities. Counseling can play an important role in helping clients accept their illness and the eventual need for home health or hospice care.

Denial can also affect counselors. For example, because of the advances being made in the medical treatment of HIV/AIDS, a counselor may be in denial that a client will die of AIDS. Counselors must recognize and confront their own denial issues so that they are able to discuss death and dying and realistically explore these issues with their clients. Programs need to have inservice education and proper supervision for counselors who work with terminally ill clients. Proper supervision will help the counselor confront her denial and help lessen her stress.

Planning for death

It is often difficult for a counselor to know how or when to talk to a client about planning for death. It is optimal, if possible, to begin a discussion of the client's future, including death, before the client is extremely ill. Questions that often lead the counselor into a discussion of death and dying, and also are centered on contingency planning, include, "if you were to become too ill to care for yourself any longer, what would you do, who

would help, where would you go?" The counselor and client should also consider where the client would like to die because different arrangements may be required.

Counselors who will be working with clients at the end stages of AIDS should examine their own beliefs about death and dying. In addition to this, counselors may need to learn about the physical and biological process of dying so that it can be explained to clients. It is also important to keep in mind that clients' perspectives on death and dying are deeply rooted in their personal histories, religious practices, ethnic customs, family traditions, and community standards.

Many clients fear dying alone or in pain, or of losing control of their bodily functions, and thus having to rely on others for care. If clients want to talk about this personal and often frightening experience, the counselor should listen and help the client locate answers to any questions concerning the process of dying. Counselors should ask their clients how much they want to know and make sure that clients know what to expect physically. Understanding the process and planning the details within their power can give clients a sense of control.

In addition, clients may ask counselors to share their own beliefs about death and dying. Minimal sharing can be reassuring, but counselors should focus on the clients' perspectives, beliefs, and needs. As counselors listen, valuable information and insight into possible resources and support needed by clients will come to light.

Pain management

Pain management is often a difficult struggle with those who are in the end stages of AIDS. The issue of pain is complex because many medical conditions related to a client's HIV/AIDS can cause her pain. Clinicians may be concerned that pain medications may reinforce an addiction. Also, clients who have achieved abstinence from drugs may not wish to use medications for pain relief. Another concern of clients is the appropriateness of pain management when it might hasten death. If a client raises this issue, the counselor should be prepared to discuss it, however, the counselor does not initiate discussion on this topic. If the topic arises, clients should be encouraged to discuss pain management issues with their physicians and, if appropriate, their significant others.

Unfinished business

One important area that counselors should explore with their clients is "unfinished business." For example, a counselor might suggest that a client make a will. But there may remain other issues to be addressed. Should a client consider making an advance directive or a living will? Will the client want to appoint a health care proxy? Should he consider granting power of attorney to a significant other? Should he appoint a guardian for his children? Are there family issues that he wants to address?

Some counselors express a desire to be there at the time of a client's death, or a client may request that someone be there until death. Counselors and health care providers may also spend more time counseling the client's significant others or support people during this time than they spend counseling the client. Here again, a little information can go a long way to reduce fear and anxiety in clients and their significant others.

Bereavement

Bereavement is a particular problem for programs with large numbers of HIV-infected clients. Bereavement can affect clients (who may grieve at the deaths of other clients, friends, or loved ones from HIV/AIDS); clients' significant others; and counselors who work with dying clients. The following strategies may be helpful in supporting those clients who are dealing with bereavement.

- Acknowledge the reality of the bereavement in supportive individual counseling.
- Encourage the expression of grief both verbally and nonverbally (e.g., art therapy, expressive movement, psychodrama).
- Provide group support for clients and their significant others who are experiencing grief and bereavement.
- Acknowledge deaths with memorial services, flowers, photographs, and participation in commemorative projects such as The NAMES Project Foundation's AIDS Memorial Quilt, which attempts to include the names of everyone who has died of AIDS.

Kubler-Ross Bereavement and Loss Model

One of the best and most often referred to models of bereavement and loss comes from physician and psychiatrist Elisabeth Kubler-Ross. In her book, *On Death and Dying*, she provides a five-stage theory that has become common language when dealing with death and dying. Her model of bereavement is essentially a series of defense mechanisms, or coping strategies, that are used by an individual confronted by death. These stages can also be observed as individuals are confronted with other traumatic circumstances or information, such as a positive HIV test, an HIV/AIDS diagnosis, or the death of a friend or peer. The five stages are denial, anger, bargaining, depression, and acceptance.

Individual interpretations of and responses to death and dying vary greatly, not only between people, but between cultures and religions. Yet, as this model eloquently describes, adjusting to death is a process, not an event that occurs seamlessly and in a logical sequential order.

The coping strategies and stages described below are not a recipe for health. Acceptance may not be the goal for everyone. Emotional processing is made more challenging when survival needs such as shelter, food, and medical care are not being met. Many clients are

used to surviving with "street smarts" and not by psychoanalytical parameters and discussions about childhood. This model is included merely to help providers understand and relate to their experiences and their clients' experiences.

Denial

This is a time of terror management, an effort to psychologically buy some time while adjusting to the information or situation. It is here that people can feel the most isolated and the most suspicious and doubtful of the information that they are receiving. Denial is a natural and healthy response. It is not necessarily something that counselors must feel compelled to confront and rid clients of at the earliest possible moment. Allowing clients to have denial can be challenging, and for the caregivers and support staff it can be anxiety producing, but it is important to remember that above all else, this is the client's experience. Denial is not always negative. The times that denial must be confronted are when it causes a danger to self or others.

Anger

This stage emerges as the person accepts the diagnosis and begins to strike out. The most common targets for this anger are the people closest and safest to him, especially caregivers and service providers. Anger can also be a test. The person facing death may want to know who can be counted on as the end nears. This can sometimes be indirectly demonstrated by the client who may test the counselor's tolerance of anger; if the anger can be tolerated, perhaps the counselor can be trusted to tolerate the client's death and feelings of fear.

Bargaining

Bargaining is the stage at which the individual commits to an uncommonly generous or humanitarian act with the belief that she will be spared or miraculously cured if deemed "good enough." The goal is a miraculous correction of the wrongs she has done, or possibly to buy some valuable time for treatment or dealing with end-of-life issues. The obvious danger is that most are not "cured" in that sense of the word, so what can happen is a loss of belief or faith.

Depression

Depression represents a loss of denial, and an acknowledgment that the information is accurate and the situation and its consequences are unavoidable. As with clinical depression, the depth and severity depends on the specifics of the situation, mitigating factors, available resources, and the individual. This stage is marked by surrender to sadness; it is appropriate and adaptive. It is a time to collect resources and energies so that more processing can occur at a later time.

Acceptance

This is the stage in which some come to terms with their situation and feel a welcomed release from struggle and strife. Option formation and reality-based planning, given the circumstances, become the focus. Acceptance occurs when there is agreement between the physical body, the emotional heart, and the cognitive mind, that death will eventually be the outcome.

Assisting Clients in Preparing Their Children for the Loss of a Parent

It is estimated that the number of children orphaned by HIV/AIDS will increase by 200 percent in the next 20 years. Parents living with HIV/AIDS face a multitude of issues in preparing both seropositive and seronegative children for the loss of their parents. Fortunately, the child care system is developing credible guidelines on working with children with parents living with HIV/AIDS. In addition, placing a focus on providing for the future care and maintenance of the children can serve as a cause for personal motivation and empowerment. Pragmatically, clients should be assisted in preparing their children for the loss of parents in the following areas:

- **Legal guardianship**. Workers should help clients identify significant others or friendswithin the client system who could serve as legal guardians for their children. By stressing that children without legal guardianship become wards of the State, clients sometimes find the motivation to search for and secure guardians for their children. Workers should understand that the search for guardians for children of clients with substance abuse and HIV/AIDS-related issues can be difficult because clients often have exhausted their support system of family and friends well before involvement in formal treatment systems or programs.
- **Standby guardianship**. A standby guardian is someone who agrees to stand ready to assume guardianship (legal responsibility) for a minor when the parent of that child dies or becomes incapacitated. A parent will use the procedure when there is significant risk that he will die or become incapacitated within a certain period of time (e.g., in New York, this period is 2 years). The parent must usually petition a court for the appointment of a specific individual to be the standby guardian. The standby guardian can assume responsibility when the parent becomes incapacitated and then relinquish it when and if the parent recovers. The standby guardian's authority is effective when she receives notification of the parent's incapacity or death.
- **Leaving a legacy of living memories**. An approach often used in agencies is working with parents to create living legacies for their

children. For instance, families may be encouraged to make videotapes or audiotapes of themselves for their children. The National Hospice Organization has an excellent library of grief and bereavement materials, including some very good age-appropriate materials for children.

