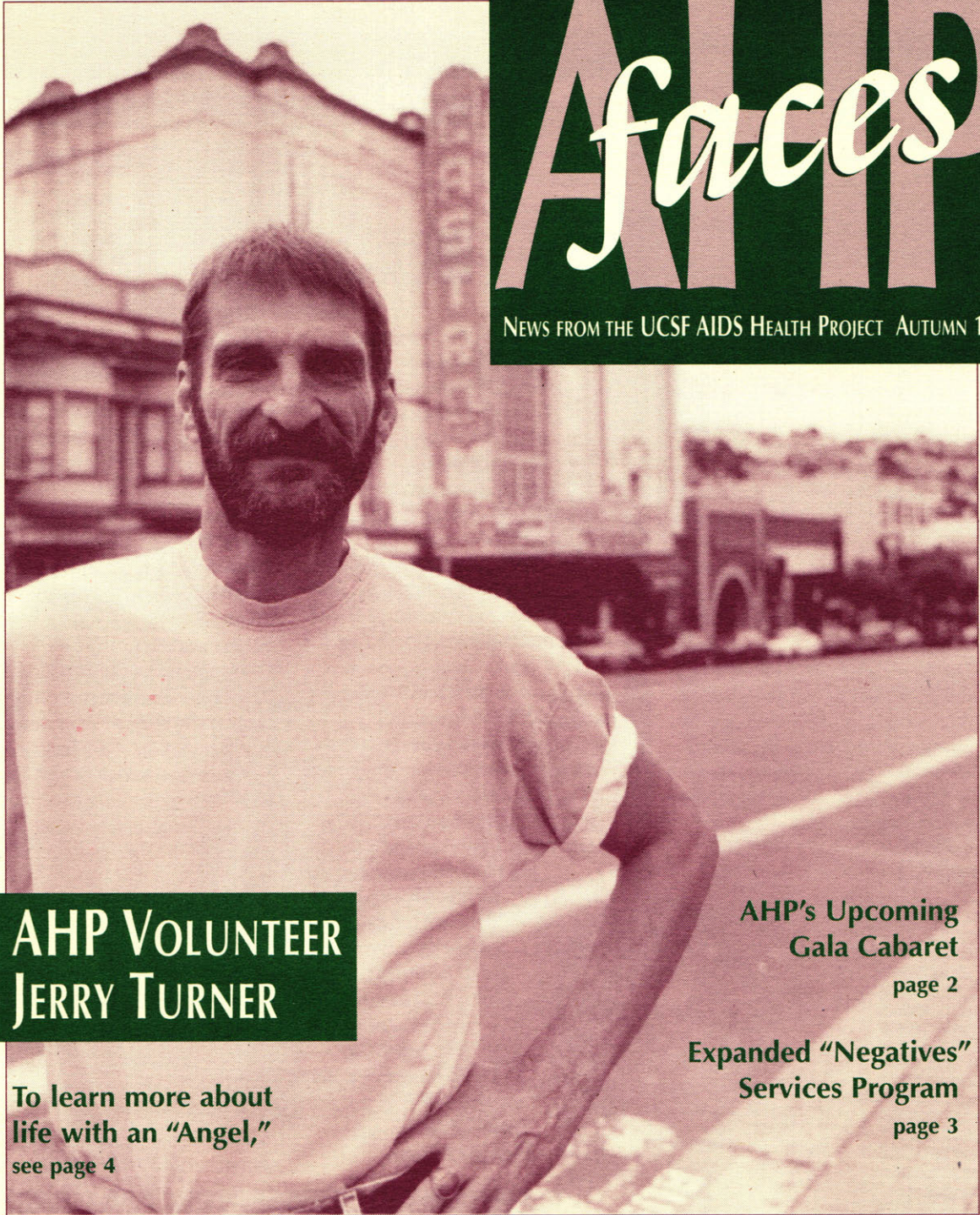




AHP *faces*

NEWS FROM THE UCSF AIDS HEALTH PROJECT AUTUMN 1995

AHP VOLUNTEER JERRY TURNER

To learn more about
life with an "Angel,"
see page 4

AHP's Upcoming
Gala Cabaret
page 2

Expanded "Negatives"
Services Program
page 3

KICKING UP HEELS TO KICK OFF AHP'S GALA CABARET

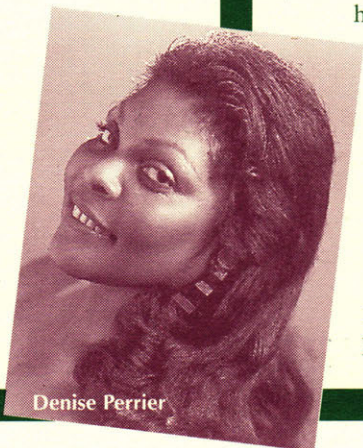
Q: *What makes a fund-raising event really successful?*

- A: a) Rubber chicken dinners
- b) Long, boring speeches
- c) No convenient parking
- d) Lots of fun and lots of money raised to stop the spread of HIV disease

Not only is "d" the correct answer, it is also the reason AHP held a cocktail reception on October 17 to raise awareness about the AIDS Health Project's November Gala Cabaret. The Fairmont Hotel sponsored the reception and jazz singer Denise Perrier performed to kick-off the sale of tickets for the November 27 Gala Cabaret.

Perrier, who is usually referred to as the "grande dame" of Bay Area club singers, is a headliner at such jazz clubs as Mason's at the Fairmont Hotel and Kimball's East and at the annual San Francisco Jazz Festival. A native of New Orleans, Perrier mixes the sounds of Cole Porter, Fats Waller, Stephen Sondheim, and Duke Ellington into her own signature style.

While guests enjoyed hors d'oeuvres and a wine reception, Perrier provided a mid-week respite, and AHP took advantage of a great opportunity to gather support for the Gala Cabaret.



Denise Perrier

Following the AIDS Health Project's grand tradition of putting together a smashing show for our friends

and supporters, the AHP 1995 Annual Gala Cabaret will be held Monday, November 27, at the Hyatt Regency Embarcadero. A wine and hors d'oeuvres reception will be the warm-up act for a cabaret show featuring the best talent in the Bay Area, including a few surprise celebrities.

The 1995 Gala Cabaret promises to be especially significant because it will honor Pat Christen, a leader in the fight against HIV disease for over 10 years. Christen is locally prominent as the executive director of the San Francisco AIDS Foundation since 1989. But it is a well-kept secret that she is also one of the pioneering activists who conceived and created the federal Ryan White Care Act, and that she

has received national praise for this important legislation. Her visionary leadership and passionate advocacy have contributed enormously to the well-being of people with HIV and AIDS throughout our city and the country. Heading up the Honorary Event

FACING THE FUTURE... TOGETHER

the UCSF AIDS health project annual

GALA CABARET HONORING

PAT
CHRISTEN



Committee is Will Rigney, the public affairs manager at Pacific Telesis and James Hormel, a community and business leader.

Through the hard work of the Event Planning Committee, co-chaired by Ron Johnson of Mosaic Special Events Management and Dennis Perry, sales manager at Key Magazine, costs of the event are being almost entirely underwritten. The Hyatt Regency is donating its facility, and the pre-show reception will feature hors d'oeuvres donated by San Francisco's best restaurants with wine generously contributed by the Carnelian Room.

Tickets for the event are \$75 for individuals and \$750 for a table of 10. Bronze, silver, gold, and platinum tables are available at \$1,000, \$2,500, \$5,000, and \$10,000, respectively. Each table sponsored will provide eight seats and underwrite limited seating for AHP clients.

For more information about the 1995 Annual Gala Cabaret and how to get tickets, contact AHP Special Events Coordinator Lisa Safran at (415) 502-5859.

WALKING FOR AHP: AGENCY'S SERVICES BENEFIT FROM AIDS WALK

The 1995 AIDS Walk San Francisco was the most successful in the event's eight-year history with more than 20,000 walkers raising in excess of \$3 million to benefit dozens of Bay Area organizations. In all, this year's AIDS Walk raised more money than any AIDS fundraiser in Northern California to date.

Through a competitive application process, AHP received \$82,500, one of the largest grants allocated from AIDS Walk proceeds, to support psychosocial services and prevention efforts offered at the AHP Castro Center.

Demand for services at the center—a site for individual psychotherapy and support groups, educational events, and workshops—has been overwhelming since it opened in April. The center is the primary location for referrals to the San Francisco AIDS Foundation and the Shanti Project, AHP's partners in the HIV Services Partnership. Funding from the AIDS Walk will support the operation of the AHP Castro Center.



San Francisco AIDS Foundation Executive Director Pat Christen awards a grant to AHP Development Director Michal Longfelder at the AIDS Walk San Francisco Thank You Celebration. Photo by Joe Nersveen

CELEBRATING HEALTH: LEVI STRAUSS SUPPORTS AHP'S HIV-NEGATIVE SERVICES

Janet Ryan Rivera, consultant to the Levi Strauss Foundation, was not aware of the newly opened AHP Castro Center when AHP Development Director Michal Longfelder approached her for a grant to support the center's services. After learning of AHP's unique HIV-Negative Services program and the need to hire a coordinator to oversee it, the Levi Strauss

Foundation awarded a one-year, \$20,000 grant toward the position.

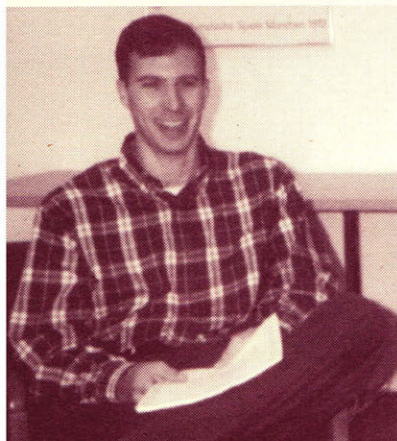
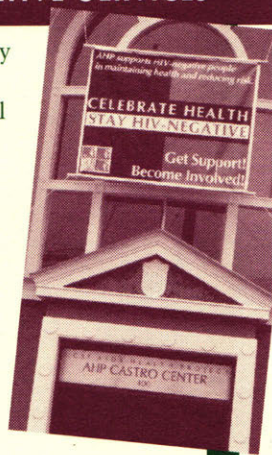
As a result, Michael Discepolo, MFT, joined AHP in June. He is now coordinating an expanded program that includes support groups, individual psychotherapy, social programs, and other community efforts geared to help HIV-negative men deal with the stress of living in the epidemic.

Discepolo says: "We're trying to legitimize psychosocial issues—such as grief and loss and having a gay identity apart from HIV—that uninfected men face as a result of this epidemic." Discepolo says that many uninfected men do not feel there's a place to talk about the challenge of maintaining their negative status. "Talking about being HIV negative may seem disloyal to the community or to friends or partners who are positive."

Discepolo has taken a variety of initiatives such as recruitment of an advisory committee, developing a

brief psychotherapy program, and producing educational materials. To promote the value of remaining uninfected, AHP has unfurled a banner from the AHP Castro Center, located at the corner of Castro and Market Streets, one of the city's most prominent intersections. The banner reads: "AHP Supports HIV-Negative People in Maintaining Health and Reducing Risk. Celebrate Health, Stay HIV Negative."

AHP is grateful to the Levi Strauss Foundation for being a major supporter of AHP's Services for HIV-Negative Gay and Bisexual Men and being a partner with AHP to maintain the health of our community.



Michael Discepolo

JERRY TURNER'S Rx: GOOD NIGHT'S SLEEP, HEALTHY

There's no doubt about Jerry Turner's devotion to the community. The local production of *Angels in America* dubbed him a community "angel" and AIDS organizations have spotlighted him as a model volunteer. But perhaps surprisingly, his motivation goes beyond devotion. Turner views volunteering as an essential part of a healthy life, as important as, say, a good breakfast or a sound night's sleep. He says: "Any kind of service work you do comes back to you in one way or another."

Turner first became a volunteer in 1985 after he attended a Stop AIDS Project meeting that he said blew him away. He jumped at the chance to volunteer as a street outreach worker, which meant talking to people about the risks of unsafe sex.

"Doing something to help others solve problems is a great form of activism, because if all you do is get angry and shake your fists, you really haven't done very much." Turner volunteered at the AIDS Health Project soon after AHP started its Disability Workshop in May 1992. He became the workshop's coordinator in fall 1993.

Turner considers his volunteer work as his first chance to take a strong part in the community. He grew up during the 1950s in a small Delaware town. And although his upbringing gave him a solid sense of community, he knew early on that rural Delaware could never be his permanent home. After reading a magazine article about gay men in New York City, he decided he would

eventually leave for a bigger city. Determined that his budding talent as an artist was his ticket out, he took every art class he could, and after high school moved to Baltimore to study art. He earned a bachelor's degree in fine art and served four years in the Air Force before moving to Northern California to work in the advertising department of the JC Penney department store chain. In 1980, he settled in San Francisco.

Twelve years later, HIV-positive, physically and psychologically fatigued, and fighting recurring bouts of sinusitis, Turner began the long process of applying for disability insurance. He remembers the sheer exhaustion of just getting through the work day: "I wasn't sure if I was going to be able to push in my chair

AHP + ABC + SSI: MORE THAN ALPHABET SOUP



Do LTD, SDI, SSI, SSA, and SSDI, or COBRA, OBRA, and MRMIP mean anything to you? These are acronyms for benefits and entitlement programs that can help guarantee a higher standard of living for someone with HIV disease who is no longer able to work. But the programs are useful only if someone understands them.

Thanks to a collaboration between the AIDS Health Project and AIDS Benefits Counselors, there is a day-

long workshop to help people with HIV understand the rules and regulations—and cope with the emotions—of the often overwhelming world of gaining access to disability benefits.

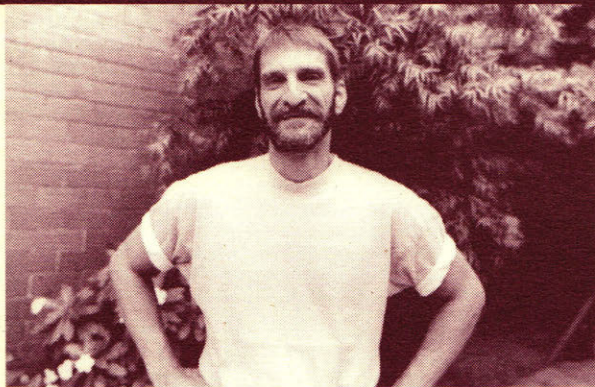
ABC and AHP began working together in 1991 when AHP saw that issues of work and disability were an increasing concern for HIV-infected clients, who were staying healthier and working and living longer than people had been earlier in the epidemic.

The collaboration makes good sense because the services of the two agencies complement one another. AHP emphasizes reducing stress to

Pictured from left: Will Bacon of ABC, Carol Kleinmaier of AHP, Daniel Fortuno of ABC, and Paul Causey of ABC in front of the AHP Castro Center. Photo by Susan S. Barmon

HEALTHY DOSE OF HELPING OTHERS

by Kelly Patton



"Doing something to help others solve problems is a great form of activism, because if all you do is get angry and shake your fists, you really haven't done very much."

at the end of the day, let alone go out and drive home."

After about six months of recuperation, Turner regained his health. Armed with first-hand knowledge, time, and energy, he got involved in putting on the Disability Workshop. He was well-acquainted with government red tape and the anxiety involved in going on disability, and he knew about disability's intended purpose—renewed health. Stability is one of his values: two years after taking over the workshop, he's still coordinating it, and he's still volunteering at the

Stop AIDS Project.

Last fall, the San Francisco producers of the play *Angels in America* named Turner an "Angel in the Community," and featured him in the play's program. Turner's response to the honor was a humble one: "It's nice to be recognized but that isn't why I do it," he said. Enabling others to take care of themselves is central to Turner's devotion, but also, and perhaps more importantly, it's how he takes care of himself.

Kelly Patton is a freelance writer.

by Paul Causey

better deal with the challenges of HIV infection. One of the most stressful aspects of living with HIV is negotiating the benefits bureaucracy. ABC's mission is to provide educational and advocacy services regarding financial benefits to people with AIDS and HIV disease, their partners and families, and to the community.

Started in 1987, ABC, which has a staff of seven, also assists clients in planning retirement, making the transition from employment to retirement due to disability, and securing benefits to which they are entitled.

Paul Causey is Executive Director of AIDS Benefits Counselors.

DISABILITY: LOTS OF QUESTIONS, LOTS OF FEELINGS. AHP CAN HELP.

The AIDS Health Project's Disability Workshop was created in 1992 as a series of four, two-hour meetings to prepare people to apply for disability benefits. When Jerry Turner got involved with AHP in 1992, attendance was spotty, so he condensed the schedule into one information-packed Saturday per month.

The change proved successful and the day-long workshop now reaches its capacity each month. Turner organizes and facilitates the workshop, which has three main parts. In the morning, a presentation by AIDS Benefits Counselors outlines logistical information about employee benefits, social security, health insurance, and dis-

ability programs. The afternoon, which involves AHP volunteers, is devoted to looking at psychosocial issues surrounding disability and includes a panel discussion of people currently receiving disability. The day concludes with an exercise that looks at dealing with the emotional concerns that often arise when a person no longer wishes to work or is unable to work.

Turner sees the workshop as a self-empowerment tool that "gives people information to evaluate their options and to support themselves through the process."