- **Dealing with survivor guilt.** The issue of survivor guilt is relevant for all family members but particularly so for the infected parent whose infant dies first. The problem of guilt must be brought forth, discussed, and processed so that clients can take a more proactive approach to their other problems.

HIV and Risk of Relapse

Declining health as a result of HIV disease is a recognized risk factor for relapse into substance abuse. Physical and psychological stresses associated with HIV disease include pain, decreased functional ability, fatigue, and weakness, as well as fear, anxiety, grief, and possibly increased isolation and separation from loved ones, all of which increase individuals' risk of resuming substance abuse.

HIV/AIDS milestones are significant for the client, her significant others, and her support network. Counselors often can anticipate crisis, upset, or a readiness for change when a client reaches an HIV/AIDS milestone. Counselors who know and understand these milestones have an opportunity to prepare clients through the development of coping skills and strategies. It is a time of great opportunity for change (becoming clean and sober) or for relapsing. Milestones can create the impetus for a new way and learning new behaviors, or they can serve as an impetus for clients to act in self-destructive or harmful ways.
Following are some of the milestones of HIV infection that counselors should learn to recognize.

- Taking an HIV test
- Receiving positive or negative HIV test results
- Experiencing the first symptoms
- Experiencing the first opportunistic infection
- Experiencing the first AIDS-related hospitalization
- Being diagnosed with AIDS
- Losing a friend, or significant other who dies from AIDS
- Beginning the medication regimen
- Experiencing little or no response to various medication regimens
- Decreasing CD4+ T cell count or increasing viral load

Alcohol and drug counselors may wish to suggest the following strategies to clients who are at risk of relapse because of HIV-related stress:

- Individual counseling

- Participation in a peer support group
- Medical attention to relieve physical discomfort and alleviate anxiety
- Relaxation and stress management techniques
- Recreational activities

Dealing with client relapse

The most successful relapse counseling is nonjudgmental. However, clients should understand that preventing relapse is their responsibility. If a client relapses into a risk behavior for substance abuse or HIV, the counselor's role is to help the client to understand the conditions that caused the behavior to occur and to identify alternative behaviors that could have been substituted to prevent the relapse. Relapse should be viewed as a learning experience and part of the recovery process. Clients should not be dismissed from substance abuse treatment or HIV/AIDS support groups because of a relapse. Rather, peer pressure may be constructively used to help clients acknowledge the reasons for and the consequences of their actions. However, if the client's relapse includes the risk of nonadherence to HIV medications, these medications should be stopped entirely to prevent the emergence of resistance. Once the client is recommitted to therapy, the regimen should be reevaluated.

Case Studies

Case Study 1

Frankie is a 21-year-old, self-admitted gay man. He has been injecting "crystal meth" off and on for 3 years. He has also been a chronic marijuana and alcohol abuser since he was 12 years old. He uses these substances particularly when he can't afford the "rig" and other drugs. He has sold his body for drugs but claims that he only has sex with "nice businessmen types." Frankie is new to the area and has been in town for about 9 months. He says his family does not approve of his lifestyle, so they made him leave home. He is in phone contact with his sister occasionally but only to let her know that he is "alive." Frankie lives in shelters and on the streets with other homeless adults and youth.

Frankie decides to enroll in an outpatient program because he has been hassled by the police lately and he went on a bad run using something called "fry" (marijuana soaked in formaldehyde, then smoked). He ended up in the emergency psychiatric unit at the county hospital and the staff there suggested that he seek some help. In addition, Frankie does know about HIV/AIDS and STDs and is concerned about his sexual behavior.

Issues for the alcohol and drug abuse counselor

Referral and linkages

Frankie will need referrals for counseling and possibly testing for HIV and STDs if the facility does not provide these services. Referrals and linkages can be obtained by getting Frankie's written consent if the facility is communicating with another organization about services for its clients. However, if an outside agency is providing services to the facility, then a Qualified Service Organizational Agreement (QSOA) or Release of Information form will be required in order for the substance abuse treatment facility to be compliant with confidentiality laws. Frankie will also need a risk assessment to help him determine just what his risks are and risk-reduction counseling regardless of his decision about any medical testing.

Special population/cultural competency

The fact that Frankie is gay could be a concern if the treatment facility has not dealt with members of the gay population or has difficulty in dealing with this population. It will be important that Frankie is assigned to a counselor who is nonjudgmental and has had some experience with young gay men.

Relapse

With Frankie, it may not be an issue of relapse as much as getting Frankie to discontinue or cut down his use. He is currently motivated for treatment but this "scare" may not last. A risk reduction model may work best with Frankie as this appears to be his first attempt at treatment and total abstinence may be unrealistic. This should be explored further with Frankie.

Denial/anger

Although Frankie may not have shown any of these emotions yet, they probably should be explored with him (as well as others, such as depression, grief, loss) specifically as it relates to his family and their treatment of him, as well as his having to survive on the streets.

Medical complications

The medical complications to the heart, kidneys, lungs, and brain would be worse if he has HIV/AIDS or any other STDs. Because he has been on the streets, he probably has not seen a doctor for anything until he ended up in the emergency room.

Case Study 2

Tina is a 29-year-old African American female. She has been using marijuana and alcohol since she was a teenager and progressed to using cocaine by her early 20s. Tina reports snorting cocaine for a couple of years when working as a dancer. She then discovered crack, which has been her drug of choice for the last 6 years.

Tina has been in and out of jail several times over the past few years, usually on prostitution charges. While in jail, she always tests for STDs and HIV/AIDS. She has repeatedly tested positive for Chlamydia and has received treatment numerous times. Despite the treatments for the STD, she continues to test positive. During her most recent incarceration she was diagnosed with pelvic inflammatory disease, had an abnormal Pap smear, and tested positive for HIV. Other than being a little underweight she looks good and states that she feels fine with the exception of some abdominal pain.

Tina is very excited about her "new life" with her boyfriend, by whom she has been trying to become pregnant. Having HIV/AIDS does not seem to be a major concern for Tina because she knows that there is medication out there for the disease. She reports that she was already getting off drugs before the bust because she wants to get married and have a baby now that she's found the right man. She reports her main support to be her boyfriend of 2 months. She does have a couple of female friends but does not consider them close.

She has been court ordered to go to substance abuse treatment. She has made several treatment attempts before and states she doesn't understand why she has to go to treatment now when she was already planning to stop her drug use voluntarily. She is now being admitted to a 30-day inpatient treatment program; otherwise, she faces going to jail for a minimum of 1 year.

Issues for the alcohol and drug abuse counselor

Relapse

This is the main area of concern. Tina has a long history of substance abuse. She reports little to no social support for her recovery. The nature of crack addiction suggests that a 30-day inpatient setting will "only be the beginning" of the treatment episode. The connection and consequences of high-risk activities need to be discussed and risk-reduction practices demonstrated and rehearsed. It appears that Tina is clearly in denial about her addiction and diseases and does not understand treatment and recovery. This may be exhibited through her either becoming a "compliant client" just to get along or a defiant, angry client because she doesn't think she needs treatment.

Medical

Tina has a number of medical issues that must be addressed and further explored. Tests and treatment for recurrent STDs, pelvic inflammatory disease, abnormal Pap smear, and HIV/AIDS are needed. With further exploration cervical cancer may be revealed, which could, in turn, give her an AIDS diagnosis. A pregnancy test may also be needed. The counselor needs to remember that it is Tina's decision about the issue of pregnancy. A counselor should watch for the issues relating to HIV/AIDS and pregnancy that can arise.

Referrals and linkages

Tina will need medical referrals. She has so many issues in this area she would benefit by having an HIV/AIDS case manager to assist her in linking with and coordinating appointments, medication, and so on. She may also need all the "standard" services such as housing, transportation, and clothing.

8. Top Mental and Physical Health Issues for LGBT Populations

This Top Health Issues for LGBT Populations Information & Resource Kit presents an overview of current health issues among lesbian, gay, bisexual, and transgender (LGBT) populations. While many challenges exist with regards to the availability of data, this kit aims to create awareness among prevention specialists and healthcare providers of the needs, experiences, and health status of LGBT Americans.

SAMHSA has identified a number of goals and action steps relevant to LGBT populations that include: increasing social inclusion and reducing discrimination; preventing suicides and suicide attempts among LGBT youth; developing culturally relevant materials related to trauma and military service; and reducing disparities in access to—and quality of—behavioral healthcare services, among others.
This section is designed for a wide-range of organizations and individuals that serve LGBT populations across the country. These include prevention specialists working in State, Territorial, and Tribal community-based organizations; behavioral healthcare providers; medical and other allied health professionals; health educators; technical assistance providers; and LGBT individuals. The tools in this information and resource kit (i.e., fact sheets and PowerPoint slides) may be used individually or together to raise awareness of the physical and behavioral health status and needs of LGBT populations.

Helpful Terms for Prevention Specialists and Healthcare Providers

As with many other populations, there are terms and definitions that are specific to LGBT populations. Creating awareness and understanding of these terms is essential to promoting cultural competence among prevention specialists and healthcare providers, as well as ensuring sensitivity toward LGBT individuals. While not exhaustive, the

following is an overview of terms and related definitions related to gender identity, gender expression, and sexual orientation that people use to self-identify. When addressing LGBT individuals, prevention specialists and healthcare providers should always ask clients how they identify and/or wish to be addressed. Note: Prevention specialists and healthcare providers should be aware that language is dynamic and evolves over time. Therefore, terms, definitions, and how LGBT individuals identify varies based upon a number of factors, including geographic region, race/ethnicity, and socioeconomic status, among others.

TERMS AND DEFINITIONS SPECIFIC TO GENDER IDENTITY

- ✓ Bigender: A person whose gender identity encompasses both male and female genders. Some may feel that one identity is stronger, but both are present.

- ✓ FTM: A person who transitions from female-to-male, meaning a person who was assigned the female sex at birth but identifies and lives as a male. Note: Also known as a transgender man.

- ✓ Gender identity: A person's internal sense of being male, female, or something else. Since gender identity is internal, one's gender identity is not necessarily visible to others.

- ✓ Gender nonconforming: A person whose gender expression is different from societal expectations related to their perceived gender.

- ✓ Genderqueer: A term used by persons who may not entirely identify as either male or female.

- ✓ MTF: A person who transitions from male-to-female, meaning a person who was assigned the male sex at birth but identifies and lives as a female. Note: Also known as a transgender woman.

- ✓ Transgender: A person whose gender identity and/or expression is different from that typically associated with their assigned sex at birth. Note: The term transgender has been used to describe a number of gender minorities including, but not limited to, transsexuals, cross-dressers, androgynous people, genderqueers, and gender non-conforming people. "Trans" is shorthand for "transgender."

- ✓ Transgender man: A transgender person who currently identifies as a male (see also "FTM").

- ✓ Transgender woman: A transgender person who currently identifies as a female (see also “MTF”).

- ✓ Transsexual: A person whose gender identity differs from their assigned sex at birth.

- ✓ Two-Spirit: A contemporary term that references historical multiple-gender traditions in many First Nations cultures. Many Native/First Nations people who are lesbian, gay, bisexual, transgender, or gender non-conforming identify as Two-Spirit. In many Nations, Two-Spirit status carries great respect and leads to additional commitments and responsibilities to one’s community.

TERMS AND DEFINITIONS SPECIFIC TO GENDER EXPRESSION

- ✓ Cross-dresser: A person who dresses in clothing typically worn by people of the opposite gender, but who generally has no intent to live full-time as the other gender.

- ✓ Drag king: A woman who dresses as a man for the purpose of entertaining others at bars, clubs, or other events.

- ✓ Drag queen: A man who dresses as a woman (often celebrity women) for the purpose of entertaining others at bars, clubs, or other events.Note: The term drag queen is also used as slang, sometimes in a derogatory manner, to refer to all transgender women.

- ✓ Gender expression: The manner in which a person represents or expresses their gender identity to others. Note: Gender expression may be conveyed through behavior, clothing, hairstyles, voice, and/or body characteristics.

- ✓ Passing: A term used by transgender people to mean that they are seen as the gender with which they self-identify. For example, a transgender man (assigned the female sex at birth) who most people see as a man might say that he is passing as a man.

- ✓ Transition: A term used to describe the period during which a transgender person begins to express their gender identity. Note: During transition, a person may change their name, take hormones, have surgery, and/or change legal documents (e.g., driver’s license, Social Security record, birth certificate) to reflect their gender identity.

TERMS AND DEFINITIONS SPECIFIC TO SEXUAL IDENTITY AND SEXUAL ORIENTATION

- ✓ Bisexual: A person who self-identifies as having an emotional, sexual, and/or relational attraction to men and women.

- ✓ Coming out: The process through which a person identifies, acknowledges, and decides to share information about their sexual orientation and/or gender identity with others.

- ✓ Gay: A man who self-identifies as having an emotional, sexual, and/or relational attraction to other men. Note: The term gay may be used by some women who prefer it over the term lesbian.

- ✓ Lesbian A woman who self-identifies as having an emotional, sexual, and/or relational attraction to other women.

- ✓ MSM: An acronym used to identify men who have sex with men. MSM is a term used to identify and describe a behavior among males and is not the same as a sexual identity or sexual orientation.

- ✓ Outing: The act of exposing information about a person's sexual orientation and/or gender identity without their consent.

- ✓ Queer: A term usually used to refer to specific sexual orientations (e.g., lesbian, gay, bisexual). Note: Some individuals use queer as an alternative to gay in an effort to be more inclusive, since the term queer does not convey a sense of gender. However, depending on the user, the term can have either a derogatory or an affirming connotation.

- ✓ Sexual orientation: A person's emotional, sexual, and/or relational attraction to others. Sexual orientation is usually classified as heterosexual, bisexual, and homosexual (i.e., lesbian and gay).

- ✓ WSW: An acronym used to identify women who have sex with women. WSW is a term used to identify and describe a behavior among females and is not the same as a sexual identity or sexual orientation.

For many, the acronym LGBT reflects a community of individuals who, in some way, are

attracted to members of the same sex. However, many people fail to realize that the "T" in the acronym does not relate to sexual attraction at all; rather, it refers to a person's sense of gender (referred to as gender identity).
There are several schools of thought or theories about how a person develops, accepts, and expresses their gender identity. These include, but are not limited to, psychoanalytic theories, gender essentialism, cognitive development theories, and gender schema theories, among many others. While not exhaustive, the following is a brief overview of some of these perspectives.

GENDER VS. SEX: A FUNDAMENTAL SHIFT FROM AN EXCLUSIVE BINARY PARADIGM

Before the 19th century, the terms gender and sex were synonymous, as these were based on an exclusive binary paradigm (i.e., male/female). Until then, the only determinant of gender was a person's assigned sex at birth. However, in the mid-1920s, German sexologist Magnus Hirschfeld published an article making the first differentiation between the desire for same-sex acts and the desire to live and/or dress as the opposite sex. It wasn't until the 1950s that the concepts and theories about gender, gender roles, and gender identity were introduced and defined in the literature. Psychologists, such as Jerome Kagan and John Money, initially believed that gender identity was the extent to which a person felt masculine or feminine. This fundamental feeling, coupled with the ability to meet cultural standards for specific gender roles (referred to as sex typing), was thought to be necessary for possessing a secure sense of self and overall well-being. During the mid-1960s to early 1980s, researchers such as Richard Green, Robert Stoller, Harry Benjamin, and Sandra Bem furthered the understanding of gender and gender identity. For example, Bem's research focused on the effects of normative behaviors and argued that adhering to gender-related standards could, in fact, promote negative rather than positive adjustment. Benjamin, Stoller, and Green believed that incongruence between a person's assigned sex at birth and their gender identity was of a biological, rather than psychological nature and went on to pioneer the establishment of gender identity clinics, as well as gender-related medical and surgical treatments. B–1

GENDER IDENTITY DEVELOPMENT: NATURE OR NURTURE?
DEVELOPMENTAL PERSPECTIVE: NATURE

In the 1990s, psychologist and researcher Diane Ruble suggested that gender identity is developed in three stages: construction (ages 0–5), consolidation (ages 5–7), and integration (ages 7 and up). During construction, children seek information about gender and do not necessarily react strongly to norm violations (e.g., a boy may play with a Barbie doll). In the consolidation phase, children have well-developed
gender stereotypes and show rigidity about their gender beliefs (e.g., a boy may avoid or refuse to touch a Barbie doll). Lastly, in the integration phase, children may show more

flexibility and individual differences in how they think about gender (e.g., a boy may choose to play with certain types of dolls).

ENVIRONMENTAL PERSPECTIVE: NURTURE

Contemporary perspectives on human development challenge the notion that the process of identity development is intrinsic to an individual or that one construct can explain such a dynamic process. Many researchers believe that identities develop as a result of complex interactions between an individual and their environment. For example, some research suggests that three external factors may influence how a person develops and ultimately expresses their gender identity: centrality, evaluation, and felt pressure. Centrality refers to how important gender is to a person's overall identity; evaluation refers to how a person views his or her gender in terms of cultural standards, beliefs, and norms; and felt pressure refers to a person's feelings about the need to conform to these cultural standards, beliefs, and norms.