To learn more about being a participant in a future workshop, call the AHP Castro Center at (415) 476-3902.

FROM AHP's EXECUTIVE DIRECTOR



James W. Dilley, MD

People often ask me why the AIDS Health Project needs private funding. Many inaccurately believe that we receive financial support from the University of California San Francisco because we are a program of UCSF's Department of Psychiatry.

Because UCSF is a world-renowned medical school and medical center, AHP's affiliation with the university is of tremendous value when we apply for government grants and contracts.

In addition, the relationship with UCSF provides AHP with important administrative support and a fiscal infrastructure with great stability. Finally, the university's emphasis on education and ongoing training comes through in our work each day: we are commit-

ted to training ourselves and others in order to always provide state-of-the art services.

Despite these advantages, we receive no direct funding from UCSF. We must seek support entirely from the government, corporations, foundations, and individuals.

Thus, AHP's services must compete for funds with every other community-based organization in the city. And because corporations, foundations, and individuals may not realize how much AHP relies on them, we must be that much more vigilant in seeking support.

I write about this now because, with the uncertainty of government funding, we must ensure the security of our funding base. Our clients must not be left without the quality of services that they desperately need. Your support will help us make sure that does not happen.

We appreciate your past support and your belief in what we do. We hope you will continue as our partner in stopping the spread of HIV infection and making life easier for those living with HIV.

FROM AHP's COMMUNITY ADVISORY BOARD CHAIR

As someone who thinks of philanthropy as a key component of life's work, I'd like to discuss why I think it's important to make the UCSF AIDS Health Project a recipient of your charitable giving. If you're like most of us, your life is filled with solicitations from a large number of nonprofit groups, all of whom may be worthy of support.

Making choices about charitable giving is a personal decision, and each of us develops unique criteria to help in making decisions. I share here some of my reasons for making an annual gift to AHP with the hope that it will help make your decision easier.

- AHP provides a service unlike any other AIDS organization in San Francisco.
- Many AHP clients are among the poorest people in San Francisco.
- The quality of AHP services—whether through programs at San Francisco General Hospital, at the new

AHP Castro Center multi-service site, at anonymous counseling and testing centers, or at support group meetings in your own neighborhood—are lauded as some of the best in the country.

- Within the past year, more than 14,000 people received services from AHP staff and volunteers.
- As the nature of the epidemic changes—with an even more diverse group of people infected with HIV and lengthening survival times—the need for AHP services will grow.

For all of these reasons—and so many more—please be sure to include AHP on your “giving” list this year.



Katherine Bella

HAPPENINGS

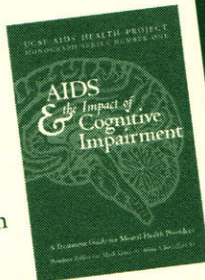
TAKING IT TO THE STREETS: COUNSELING AND TESTING AT FALL STREET FAIRS

In another example of tremendous community support for AHP, the San Francisco Furniture Company underwrote the mobile HIV Counseling and Testing at the Castro Street Fair October 1. The Counseling and Testing Program also had a major presence at the Folsom Street Fair in September. Not only did AHP counselors see more than 120 clients at the fairs, AHP also took advantage of the occasions to reach out to the diverse crowds and spread the message about the availability of HIV testing.

Every week, AHP provides HIV counseling and testing at six different sites across the city, and the mobile program visits community events throughout the year.

NEW PUBLICATION ADDRESSES COGNITIVE IMPAIRMENT

This fall, AHP published *AIDS and the Impact of Cognitive Impairment: A Treatment Guide for Mental Health Professionals*, a 96-page handbook describing the HIV-related conditions that cause cognitive impairment and the approaches providers can take in response. The handbook is the first volume in the UCSF AIDS Health Project Monograph Series, which consists of one volume a year. Each Monograph will provide frontline counselors with brief, accessible, and practical ways to address challenging issues. The first monograph is available for \$7.95 (plus shipping and handling) by calling (415) 476-6430.



ANNUAL REPORT TO CHRONICLE AHP WORK

As part of a campaign to broaden our funding base and increase private support, AHP is producing a 1994/1995 AHP Annual Report. In addition to financial statements and summaries of the past year's work, the report describes accomplishments of each of AHP's programs—from case management of HIV-infected clients with substance abuse histories to training and support for professional HIV service providers. Most importantly, production of the 1994/1995 AHP Annual Report is being underwritten by Pacific Telesis, which is printing all 5,000 copies. Photography in the report is the work of Bay Area professional photographers who donated their services. Publication is scheduled for December 1.

Pictured from top: Liz Manglesdorf, Kevin Dwarka, and Judi Parks (with Kathy Bella), volunteer photographers for the first-annual AHP Annual Report. Not pictured: volunteer photographer Lori Eanes. Photos by Kelly Van Noord



UCSF AIDS Health Project

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AHP MISSION STATEMENT

The mission of the UCSF AIDS Health Project is to provide culturally sensitive counseling and education to stop the spread of HIV infection, and to help people face the emotional, psychological and social challenges of living with HIV disease.

IN APPRECIATION

The AIDS Health Project is grateful for the support of many individuals, corporations, and foundations. During recent months, we have received in-kind donations or financial support through grants and gifts of \$500 and above from the following:

Individual Donors

Anonymous *James Rosenfield*

Corporate and Foundation Grants

AIDS Walk San Francisco

Chevron *Classical Action*

Levi Strauss *Pacific Bell*

In addition, we'd like to acknowledge the following for contributions of food and drink at the grand opening celebration of the AHP Castro Center:

Anchor Oyster Bar *Marcello's Pizza*

Ristorante Bacco *The Midnight Sun*

Bad Man Jose's *Mrs. Fields Cookies*

Bakers of Paris *Noah's Bagels*

Bagdad Cafe *Pasqua Coffee Bars*

Cafe Flore *Rossi's Delicatessen*

Escape from New York Pizza *The Sausage Factory*

Harvest Ranch Market *Scandinavian Restaurant*

Luk Chan Canton Restaurant *Sushi Castro*

Luna Piena *Welcome Home*

Ma Tante Sumi *Zapata Taqueria*



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AHP's culturally sensitive counseling and education programs are vital to stopping the spread of HIV infection and helping people face the emotional, psychological and social challenges of living with HIV disease.

Your continued support is greatly appreciated.

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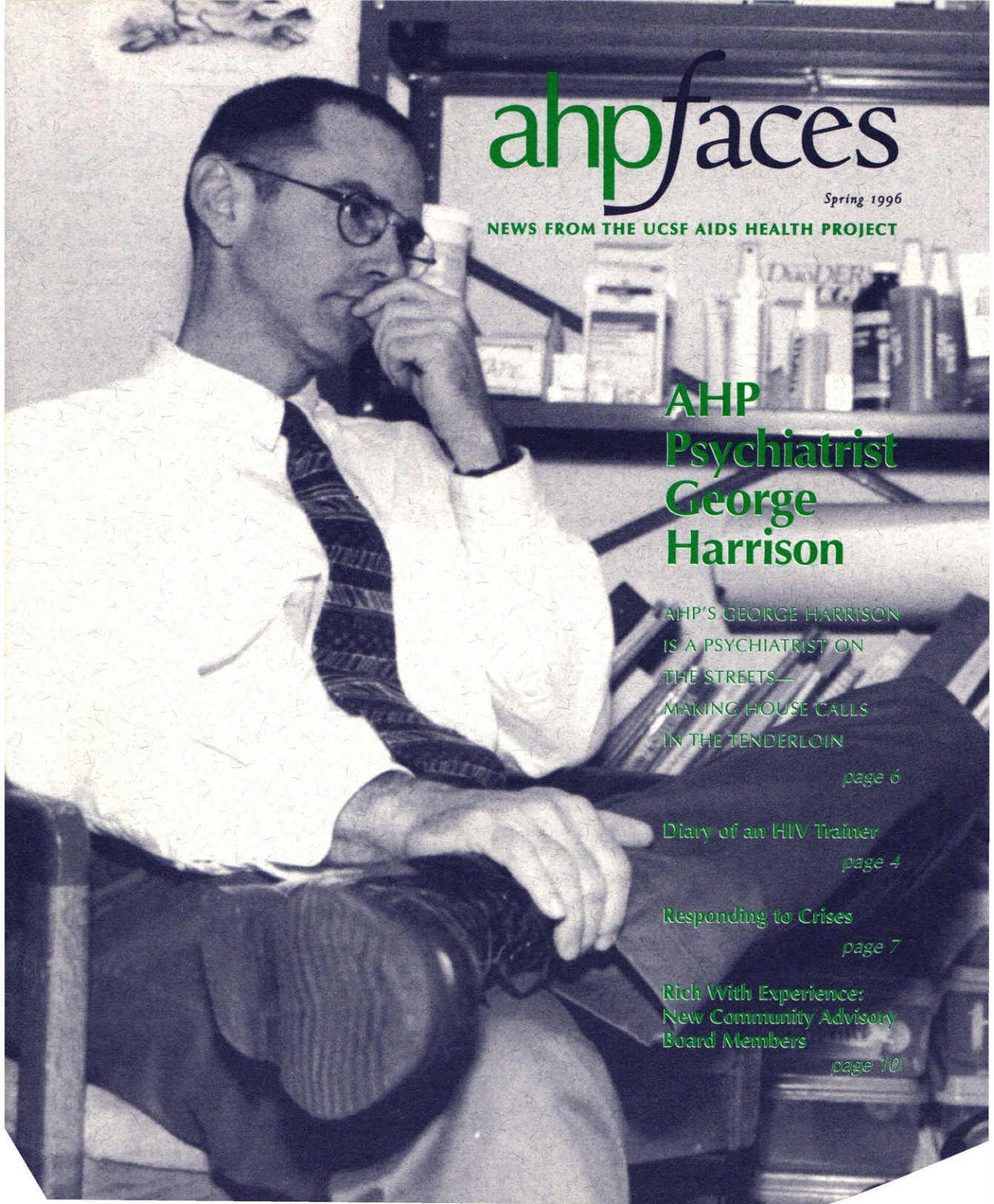
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ahpfaces

Spring 1996

NEWS FROM THE UCSF AIDS HEALTH PROJECT

AHP Psychiatrist George Harrison

AHP'S GEORGE HARRISON
IS A PSYCHIATRIST ON
THE STREETS—
MAKING HOUSE CALLS
IN THE TENDERLOIN

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Rich With Experience:
New Community Advisory
Board Members

page 10



James W. Dilley, MD,
Executive Director

From AHP's Executive Director

The HIV epidemic is taking new tolls. Increasingly, people with HIV face serious mental health and substance abuse problems. Many of those dealing with these issues have few economic resources.

In reality, these are the "forgotten people" of society—the people most of us never encounter in our daily lives. But they are among those most in need and AHP is committed to helping them cope. In December 1995, AHP established an HIV Mental Health Crisis Team providing mental health and substance abuse services. Located in the Tenderloin to provide easy access for those most in need of its services, this program has the following goals:

- Intervene, assess, and stabilize clients in crisis.
- Reduce the use of over-crowded city crisis clinics and psychiatric inpatient beds.
- Increase clients' use of other HIV services.
- Improve clients' quality of life.

The Crisis Team includes a psychiatrist, a psychiatric nurse, a psychiatric social worker, and other professionals. Our staff's expertise is critical to the success of this program and means that clients receive outstanding mental health care. In keeping with AHP's history as a leader, we have brought to this enterprise a level of quality care that is unparalleled in the HIV community mental health field.

Since the Crisis Team began, response has been overwhelming. Nearly a hundred clients have been treated in the past four months alone and AHP's presence is truly making a difference—as evidenced by a front-page article from the *Bay Area Reporter* in February (see page 7 for details). We are all proud of the work of the Crisis Team.

Over the years, AHP's trademark has been to respond to the epidemic with mental health services in areas where clients most need them. Today, 12 years after we began, AHP is still committed to filling these needs.

From AHP's Community Advisory Board Chair

As the new chair of the AIDS Health Project Community Advisory Board, I am both enthusiastic and somewhat in awe of the responsibility before me.

Because AHP provides the highest quality mental health services, it sets for itself the highest standards: the challenge AHP takes by doing this can be daunting. One challenge in which all of us can be involved is in responding to AHP's need for a stable and diverse funding base. Historically, AHP has been successful in obtaining nearly all of its funding from government contracts and grants. With government funding for HIV and AIDS organizations almost certain to decline in the years ahead, a stronger commitment from the private sector is critical to maintaining existing services and ensuring AHP's ability to continue to respond quickly and effectively to new challenges.

During the next year, I will be leading an effort to secure the resources AHP needs to continue serving those affected by HIV disease—from the uninfected gay man struggling to have a healthy life in the midst of the epidemic's despair to the small-town mental health professional who is treating his or her first HIV-infected client.

I ask you to join me in reaching out for the help of corporations, foundations, friends, and colleagues. By telling AHP's "story" to those who care and can help, you will be a part of the effort to ensure that no one will ever be turned away at AHP's door. Everyone of us can have a significant role in making the future better for those we care about.



Victor Murphy,
Chair,
Community
Advisory
Board

PAUL VOLBERDING AT AHP GATHERING:

New Treatment Frontiers Bring Hopes, Challenges

by Lisa Safran

One of the most unsettling issues looming in the future of the AIDS epidemic has less to do with the success of treatments and more to do with who will be able to afford medications and who might be forced by financial constraints to go without.

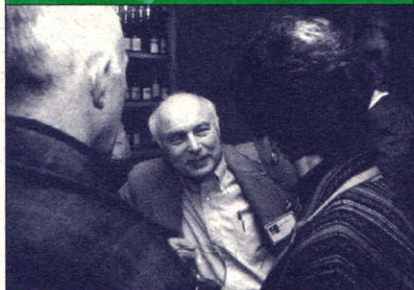
Friends and supporters of the AIDS Health Project listened as AIDS treatment pioneer and UCSF professor Paul Volberding discussed the success of new drug therapies and highlighted some of the challenges that we face in getting treatments to those who need them.

Volberding, who is Director for the Center for AIDS Research at UCSF and Director of the AIDS Program and Clinical Oncology at San Francisco General Hospital, spoke at the AHP event "New Frontiers in Treatments for AIDS: Hopes and Challenges." Hosted by Linda Servis, a member of the AHP Community Advisory Board and Victor Murphy, chair of the board, the event was held earlier this year at the Hayes and Vine Wine Bar in San Francisco's Hayes Valley.

Volberding focused on the success of new drug combinations consisting of drugs such as AZT, ddI, 3TC, and one of several recently introduced protease inhibitors. Because of the proven effectiveness of the new combinations, Volberding said that many people with HIV infection who had not previously taken treatments will flood the medical system.

The protease inhibitors, in particular, raise questions of financial access. At more than \$10,000 a year, the protease inhibitors are far more expensive than drugs like AZT and 3TC, which cost about \$3,000 a year. Unlike AZT and similar drugs, however, most health insurers are not yet covering protease inhibitors, making them inaccessible to many people. Access is even more limited to people in developing countries, particularly African nations, where citizens already have little, if any, access to treatments.

Volberding emphasized that as treatment improves, people with HIV and AIDS will live longer and, as a result, there will be a greater need for counseling services. More than ever, AHP will be a crucial component in the care of those with HIV and their caregivers. ■



▲ Top: Annemarie Madison, seated, listens as Paul Volberding addresses AHP's Hayes and Vine gathering. Middle: (left to right) AHP's Executive Director Jim Dilley and Publications Director Robert Marks with AHP supporters Kris Getz and Puddy Mitchum. Bottom: AHP supporter Sam Thal.

Left: Paul Volberding. Right: (left to right) AHP supporters Al Baum and Mario Diaz.



diary of a trainer



▲ Trainers Ed Wolf and Robin Ortiz-Young, AHP Training Coordinator, and the training class for the three-day HIV Test Counselor Training.

PHOTO: ASA MATHAT

► Ortiz-Young prepares poster-board displays which highlight key training points.

The AIDS Health Project has been training mental health professionals to deal with issues of HIV infection in their work since 1984. AHP Training Unit staff, with help from the federal Centers for Disease Control and Prevention, "wrote the script" for the three-day training used to this day across California to prepare HIV test counselors. In addition, staff consult with the state's Office of AIDS in the training and ongoing education of test counselors who see more than 400,000 clients seeking an HIV test each year.

And, AHP trainers travel to towns across the state—from San Diego to Eureka—conducting various trainings, including ongoing workshops to help counselors hone their skills. Last year, AHP directly trained more than 1,000 counselors. The trainings focus on building basic skills in assessing clients' risks, being effective listeners, helping clients change their behavior, and providing empathy and support to clients who test positive or negative.

The three-day training is intensive; it has to be to prepare counselors for the emotionally riveting experience of the test-counseling session. To get an inside look at the training experience, *Faces* asked AHP Training Coordinator Robin Ortiz-Young to keep a diary of a recent three-day training that she and co-trainer Ed Wolf conducted in San Francisco.

The story of any training begins well before the first day of class, as registrants complete pre-training readings and a quiz, and trainers discuss with one another the needs of participants. Ortiz-Young begins her diary a day before the training starts.

Before the Training:

Tomorrow, I start a three-day test counselor training. I love doing this training; it's one of the best parts of my job.