GENDER IDENTITY DISORDER: A MEDICAL PERSPECTIVE

Though many people, including clinicians, do not consider transgender people to have a disorder, the medical community developed a specific diagnosis now known as Gender Identity Disorder (GID), for children and adults whose gender identity and gender expression are not aligned with their assigned sex at birth.

Diagnoses related to gender identity first appeared in the third version of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III) published in 1980 and included Gender Identity Disorder for Children, Transsexualism (for adolescents and adults), and gender identity disorder of adolescence and adulthood, nontranssexual type (added in the DSM III-R in 1987). With the release of the DSM IV in 1994, the three gender identity-related diagnoses were collapsed into one, known as Gender Identity Disorder, with different criteria for children and adults that included a persistent discomfort with the assigned sex at birth; a persistent discomfort with the role typically associated with their assigned sex at birth; and significant discomfort or impairment at work, social situations, or other major life areas.

There are no comprehensive studies of the prevalence of GID among children, adolescents, or adults. Nonetheless, there is stark contrast in the literature about the estimated prevalence of GID. According to researchers who use estimates from a government-subsidized gender identity clinic in the Netherlands as a benchmark, the prevalence rate of GID among men is approximately 1 in 11,900 and among women is approximately 1 in 30,400. However, it is important to note that this and other prior estimates are based solely on the transsexual minority of transgender people (i.e., those who present for a diagnosis of GID and referral for treatment for medical transition to the

opposite gender). It is likely that many more transgender people do not present for such treatment and have not been included in these estimates.

TRANSGENDER

Nowadays, the term transgender is an umbrella term for people whose gender identity, expression and/or behavior is different from those typically associated with their assigned sex at birth. Since the 1990s, the term has often been used to describe groups of gender minorities including but not limited to transsexuals, cross-dressers, androgynous people, genderqueers, and gender non-conforming people. To clarify gender differences among transgender individuals, transgender men had or have female body parts; however, they may identify and/or express themselves as male. Conversely, transgender women had or have male body parts; however, they may identify and/or express themselves as female.

RELATIONSHIP TO SEXUAL ORIENTATION

Research shows that gender identity, in many cases, is independent of sexual orientation. For example, transgender men may be attracted to men, women or both, and transgender women may be attracted to men, women or both. Transgender men may also partner with other transgender men and transgender women, and transgender women may also partner with other transgender women and transgender men. Prevention specialists and healthcare providers should be aware that beliefs around gender can, and often do, touch upon many aspects of life. These beliefs can manifest in a number of areas ranging from reactions toward clothing individuals wear to the pronouns used during clinical assessments. It is important for providers to demonstrate sensitivity to all clients, regardless of perceived gender, when communicating to and/or about clients.

Top Health Issues for Lesbians

PHYSICAL HEALTH HEART DISEASE

The more risk factors a woman has, the greater the chance that she will develop heart disease. Factors that raise women’s risk for heart disease include physical inactivity, obesity, and smoking—all of which have been found to be more prevalent among lesbians than other women.
CANCERS: Lesbians are at significantly higher risk for developing breast cancer than heterosexual women. Risk factors for breast cancer among lesbians include fewer full-term pregnancies, fewer mammograms and/or clinical breast exams, and being overweight. Traditionally, lesbians and bisexual women have been less likely to bear children and, as a result, may not fully benefit from hormones released during pregnancy and breastfeeding. These hormones are believed to protect women against different types of cancers.

Lesbians have also been less likely to visit a doctor or nurse for routine screenings than heterosexual women. Routine screenings, such as Pap tests and mammograms, are critical to the prevention or early detection of breast, cervical, and other cancers among all women.

FITNESS: Some research has indicated that adult lesbians are not sufficiently physically active. In a recent study, lesbian participants identified barriers to participating in exercise, such as being too tired, not having a physical activity partner, finding a lack of lesbian-focused physical activity groups, and lacking same-sex family memberships to fitness facilities. Interventions developed for the general population of women are likely to be less effective in assisting lesbians to include exercise as part of their daily or weekly routine. Providers should be aware of an additional important factor: lesbians tend to possess somewhat different attitudes about beauty than do heterosexual women. As a result, lesbians' current weight, and perceptions of being overweight, may not necessarily contribute to their likelihood of engaging in frequent exercise.

OBESITY: Some groups of lesbian women are more likely to be overweight and obese than females of other sexual orientations. Specifically, higher prevalence rates of obesity have been found among lesbians who are: AfricanAmerican; live in rural or urban areas; have lower levels of education; and are from a low socioeconomic status. Providers should encourage all women to seek routine health assessments to determine their weight status.

INJURY/VIOLENCE: Studies have shown that lesbian women and gay men report experiencing harassment or physical violence from family members due to their sexual orientation.15 In addition, when compared with straight adults (17.5 percent), a significantly higher percentage of lesbian or gay adults (56.4 percent) and bisexual adults (47.4 percent) report experiencing intimate partner violence.16 Providers should routinely assess women for a history of domestic violence and/or victimization.

BEHAVIORAL HEALTH MENTAL HEALTH: Many factors affect the mental and emotional health of lesbian women. For example, a research study found that adverse, punitive, and traumatic reactions from parents and caregivers in response to their children's sexual orientation were closely correlated with poor mental health and an increase in substance use. Among adults, a study that examined the risk of psychiatric disorders among individuals with same-sex partners found that, during the previous 12 months, women with same-sex partners experienced more mental health disorders—such as major depression, phobia, and post-traumatic stress disorder—than did women with opposites partners. Studies have found that lesbian and bisexual women consult general practitioners for emotional reasons more often than heterosexuals if their primary care physician is aware of their sexual orientation. However, not all lesbian and bisexual women want to disclose their sexual orientation. Building positive rapport with clients and creating a safe environment for the sharing of sensitive information, such as sexual

orientation and/or sexual behaviors, could lead to more opportunities for the screening and monitoring of critical behavioral health indicators such as smoking status, alcohol use, and mental health.

SUICIDE: Results from an anonymous survey administered in 33 healthcare sites across the United States showed that sexual orientation was associated with higher levels of emotional stress and other types of mental health disorders. Specifically, the study found that lesbian and bisexual women who were “out” experienced more emotional stress as teenagers and were 2 to 2.5 times more likely to experience suicidal ideation in the past 12 months than heterosexual women. Meanwhile, lesbian and bisexual women who were not “out” were more likely to have attempted suicide than heterosexual women. It is critical for providers to discuss with clients their coming out experience and/or plans to come out to friends and family. Many times, clients will need resources and support for this critical milestone.

SUBSTANCE ABUSE: Studies have found that lesbians are between 1.5 and 2 times more likely to smoke than heterosexual women. Among lesbians, younger women are more likely to smoke than older women, while “butch” lesbians are much more likely to smoke and use marijuana than young “femme” lesbians. Experiences of gay-related stressful events, internalized homophobia, and emotional distress were found to account for most of the butch/femme differences in tobacco and marijuana use. The difference between the two age groups may be explained, in part, by younger women being more likely to socialize in bar settings. A number of studies have also suggested that lesbians are significantly more likely to drink heavily than heterosexual women. Specifically, exclusively heterosexual women tend to have lower drinking rates than all other women, while bisexual women report more hazardous drinking than heterosexual or lesbian women. These findings suggest that prevention and treatment programs aimed at addressing substance use among lesbian and bisexual women must also address experiences of gay-related stress and emotional distress.

This publication lists non-Federal resources to provide additional information. The views and content in these resources have not been formally approved by the U.S. Department of Health and Human Services (HHS). Listing of the resources is not an endorsement by HHS or its operating divisions.

Top Health Issues for Gay Men

PHYSICAL HEALTH HEART DISEASE: Heart disease remains a significant concern for men of all sexual orientations. Major risk factors for heart disease among men include tobacco use and alcohol use—behaviors prevalent among gay men.

CANCER: In some cases, gay men are at increased risk for several types of cancer—including prostate, testicular, and colon cancers. In addition, gay men, as well as anyone

who has receptive anal sex, are at higher risk for anal cancer due to an increased risk of becoming infected with human papillomavirus (HPV), the virus that causes genital and anal warts. However, access to screening services may be severely limited due to issues and challenges in receiving culturally sensitive care.

INJURY AND VIOLENCE: Data show that gay men generally experience two types of violent victimization: criminal violence based on their sexual minority status, and violence from an intimate male partner. As a result, providers should routinely assess their male clients for a history of domestic violence and/or victimization.

FITNESS: Problems with body image are more common among gay men than among their straight counterparts. In addition, gay men are much more likely to experience an eating disorder such as bulimia or anorexia nervosa.Therefore, providers should be able to recognize the signs and symptoms of eating disorders and supply their male clients with the necessary referrals for behavioral health services.

BEHAVIORAL HEALTH/MENTAL HEALTH: Multiple studies have shown that depression and anxiety affect gay men at a higher rate than the general population, and are often more severe for men who remain “in the closet.” Culturally sensitive mental health services that specifically target gay men have been shown to be more effective in the prevention, early detection, and treatment of these conditions.

SUICIDE: Factors such as verbal and physical harassment, negative experiences related to “coming out” (including level of family acceptance), substance use, and isolation all contribute to higher rates of suicidal attempts and completions among gay men and youth than among other populations.

SUBSTANCE ABUSE: Recent studies have improved our understanding of substance use in the gay community. Specifically, some studies show that gay men use substances, including alcohol and illicit drugs, at a higher rate than the general population—not just in larger communities such as New York, San Francisco, and Los Angeles. Many studies also indicate that gay men use tobacco at much higher rates than straight men—reaching nearly a 50 percent difference in some cases. It is important for providers to understand that alcohol and illicit drug use among gay men is significantly affected by factors such as age, affiliation with gay culture, level of stress, and how “out” an individual is, among others. Therefore, culturally sensitive and accessible prevention and treatment programs are critical for addressing substance use among gay men.

SEXUAL HEALTH/SEXUALLY TRANSMITTED DISEASES: HIV/AIDS: The fact that men who have sex with men (MSM) are at an increased risk of HIV infection has been well documented. In 2006, MSM accounted for 48 percent of the more than 1 million people living with HIV in the United States and accounted for 53 percent of all

newly diagnosed HIV infections in the United States. While the Centers for Disease Control and Prevention (CDC) estimates that MSM account for just 4 percent of the U.S. male population ages 13 and older, the rate of new HIV diagnoses among MSM in the United States is more than 44 times that of other men (range: 522–989 per 100,000 MSM vs. 12 per 100,000 other men). Of young MSM, African-American MSM bear the greatest HIV/AIDS burden. More than twice as many AfricanAmerican MSM ages 13–24 were diagnosed with HIV infection or AIDS in 2006 as their White or Hispanic counterparts. In addition, African-American and Hispanic MSM were more likely to become infected with HIV at a younger age (13–29 years), whereas White MSM were more likely to become infected when they were older (30–39 years). The effectiveness of safer sex practices for reducing the rate of HIV infection is one of the gay community's great success stories. Safer sex has been shown to be effective in reducing the risk of receiving and transmitting HIV. However, studies over the last few years have demonstrated the return of many unsafe sex practices. Providers should be aware of how to counsel their patients to support the maintenance of safer sex practices.

SEXUALLY TRANSMITTED DISEASES: OTHER INFECTIONS: Sexually transmitted diseases (STDs) occur at a high rate among sexually active gay men. This includes STD infections for which effective treatment is available (e.g., syphilis, gonorrhea, chlamydia, pubic lice, anal papilloma) and for which no cure is currently available (e.g., HIV; hepatitis A, B, or C virus; human papillomavirus).

SYPHILIS: Over the past several years, an increase in syphilis among MSM has been reported in various cities and areas— including outbreaks in Chicago, Seattle, San Francisco, Southern California, Miami, and New York City. These areas have experienced high rates of syphilis and HIV co-infection, ranging from 20 to 70 percent. The health problems caused by syphilis can be serious. Additionally, it is now known that contracting syphilis also makes one more likely to transmit or acquire HIV infection sexually.

HPV: The human papillomavirus (HPV), which causes anal and genital warts, is often downplayed as an unsightly inconvenience. However, HPV infections may play a role in the increased rates of anal cancers among gay men. Gay and bisexual men are estimated to be 17 times more likely to develop anal cancer than heterosexual men. While treatments for HPV do exist, recurrences of the warts and the rate at which the infection can be spread between partners are very high. Certain populations (including gay and bisexual men, people with weak immune systems, and people with HIV/AIDS) are also at higher risk for some HPV-related health problems. There is no doubt that safer sex reduces the risk of STDs; prevention of these infections through safer sex is key.

HEPATITIS: MSM are at increased risk of acquiring sexually transmitted infections carrying viruses that cause the serious liver condition known as hepatitis. In the United States, cases of hepatitis among MSM are primarily caused by one or more of the

following viruses: Hepatitis A virus (HAV) is primarily transmitted by the fecal-oral route, through either person-to-person contact or consumption of contaminated food or water. Hepatitis B virus (HBV) is transmitted through percutaneous (puncture through the skin) or mucosal contact with infectious blood or body fluids. HBV can cause acute illness and/or lead to chronic or lifelong infection, cirrhosis (scarring) of the liver, liver cancer, liver failure, and death. Hepatitis C virus (HCV) is spread by sexual contact and/or contact with the blood of an infected person, and can cause a liver disease that sometimes results in an acute illness, but more often becomes a silent, chronic infection that can lead to cirrhosis (scarring), liver failure, liver cancer, and death. While some infections can be fatal, especially among MSM with other chronic conditions (e.g., HIV) immunizations are available to prevent two of the three hepatitis viruses. Universal immunization for HAV and HBV is recommended for all MSM. Data furthermore show that safer sex is effective at reducing the risk of viral hepatitis and is currently the only means of prevention for HCV.

Top Health Issues for Transgender People

PHYSICAL HEALTH: Available research related to physical health issues among transgender people is extremely limited and mainly conducted abroad. Furthermore, studies of how medical interventions, such as hormone therapy and/or sexual reassignment surgeries, affect overall physical health and well-being remain extremely limited. There is limited evidence to suggest an association between feminizing hormone therapies, such as estrogenprogestin combinations, and an elevated risk for venous thromboembolic disease and increased levels of prolactin. Some research also suggests an association between masculinizing hormone therapies, such as testosterone, and elevated liver enzymes, loss of bone mineral density, and increased risk for ovarian cancer. However, no clinical trials have been conducted to examine, longitudinally, the long-term effects of hormone therapies on overall physical health.

INJURY AND VIOLENCE: Violence against transgender people, especially transgender women of color, continues to occur in the United States. Numerous studies have suggested that between 16 to 60 percent of transgender people are victims of physical assault or abuse, and between 13 to 66 percent are victims of sexual assault. Intimate partner violence has also been found to be a prominent issue for transgender people. Social stigmatization and other factors may additionally lead to an under-reporting of acts of violence committed against transgender people.

BEHAVIORAL HEALTH/ SUICIDE: Studies have shown that suicidal ideation is widely reported among transgender people and can range from 38 to 65 percent. More alarmingly, studies have also found that suicide attempts among transgender people can range from 16 to 32 percent. Access to culturally-sensitive suicide prevention resources and supportive services for transgender people remains a critical priority.

MENTAL HEALTH: Data about the prevalence of mental health disorders such as depression, anxiety, and other clinical conditions among transgender people are extremely limited. To date, most studies focusing on mental health disorders among transgender people use non-probability samples, and few compare the mental health of transgender to non-transgender people. The few recent studies that have compared the mental health status of transgender people to non-transgender people have yielded mixed results. On one hand, a recent study found that transgender women were more likely than non-transgender men and heterosexual women to report suicidal ideation and attempts, take psychotropic medications, and have a problem with alcohol; but no such differences were found between transgender women. On the other hand, another study found that, when compared to men who have sex with men and bisexually active women, transgender women were most likely to report depressive symptoms and suicidal ideation.

SUBSTANCE ABUSE: Alcohol and substance abuse has been identified as a major concern among transgender people in the United States. Some studies have shown that marijuana, crack cocaine, and alcohol are the most commonly used drugs by transgender people. Other studies have also found alarming rates of methamphetamine use (4 to 46 percent; with the highest rates found in Los Angeles and San Francisco), as well as injection drug use (2 to 40 percent). High rates of tobacco use, specifically cigarette smoking, have also been found among transgender people. Some studies suggest that tobacco use rates can range from 45 to 74 percent. It is critical for prevention specialists and healthcare providers to note that, in transgender women who take estrogen, smoking greatly increases the chances for blood clots. These risks are similar to those faced by non-transgender women who smoke and take oral contraception or undergo hormone replacement therapy (HRT). In addition, transgender men who take testosterone increase their risk of heart disease, and smoking further increases that risk. Access to substance abuse treatment services can be very difficult for transgender people and therefore remains a critical priority. Studies have suggested that barriers to treatment services often include discrimination, provider hostility and insensitivity, strict binary gender (male/female) segregation within programs, and lack of acceptance in gender-appropriate recovery groups. Enhancing access to culturally-competent prevention and treatment providers for transgender people is essential in addressing the current behavioral health disparities within this population.