My co-trainer, Ed, and I have graded the pre-training quizzes and divided parts of the training we're each coordinating; our training program assistant José Alvarado has confirmed that everyone is coming; and

I've made sure that the 12 pages of poster-sized charts I prepared are in place.

Today, I've focused on making sure I'm ready for an experience that is as draining as it is rewarding. Beginning tomorrow I'll be taking care of the feelings of 20 people for the days we are together. My children are aware that I'm not going to be emotionally available to them for the next 72 hours. Usually, my partner takes on 90 percent of the parenting responsibilities when I'm doing a training. This time, though, he's out of the country and so I've lined up outside support.

I expect this training to be especially difficult because a woman I love—one of the people who was instrumental in helping me develop my career as a trainer—has AIDS and has recently been in the hospital. Her spirit will be there motivating me in the training.



Day 1:

I woke up at 4:45 this morning, made lunches for my children, did some stretching, and read affirmations for the day. I noticed I had a huge pimple over my lip. I decided to be bold and wear purple and red. Hopefully, it distracted attention from the pimple.

I always have a lot of energy when a training starts. Today, I was equally nervous and excited. Nineteen participants showed. In the introductions, three people identified as being HIV-positive. In four years of training, I'd never had this many people disclose at the start of a training that they have HIV.

This is a diverse group: there are nine men and 10 women, five African-American women, five gay men, two lesbians, and several people for whom English is their second language. Interestingly, the training includes a lawyer who is sitting next to someone who has spent more than 25 years in prison. Such a diverse group gives trainees the opportunity

to experience cross-cultural communication and its effects on counseling.

By 5 p.m., Ed and I felt the group had caught on to the training. But my day wasn't over: I went from the training to my AHP office to deal with the day's e-mail and phone messages. Finally, at 8:30, I headed home to see the kids.

Day 2:

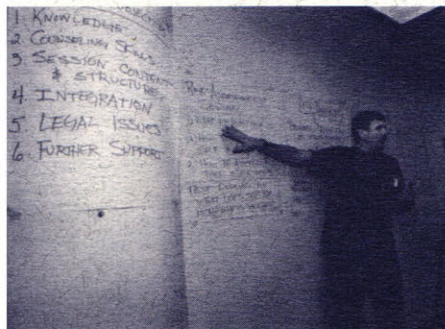
I started the day exhausted (I should have gone directly home from the training yesterday). Today, we started with a diversity exercise, which gave trainees a chance to recognize their feelings about racism, sexism, classism, and heterosexism. One of the women in the group who is living with HIV expressed concern when some other trainees said they hadn't been affected by HIV. She said "everyone is affected by HIV, regardless of whether they're infected." The exercise gave participants a chance to con-

CONTINUED ON PAGE 9



▲ Wolf plays the part of a counselor and training participant Jeffery Waterbury plays a client receiving HIV testing and counseling services in a role-play.

PHOTO: ASA MATHAT



◀◀ Trainer Ed Wolf.

◀ Training participant James Shaw (right) in a discussion during the training.

PHOTOS: ASA MATHAT

A REAL-LIFE MARCUS WELBY:

Making House Calls with George Harrison

Remember when doctors were known for making house calls? At least one still does.

Meet George Harrison, Medical Director of AHP's HIV Psychiatric Consult Service. It's a typical Wednesday. Harrison's workday begins at AHP's 10 United Nations Plaza office with staff rounds, consultations, and patient visits. Then, he's off to San Francisco General Hospital's Ward 86 or to the Visiting Nurses Hospice for more patient visits. This might sound like a full, yet typical, doctor's schedule. But Harrison's no typical doctor—the rest of this Wednesday afternoon, and possibly a good part of the evening, are reserved for house calls.

Harrison travels by car and foot throughout the Tenderloin and other parts of the city to see clients who need psychiatric care but are unable to leave their homes to get it. Patients who can travel see Harrison at his office. Those he sees in their homes have debilitating physical or psychiatric conditions resulting from HIV or AIDS. Most are poor and socially disenfranchised, and many have a history of substance abuse. A typical setting is the Tenderloin's Ambassador Hotel, where Harrison saw resident Ron Emery, a client in the late stage of living with HIV disease.

Harrison has the opportunity to see some clients—like those he sees at hospice-care facilities—on an ongoing basis, but his home visits with clients like Emery are generally one-time interventions. Harrison's primary role, after consulting with social workers, hospice workers, or other health care profes-

sionals, is to evaluate the mental health

"It's important that my clients know I am a transient figure in their lives."

problems of his HIV-infected clients and prescribe psychiatric medications. Once clients are stable, they generally return to their regular providers. The nature of Harrison's intense, but abbreviated, sessions is not unlike the work of an emergency room physician.

"It's important that my clients know I am a transient figure in their lives, and that they don't feel abandoned when I leave," Harrison said. Because he communicates this to clients, they

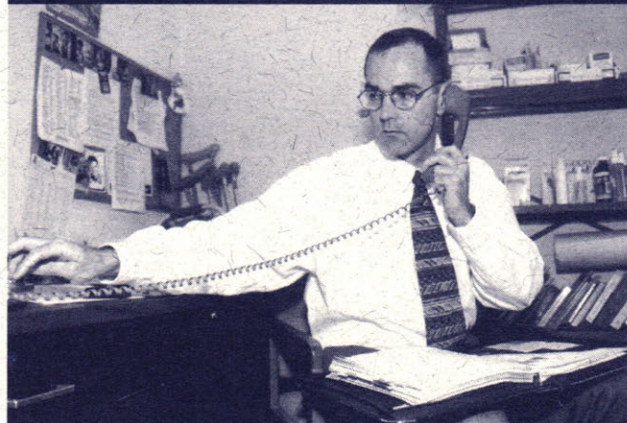


▲ George Harrison
visiting client
Ron Emery.

PHOTO: JUDI PARKS

▼ George Harrison
in the Visiting
Nurses Hospice
office at the
Ambassador
Hotel.

PHOTO: JUDI PARKS



► Sabryna Moore of
the AHP Psychiatric
Consult Service
at 10 United
Nations Plaza.

► February 8th cover
story of the *Bay Area
Reporter* newspaper
highlights work of
AHP's HIV Mental
Health Crisis Team.

► AHP Psychiatric
Nurse Mai Alyschild
and Psychiatric
Social Worker
Ed Schultz,
members of
AHP's Crisis Team,
at 10 United
Nations Plaza.

CONTINUED ON PAGE 8

by Kelly Patton

HIV MENTAL HEALTH CRISIS TEAM: Terrifying Crises Within the AIDS Crisis

by John Tighe

A resident of the Tenderloin's Ambassador Hotel had attempted suicide by jumping from the roof of the building. Days earlier, a convicted sex offender had gone on a violent rampage attacking residents of the hotel; he was stopped only after being shot by police.

These traumatic incidents earlier this year left an especially bleak scene at the Ambassador, where nearly 100 of the residents have HIV or AIDS. Residents were shaken and terrified. But when a local activist called for help, the AIDS Health Project HIV Mental Health Crisis Team was prepared to respond. A mental health counselor met with residents to assess the impact of the events and to provide emotional support. "We wanted to help these people restore some sense of balance and safety amid the violence... and we wanted to provide an outlet for them to talk about all they'd experienced," said Lori Thoemmes, coordinator of the Crisis Team.

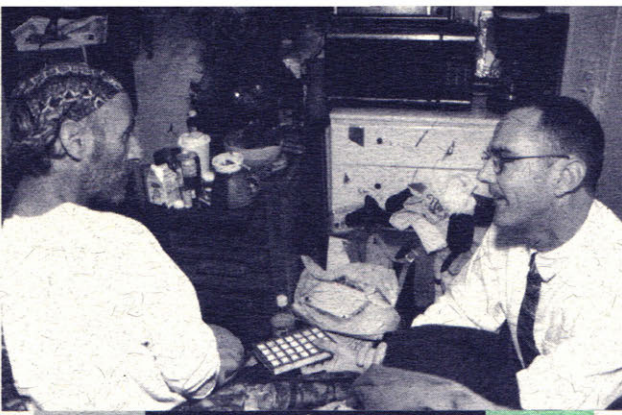
The Crisis Team, which is part of AHP's Psychiatric Consult Service, was established in December 1995, specifically targeted to help low-income people with HIV infection. Since then, its staff—from

social workers to receptionists—have become accustomed to dealing with acute and immediate crises in the lives of their clients.

Those who seek the team's services are people in an acute psychiatric crisis, or others acting on their behalf. A crisis might involve a person who is contemplating suicide or someone who is concerned about potentially doing harm to him or herself or to others. Thoemmes said: "The Crisis Team provides immediate access to clients whose psychiatric needs precludes their ability to wait for services."

AHP is one of only a few agencies in the Bay Area that works with HIV-infected clients who are facing serious mental health issues. The team was set up so that people can come right into the office without an appointment. If a client is unable to leave his or her residence, clinical staff will make a home visit. In either case, AHP's staff, which includes a psychiatric nurse, psychiatric social workers, and a psychiatrist, assess a client's psychiatric needs and focus on bringing stability to the crisis. The Crisis Team does short-term counseling, care coordination, medical evaluation and monitoring, and then links the client to other health care professionals for long-term care. Not only is the service important for clients, it also reduces the overwhelming strain on city crisis clinics and inpatient psychiatric units. ■





"Seeing them in an air-conditioned office doesn't tell you about what it's like where they live or what their experience is." when they have to go into an unfamiliar and intimidating office. The work is untraditional, but then so is Harrison. After a 13-year career as a respiratory therapist, he entered medical school. As a resident, he was thrilled by the remarkable progress people made as a result of psychiatric medications. "Psychiatry was a natural place for

▲ George Harrison with client Ron Emery.
PHOTO: JUDI PARKS

my interest and a place I could support the community in a positive way."

Harrison's work often focuses on helping people at the end of their lives. In his own life, from growing up in Peoria, Ill., where he faced the death of a close friend while in high school, to his days as a respiratory therapist in Boston working mostly with people near death, Harrison has seen the potential to make a difference at the end of people's lives. He has taken on this challenge. In his work, this involves assessing and providing treatment for clients' neurological and psychological problems. He points to the role of medications, particularly antidepressants, in allowing people to make great emotional strides at the end of their lives and to come to terms with dying. He has seen clients who had long histories of drug addiction stop their drug use and reunite with their families. "When your head is clouded with depression, it's hard to do that." Client Ron Emery, who recently died, is among those who expressed appreciation for Harrison's work.

Harrison acknowledges the work is difficult, and it isn't only the challenges created by HIV that make it that way. Daily, he sees inexcusable social settings and disparaging poverty. Still, the rewards outweigh the challenges. "So many of the better parts of this job are such an honor to do. It's really amazing I get to do it." ■

IN MEMORIAL:

Arnie Bellefontaine

After a short illness, Arnie Bellefontaine, a long-time friend of the AIDS Health Project, died on February 2. Bellefontaine graciously gave his time and energy to AHP as a member of the Community Advisory Board and as a volunteer facilitator for AHP support groups.

Last fall, Bellefontaine moved to Los Angeles to be closer to his family and to take care of his mother. His family was by his side when he died. Bellefontaine brought laughter, humor, and compassion to AHP, and he is sorely missed.

Arnie Bellefontaine representing AHP at an AIDS fundraiser in 1995. ►



▶ Training participants critique a role-play exercise.

PHOTO: ASA MATHAT



▲ AHP Training Coordinator Robin Ortiz-Young.

sider in new ways others' beliefs and values.

Later we did a visualization exercise in which training participants imagined receiving a positive HIV test result. This was powerful. The three women in the group with HIV shared their stories of actually receiving positive results.

Their experiences were awful; not one of them received counseling when getting her result. They felt so alone and isolated at a time when they needed someone to listen, to support them, to give guidance, and to respond to their questions. In the case of one of the women, she was told at a health clinic that she'd tested positive, but she wasn't told what this meant. She took it to mean she was going to die immediately. Terrified of this, she didn't want to leave the clinic, and clinic staff forcibly removed her. It became amazingly clear why counseling is so important. I don't think there was a dry eye in the room after listening to their stories.

The afternoon began with role plays of counseling sessions. Ed did the first one, taking the role of a counselor disclosing a negative result to a trainee, who was in the role of a client. Ed did an exceptional HIV-negative role play. He allowed the client to express his feelings and talk about what it is like to be uninfected, especially for someone who is young and gay. The client said most of his friends were young gay men who assumed they would become infected. Ed then masterfully took the conversation back to focusing on pre-

vention issues and explored the client's options for reducing risk. By the end of the day, I was exhausted. I went directly home. A friend took the children to dinner and tucked us all into bed—me first.



vention issues and explored the client's options for reducing risk.

By the end of the day, I was exhausted. I went directly home. A friend took the children to dinner and tucked us all into bed—me first.

Day 3:

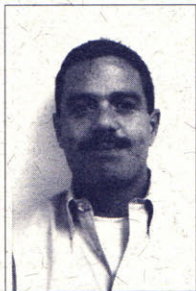
Today, I was energized. The training group really bonded. Several trainees said during the morning check-in that they didn't want the training to end. We separated into two groups and each trainee performed a role play. Ed and I evaluated each trainee's role play. If trainees do not pass this part of the training, they will not receive a certificate of completion.

One of the women with HIV insisted on doing the first role play. She froze during it and then burst into tears. This was the most difficult part of the training for me. She shared that she had felt so isolated because of her HIV status. Many of her tears were tears of joy that there would be great counselors and that other women would receive what she did not.

It was intense at the end of the training when participants discussed their feelings. There were tears of joy and a lot of appreciation. Even I had a few tears. One of the women living with HIV said she experienced a tremendous sense of peace knowing that there would be 19 great new counselors doing this important work. ■

AHP Introduces New Community Advisory Board Members

The AIDS Health Project is pleased by the addition of six members to its Community Advisory Board. Here's a brief introduction of the new members:



Stephen Fleming

In 1991, Stephen Fleming, Director of Catering and Sales for Pier Restaurants, Inc., at Pier 39, became an AHP volunteer facilitator for support groups. He sees being a board member as an extension of his original goal in becoming a volunteer: "to communicate the mission of AHP."

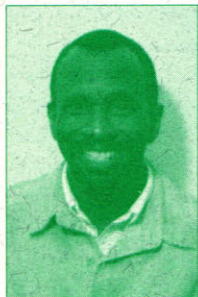
Ron Johnson

Ron Johnson brings years of event planning experience to the Community Advisory Board as Event Manager for Mosaic Event Management. Johnson is also a lecturer on special events and meeting management, and was named "Best Volunteer of the Year" by the American Heart Association's San Francisco division, where he serves on its board of directors. Johnson chaired the event planning committee for the AHP 1995 Gala Cabaret.



James Jones

James Jones is the medical director of the Inpatient Consolidation for the San Francisco Department of Mental Health and Substance Abuse. He is also staff psychiatrist at Baker Places-Westside Lodge, a transitional residential psychiatric facility. Jones completed a fourth year Psychiatry Residency elective working at AHP. He joined AHP's Community Advisory Board because, "I wanted to support and help the agency to continue to provide a broad range of high quality services to a diverse population."



Rachel Schochet

Rachel Schochet, a clinical psychologist in private practice and a consultant on HIV and mental health issues, is a long-time volunteer in AHP's Volunteer Therapist Program. As a new board member, she wants to contribute her experience in fine-tuning AHP programs and serving as liaison with other mental health providers and agencies.

Linda Servis

Linda Servis is President and an owner of Hartford Properties. She is a force behind the San Francisco real estate firm's commitment to being an exemplary corporate citizen, responding to the AIDS epidemic by providing volunteers and making long-term financial contributions to numerous HIV agencies. Being a board member, Servis says she can make use of her business contacts and expertise. "That is very exciting for me, because I know how to raise money and I can do it to help a worthy cause."



Jerry Tucker

A volunteer facilitator for AHP support groups and a board member of Replenish, which provides support to caregivers, Jerry Tucker's volunteer experience dates to the early 1980s when he was an emotional support volunteer for the Shanti Project. A former Manager of Group Enrollment for Blue Shield of California, Tucker says: "A role I see for myself on the board is to make sure AHP keeps its focus on the needs of the HIV community, and to support the agency in doing that."



IN APPRECIATION:

AHP is particularly grateful for the outstanding support of Pacific Telesis Group/Pacific Bell for the publication of AHP's Annual Report.

AHP is also grateful for the support of many individuals, corporations, and foundations. During recent months, we have received financial contributions through grants and gifts of \$500 or more from the following:

Contributions from August 1995 through January 1996:

AIDS Walk 1995
Academy of Friends
Blue Shield of California
Curtis Brown
Corporate Scenes, Inc.
Dean Alan Krechevsky
Evergreen Media Corp/
KMEL Radio
Franklin Bank
James Green
The Niagara Trust, S.A.
Sandra G. Nowicki
Steven Sams
The Tides Foundation
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Contributions from the 1995 Gala Cabaret:
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AIDS/HIV Life Center/
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Peter Bradley
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Stephen Follansbee, MD
Steven Sams
Timothy Schott,
Michere Feldstein
& Friends
Wells Fargo Bank

In addition, we'd like to acknowledge the following for in-kind contributions of \$500 or more:

For our Gala Cabaret:
Asa Mathat Photography
Kevin Dwarka
Flowers for the Soul

For the recent move of our administrative offices:
Kreiss Collection
IBM

In addition, we'd like to acknowledge the following for contributions of food and drink to our Gala Cabaret:

The Carnelian Room
Epic Wines
Forest Glen Winery
Gallo-Sonoma
Grand Cru Vineyards
Guenoc Winery and
Vineyards
Schieffelin & Somerset
Simi Winery
Southern Wine & Spirits
of Northern California
Trefethen Vineyards
The Wine Alliance

Cafe Latte II
Chevy's Mexican
Confetti
Gaylord India Restaurant
Julie Ring Heart & Soul
La Brasserie Francaise
Mason's Restaurant
Mercedes Hair of the Dog
Cantina
The Midnight Sun
Park Grill Restaurant
Pizzeria Uno
James Reid Catering
Scott's Seafood
Standing Room Only
Western Espresso

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<i>Development Director</i>	Michal Longfelder
<i>Publications Director</i>	Robert Marks

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AHP Mission Statement

The mission of the UCSF AIDS Health Project is to provide culturally sensitive counseling and education to stop the spread of HIV infection, and to help people face the emotional, psychological and social challenges of living with HIV disease.

A Cinderella and Fairy Godmother in One

Once upon a time, Cinderella decided to come to the rescue of a very worthy HIV mental health agency. Glen Robinson, the proprietor of a house maintenance company, first heard about the AIDS Health Project from

Daniel Hernandez, a member of AHP's Community Advisory Board. Intrigued by AHP's services,

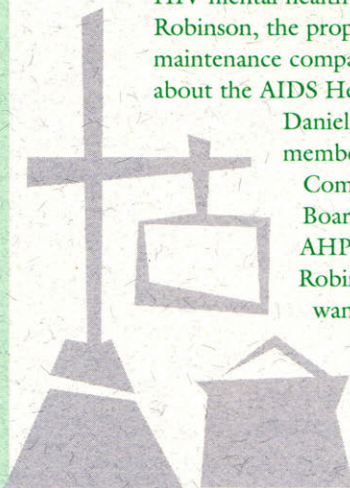
Robinson decided he wanted to be a part

of our efforts to fight HIV.

And so it came to be that

Cinderella's Housekeeping, a small, privately owned San Francisco business, joined with corporate giants such as Pacific Telesis Group, Bank of America, Wells Fargo, and The Gap in sponsoring the 1995 AHP Annual Gala Cabaret. In doing so, Robinson proved it isn't just the "big guys" who can have a real impact on stopping the spread of HIV; everyone can be a part of making a difference in the quality of life for the thousands of people who depend on AHP for support, education, counseling, and more.

They say that fairy tales can't come true, but here's one spun from gold, and we know it isn't "The End."



Cinderella's Housekeeping Agency



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Winter 1996/97

NEWS FROM THE UCSF AIDS HEALTH PROJECT

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THE FACE OF HOPE

Honoring Nancy Pelosi: A True Champion

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Substance Abuse Program 4

One Client's Story 5

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James W. Dilley, MD,
Executive Director

From AHP's Executive Director

This year has brought many research advances, including the promise of protease inhibitors and combination drug therapies in slowing disease progression. Despite the hope of better treatments, the epidemic continues to take lives and steal dreams.

AHP has played an active role from the start of the epidemic, helping people infected with HIV to cope with the challenges of living with the disease and helping those at risk to remain free of infection. Now, in our 12th year, our commitment continues.

This commitment to the well-being of our clients drives us to provide the best possible services. To do so, we rely on your ongoing help and support. That is

why I am so pleased by the phenomenal success of our 1996 annual gala, "The Face of Hope." But, it was the words of AHP staff, who told stories about their clients and their experiences, that was most compelling and touching.

Your belief in us and the work we do is an example of what happens when a community unites with a common cause. With your help, AHP will continue to provide much needed services until the day we can finally put the epidemic behind us.

*the
face
of
hope*



Victor Murphy, Chair,
Community Advisory
Board

From AHP's Community Advisory Board Chair

This is a very exciting time to be leading the Community Advisory Board for the AIDS Health Project. Not only is the board a dynamic, enthusiastic team of AHP supporters, it is also a group given to outbursts of optimism and visionary thinking. We are just vacuuming the carpets and drying the glasses from our third AHP gala, "The Face of Hope," and I have to tell you, we are patting ourselves on the back for a job well-done. Through hard effort and an encouraging response from the community, we raised more than \$75,000 that will fuel our work on behalf of

people with AIDS into 1997.

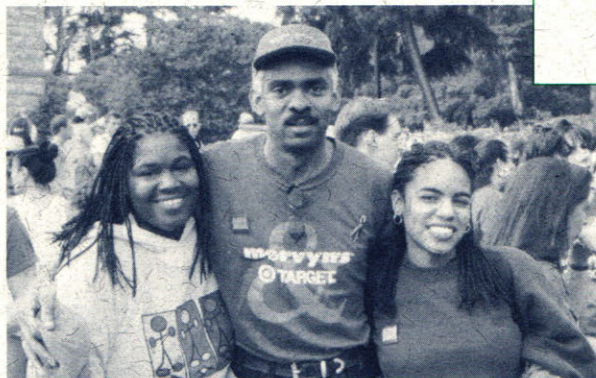
No sooner had we turned off the lights on the event, then we reassembled to plan AHP's move to bigger and better quarters. Once we have secured the space, the board will take the lead in raising the money and obtaining the in-kind donations to revamp the space so that it works for our clients and our services.

Would you like to join our team? If you have skills or financial resources to share, I assure you that AHP is an excellent investment. It is the kind of organization that makes you proud to be a part of it. I certainly am.

BERNARD BOUDREAUX:

No Silence in this Voice

by Charles R. Temple



▲ Mervyn's Senior Buyer Bernard Boudreaux (center) with a family member and a friend.

Bernard Boudreaux is never quiet in his passion to raise consciousness in the workplace about the AIDS epidemic. He has been instrumental in persuading his employer, the department store chain Mervyn's California, to be a major supporter of AIDS Walk San Francisco. And, he has been a driving force in the turnout of hundreds of Mervyn's employees—young and old, male and female, heterosexual and gay, executive and clerical—for the walk.

More recently, he has adopted the AIDS Health Project as a beneficiary of his efforts. At the root of his success is "a big mouth, a God-given talent I don't hesitate to use."

Boudreaux's father, a Santa Rosa minister, fostered in him and his six older siblings a sense of community responsibility. The credo was simple: "Someone always has it tougher than you, so try to make another's life easier." During college, Boudreaux, who has always had a passion for a nice wardrobe, worked part-time selling men's clothing. He found the work so interesting he decided upon graduation to make retailing his career. Now, at age 36, he is senior buyer at Mervyn's, working long hours and traveling constantly in and out of the country.

As the AIDS epidemic began taking its toll in the early '80s, Boudreaux remembered his father's teachings. He saw friends and acquaintances become ill and die; he knew people who lost sons and brothers and daughters and sisters. He responded as a caregiver and he opened his home for educational meetings sponsored by the Stop AIDS Project. In 1985, his work increased and he pulled back from AIDS efforts.

In 1992, however, he felt it was time to return. He participated in AIDS Walk San Francisco, and knowing that

HELPING AHP:

A Year-End Opportunity

The end of the year is approaching, and it's an excellent time to send your annual contribution to AHP.

If you have not yet become an annual contributor, this is your chance.

Use the reply envelope between pages 6 and 7 to send your tax-deductible contribution.

If you have questions about our giving programs or ways in which we put financial contributions to work to serve the community, call Joanna Rinaldi at 415/476-6430.

AHP'S AIDS AND SUBSTANCE ABUSE PROGRAM:

Walker Exemplifies Program's Spirit

by Charles R. Temple

► Scott Walker, retired ASAP case manager. In his six years at AHP, Walker brought his activism and personal history into his work.

PHOTO: KELLY COSTA

Scott Walker's right forearm bears a tattoo of a green dragon curled around a red heart over which is written "H.I.V." Walker retired earlier this year as a case manager for AHP's AIDS and Substance Abuse Program (ASAP) and received the tattoo as a gift from his colleagues.

Of the tattoo, he says: "I think I wanted to draw attention to myself—as an example of a healthy-

looking, middle-aged, HIV-positive man ready and able to deal with the disease."

The fierce energy expressed by the tattoo is found throughout ASAP's staff. Whether advocating on behalf of clients or listening to them reveal their life stories, case manager Matthew Chappell said that ASAP staff are committed to helping clients "gain self-respect and a sense of dignity... and recognize the possibility of choice in their lives."

Most ASAP clients come from populations that traditionally

At the heart of AHP's case-management model is the belief that the client should be an equal player in his or her recovery.



"fall through the cracks": women and men of color, youth, transgender persons, and people who are homeless. ASAP staff—several of whom are in recovery—provide a client-centered, flexible program that links clients to substance-abuse recovery groups, HIV-related services, medical and psychiatric care, stable housing, and HIV risk-reduction support. They do this, according to Supervising Case Manager Bonnie Schwartz, by providing a safe and welcoming environment.

For each client, case man-

◀ ASAP Case Management Team (left to right): Bonnie Schwartz, Veronica Delgado, Yvette Phillips, Shawn Hall, Grace Chu, Dee Hampton, and Matthew Chappell. Not pictured: Eric Maxey.

PHOTO: KAREN KOLTUNOW



CARY HAAK: Facing Life, One Challenge at a Time

by Cathy Hultin

Cary Haak has faced a lifetime of adversity: dealing with terrifying and ongoing battles with both schizophrenia and a heroin addiction, facing challenges as a person with HIV, and suffering the loss of his wife. Through it all, his spirit has focused on a brighter future.

At age 10, Haak escaped a difficult family life in Milwaukee to find refuge in Chicago, where he lived in and out of foster homes. By age 13, he was selling heroin to support himself and later was forced to lie about his age to get a job at a steel mill.

At 20, he moved to San Francisco where he was arrested on a robbery charge. This led to six months in jail and two years in a state mental institution—the first of several bouts with law enforcement. In 1983, the last time he was incarcerated, Haak learned that he was HIV-positive.

Upon his release, Haak and his wife—they'd met years earlier at an alcohol detoxification center—together made plans to deal with his illness. Last year, however, it was his wife who entered the hos-

pital and later died of liver problems. "That was not the way we planned it," he recounted with sadness.

Without his wife to help him, Haak has needed to be especially self-reliant. He has turned to AHP for help. Haak found AHP in 1990 while in a substance abuse treatment program at San Francisco General Hospital.

AHP Case Manager Veronica Delgado has helped Haak maintain housing, keep his psychiatric appointments, and manage his medications. He praises AHP for its "personal touch"—including home visits by Delgado when necessary—and for helping him maintain sobriety since 1993. "I would have been lost without Veronica," he said.

Haak is now trying to save money for a plaque to put with his wife's ashes in a cemetery. "It's important to do this so she will be remembered," he said. "Everybody wants to be remembered."



▲
ASAP client
Cary Haak
with his AHP
case manager
Veronica Delgado.
PHOTO: SHAWN HALL

agers prepare a comprehensive assessment of psychosocial, medical and nursing, and practical support needs. They then create an individual care plan, implement the plan, monitor each client's progress, and reassess the plan in response to changes in a client's situation. At the heart of AHP's case-management model is the belief that the client should

be an equal player in his or her recovery and should participate in all decisions. "Clients, like ourselves, are responsible for their actions—we make that clear," said case manager Yvette Phillips.

Walker's personal story involves nearly a quarter century of active addiction: he started drinking when he was eight. He was able to stop using drugs for good 12

years ago. Otherwise, he might have become an ASAP client rather than a case manager.

Walker first sought sobriety when his lover was dying of AIDS, realizing that if he was always high he wouldn't provide the best care. He remained clean and sober for a year, but after his lover died he was back on drugs.

CONTINUED ON PAGE 11

AHP ANNUAL GALA: "THE FACE OF HOPE"

Event Honoring Pelosi Raises \$75,000+



▲ Leslie Johnston, event stage manager, with actor Kevin Pollak, gala emcee.

► Executives from Pacific Telesis Group/Pacific Bell and others at a table sponsored by the company. Pacific Telesis Group/Pacific Bell was a Platinum sponsor of the Gala, contributing \$10,000.



Platinum, \$10,000
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Gold, \$5,000
Gordon H. Chong & Partners
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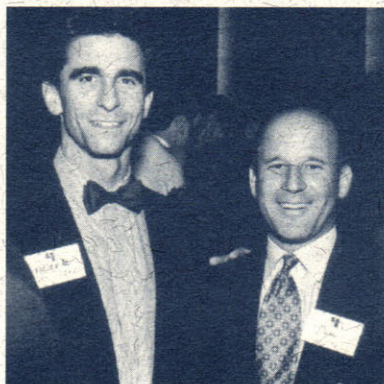
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Mark Leno/Human Rights Campaign
Midnight Sun
James & Robyn Mizes
Thabiti Mtambuzi/Forensic Health Care, Inc.
Norcal Waste Systems, Inc.
Kenneth W. Pearce
Production Resources, Inc.
Bob Ross
Steven Sams
San Francisco Giants
Jack & Mercedes Seitchik
Shanti
Starbucks Coffee
World Wrapps
WrapWorks

◀◀ Bay Area jazz performers Scotty Wright and Clairdee headlined the gala's entertainment. The two have become AHP gala regulars.

◀ AHP supporter Mark Leno and Dana Van Gorder, coordinator of lesbian and gay health services for the San Francisco Department of Public Health.





▶ AHP staff members George Harrison, Robin Ortiz-Young, and Francis Salmeri. The three were joined by AHP staff Ron Harris, Dee Hampton, and Emily Leavitt in reading vignettes of personal experiences working with clients.

◀ In his vignette, AHP psychotherapist Ron Harris recalled the experience of sitting with a depressed client who was forced to give up his pet:



“(My client) had developed allergies to the one thing that meant the most to him—his dog. At that point he wasn’t thinking about his heart condition or his kidney failure or his AIDS. He was thinking about his loneliness.”

—excerpt from client vignette read by AHP Psychotherapist Ron Harris

▶ AHP Executive Director Jim Dilley speaks with actress and AHP supporter Uma Thurman. AHP Deputy Director Joanna Rinaldi is at center.

More than 600 guests enjoyed a light supper and wine tasting in the Terrace Room before gathering in the Grand Ballroom. The Fairmont Hotel generously donated space for the event and allowed outside contributors to provide food and wine.



▼ AHP supporter David McMurry and AHP Community Advisory Board member Tim Schott.





Lynn Sheehan, executive chef of MECCA, with AHP supporter Meg Honan. The fashionable Upper Market Street restaurant was one of 15 restaurants providing the Gala's light supper. ▼



AHP's 1996 Annual gala on October 29 was a phenomenal success, bringing together 650 AHP friends and supporters

◀ Kevin Pollak at center stage in the Grand Ballroom at the Fairmont Hotel.

Food Generously Donated by
 Bon Appétit
 Cafe 222 at Hotel Nikko
 Cafe Kati
 The Cliff House
 Gabbiano's
 Ivy's Restaurant and Bar
 Julie Ring's Heart and Soul
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Gala Emcee
 Kevin Pollak

Gala Entertainment
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 Fairmont Hotel

◀◀ AHP Annual Event Manager Eileen Blumenthal with San Francisco Supervisor Michael Yaki.

◀ Noah's New York Bagels executive Jim Mizes and AHP supporter Michael Epstein.

LINDA SERVIS:

Her Time to Volunteer Again

by Kathleen McGee



Last time Linda Servis volunteered, it was the 1970s, and she was a college student helping a women's rights organization by stuffing envelopes.

Now, as the owner of a San Francisco real estate firm, she's using her business contacts to help raise money and ensure that AHP clients get the highest quality care.

Servis joined AHP's Community Advisory Board earlier this year and immediately went to work. Along with CAB Chair Victor Murphy, she procured thousands of dollars' worth of wine for AHP's Annual Gala, and then she went out and convinced colleagues in the real estate business to be financial sponsors of the event.

"I've felt a need for some time to give back to the community," Servis said, "but I needed to establish myself in the real estate business first." As the owner of Century 21-Hartford Properties, a 40-person Upper Market Street firm she joined in 1988, she has succeeded in making her mark.

A Bay Area resident for 20 years, Servis brings to AHP experiences and expertise from a rich and storied past, including jobs at the U.S. State Department, the Abortion Rights Action League, and a radio station in Michigan. The impact of AIDS in her life is deep: her first friend in San Francisco was diagnosed with AIDS in 1982 and died two years later.

She came to AHP in 1996 because "AHP's support groups and prevention efforts are very important." And successful fundraising is vital. She said, "I can make use of my business skills and contacts. I know how to do it."

BERNARD BOUDREAUX, CONTINUED FROM PAGE 3

many Mervyn's co-workers also walked, Boudreaux suggested to Mervyn's executives that the company sponsor walkers the next year. He was so successful that the company pledged \$150 for each employee who walked, and in 1993, a team of 50 walkers included the company's president at the time, Joseph Vesce. Even more employees have walked since then, including current president Paul Sauser.

Encouraged by his success, Boudreaux lobbied for more support. At the same time, his friend Steven Sams, a member of AHP's Community Advisory Board and perennially the leading money-raiser for the AIDS Walk, told Boudreaux about AHP's work.