SEXUALLY TRANSMITTED DISEASES: HIV/AIDS: The HIV/AIDS epidemic has had a significant effect on transgender people. However, due to a lack of systematic surveillance and reporting of HIV prevalence rates among transgender people, the exact prevalence of HIV among this population remains unknown. In a recent 12-city study, HIV prevalence rates among transgender women were found to vary from 5 to 68 percent. Studies continue to suggest that HIV infection is highest among transgender women of color, with HIV prevalence rates ranging from 41 to 63 percent among African-American transgender women; 14 to 50 percent among Latina transgender

women; and 4 to 13 percent among Asian-Pacific Islander transgender women. Although under-examined, HIV prevalence in transgender men (FTMs) is estimated to range from 2 to 3 percent. In the first studies of HIV among MTF transgender youth, HIV prevalence varied from 19 to 22 percent, showing them to be at high risk for infection. Despite high HIV prevalence rates among transgender women, some studies suggest a disparity in the availability of HIV treatment services. For example, a recent four-city study found that transgender women were less likely to receive highly active anti-retroviral therapy than a control group of men who have sex with men (MSM), heterosexual women and men, and male intravenous drug users (IDUs).

OTHER INFECTIONS: As with HIV/AIDS, there is a lack of systematic surveillance of sexually transmitted diseases (STDs) among transgender people. However, some research has found varying prevalence rates of syphilis (3 to 79 percent); gonorrhea (4 to 14 percent); chlamydia (2 to 8 percent); herpes (2 to 6 percent); and human papillomavirus (HPV) (3 to 7 percent) within the population.Prevalence rates of other infectious diseases among transgender people are not well known. Limited studies have found hepatitis C prevalence rates between 11 to 24 percent and hepatitis B rates from 4 to 76 percent among specific samples of transgender women. Other studies on non-sexually transmitted diseases, such as tuberculosis (TB), found a prevalence rate of up to 13 percent among transgender women in San Francisco.

The following resources are provided to assist prevention specialists and healthcare providers in understanding the health issues of LGBT populations. Resources are organized into three categories: Substance Abuse-Related Resources; Other LGBT HealthRelated Resources; and LGBT Advocacy, Education, Research, and Services Resources. Within these three categories, the resources are separated into Federal Resources, State/ National Resources, and Other Research-Based Resources. This list of resources is not intended to be exhaustive. Rather, it is meant to provide additional sources of information on health-related issues for LGBT populations to supplement the information provided in this information and resource kit.

SUBSTANCE ABUSE-RELATED RESOURCES FEDERAL RESOURCES

National Institute on Alcohol Abuse & Alcoholism (NIAAA): Social Work Curriculum on Alcohol Use Disorders: Module 10G: Sexual Orientation and Alcohol Disorders: The goal of this module is to increase social workers' understanding of, and responsiveness to, the unique characteristics and concerns of LGBT individuals in relation to alcohol use, prevention, and treatment. Some of the contents of this module have been adapted for this article. http://pubs.niaaa.nih.gov/publications/social/Module10GSexualOrientation/Module10G.html

SAMHSA Center for Behavioral Health Statistics and Quality (CBHSQ) (formerly Office of Applied Studies [OAS]) OAS Data Spotlight, June 2010: This brief report on data from the National Survey of Substance Abuse Treatment Services (N-SSATS) shows that only 777 of 13,688 (6 percent) substance abuse treatment facilities across the Nation offers special programs for gay and lesbian clients. http://oas.samhsa.gov/spotlight/Spotlight004GayLesbians.pdf

SAMHSA/CSAT: A Provider's Introduction to Substance Abuse Treatment for Lesbian, Gay, Bisexual and Transgender Individuals Training Curriculum, First Edition Based on the 2001 SAMHSA/CSAT publication, the curriculum was released in 2007 and offers skill-building knowledge to enhance sensitive, affirmative, culturally relevant, and effective treatment to LGBT individuals in substance use disorders treatment. http://www.attcnetwork.org/regcenters/generalContent.asp?rcid=12&content=STCUSTOM3

SAMHSA/CSAT Una Introducción para el Proveedor de Tratamiento de Abuso de Sustancias para Lesbianas, Gays, Bisexuales e Individuos Transgénero In March 2010, the CSAT-supported Caribbean Basin & Hispanic Addiction Technologies Transfer Center released its Spanish-language curriculum based on the 2001 CSAT A Provider's Introduction publication. http://www.attcnetwork.org/regcenters/productdetails.asp?prodID=553&rcID=1

STATE/NATIONAL RESOURCES

Association of Lesbian, Gay, Bisexual, and Transgender Addiction Professionals and Their Allies (NALGAP) NALGAP is a membership organization founded in 1979 and dedicated to the prevention and treatment of alcoholism, substance abuse, and other addictions in LGBT communities. In 1994, the group issued a three page Prevention http://www.nalgap.org

LGBT TRISTAR
This is a San Francisco-based technical assistance contractor funded by the California Department of Alcohol and Drug Programs to improve access to appropriate substance abuse prevention, treatment, and recovery services for California's LGBT population. TRISTAR has issued a series of "Best Practices" papers, archived on its site, that include information likely to help in designing effective prevention for this population. http://www.lgbt-tristar.com/

Los Angeles Gay & Lesbian Center: Alcohol, Tobacco, & Other Drug Prevention
This calendar of substance-free events is offered through the Center's Alcohol, Tobacco, & Other Drug Prevention program. Some events were developed as environmental prevention strategies to counter alcohol and tobacco promotions at LGBT festivities.

National LGBT Tobacco Control Network
Housed at The Fenway Institute, the network works to support the many local tobacco control advocates in helping to eliminate tobacco health disparities for all LGBTs. Within the Guidelines and Best Practices area of its Resources pages are community assessments and other documents useful in developing substance abuse prevention for LGBTs. http://www.lgbttobacco.org/

National Network to Eliminate Disparities (NNED) in Behavioral Health
NNED is supported by the Substance Abuse and Mental Health Services Administration (SAMHSA), National Institutes of Health/National Center on Minority Health and Health Disparities, and the Annie E. Casey Foundation. The NNED Web site archives files of documents and presentations relating to events and news about health disparities.

OTHER RESEARCH-BASED RESOURCES

American Lung Association (ALA): Smoking Out: A Deadly Threat: Tobacco Use in the LGBT Community as part of ALA's Disparities in Lung Health series, this report summarizes recent data on smoking prevalence among lesbian, gay, bisexual, and transgender (LGBT) individuals and reviews contributing factors and potential strategies to reduce smoking in this population. http://www.lungusa.org/assets/documents/publications/other-reports/lgbt-report.pdf

American Legacy Foundation: Lesbian, Gay, Bisexual, and Transgender (LGBT) Communities and Smoking Factsheet This two-page summary contains key facts from published sources about LGBT tobacco use, with footnoted reference citations. http://www.legacyforhealth.org/PDFPublications/LGBTfactsheet.pdf

Arizona Division of Behavioral Health Services LGBTQ Advisory Committee Training Webinar Series, the advisory group hosted a series of training Webinars on a broad range of LGBTQ behavioral health topics. Fifteen of these training programs were recorded and archived; several relate directly to substance abuse. http://www.azdhs.gov/bhs/pdf/LGBTQSeriesRecordings.pdf

WHO Guidelines for the Prevention and Treatment of HIV among men who have sex with men and transgender people The Guidelines focus on the prevention and treatment of HIV and other sexually transmitted infections (STIs) among men who have sex with men (MSM) and transgender people. They include evidence-based recommendations, the summary and grading of evidence, implementation issues and key research gaps. http://www.who.int/hiv/pub/guidelines/msm_guidelines2011/en/index.html

OTHER LGBT HEALTH-RELATED RESOURCES

FEDERAL RESOURCES

Agency for Healthcare Research and Quality (AHRQ), U.S. Department of Health and Human Services (HHS) Documents archived in the AHRQ Web site's Innovations Exchange pages include a snapshot of a statewide LGBT tobacco cessation program in Minnesota, New Communication Protocols, Inclusive Policies, and Ongoing Training Lead to Culturally Competent Care for Lesbian, Gay, Bisexual, and Transgender Patients, issued at the end of 2010, and a quit guide for LGBT communities. http://www.innovations.ahrq.gov/innovations_qualitytools.aspx?search=LGBT

CDC Compendium of HIV Prevention Interventions with Evidence of Effectiveness Interventions identified by CDC's HIV/AIDS Prevention Research Synthesis Project were found to be effective in reducing sex- and drug-related risk behaviors or improving health outcomes. Some target LGBTs; others target groups likely to include LGBTs. http://www.cdc.gov/hiv/resources/reports/hiv_compendium/

CDC Health Risks Among Sexual Minority Youth
This section of the CDC Web site summarizes the findings of a report published in Morbidity and Mortality Weekly Report, Vol. 60. LGBT youth were found to be more likely than their non-LGBT peers to engage in a list of unhealthy behaviors in an analysis of data from Youth Risk Behavior Surveys that was conducted in seven States—Connecticut, Delaware, Maine, Massachusetts, Rhode Island, Vermont, and Wisconsin—and six large urban school districts—Boston, Chicago, Milwaukee, New York City, San Diego, and San Francisco. Report sections provide specific estimates for alcohol, tobacco, and drug use among this population.