Boudreaux decided AHP would be a worthy recipient of a share of the 5 percent of net profits Mervyn's gives each year to

community activities. He knew this effort would take some work, and time. In 1995, when he didn't get company financial backing to sponsor a table at AHP's Gala Cabaret, he and a group of friends brought out their own money and represented Mervyn's unofficially. This year, Boudreaux won company support for AHP's 1996 gala, "The Face of Hope." He was also successful in lobbying for an in-house education program. Mervyn's established an AIDS awareness day this year, which began with an employee rally in the atrium of the Hayward store and continued with events throughout the day.

"In the end, it's simple," he said. "Money and education are vital in dealing with AIDS. "And, individuals can make a difference in both."

Generous Support for AHP Services

Through their generous contributions, corporations and community-based organizations provide vital support for AHP's services. Recent contributors include: Castro Lions Club Charities; Charles Schwab Corp.; Community Thrift Store; Evergreen Media Corp./KMEL Radio; Century 21 - Hartford Properties; Hole in the Wall Saloon; and Pacific Telesis Group/Pacific Bell.

We also wish to acknowledge the following recent foundation contributions and grants: \$82,500 from TIDES Foundation/AIDS Walk; and \$20,000 from the Levi Strauss Foundation for primary prevention services for gay and bisexual men.

Never Losing Focus: AHP Newsletter Turns 10

HIV testing had just become available and the term "AIDS" was only two years old in 1985 when AHP published the first issue of its monthly newsletter. Earlier this year, *FOCUS: A Guide to AIDS Research and Counseling* recognized its 10th-year anniversary, making it one of the, if not the, longest-running AIDS newsletters.

No other AIDS newsletter brings together such a range of experts to address crucial psychosocial issues. The newsletter provides

education and support to a broad readership, ranging from psychotherapists and social workers in AIDS epicenters to primary care physicians in rural settings where services are few.

FOCUS is also unique in its consistency: Executive Editor James W.

Dilley, Medical Adviser Stephen Follansbee, and Founding Editor Michael Helquist were involved from the start and continue, 131 issues later, without stopping. Helquist turned over the position of editor to current editor Rob Marks in 1989, but has remained as an advisor. And, *FOCUS* has remained a bargain: one-year individual subscriptions still sell at the 1985 price of \$36.

Arts and Crafts, Shish Kebob and Smoothies, and Counseling and Testing

AHP had a major presence at this year's Folsom and Castro Street Fairs, providing counseling and testing to more than 125 people and reaching out to educate thousands of others about the range of AHP's services.

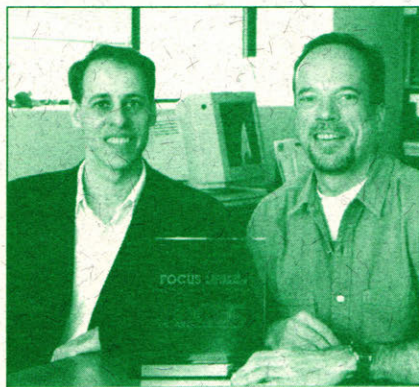
In its fifth year, AHP's mobile testing program is successful because it attracts people who didn't plan to test immediately but have been "meaning to get around to it." Many say they test only because of the presence of mobile testing.

Turn Pots and Pans into AHP Cash

One person's tired old rug may be another's magic carpet. Every day, people drop off their unneeded household items, such as clothing, furniture, and other merchandise, to San Francisco's Community Thrift Store, and designate AHP to receive proceeds when the goods sell. In a recent three-month period, AHP received a \$555 check from Community Thrift.

AHP is one of dozens of non-profit agencies that benefit from Community Thrift, which is located at 623 Valencia Street in San Francisco's Mission Neighborhood. Community Thrift accepts donations from 10:30 am to 5 pm every day, and its store is open from 10 am to 6:30 pm daily.

Rob Marks,
AHP's Publications
Director and Editor
of AHP's *FOCUS*,
a Guide to
AIDS Research
and Counseling,
with Founding Editor
Michael Helquist



**ASAP,
CONTINUED FROM PAGE 5**

Three months later, he checked into another rehabilitation center, and he has been clean and sober since. He got a job at a rehabilitation center, completed a two-year academic program in drug abuse and treatment, and eventually found his way to ASAP. In addition, at a time when HIV services for young people were nearly nonexistent, he co-founded—with psychotherapist Julie Graham—Bay Area Young Positives as a once-a-week support group. BAY Positives is now an independent, full-service agency for HIV-infected youth. Early members of the group describe Walker as a mentor and an inspiring friend. Walker's role in the lives of young people extends into being a foster parent to eight young people. One of these became his son, now a 21-year-old college honors student.

Stories of changed lives are common at ASAP. One client, desperate, incoherent, and homeless, was able to enter a rehabilitation program after weekly meetings with a case manager. The client is now free of drug use and has found housing and a job. Less dramatic changes can be equally significant. One client, as a result of addiction to marijuana, was unable and unwilling to get out of his apartment to buy food. Over time, an ASAP case manager helped this client abstain from marijuana use three mornings a week. This small shift gave the client the energy and motivation to go out. Sometimes, Walker says, "a client's simply being alive is a sign of success."



▲ In retirement, former case manager Scott Walker is still doing volunteer HIV work, and also trying to find time to play.

PHOTO: KELLY COSTA

IN APPRECIATION:

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AHP Mission Statement

The mission of the UCSF AIDS Health Project is to provide culturally sensitive counseling and education to stop the spread of HIV infection, and to help people face the emotional, psychological and social challenges of living with HIV disease.

AHP Counseling and Testing on the Front Lines



Brad Grant, joined by his staff at BG Productions, signs a \$1,722 check to support AHP prevention efforts. BG Productions operates Blow Buddies, a South of Market neighborhood sex club for gay and bisexual men. AHP provides HIV counseling and testing services two nights a month at Blow Buddies. Working with Grant, AHP is bringing vital services to the front lines of the epidemic where people are having sex. AHP began offering services at the club as a pilot project in 1993, and earlier this year, designated Blow Buddies as one of AHP's permanent HIV counseling and testing sites.



Barbara Adler, Director of AHP's Counseling and Testing Services, displays Grant's donation at an AHP staff meeting. BG Productions staff members are in the background.

PHOTOS: JOHN TIGHE



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AHP Executive Director
Jim Dilley at AHP's
October 29 gala.
Pelosi received AHP's
Champion Award.

All Gala photos by
Asa Mathat



AHP's culturally sensitive counseling and education programs are vital to stopping the spread of HIV infection and helping people face the emotional, psychological and social challenges of living with HIV disease.

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HIV COUNSELOR PERSPECTIVES

Volume 6 Number 1 January 1997

SEXUAL ASSAULT & HIV INFECTION

In addition to physical and psychological trauma of sexual assault, sexual assault can put a person at risk for infection with HIV and other sexually transmitted diseases (STDs). Yet, society often avoids the topic of sexual assault, and people who have been assaulted may be afraid to disclose that they have been assaulted.

This issue of PERSPECTIVES examines concerns, questions, and fears faced by people who have been sexually assaulted. It discusses education, prevention, and other psychosocial issues involved in counseling those with sexual assault and HIV risks.

Research Update

Sexual assault, or rape, refers to any sexual act between two people in which one person is forced to engage in the act without his or her consent.¹ Rape is not about sexual expression; it is an expression of violence and anger and an attempt to achieve power and control. Studies find that as many as one in three women and one in seven men in the United States is sexually assaulted over the course of a lifetime.² At greatest risk for sexual assault are women between 16 and 24 years old.³

A person forced to engage in sexual behavior against his or her will is considered a victim of sexual assault. The term "victim" is sometimes used to indicate a person currently in an abusive situation. The word "survivor" is used to define a person as he or she attempts to cope over time with the effects of an attack. Many use it to recognize the healing process.⁴

While some people may imagine rape occurring in the setting of a dark alley where a stranger attacks an unsuspecting woman, this is not the reality of most assaults.⁵ Sexual assault occurs in many settings, and assailants can be friends, lovers, spouses, parents, or other relatives of those who are attacked; 85% of people attacked know their assailants.⁶ While most instances of sexual assault are committed by men against women, men are also assaulted, and some women commit sexual assault. Sexual assault occurs among people of all ethnicities, sexual orientations, and socioeconomic levels.

Societal stigmas attached to sexual assault and a historic lack of response from the legal and justice systems have led many people not to report sexual assault crimes. Only an estimated 10% of sexual assaults are reported to police. Fewer than 40% of reported incidents are prosecuted, and only 3% of prosecutions result in conviction.⁷

HIV Transmission and Assault

Little research has been conducted on the rates or risks of HIV transmission through sexual assault. As a result, health service providers have relied upon anecdotal information in assessing and discussing infection risks.

Service providers anecdotally suggest that the HIV infection rate for women who have been raped by men may be higher than the rate of heterosexual transmission in the general population. Service providers make this suggestion based partly on the idea that the forced nature of vaginal and anal

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- 1 Research Update
- 3 Effects of Sexual Assault
- 4 Implications for Counseling
- 7 Case Study
- 8 Test Yourself
- 8 Using PERSPECTIVES

penetration during an assault may lead to tissue trauma, increasing the risk of HIV transmission.^{8, 9} In addition, because of the inherently violent nature of sexual assault, assailants often have little respect for the health risks they pose to their victims.

Many victims of sexual assault do not consider or discuss the possibility of HIV infection. Some rape counselors do not discuss HIV, perhaps because they feel that they are not trained to provide appropriate services or they are concerned that discussing HIV may unreasonably raise fears among clients.

However, there are compelling reasons to address HIV infection risks promptly, even though the immediate shock of sexual assault

may inhibit a victim's ability to discuss what has happened or to give informed consent for an HIV test. Most importantly, victims often do not return for follow-up visits with rape service providers and so may never receive adequate HIV education or counseling.^{10, 11}

Societal Biases about Sexual Assault

People who have been sexually assaulted face not only the distress of being attacked but also the societal attitudes that discount the severity of assault and blame victims for the violence of assailants.¹²

Recent research indicates that people empathize less with the distress of women who have been raped by an acquaintance than those women who have been raped by a stranger.¹³ Women who are raped by an acquaintance are more likely to be blamed, and to blame themselves, for "allowing" the sexual assault to occur. A random survey of American men found that, in instances of acquaintance rape, these men were more likely to consider female victims, rather than male assailants, as being responsible for the assault.¹⁴

According to a survey that measured views toward victims of acquaintance rape in various scenarios, the threat of HIV infection has created added biases against some victims of sexual assault. In the survey of female college students, participants believed those infected with HIV during assault were less respectable than assault victims who did not become infected during assault. Survey participants also were more likely to judge as being at fault those raped by someone the victims knew to have AIDS compared to someone they knew did not have AIDS.¹⁵

Many people do not recognize that men can be victims of sexual assault. Others may incorrectly believe that sexual assault of men occurs only in jails or prisons, or only to men who are gay. These

beliefs result from a variety of misconceptions. For instance, many people expect men to be powerful enough to defend themselves against sexual assault.¹⁶ In fact, most people, regardless of gender, are unable to defend themselves when physically attacked.¹⁷

Domestic and Childhood Assault

Numerous factors complicate attempts to deal with sexual assault that occurs within existing or primary relationships. These include loyalty to and dependence on a partner and low self-esteem. Both of these factors may subject partners to repeated assaults. Emotional and economic attachments to an attacker can make survivors of sexual assault especially likely to blame themselves for the attack. Abusive partners often encourage victims to blame themselves, claiming violence to be an "appropriate punishment" for disobedience.¹⁸ In addition, those being abused within relationships often assign blame to themselves as a rationale for not leaving harmful relationships.

Sexual assault of children has taken on additional consequences as a result of the threat of HIV infection. In a study of 96 HIV-infected children, 14 of the children were confirmed to have been sexually abused; sexual assault was the proven method of transmission in four of these cases.¹⁹ In a survey of service providers who work with sexually abused children, providers reported that 41 of 5,622 children who received HIV tests were positive. In 28 of these cases, sexual assault was the only HIV risk factor.²⁰ Given the presence of 6,611 pediatric AIDS cases reported in the United States through June 1996,²¹ and thousands more children estimated to be infected with HIV, research suggests that many more cases of HIV infection may have resulted from child sexual assault.

Sexual Assault Survivors and Fears of HIV Infection²⁹



Percentage of survivors reporting fears of becoming infected with HIV through the sexual assault

In addition to posing an immediate risk of HIV infection, childhood sexual assault negatively impacts psychological and social development. Psychological trauma resulting from childhood assault can lead to unsafe behaviors in adulthood.²² Men and women who have been sexually abused as children are more likely than others to work in the sex industry, to abuse substances, to have compulsive sexual patterns, and to have a history of STDs. In addition, they are likely to engage in sex with "casual" acquaintances more often than those who do not have a history of being sexually abused,²³ and they can be at risk for later abusing others.

Studies have estimated that before age 18, one in four girls and one in six boys in the United States has been sexually assaulted, while only about one-third of all cases are reported to authorities.²⁴

Ethical and Legal Issues

While laws exist to protect people who have been sexually assaulted, legal experts state that these laws provide limited protection to victims and these laws are subject to abuse. For instance, alleged assailants often gain access to survivors' medical and psychological records, including HIV test results, during court proceedings. Such material can then be used to discredit someone who has been assaulted.

A 1994 California law requires that convicted assailants be tested for HIV and that victims have access to test results. Considering the small percentage of sexual assailants who are convicted, however, mandatory testing laws have limited value.

HIV Treatment and Prophylaxis

Protocols for health care workers call for taking anti-HIV treatments immediately following occupational exposure to HIV.²⁵ This is based

on research that indicates immediate treatment may prevent HIV infection.²⁶ Treatment advances have reinforced adherence to such protocols.

However, partly because questions remain unanswered about the effectiveness of prophylaxis and the possible negative effects of drug treatments, there are no standard protocols for others, including people who have been sexually assaulted. Health care providers and researchers have discussed the issue of post-exposure prophylaxis for those who have been sexually assaulted, and, in light of recent treatment advances, discussions continue.²⁷ One report suggests that decisions about whether to initiate prophylaxis following sexual assault should be based on a risk assessment of the exposure, taking into account such things as the serostatus of the assailant, if this is known, and the type of exposure.²⁸

Related Issue: Effects of Sexual Assault

Sexual assault can affect a person in many ways. Survivors of sexual assault experience grief, irritability, anger, fear, depression, sadness, denial, and self-blame related to the assault.³⁰ A history of assault can lead to patterns of self-destructive behavior, such as suicide attempts, isolation, and increased exposure to violence. Also, recent research suggests that sexual abuse may predispose a person to substance abuse.³¹ Researchers suggest that alcohol and other drugs are used as coping strategies to deal with the range of stress that survivors might experience.³²

In the absence of support and counseling, survivors may feel powerless in subsequent sexual encounters, and may develop a pattern in their relationships in which sexual or physical abuse continues and feelings of helplessness are reinforced.

A person who has been sexually assaulted is also likely to experience rational fears related to the genuine threat of HIV infection. Forty percent of the sexual assault survivors participating in one large study reported fears of being infected with HIV

through the sexual assault.³³ Partners of rape victims also expressed heightened fears of infection for themselves.³⁴

A survivor's level of concern is affected by perceptions of how his or her social network would react to HIV infection. For instance, someone who is in a supportive environment likely will have decreased fears of being infected compared to someone in an unsupportive environment.³⁵ Even with an HIV test, fear and anxiety related to possible HIV infection are unlikely to diminish unless testing is accompanied by thorough counseling.³⁶

Sexual assault can affect a person's views toward sexual expression and sexual identity. For instance, after being assaulted, people may develop the belief that all sexual expression is assaultive. Some gay men assaulted by other men may experience internalized homophobia and feel that because they are homosexual they are somehow responsible for attracting an assailant. Some heterosexuals may feel their heterosexuality to be challenged by an assailant of the same gender.³⁷

Implications for Counseling

When clients disclose that they have been sexually assaulted it is important for counselors to do the following: listen and provide support for the disclosure; assess needs and provide referrals for support and other services; evaluate HIV infection risks from the assault; evaluate the appropriateness of testing; and validate clients' desires and decisions of whether to test. To the extent possible, offer referrals that might help clients reduce the risk of future assault.

Counselors may have good reasons to feel hesitant about discussing sexual assault with clients. They may believe they do not have enough knowledge or they may have unresolved feelings from personal experiences of being assaulted or knowing friends or family members who have been assaulted. They may fear that these feelings will interfere with their ability to provide objective, detached support. An HIV test counselor is not expected to be an expert on the subject of sexual assault, but he or she is responsible for assessing a client's HIV infection risks, supportively listening to a client, and providing referrals.

Client Disclosure and Assessment

For a variety of reasons, some clients who have been sexually assaulted may not wish to disclose this to an HIV counselor. They may feel ashamed, they may not believe that a discussion of sexual assault is relevant in an HIV test counseling session, or they may not want to bring up the painful experience in a "casual," one-time counseling session. In addition, they may be afraid to acknowledge to themselves the possibility of having been infected by an assailant.

Other clients, even if they have never before disclosed their assault, may be particularly forthcoming in an HIV test counseling session.