CDC Lesbian, Gay, Bisexual and Transgender Health
This CDC site provides information and resources on health issues and inequities affecting LGBT communities for both professional and general public audiences, including links to other sources. http://www.cdc.gov/lgbthealth/

HHS Healthy People 2020
HHS's Healthy People 2020 provides science-based, 10-year national objectives for improving the health of all Americans. The document integrates input from public health and prevention experts, a wide range of Federal, State, and local government officials, a consortium of more than 2,000 organizations, and the public. More than 8,000 comments were considered in drafting a comprehensive set of Healthy People 2020 objectives. Based on this input, a number of new topic areas are included in the new initiative, including LGBT health.

SAMHSA Homeless Resource Center (HRC)
The Homeless Populations: LGBTQI2-S pages of the HRC site contains links to numerous articles, publications, archived listening tours and teleconferences, and other resources on various aspects of homelessness as it relates to this population. http://www.homeless.samhsa.gov/Channel/LGBTQ-153.aspx

SAMHSA/Office of Behavioral Health Equity (OBHE)
Announced in February 2011, the SAMHSA/OBHE mission is to improve access to quality behavioral health services for populations that experience disparities in health care, including sexual minorities. http://www.samhsa.gov/about/obhe.aspx

STATE/NATIONAL RESOURCES

Advocates for Youth
Advocates for Youth is dedicated to creating programs and policies that help young people make informed and responsible decisions about their sexual and reproductive health. www.advocatesforyouth.org

Ambientejoven (Spanish) Advocates for Youth (see above) provides a separate Web site for Spanish-language information. http://ambientejoven.org/

American Psychological Association (APA)
APA is a scientific and professional organization established to advance the creation, communication, and application of psychological knowledge. Approximate membership is 154,000. http://www.apa.org/

LGBT Concerns Office (LGBTCO) LGBTCO works to improve the health and well-being of LGBT people; increase understanding of gender identity and sexual orientation; and reduce stigma, prejudice, discrimination, and violence toward LGBT people. The LGBTCO Web site describes programs and activities (such as the Healthy LGBT Students Project, below) and provides links to many resources. http://www.apa.org/pi/lgbt/index.aspx

Healthy LGBT Students Project
A project supported by the Centers for Disease Control and Prevention (CDC) "…to provide capacity-building assistance to schools and other organizations that serve gay and bisexual young men at risk for HIV infection, especially African-American and Latino youth." http://www.apa.org/pi/lgbt/programs/hlgbsp/index.aspx

9. Sexual Dysfunction and Disorders

Sexual dysfunction is characterized by the difficulty experienced by an individual or a couple during any stage of a normal sexual activity, including desire, arousal or orgasm.

Sexual desire disorders

Sexual desire disorders are characterized by a lack or absence of sexual desire or libido for sexual activity and/or of sexual fantasies for a specified length of time. Disorders range from a general lack of sexual desire to a lack of sexual desire for the current partner. Sexual desire disorders can develop following a period of normal sexual functioning or the person may always have had no/low sexual desire *(Source: Disorders of Sexual Desire)*.

Sexual desire disorder causes vary. However, frequent occurrences include possible estrogen production decrease in women or testosterone in both men and women. Additional possible causes include aging, fatigue, pregnancy, medications, or psychiatric conditions. Loss of libido from SSRIs normally stabilizes following the discontinuation of SSRIs, but in some cases it does not *(Source: Disorders of Sexual Desire)*.

Sexual arousal disorders

Sexual arousal disorders were previously known as frigidity in women and impotence in men, though these have now been replaced with less judgmental terms. Impotence is now known as erectile dysfunction, and frigidity has been replaced with a number of other clinical terms. Sexual arousal disorders can manifest themselves as an aversion to, and avoidance of, sexual contact with a partner. Males can exhibit a partial or complete failure to attain or maintain an erection, or a lack of sexual excitement and pleasure in sexual activity. There may be medical causes to these disorders, such as decreased blood flow or lack of vaginal lubrication. Chronic disease can also contribute, as well as the nature of the relationship between the partners. The widespread effectiveness of Viagra demonstrates that most erectile disorders primarily have physical causes.

Erectile dysfunction

Erectile dysfunction is a sexual dysfunction characterized by the inability to develop or maintain an erection of the penis. There are various underlying causes, such as damage to the nervi erigentes which prevents or delays erection, or diabetes, which simply decreases blood flow to the tissue in the penis, many of which are medically reversible *(Erectile Dysfunction Causes. Erection Problems, Erectile Dysfunction)*.

The causes of erectile dysfunction may be psychological or physical. Psychological impotence can often be helped by almost anything that the patient believes in; there is a very strong placebo effect. Physical damage is much more severe. One leading physical cause of ED is continual or severe damage taken to the nervi erigentes. These nerves

course beside the prostate arising from the sacral plexus and can be damaged in prostatic and colo-rectal surgeries. The following includes common causes of ED:

- Neurogenic Disorders (spinal cord and brain injuries, nerve disorders such as Parkinson's disease, Alzheimer's disease, multiple sclerosis, and stroke)
- Hormonal Disorders (pituitary gland tumor; low level of the hormone testosterone).
- Arterial Disorders (peripheral vascular disease, hypertension; reduced blood flow to the penis).
- Cavernosal Disorders (Peyronie's disease)
- Nonphysical causes: Mental disorders (clinical depression, schizophrenia, substance abuse, panic disorder, generalized anxiety disorder, personality disorders or traits), psychological problems, negative feelings.
- Surgery (radiation therapy, surgery of the colon, prostate, bladder, or rectum may damage the nerves and blood vessels involved in erection. Prostate and bladder cancer surgery often require removing tissue and nerves surrounding a tumor, which increases the risk for impotence)
- Aging.
- Lifestyle: alcohol and drugs, obesity, cigarette smoking (Incidence of impotence is approximately 85 percent higher in male smokers compared to non-smokers. Smoking is a key cause of erectile dysfunction. Smoking causes impotence because it promotes arterial narrowing. See also Tobacco and health.)
- Other disorders.

Orgasm disorders

The inability to have orgasm is called anorgasmia, ejaculatory anhedonia, or inorgasmia. If a male experiences erection and ejaculation but no orgasm, he is said to have sexual anhedonia. Orgasm disorders are characterized by “persistent delays or absence of orgasm following a normal sexual excitement phase”. The disorder exists in both men and women. SSRI antidepressants are sometimes a cause for the disorder because it’s side effect include the delay of orgasm or eliminate it entirely *(Christopher Shea,“Orgasmic Science”. The Boston Globe)*.

Sexual pain disorders

The majority of sexual pain disorders impact females such as dyspareunia (painful intercourse) or vaginismus (an involuntary spasm of the muscles of the vaginal wall that interferes with intercourse). Dyspareunia can occur due to inadequate lubrication in women which may result from insufficient excitement and stimulation, or from hormonal changes caused by menopause, pregnancy, or breast-feeding. Dryness can also result from irritation from contraceptive creams and foams as well as experiencing fear and

anxiety about sex *(Kaplan, Helen Singer, The New Sex Therapy: Active Treatment Of Sexual Dysfunctions, New York, Brunner/Mazel)*.

General

Most people seek treatment for sexual dysfunction during their late twenties and thirties. The incidence also increases in the geriatric population, likely due to the medical causes of sexual dysfunction. Sexual dysfunction is more common in people who abuse alcohol and drugs. It is also more likely in people suffering from diabetes and degenerative neurological disorders. Ongoing psychological problems, difficulty maintaining relationships or chronic disharmony with the current sexual partner can also interfere with sexual function *(Masters, W.H.; Johnson, V.E., Human Sexual Inadequacy. Toronto; New York: Bantam Books)*.

Causes

There are many factors which may result in a person experiencing a sexual dysfunction. These may result from emotional or physical causes. Sexual dysfunction may develop from interpersonal or psychological problems. Interpersonal problems may arise from marital or relationship problems, or from a lack of trust and open communication between partners, and psychological problems may be the result of depression, sexual fears or guilt, past sexual trauma, sexual disorders, among others. Sexual activity may also be impacted by physical factors. These would include use of drugs, such as alcohol, nicotine, narcotics, stimulants, antihypertensives, antihistamines, and some psychotherapeutic drugs. Injuries to the back may also impact sexual activity, as would problems with an enlarged prostate gland, problems with blood supply, nerve damage (as in spinal cord injuries). Disease, such as diabetic neuropathy, multiple sclerosis, tumors, and, rarely, tertiary syphilis may also impact on the activity, as would failure of various organ systems (such as the heart and lungs), endocrine disorders (thyroid, pituitary, or adrenal gland problems), hormonal deficiencies (low testosterone, estrogen, or androgens), and some birth defects *(Mary-Ann Shafer, Anna-Barbara Moscicki, Sexually Transmitted Infections)*.

Symptoms

Psychological sexual disorders DSM-5

The new DSM-5 classification of sexual dysfunctions has simplified sexual disorders and dysfunction. There are now only three female and four male dysfunctions, as opposed to five and six that were listed in the DSM-IV.

- ➢ Female Hypoactive Desire Dysfunction and Female Arousal Dysfunction were combined into Sexual Interest/Arousal Disorder.
- ➢ Dyspareunia and Vaginismus are now called Genitopelvic Pain/ Penetration Disorder.

Male Hypoactive Sexual Desire Disorder is now separate. Male Orgasmic Disorder is now Delayed Ejaculation. Male Dyspareunia or male sexual pain does not appear in the sexual dysfunctions chapter of the DSM-5.

Additionally, Sexual Aversion Disorder and Sexual Dysfunction have been eliminated. The Not Otherwise Specified (NOS) category was also eliminated from the sexual dysfunctions chapter. Substance Induced Sexual Dysfunction remains unchanged.

The new DSM-5 has added gender specific dysfunctions. The DSM-5 has also combined or deleted previous sexual dysfunction diagnoses contained in the DSM-IV. Sexual dysfunction diagnosis in the DSM-5 now requires symptoms to persist for approximately 6 months in order to meet the criteria.

Female Orgasmic Disorder is another addition listed in the DSM-5, which was previously categorized as Orgasmic Disorder in the DSM-IV. This diagnosis is now exclusive to females. DSM-5, Criterion A lists marked delay in, marked infrequency of, or absence of orgasm.

- ➢ *Female Sexual Interest/Arousal Disorder* is a combination of two previous disorders including Sexual Aversion Disorders and Sexual Arousal Disorders. This disorder is also now exclusive to females. The DSM-5, Criterion A lists absent/reduced interest in sexual activity. Symptoms are more focused on reduction of sexual interest and arousal. The DSM-5 identifies severe relationship distress and other stressors as possible conditions for exclusion from this diagnosis, which did not exist in the DSM-IV.

➢ *Male Hypoactive Sexual Desire Disorder* is now identified as exclusive to males. It was previously known as Hypoactive Sexual Desire Disorder. General and socio-cultural contexts are now being considered for diagnosis. Symptoms must cause clinically significant distress to the individual in order to formulate a diagnosis. Severe relationship distress and other stressors are now possible potential conditions for exclusion from this diagnosis.

➢ *Premature ejaculation* also has some changes in the DSM-5. Nonsexual mental disorders, severe relationship distress, and other stressors as potential exclusionary conditions are included in the DSM-5 for premature ejaculation, which was no present in the DSM-IV. The DSM-5 also places stricter criterion on this disorder by clarifying premature ejaculation as "within approximately 1 minute following vaginal penetration." With premature ejaculation, details concerning whether the disorder is due to psychological factors have been eliminated in DSM-5. In order to be diagnosed in either of these conditions, the DSM-5 states that symptoms must cause clinically significant distress to the individual. The DSM-5 also considers nonsexual mental disorders, severe relationship distress and other stressors as potential conditions for exclusion from this diagnosis, which was not presented in the DSM-IV.

Other sexual problems

- Sexual dissatisfaction (non-specific)
- Lack of sexual desire
- Anorgasmia
- Impotence
- Sexually transmitted diseases
- Delay or absence of ejaculation, despite adequate stimulation
- Inability to control timing of ejaculation
- Inability to relax vaginal muscles enough to allow intercourse
- Inadequate vaginal lubrication preceding and during intercourse
- Burning pain on the vulva or in the vagina with contact to those areas
- Unhappiness or confusion related to sexual orientation
- Transsexual and transgender people may have sexual problems (before or after surgery), though actually being transgendered or transsexual is not a sexual problem in itself.
- Persistent sexual arousal syndrome
- Post SSRI Sexual Dysfunction
- Sexual addiction

- Hypersexuality
- Female genital cutting

Other related problems

- Infertility
- Paraphilia

Treatment for females

Although there are no approved pharmaceuticals for addressing female sexual disorders, several are under investigation for their effectiveness. A vacuum device is the only approved medical device for arousal and orgasm disorders. It is designed to increase blood flow to the clitoris and external genitalia. Women experiencing pain with intercourse are often prescribed pain relievers or desensitizing agents. Others are prescribed lubricants and/or hormone therapy. Many patients with female sexual dysfunction are often also referred to a counselor or therapist for psychosocial counseling *(Kaplan, Helen Singer, The New Sex Therapy: Active Treatment Of Sexual Dysfunctions, New York, Brunner/Mazel)*

A manual physical therapy, the Wurn Technique, which is designed to reduce pelvic and vaginal adhesion, may also be beneficial for women experiencing sexual pain and dysfunction. In a controlled study, *Increasing orgasm and decreasing intercourse pain by a manual physical therapy technique*, twenty-three (23) women reporting painful intercourse and/or sexual dysfunction received a 20-hour program of manipulative physical therapy. The results were compared using the validated Female Sexual Function Index, with post-test vs. pretest scores. Results of therapy showed improvements in all six recognized domains of sexual dysfunction. The results were significant (P </= .003) on all measures, with individual measures and P-values as follows: desire (P < .001), arousal (P = .0033), lubrication (P < .001), orgasm (P < .001), satisfaction (P < .001), and pain (P < .001). A second study to improve sexual function in patients with endometriosis showed similar statistical results *(Kaplan, Helen Singer, The New Sex Therapy: Active Treatment Of Sexual Dysfunctions, New York, Brunner/Mazel).*

Clinical studies

Prior to Masters and Johnson the clinical approach to sexual problems was largely derived from the thinking of Freud. It was held with psychopathology and approached with a certain pessimism regarding the chance of help or improvement. Sexual problems were merely symptoms of a deeper malaise and the diagnostic approach was from the psychopathological. There was little distinction between difficulties in function and variations nor between perversion and problems. Despite work by psychotherapists such as Balint sexual difficulties were crudely split into frigidity or impotence, terms which too soon acquired negative connotations in popular culture *(Masters, W.H.; Johnson, V.E., 1966. Human Sexual Response. Toronto; New York: Bantam Books).*

The achievement of *Human Sexual Inadequacy* was to move thinking from psychopathology to *learning*, only if a problem did not respond to educative treatment would psychopathological problems be considered. Also treatment was directed at couples, whereas before partners would be seen individually. Masters and Johnson saw that sex was a joint act. They believed that sexual communication was the key issue to sexual problems not the specifics of an individual problem. They also proposed co-therapy, a matching pair of therapists to the clients, arguing that a lone male therapist could not fully comprehend female difficulties and vice versa *(Masters, W.H.; Johnson, V.E., Human Sexual Inadequacy. Toronto; New York: Bantam Books)*.

Masters and Johnson's treatment program included a two week program designed to develop effective sexual communication. Couple-based and therapist led the program began with discussion and then sensate focus between the couple to develop shared experiences. From the experiences specific difficulties could be determined and approached with a specific therapy*(Masters, W.H.; Johnson, V.E., Human Sexual Response. Toronto; New York: Bantam Books)*.

Masters and Johnson defined a boundary between dysfunction and deviations. Dysfunctions were transitory and experienced by the majority of people, dysfunctions bounded male primary or secondary impotence, premature ejaculation, ejaculatory incompetence; female primary orgasmic dysfunction and situational orgasmic dysfunction; pain during intercourse and vaginismus. According to Masters and Johnson sexual arousal and climax are a normal physiological process of every functionally intact adult, but despite being autonomic it can be inhibited. Masters and Johnson treatment program for dysfunction was 81.1% successful. Despite the work of Masters and Johnson the field in the US was quickly over-run by enthusiastic rather than systematic approaches, blurring the space between 'enrichment' and therapy. Although it has been argued that the impact of the work was such that it would be impossible to repeat such a clean experiment *(Masters, W.H.; Johnson, V.E., Human Sexual Response. Toronto; New York: Bantam Books)*.

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