They may feel that as a result of the anonymity or confidentiality offered in the test counseling session, they can freely disclose it.

In the risk assessment session, assess the possibility that clients have been sexually assaulted. Be alert to the possibility of sexual assault when a client describes a sexual setting in which he or she has had sex without consent even if he or she does not consider such an act to be rape. Also be mindful of the possibility of sexual assault when a client discusses genital, vaginal, or anal injuries without offering an explanation for their occurrence. A client may be afraid to view him or herself as not having control over a given situation or a client may fear placing blame on a partner. Acknowledging a lack of control over a violent and abusive situation can be a frightening experience.

Counselors in confidential settings are required by state law to report to law-enforcement authorities cases in which they reasonably suspect a client is suffering physical injury as a result of current or ongoing assaultive or abusive conduct. *This law does not apply in anonymous counseling and testing settings.*

After an assault, it is important that a person seek services immediately from a rape counseling and treatment center and that a person receive a medical exam, which can detect pregnancy and the presence of STDs as well as evaluate physical trauma.

The Effects of Sexual Assault

It is important for counselors to understand the ways in which sexual assault can affect a person's life, particularly as these relate to sexual expression and HIV risks. Be aware of the feelings of powerlessness and threat that occur during the assault and afterwards.

Recognize that responses to sexual assault involve immediate fears

expressed by feelings of shock, fear, disbelief, anxiety, and vulnerability. When fears of HIV infection emerge, a victim's reactions may intensify. Help clients understand these feelings as normal given the severity of what has happened, and be supportive of the range of feelings a client may experience.

In supporting clients, be aware of, and help clients understand, the following:

Being raped is never the victim's fault. People often blame themselves and view themselves as having less value as a result of being attacked. Families, friends, partners, and others in society may promote such harmful views. Help clients understand that these views are not correct, while acknowledging clients' feelings of shame and self-blame.

It takes time to heal. The effects of sexual assault can be long-lasting, and the process of physical and emotional recovery can be slow and difficult. Regardless of when a person was sexually assaulted, anxiety about being infected with HIV during rape may not diminish even after a person receives a negative test result. When this occurs, ongoing counseling becomes especially important.

Support is important. While people who have been sexually assaulted may express a desire to be alone, support can be especially valuable in reducing feelings of isolation or vulnerability. Determine whether a client has received support, either formally or from friends or family, and offer referrals to a rape crisis center or hotline. Emphasize the value of talking to someone the client trusts, but accept that clients may be unwilling to disclose an assault to others. There are times when clients might feel that no one in their lives can be trusted. This feel-

ing may be heightened when a person has been assaulted by someone he or she once trusted.

Sexual Assault and HIV

While survivors may have received support from rape service providers, they may have never discussed HIV infection risks related to the assault or received education about HIV testing. It is important to discuss with clients the specific acts that occurred during the assault in order to assess possible HIV infection risks. In some cases, clients may not realize that behaviors they were forced to engage in posed a risk for HIV infection. In other cases, behaviors might not have involved HIV infection risks, but clients may fear, nonetheless, that they were exposed to HIV.

In order for a client to discuss risks associated with an assault, it is important to create an environment that supports disclosure and to convey to the client that he or she did not cause the assault. Explain to the client that he or she can also receive support, education, and referrals regarding HIV risks that are related to sexual assault.

Help clients understand that sexual assault may affect a person's subsequent sexual behaviors, including HIV risk behaviors. For instance, someone sexually assaulted as a child may unconsciously view abuse as "normal" and may subconsciously seek abusive environments in which he or she is at greater risk for assault or unsafe sex. Someone who has been sexually assaulted may wish to be sexual but be afraid of having any sexual contact, and may need more extensive counseling. A person in an ongoing relationship who has been sexually assaulted by someone other than a primary partner may feel unable to disclose the sexual assault to this partner, yet engage in unprotected intercourse within the relationship and potentially place the partner at risk.

Clients may report incidents in which they have been willing to engage in safer sex with someone, but were instead forced to engage in unsafe sex with that person. They may, therefore, not see the act as an assault. Assess clients' reasons for not viewing this as a violation and help them see that this is an assault. Make clear to clients their right to refuse to engage in sex or specific sexual behavior with partners.

Emphasize the role of communication between partners about safer sex and behaviors in which each partner is willing to engage. Explore clients' ability to assert their needs for safer sex and their options when partners violate or attempt to violate these boundaries. Recognize that people in abusive relationships may feel little control, hope, or power either to be respected in their relationships or to leave relationships. Provide referrals, when appropriate, to counseling centers that deal with domestic violence and to shelters for those who are abused.

HIV Testing

Help clients understand both the value and the limitations of HIV testing related to sexual assault. Rape service providers generally recommend that those who have been sexually assaulted seek an HIV test within one week of the assault to establish a baseline for determining whether they were infected during an assault. Such a test might be used in criminal proceedings or in receiving government financial support. Testing in a timely manner can also be useful in easing feelings of anxiety or fear a person may have about the testing process. Acknowledge the value of this approach, but make sure clients understand that it may take as long as six months after an assault before HIV testing can conclusively prove the absence of HIV infection. Service providers often recommend that, after a baseline test, those at

A Counselor's Perspective

"As a test counselor, some of my most important work with clients who have recently been sexually assaulted is to make sure that I give them referrals to a rape crisis center and medical providers, and that we discuss their willingness to pursue these services."

risk for infection through sexual assault should test again midway through the six-month "window period" of infection and then again when this period has passed.

People need to make a series of choices about testing. If they want to use test results for criminal or civil proceedings at any point in the future, they should be tested in a confidential setting. For example, testing at a physician's office or a private medical clinic, where records of testing exist, ensures that test results can be available for legal proceedings; if clients want the greatest protection of privacy, they can test at an anonymous site, but this information would not be accessible to a court. Explain to clients that if their HIV testing is documented, they may lose protections of confidentiality or anonymity, and they should discuss these options with an attorney and a rape crisis counselor.

In some cases, clients may wish to test anonymously prior to choosing to document their status for criminal proceedings. Anecdotal reports suggest that people who have been sexually assaulted are more likely than other clients not to return to the test site for test results.

They may have strong feelings related to learning a result or recalling the abusive experience. During the risk assessment session discuss directly their feelings about returning for a result and any possibility they may feel unable to do so. If they acknowledge feelings of uncertainty or hesitation, help them determine when they might feel more prepared to complete the full testing sequence.

Domestic Violence

Someone in an ongoing relationship may engage in sex with a partner against his or her will but not label the behavior as sexual assault. This may be especially true for someone who expresses a desire to engage in safer sex but whose partner forces him or her to have unsafe sex. Determine whether such clients are able to view the behavior as abusive or whether they feel any discomfort about this. Keep in mind that peo-

ple in abusive situations may not view their partners as harmful. Counselors will have to assess on a case-by-case basis the extent to which they can gently challenge clients concerning situations that seem abusive.

Clients may remain at risk for assault even after they have separated or distanced themselves from an abusive partner. Because of this, refer clients to counselors experienced in issues of domestic violence or sexual assault.

Rape Prevention Awareness

Sexual assault can occur regardless of the steps a potential victim takes to reduce his or her risk of assault. People can, however, adopt strategies to reduce their risks of being assaulted and the harm that occurs when they are attacked. It is important for people to trust their instincts to protect themselves, and to know that it is okay to do whatever is necessary to get out of situa-

tions that feel dangerous or uncomfortable.

Help clients understand that they have the right to say "no" to sex at any time to anyone. Assess to what extent clients believe this. For instance, clients may report that this concept feels foreign to them, and that as partners become aggressive in demanding sex, they feel less able to assert their desires. Often, people are quick to view their own desires as wrong and those of their partners as right, and may perceive their unwillingness to comply with a partner's demands as unreasonable.

When there is ongoing abuse within relationships, help clients see that it is not their fault that the abuse is happening and that they in no way deserve to be abused. Assess whether they are willing to talk to someone who might help them. Provide referrals to help people gain self-defense skills that may help them reduce harm that

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Additional Resource

Vasso ER. Counseling a rape survivor. *Women Organized to Respond to Life-Threatening Diseases* newsletter. May 1994. For more information on this newsletter, call (510) 658-6930.

Case Study

Stephanie is a 21-year-old college student. She is seeking an HIV test because she was raped on a date by another student six months ago, and was forced to engage in vaginal intercourse. The assailant did not use a condom. She blames herself for the assault, saying, "I shouldn't have been drinking," and, "I should have known he was going to do it." She has not told anyone of the assault and sees no need to tell anyone else. She says she has tried to forget that it happened but has been unable to do so.

Stephanie discloses that she was also sexually assaulted five years ago. In addition, she says that she has had unsafe sex on several occasions because she felt pressure from her partners and that she has difficulty asserting her desire to engage in safer sex in the face of such pressure. She says that as a result of the pain and struggle of her past experiences, she feels confused about whether she wishes to date or be sexual at all.

Counseling

Empathize with Stephanie. Affirm that the assault was not her fault and that a crime has been committed against her. Support her decision to seek HIV testing services.

Assess her relationships with friends or family members, and learn whether she is willing to talk with those in her life about having been assaulted. Explain that isolation can hinder the healing process and that talking to someone she trusts and getting support may be essential to healing. Getting this support could enable her to be more assertive in the future, reducing the risk of further assaults. Detail the benefits that might come from disclosing the assault or from seeking counseling or other support. Encourage her to pursue support during the period in which she is waiting for her test result. Provide the phone number of a rape crisis hotline and the address of a rape treatment center.

Explain the importance of a medical exam to detect pregnancy and other STDs. If she is resistant, compare the decision to seek such an exam to the decision to seek HIV testing services.

Learn more about her earlier assault, and ask

whether there have been other assaults. Ask how sexual assault may have affected her views toward sexual expression and learn more about her current ambivalence about dating and sex. Respect that Stephanie may not wish to be sexual, but help her understand options available to her if she does desire to date or have sex in the future.

Assess her willingness to use condoms. Empathize with her difficulty asserting and protecting herself in sexual situations. Help her understand that she has the right both to tell people she will not have sex with them, and that when she does choose to be sexual, she has a right for it to be safer sex.

Acknowledge that the earlier assault may have made it difficult for Stephanie to assert herself in sexual situations. Help her understand this possibility, and explain that she can still receive support in response to that assault. Suggest that being unable to assert to partners the need for safer sex is an effect that often occurs as a result of sexual assault. Help her see that she is at risk for engaging in unsafe sex in the future, and that counseling related to her sexual assault experiences can help her deal with her vulnerability to unsafe sex.

can occur if they are attacked.

Counseling an Abuser

While it is infrequent that a person will acknowledge having sexually abused another person, some people may make such a disclosure. They might do this through a direct disclosure or by reporting behaviors in which they sexually assaulted another person, even though they may not consider an incident to have been an assault.

By law, when a client threatens to assault a specific person and that person is in imminent danger,

some service providers have a "duty" to warn law-enforcement authorities or the individual in danger. This duty does not apply to anonymous test counseling sessions, and in most cases it does not apply to confidential test counseling sessions. For further information, consult with a supervisor.

If a client discloses that he or she has forced another person to engage in sex without that person's consent, learn more about specific incidents and determine the client's feelings related to his or her behavior. Do not discount the

harm, violence, or illegality of this client's actions, but attempt to maintain a productive dialogue. Determine the client's willingness to stop abusive behaviors and seek help. Help him or her understand that it is possible to stop and that support is available to help abusers overcome violence. Assess and respond to factors that may affect a client's willingness to seek support or counseling services. Rape crisis centers and anti-violence programs can provide counselors with information about programs for sexual abusers.

Test Yourself

Review Questions

1. True or False: People of all ages are at risk for sexual assault, but those at greatest risk are women between 16 and 24 years old.
2. The following are among the inaccurate societal views about sexual assault: a) a woman raped by an acquaintance is at fault, b) when HIV infection occurs during sexual assault, it is the victim's fault, c) men cannot be victims of sexual assault, d) all of the above are examples of inaccurate societal views about sexual assault.
3. True or False: There are times when a victim of sexual assault is at fault for causing an assault.
4. True or False: A history of sexual assault can lead to patterns of self-destructive behavior, which may include abusing substances or engaging in unsafe sex.
5. Which of the following may be true about sexual assault? a) it is an expression of violence and anger, b) it almost always poses little HIV risk, c) it is based primarily in an assailant's desire for sexual expres-

sion, d) all of the above.

6. True or False. A person who has been sexually assaulted may develop fears related to the threat of HIV infection, and many of these fears may continue even if the person receives a negative test result.

7. True or False: Most people who are sexually assaulted know their assailant.

8. Which of the following factors can make it difficult for people to remove themselves from ongoing abuse within relationships? a) loyalty to partners, b) economic or other dependence on partners, c) beliefs that they can remain in the relationship and stop the abuse or that their partners will no longer be abusive, d) all of the above.

Discussion Questions

1. There are many reasons that a client who has been sexually assaulted might hesitate to raise this issue in an HIV counseling session. What steps can counselors take to make such disclosures more likely?
2. Most HIV counselors do not

have specialized training in counseling people who have been sexually assaulted. If a client does present a history of being sexually assaulted, what are the most important interventions the HIV counselor can offer?

3. Should the issue of sexual assault be a regular point of discussion in HIV counseling sessions, or is it more appropriate to discuss the issue only if a client raises it?

4. Is it appropriate for a counselor who has been personally affected by sexual assault to disclose this to a client? Why and when might this be appropriate or inappropriate?

Answers to Test Yourself

1. True.
2. d. All of the above are true.
3. False. Being attacked is never the fault of the victim, regardless of where the person was or what he or she did.
4. True.
5. a.
6. True.
7. True. About 85% of people who are sexually assaulted know their assailant.
8. d. All of the above are true.

Using PERSPECTIVES

PERSPECTIVES is an educational resource for HIV test counselors and other health professionals.

Each issue explores a single topic. A *Research Update* reviews recent research related to the topic. *Implications for Counseling* applies the research to the counseling session. Also included are a *Case Study* and two sets of questions for review and discussion.

HIV Counselor PERSPECTIVES

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HIV COUNSELOR PERSPECTIVES

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UNINFECTED GAY & BISEXUAL MEN

Counselors might assume that a negative HIV test result is good news for a client. Understandably, most people are relieved and happy to receive a negative result. But some people who test negative may feel confused, disappointed, and even depressed. For these clients, counseling may be more complex. This issue of PERSPECTIVES examines the concerns of some of these clients, especially gay and bisexual men, whose communities have the highest rates of HIV infection. A Related Issue article looks at the manifestations of being seronegative in other communities. The Implications for Counseling section presents strategies counselors can use to respond to the concerns of people who are uninfected.

Research Update

For many gay and bisexual men, whether infected or not, HIV has defined a large part of their lives. Some have lived through the entire epidemic and have lost much of their social network to the disease. Young gay and bisexual men may have never known a time when AIDS was not a part of the gay community. Some even perceive HIV infection to be an inevitable consequence of coming out as gay, and uninfected gay and bisexual men may actually feel disenfranchised from the gay community. For example, in areas most affected by HIV disease, many social services exist to support those infected with HIV, but there are relatively few support services to help people who are uninfected.

Testing Negative

A negative HIV test result can suggest many possibilities. Perhaps someone has engaged only in no-

risk or low-risk sexual behaviors. Maybe he or she has engaged in high-risk behaviors but has not had contact with a person who has HIV, or perhaps he or she is in the window period of infection, the time between infection and the development of HIV antibodies.

In a disclosure session for someone at high risk for HIV infection who has tested negative, a counselor is expected to spend at least 15 minutes* giving the result, reviewing the discussion that occurred in the risk assessment session, ensuring that the client understands any risks associated with his or her sexual or needle use behavior, and providing further counseling, support, and referrals. However, one study found that counselors often spent only two minutes with clients

whose test results were negative.¹ Several factors may be responsible for this: for instance, clients may not want to talk about their results or test counselors may incorrectly assume that a person who receives a negative result needs no further counseling about or support for staying uninfected.²

Inadequate counseling can result when counselors misinterpret or make assumptions about how a client will respond to testing negative. Counselors may assume a client wants to stay uninfected

Inside PERSPECTIVES

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- 2 Various Populations of Uninfected People
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- 7 Case Study
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- 8 Using PERSPECTIVES

*Effective July 1, 1997, state-funded counseling and testing programs will allot 25 minutes—compared to the current allotment of 15 minutes—for disclosure sessions with high-risk clients who test negative.

and will maintain safer behaviors and change unsafe ones. But a person who has been engaging in unprotected sex or sharing needles may view a negative result in a variety of ways. For example, this person may take the result as a sign that he or she is immune to infection. Or, the client may believe that a negative result affirms that a risky activity he or she has engaged in is actually safe. Others may interpret a negative test result as a "clean bill of health," and may want to "celebrate" by having unprotected sex. According to the State of California, Department of Health Services, Office of AIDS, nearly 54 percent of people who tested positive over the course of a year had previously tested negative at least once.³ Sixty-six percent of those who test positive after repeatedly testing negative are gay or bisexual men.⁴

Isolation from a support network may lead people to seek connection by engaging in higher risk behaviors such as unsafe sex and substance abuse.⁷

Being Uninfected

While most people will be relieved and happy to be HIV negative, some people may see being uninfected as temporary; others as unbelievable, and still others as confusing.⁵ Being uninfected may leave these people feeling uncertain because they do not know whether they will be able to remain free of infection. Or, they may feel depressed because they realize that remaining uninfected and being a "survivor" of the epidemic means having to watch other people in their lives become ill or die. These feelings may be short-lived—occurring among people who are essen-

tially happy about being uninfected—or they may be chronic and lead to or signal other problems.

The subject of personal attitudes toward being uninfected has emerged only recently as an HIV prevention issue. As a result, there has been little formal research on it. While it is clear that being uninfected can be concerning for some people, little is known about the numbers of people for whom this is a concern, how long-lasting concerns might be, or the extent to which concerns may lead to unsafe behaviors. Most of what is known comes from anecdotal reports, for instance from what service providers

Related Issue: Various Populations of Uninfected People

Research on the effects of HIV among those who are uninfected is extremely limited, and the research that does exist focuses on gay and bisexual men. However, clinical reports suggest that uninfected people who identify with other groups strongly affected by the epidemic may have similar psychosocial issues.

Uninfected children in families with seropositive parents may experience isolation at school and in peer relationships because of the burden placed on them to be caregivers. When other children in the family have HIV, parents or guardians may be preoccupied with those children, and uninfected siblings may suffer from a lack of attention and support or they may feel guilt about surviving their siblings.¹⁴

One study found that 11 uninfected women whose partners were HIV-infected men with hemophilia continued to have unprotected sex with their partners because of a desire to share the partner's fate, an unwillingness to add to the partner's burden by communicating rejection, and a false assurance that they were immune because of a negative test. Some of these women felt an obligation not to

introduce condoms into the relationship because they did not wish to "remind" their partners of having AIDS.¹⁵

Any group—especially those that feel marginalized in society—may experience trauma and loss when people in the group are affected by the AIDS epidemic. Heterosexual and lesbian caregivers who continue to encounter gay men with HIV disease, for instance, may experience feelings of guilt as survivors of the epidemic.⁶

Injection drug users in inner-city areas may feel a sense of inevitability or hopelessness about becoming infected because they are immersed in a community with a high rate of HIV infection. At the same time, these feelings are complicated by the need to continue injecting drugs. Injection drug users who are uninfected may also experience a lack of social support because medical care, many detoxification programs, and other types of support for drug users are targeted to people who are also infected with HIV. They may feel no support for remaining uninfected, particularly in areas where needle exchange programs and over-the-counter syringe sales are still illegal.¹⁶

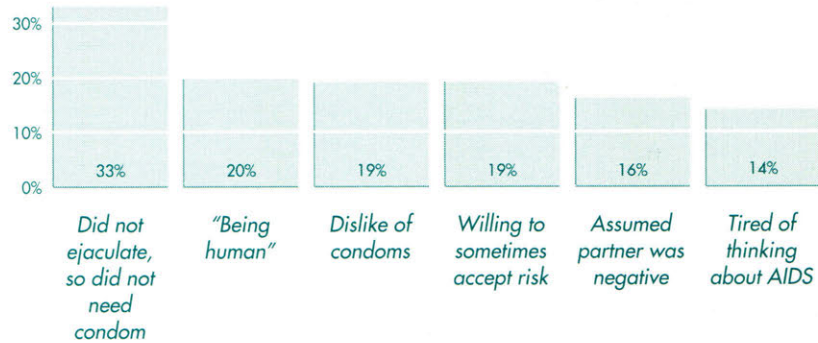
observe during outreach work or in clinical settings such as support groups. These reports are relevant because they demonstrate that some people who test negative have trouble adjusting to this reality. But, there is as yet no research supporting the idea that most or even many people who test negative have these concerns.

Because these reports arise in clinical settings, they cannot be applied generally to the overwhelming majority of people not receiving such services. And, researchers know little about the extent to which the feelings that some people attribute to being uninfected may actually result more from other concerns, for example internalized or societal homophobia, depression, or anxiety. While researchers explore these questions, service providers have identified several factors related to being uninfected that they believe may contribute to a person's conflicting feelings. It is important to note that these factors are based on providers' personal experience and beliefs; they do not represent academic or peer-reviewed research.

Isolation. In a study of uninfected clients receiving HIV support services, nearly one-third had a partner infected with HIV, and about half had close friends with HIV.⁵ When a large percentage of a person's social network is infected with HIV, a negative test result can feel isolating. Some uninfected gay men may believe that they can no longer identify with friends or partners who are infected with HIV, or even with the larger gay community. These men may also feel that they will not get the social support they would receive if they were infected because gay communities are more mobilized in helping those who are infected with HIV. For gay men who felt socially disenfranchised early in their lives, being uninfected may actually be yet another impediment to a sense of "belonging."

Reasons for Engaging in Unprotected Anal Sex

Among 207 uninfected gay men¹³



This lack of connection can be intensified when uninfected men feel they cannot talk about their experiences. Some uninfected men are afraid to tell others their serostatus because they do not want to be perceived as "bragging" or of being insensitive to people with HIV infection. They may be afraid to ask for help because they fear that in doing so, they might take resources away from people who are infected.⁶ Isolation from a support network may lead people to seek connection by engaging in higher risk behaviors such as unsafe sex and substance abuse.⁷

Guilt and Shame. Guilt about being uninfected is more common among men whose risk behaviors are the same as their friends and partners who are infected or who have died. This experience is known as "survivor guilt"—a condition first identified in people who survived concentration camps during the Holocaust and now associated with other disasters that impact large parts of a community. Survivor guilt may co-exist with feelings of relief about being uninfected.

Gay men may experience shame as a result of internalized homo-

phobia or discomfort with sexual identity. Shame can be especially common among younger men who do not have affirmative gay role models and who equate homosexuality with HIV infection. Both shame and guilt can occur for a person who has heard throughout life that being gay is not normal and that people who are homosexual somehow "deserve to get AIDS."⁷ Survivor guilt and shame can disrupt a person's life, leaving someone feeling that the future is marred, or that he or she does not deserve to live while others are ill.⁸

Loss. People who are uninfected may experience the loss of friends, family, and partners who have died. They may also feel loss because of ways in which the epidemic has affected the gay community as a whole. For instance, the epidemic has meant that people cannot engage in unprotected sex—especially anal intercourse—without fear of contracting HIV.⁵ The effect of this loss has been frequently underestimated, but the meaning of sex and the intimacy that arises from specific sexual behaviors is crucial to emotional well-being.⁶

Anxiety. People who are unin-

ected may feel anxious about the prospect of becoming infected. This may lead to sexual dysfunction—in which a person is unable to experience sexual intimacy because of impotence or phobia of future infection. A person may lose interest in sexual activity, be unable to have an orgasm, or seek to forego intimacy because of concerns about remaining uninfected or being alone when a sexual partner dies. Conversely, these fears may also lead to increased sexual risk-taking. Sexual binges commonly occur following the death of a friend, when a friend receives an HIV-positive test result, or as a person feels increasingly isolated and unable to express feelings.

For some people, the testing process itself raises anxiety, and this may be especially true for people who test repeatedly. Some gay and bisexual men even feel relief when they test positive because, despite its implications, it means they no longer need to go through the anxiety of getting tested.⁹

Serodiscordant Relationships

In relationships in which one partner is positive and one is negative—sometimes called “serodiscordant” or “magnetic” relationships—it is sometimes easier for couples to incorporate safer sex behaviors because each partner is aware of the other’s serostatus. In some cases, some uninfected men may feel more comfortable with partners they know to be infected because they can concentrate on having safer sex instead of being concerned that their partner is not truthfully disclosing his status or has become infected after testing negative.

However, being serodiscordant can also cause conflict. The differences that an uninfected gay man and his positive partner may perceive about their goals for the future, for instance, may be complex and difficult to discuss.

Dangerous Assumptions

17% of uninfected men who engaged in unprotected anal sex assumed their partner was uninfected because he was willing to have sex without a condom.¹³

43% of infected men had unprotected anal sex assuming that their partner’s willingness to take risks meant they were also infected.¹³

Emotional intimacy in a serodiscordant relationship can also present the risk of partners lapsing in their safer sex practices. In a study of 15 serodiscordant couples, some reported they would stop using condoms to avoid being reminded of their mixed serostatus. They also reported that, as emotional intimacy increased, the perception that one partner could “harm” the other declined.¹⁰ A “positive-negative” relationship can also be strained if one or both partners is anxious about transmission.¹¹

Negotiating Safety with Others Who Are Uninfected

Related to the risk of HIV infection, unprotected sex can be safe if both partners are known to be uninfected. People may involve themselves in relationships in which they can ensure such a situation through a process of “negotiated safety.”¹² Negotiated safety refers to the terms of a relationship to which partners will agree in order to have unprotected sex. However, the safety of unprotected sex in such a relationship can be threatened when the sexual terms of the relationship are not clear to or met by one or both partners, or when one partner becomes infected through non-sexual behavior.

Negotiated safety requires that trust be an explicitly defined part of the relationship. Trust may involve committing to monogamy, having only protected sex with

people outside of the relationship, or having only certain types of sex—such as masturbation or oral sex—with others. Negotiated safety must include a way for partners to talk about lapses and respond to them. For example, the partners might decide that if one of them has unprotected anal sex outside the relationship, they will not have unprotected sex again until that person has tested negative after the infection window period has passed.

Sex Outside Pre-Existing Relationships

Uninfected men might have sex with someone whose serostatus is unknown. In some cases, sex that occurs outside a previously existing relationship may involve little or no verbal communication and each partner may make assumptions about the other’s serostatus. For example, someone who is uninfected might make the dangerous assumption that a partner who does not mention condoms or his serostatus is also uninfected. In one study, 17 percent of uninfected men who engaged in unprotected anal sex assumed that their male partners were uninfected because they were willing to have sex without a condom.¹³ In the same study, 43 percent of infected men had unprotected anal sex assuming that their partners’ willingness to take risks meant that they were also infected.¹³

Implications for Counseling

For most clients, testing HIV negative and being uninfected is a comfortable and welcome experience. There are some clients, however, for whom testing HIV negative may prompt concerns, ranging from a fear of betraying friends with HIV infection to a belief that it is only a matter of time before a person does indeed test positive. These responses can occur for any client, but they are more likely among gay and bisexual men and those who identify with groups or communities that are hardest hit by the HIV epidemic. Remember that these responses may be short-lived—occurring among people who are essentially happy about testing negative—or they may be chronic and signal problems with grief, depression, anxiety, or other psychological distress.

Even when a client does express concerns about being uninfected, be careful not to “diagnose” all of the client’s concerns as being related to a negative test result. A client may have other issues—for instance, a history of substance abuse behavior, depression, or low self-esteem—that need attention and which may be unrelated to serostatus.

Being Uninfected

It is important for counselors to recognize and validate the various reactions a client may have in response to receiving a negative result and to be aware of what it is like for a person to be uninfected in a community in which many people are infected. Assess and recognize the following possible experiences.

Isolation. Does the client feel alone? Does he or she have people in his or her life who are uninfected or who see value in being uninfected? Do clients see their generation of peers dying and therefore feel little desire to remain alive?

Guilt. Does the client believe it is okay to be uninfected, or does he or she view this as a betrayal to his or her community, or to friends who are infected?

Loss and Identity. Has the client’s experience with others’ illness and death affected his or her thoughts about the future and making plans for it? To what extent is the client’s life and identity tied to the epidemic? To what extent does the client relate being gay or bisexual to being infected with HIV?

Absence of Worthwhile Future. Can the client envision and value a future in which he or she is uninfected?

Depression. Be alert to the fact that feelings about being seronegative can lead to depression, which can affect sleep, eating habits, and a person’s thoughts and behaviors.

Counseling Seronegative Clients

Recognize and validate the range of emotions clients might have to testing negative. These can include relief, confusion, disappointment, happiness, disbelief, or anger. Emotional reactions may appear to be conflicting: for instance, a person might express relief but also feel overwhelmed by the burden of continuing to have to avoid becoming infected.

In the risk assessment session,

A Counselor’s Perspective

“I need to remember that clients might have lots of different feelings in response to testing negative.

They might feel relief, and at the same time feel confused.”

discover the significance of a negative result for the client. If the client has tested negative before, ask how he or she felt after receiving previous results. Clients may hesitate to acknowledge concerns about testing negative; they may feel ashamed about their conflicting feelings regarding what most consider to be good news. Give adequate time for clients to consider the significance of a negative and a positive result, and do not assume that a negative result is either “good” or “bad” for them. Throughout the process, be cautious not to convey to clients that there are certain feelings they *should* have. Doing this can lead people to feel they are inadequate if they do not have these feelings.

After disclosing a negative result, ask a client once again about the personal significance of the result. Be especially alert to the possibility of the following reactions.

Disbelief. Does the client believe the result? Some people living in communities with high rates of infection expect to test positive, regardless of their previous risks. Acknowledge this perception, and clarify for clients that these two things are not the same.

There are some clients who may test repeatedly because they see the testing process as being incomplete as long as they receive a negative result. This process may occur without the client being conscious of it. Explore this issue when it appears: a client for whom this occurs may need “permission” from a counselor not to test again.

Sadness. Clients may focus on losses they have experienced or those they expect, for instance the loss of friends, partners, or family members who are ill or have died, or changes the epidemic has had on daily life. When testing, feelings about these losses can be overshadowed.

owed by the uncertainty of one's serostatus. Upon learning he or she is uninfected, a client may return to focusing on these concerns.

Numbness. Consider whether the HIV epidemic has so deeply affected a client's life that he or she is unable to feel anything at all upon receiving a negative test result. Give clients extra time to consider feelings about testing negative.

Help clients recognize their reactions are understandable. Assess the extent to which a client is comfortable acknowledging his or her feelings. At this point, some clients may attempt to dismiss their concerns. They may say, for instance, that their challenges are insignificant compared to someone who is infected. Validate that the needs and concerns of someone who is uninfected are important.

Remaining Uninfected

Recognize that the time just after receiving a negative test result can be one of the riskiest for HIV infection. Learn the extent to which a client values the prospect of remaining uninfected, both now and in the past. When a client displays ambivalence, learn more about this. For instance, a client may say he or she does not want to

become infected, but state there is no reason for "sticking around" when others are ill or dead.

When discussing safer sex behaviors, acknowledge the loss of not being able to engage in sex "naturally," without protection, and a client's feelings about this. Also, be aware that some clients may engage in relatively low-risk behaviors, but overestimate their risks based on their experience of being surrounded by so many people who are infected.

Negotiation with Partners

Help clients develop skills to negotiate the safety they need in terms of the risks they are willing to accept. Assess a client's negotiation skills and learn how a client communicates with partners. To what extent do clients believe they are able to talk with sex partners about sex beforehand? Do they believe they can let partners know what they will and will not do, and what they like and do not like? Are there ways they can communicate during sex to let partners know what feels comfortable or unsafe?

People who are uninfected may grow weary of negotiating with partners, and, without accurate information, make assumptions

about the serostatus of partners as a way to avoid negotiating. Assess the extent to which clients base the behaviors in which they engage on assumptions of a partner's serostatus, and explore the dangers of doing so.

Negotiating sex in or out of pre-existing relationships involves balancing positive feelings toward sex with concern of contracting HIV. Learn what is important to a client in sexual encounters. Understanding the importance of specific parts of the sexual experience is crucial to negotiation. If a client skips this step, he may find continual dissatisfaction with safer sex, and may abandon safer sex guidelines altogether.

Discuss trust. What does trust mean to a client? What trust does a person place in a partner who says he or she is uninfected? Trust may mean believing that a partner engages only in safer sex outside a relationship, or it may mean believing that partners with HIV infection will respect the client's boundaries of acceptable and unacceptable sexual behaviors.

Ask clients to describe their experiences of trusting others and the extent to which they feel trust

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with partners and with themselves. Learn the extent to which they have discussed the issue of trust with partners. Acknowledge that such discussion can be difficult. If the client is afraid of such a conversation, respect this and learn more about this fear.

Beyond the Counseling Session

Assess a client's support network and the extent to which he or she feels a connection to a group. Learn whether clients believe they can talk with friends or partners

about their concerns of being uninfected, and explain benefits of such conversations. Explain that getting involved in a community—of friends, co-workers, classmates, neighbors, or others—is a powerful way to reestablish a desire for life. If a client wants greater involvement in a community, explore his or her various interests, and direct the client to clubs or social organizations. Community newspapers often list such organizations.

Many issues are best dealt with

in supportive settings beyond the test counseling session. After a discussion, acknowledge the value of further dialogue and provide a referral, saying, "Here's somewhere else that people are talking about their grief or caregiving or the experience of being uninfected." Know community resources for high-risk, HIV-uninfected clients and assess which resource is best for each client. Provide referrals for all high-risk clients who test negative.

Case Study

Rick is a 24-year-old gay-identified man. He says he is unsatisfied with sex because it always involves using a condom: "I don't want to use a condom for the rest of my life." He adds: "Sometimes, I really don't care whether I get infected. I hate my job, my family doesn't support me, sex has become boring, men are jerks, and I feel life is worthless. Besides, so many guys I know have HIV and they're doing okay on all these new treatments. I'm not saying I want to get HIV, but it's not worth being so careful."

Counseling Intervention

Be aware of two main points in counseling Rick. First, he says he does not like condoms, but uses them nonetheless. Second, he says he does not care if he gets infected. Because Rick is someone who describes himself as being on the brink of "giving up," help him look at some of the underlying issues he is facing; provide him some help in understanding why he feels as he does; and offer him an appropriate referral.

Make sure Rick feels comfortable venting his feelings. Validate his view that sex with condoms can be unsatisfactory, that he feels unsupported by his sexual partners, that his experiences with his family are difficult, and that some people with HIV infection are doing well.

Ask whether there are specific reasons or motivations he has for testing at this time. Learn more about Rick's current relationship to alcohol and other drugs. If he is currently using alcohol or other drugs, see if there is a connection between this and his feeling that "life is worthless a lot of the time."

Find out more about his current level of support. Is there anyone he can talk to about his family, his relationships, and his anger? If he appears to be benefiting from expressing these feelings in the counseling session, explain that there are other

places where he can continue this process, for instance in a support group, with a psychotherapist, or with a friend he has not previously considered. Does Rick know other uninfected men? Is he aware that some of his feelings are shared by others who are trying to find ways to live, work, love, and survive this epidemic?

Learn the kinds of losses Rick has experienced throughout life. How has he expressed his grief about these events? Validate any feelings of sadness that Rick shares, and then link him to follow-up services, for instance a group or an individual with whom he could explore feelings further.

Help Rick understand that a goal of the session is to help him find ways or reasons to live through this epidemic. Help him see that his comments reflect how he feels at this moment, but they may not reflect how he feels most of the time. For example, in his statement, "I'm not saying I want to get HIV," he is expressing that he wants to be alive. Help him see that sustaining a desire to remain uninfected can be difficult and build on any areas where he seems motivated or is aware that he could use some help.

The counselor should also make it clear that it is important to him or her that Rick not become infected. The counselor may be one of the first people in Rick's life to express this level of concern for him.

Test Yourself

Review Questions

1. True or False: All gay men will feel sad, confused, or angry upon receiving a negative test result.
2. True or False: After disclosing a negative test result, a counselor should ideally go through a risk-assessment with the client again.
3. True or False: In a study of HIV-uninfected men, nearly one-third of those who had engaged in unprotected anal sex stated that it was not necessary to use a condom because this sex did not involve ejaculation.
4. True or False: People who repeatedly test negative are highly unlikely to ever seroconvert.
5. True or False: Isolation is something experienced by people with HIV infection, not by people who are uninfected.
6. A binge of unsafe sex may follow a) the loss of friends and partners to AIDS; b) an HIV-negative test result; c) the decision to abstain from sex; d) any of the above.
7. Uninfected gay men experience loss because a) people close to

them have died of AIDS; b) the gay community as a whole has been heavily impacted by AIDS; c) they associate sex with illness or death; d) all of the above.

8. True or False: Only uninfected gay and bisexual men have concerns about the experience of being uninfected in an environment with high rates of infection.

Discussion Questions

1. What can counselors do to avoid making assumptions about how HIV has affected the life of someone who is uninfected? How can counselors ensure that they are not applying assumptions to clients' needs?
2. When counselors do not themselves identify as being strongly affected by the HIV epidemic, how can they make sure that they are empathic to those whose lives have been greatly affected?
3. There can be many priorities for a client who tests negative. How can a counselor decide which areas need focus: for instance, helping a client make or maintain a commit-

ment to stay negative, build a sense of community, or enhance safer sex negotiation techniques?

4. What can counselors do to learn about referral resources in their communities and to help develop additional services?

Answers to Test Yourself

1. *False.* While some gay men who test negative will have such feelings, most will likely react with relief or happiness. It is important that counselors not make assumptions, but instead respond to whatever reactions clients have.
2. *True.*
3. *True.*
4. *False.* Data from the State of California, Department of Health Services, Office of AIDS demonstrate that nearly 40 percent of people who tested HIV-positive had previously received a negative test result.
5. *False.* Like people infected with HIV, those who are uninfected, especially those who live in areas strongly affected by HIV, may feel a lack of belonging to their community.
6. *d.*
7. *d.*
8. *False.* While gay men can be affected, others, including injection drug users and those in other environments strongly affected by the HIV epidemic, might have concerns about being uninfected.

Using PERSPECTIVES

PERSPECTIVES is an educational resource for HIV test counselors and other health professionals. Each issue explores a single topic. A *Research Update* reviews recent research related to the topic. *Implications for Counseling* applies the research to the counseling session. Also included are a *Case Study* and two sets of questions for review and discussion.

HIV Counselor PERSPECTIVES

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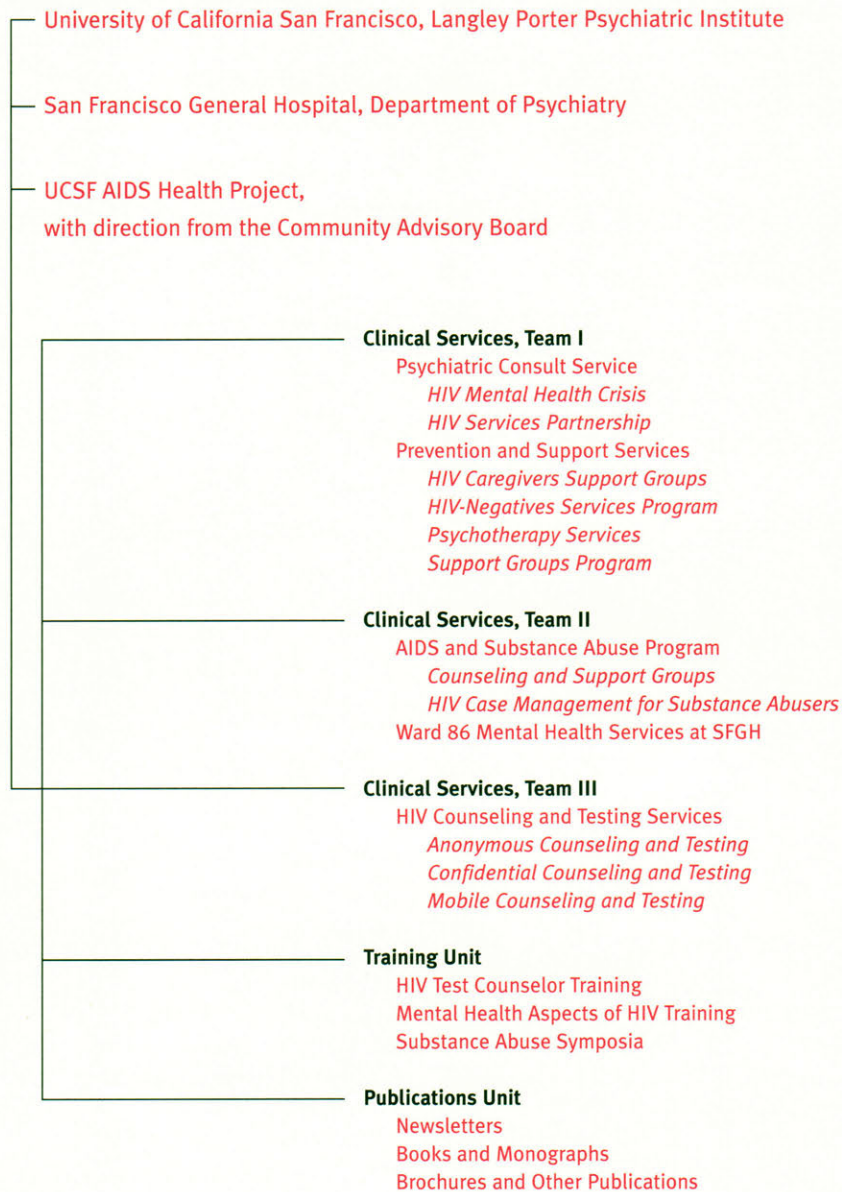
UCSF AIDS Health Project

Annual Report 1995-1996



Organizational Chart

The AIDS Health Project is affiliated with the University of California San Francisco. While UCSF provides no funding to AHP, it does contribute administrative support and the resources of a world-renowned medical school.



hope.

“To desire with expectation or with belief
in the possibility of obtaining.”[†]

The compelling research showing that protease inhibitors
in combination with other antiviral drugs
reduce the amount of HIV in the blood to undetectable levels.

The living-and-breathing reality that our loved ones are feeling better,
are living longer, are able to do more,
are excited about life.

“An enduring feeling that life makes sense.”[‡]

The UCSF AIDS Health Project, a calm port in stormy seas.
A place where emotional health is as important as physical health.
A place for each individual to discover what is meaningful,
what most characterizes hope for him or her,
and how to maintain equilibrium in the face of constant change.

A place of hope when all other hope fails.

[†] Webster's Third New International Dictionary

[‡] Jeanne Achterberg, Saybrook Institute

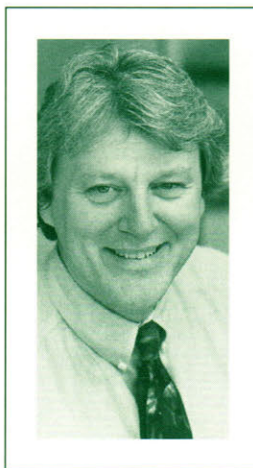
Letter from James W. Dilley, MD

AHP Executive Director

The past year has brought me the gift of hope, more hope than I've had in many years about our ability to manage HIV disease. The International Conference on AIDS in Vancouver was a symbol for me of the powerful combination that results when you bring together researchers, physicians, mental health providers, activists, and people with HIV disease.

In the wake of the excitement about triple combination therapy, viral load testing, and the potential of extending life, there is an element of confusion. This is where the AIDS Health Project's challenge lies and where our strength is most evident. What does it mean to live with HIV infection during these changing times, and what does it mean to remain uninfected?

What do we say to a person who hears about the wonders of combination therapy but fails to tolerate one drug after another? How do we relieve the frustration of those who have watched loved ones die, missing by what seems to be a moment the treatment that might have kept them alive? How can we help people for whom treatment works to adjust to the idea of a healthy future after having finally accepted the limits imposed by HIV? What can we do to prevent the impression that HIV is conquered and that risk reduction practices such as safer sex and safer needle use are unimportant? How do we continue to respond to the exhaustion, depression, trauma, and stress that plague—almost as tenaciously as HIV—people living at the heart of the epidemic?



James W. Dilley

AHP is in a unique position to help people respond to these concerns. With support groups, psychotherapy, case management, and crisis counseling, AHP offers the precise remedy for each individual's emotional challenge. And since we have grown as the epidemic has widened, we have been able to tailor these services to the needs of the diverse communities we serve, ranging from people who use injection drugs to men who have sex with men, from African-American heterosexuals to recent Latin-American immigrants, from people adjusting to disability and job loss to homeless people with mental illness.

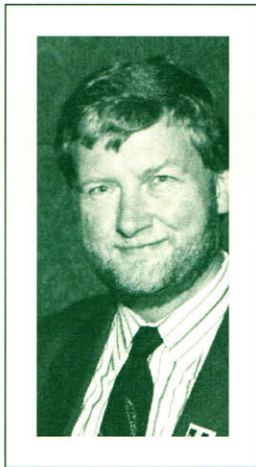
Like any potent medication, hope may be accompanied by unexpected and uncomfortable side effects. It is AHP's task to respond to these, to maintain hope where it is useful, but never to accept it as a substitute for real medical and mental health achievements.

Letter from
Victor Murphy
AHP Community Advisory Board Chair

The past twelve months have been important ones for the AIDS Health Project, both in terms of our financial health and our connections to the communities we serve.

During the 1995-1996 fiscal year, AHP secured generous contributions from hundreds of private funders, including more than \$65,000 from 600 individuals and almost \$175,000 from 30 businesses, corporations, and foundations. And AHP gratefully accepted in-kind donations ranging from computer equipment to office partitions to printing services.

AHP has also sought over the past year to become a more prominent presence in San Francisco—using special events not only to raise money but also to strengthen AHP's connection to the communities we serve. Our October 1995 annual gala, which honored Pat Christen, one of the primary forces behind the Ryan White CARE Act, raised more than \$40,000 to help AHP continue to provide the highest-quality mental health services and brought together hundreds of people committed to AHP's mission.



L. Christen

These achievements have enabled us to begin to respond to the drop in government funding for HIV services that we are already feeling and that is certain to worsen in the coming years. I know that one year's success will not secure the future of the clients for whom AHP services are critical. AHP will look for even greater support

from the private sector, seeking creative solutions to the change in the non-profit funding landscape. I am happy to report that one of the many components of this process—AHP's Community Advisory Board—has been strengthened during the past year as we welcomed six new members whose commitment has been, in and of itself, a tribute to AHP's work.

It is this experience of people giving time, expertise, energy, and financial support that leads me to be hopeful about AHP's future and the future of the clients it serves—hopeful that others will step forward with support in the coming year.

AHP's Services Are Everywhere!

But it all starts at 15th and Folsom



"At AHP, we take our pioneer status seriously. We consider it an obligation to share with other AIDS providers the lessons we've learned during the past 12 years."

Joanna Rinaldi
AHP Deputy Director

The AIDS Health Project's staff and services are everywhere. AHP is one of the only organizations in the United States that is devoted to the comprehensive mental health needs of people with HIV disease and those affected by the epidemic. We've got to be everywhere, because no other organization in San Francisco offers the range and quality of HIV counseling and mental health services that we do.

From a base of operations at 15th and Folsom Streets, AHP plans and refines programs to meet the needs of a wide variety of clients with an even wider variety of emotional and psychological concerns. AHP reaches out to the neighborhoods hardest hit by HIV disease:

- ▶ From the Castro District, the heart of the city's gay community, to the Tenderloin, where San Francisco's homeless population seeks services.
- ▶ From the Mission District, where AHP runs its AIDS and Substance Abuse Program, to San Francisco General Hospital, where AHP offers psychiatric and social work services for people with HIV disease.
- ▶ From 24th Street at the Cinco de Mayo festival and South of Market at the Folsom Street Fair to sites all over the city, AHP's Roving Team and Mobile Test Sites offer HIV counseling and testing services in every place we can to reach people who are at risk of HIV disease.

The keystone of AHP's planning efforts is to identify the needs of our clients before these needs arise. We do not believe that a concern should evolve into a crisis before it receives attention. This past year, AHP pursued and attained funding to complete the "continuum of care" that we offer clients at all of our sites. This funding has enabled us to provide neuropsychiatric testing to detect HIV-related dementia and to expand our capacity to provide support group services facilitated by licensed professionals. It has also allowed us to expand the number and type of support groups we offer, so

that support is more frequent and more accessible to the people who need it most.

AHP has been doing this work since 1984, and it is one of our goals to make sure that other AIDS providers have access to the knowledge we've gained over the years. With psychiatric consultation, professional training programs, and a variety of publications, we share our experience, so that others don't have to spend time and energy reinventing a wheel that we started turning 12 years ago.

"We like AHP because it serves everyone: not only those infected with HIV, but those affected by the epidemic. Franklin Bank is proud that AHP is one of the biggest beneficiaries of its California Card Affinity Program."

Renee Beare
Associate Product Manager
Franklin Bank
a subsidiary of Franklin Resources, Inc.

"AHP's support programs and the money to finance them are vital. Individuals can work together to raise money and make a difference."

Bernard Boudreaux
Senior Buyer
Mervyn's California



400 Castro Street: The Heart of the Epidemic

The heart of San Francisco's gay and lesbian community is the heart of the epidemic, the area hardest hit by HIV disease. In the Castro, AIDS is an unavoidable reality, and tragically routine.

To the large number of gay men with HIV disease—roughly 50 percent of the city's gay men are infected—and their friends, families, and partners, the AHP Castro Center is a haven. At the Castro Center, the AIDS Health Project offers more than 50 weekly support groups, individual psychotherapy, social events, and day-long workshops on subjects such as sex, dating, intimacy, and issues facing men over 40. All of these services ensure that seropositive and seronegative people have a place to go to help them cope with the undeniable reality in their midst: exhaustion, unending grief, and the struggle for

both infected and uninfected people to remain healthy.

Carlos Gonzales came to 400 Castro because, as an HIV-positive man, he was curious about AHP's services. The center became an important place for him during a difficult time in his life. He says: "I became much more aware, really looking at things in my life. Now, I feel pretty good. I'm starting to relax. I haven't done that in years."

When Luke Mauerman moved to San Francisco six years ago, he met new people, dated, and did his best to have safe sex. But by last year, Mauerman had lost the impetus to remain safe all the time, as he detected an attitude among some of his peers that safe sex didn't really matter, because everyone was going to die anyway. Since then, Mauerman has had unprotected sex

with people he knew were HIV-positive. No, he didn't want to die; he just wanted the epidemic to go away, and denying it—if only for a brief time—seemed like a way to do that. Ridden with guilt about still being negative and scared about becoming positive, he found his way into an AHP support group. At AHP, he says, "I am not alone. There is momentum to stay alive."

"People are having unsafe sex. It's time to recognize this and to arm ourselves with more than just condoms. We're all going to need help getting through this."

Luke Mauerman

"The Noah's Bagels Foundation has always had a focus on education in the communities where our stores are located. We pay the rent for the AHP Castro Center because we value the information and education that AHP provides to people in this community. Public-private partnerships are crucial today, and I couldn't choose a better partner than AHP."

Noah Alper
Founder, Noah's New York Bagels



10 United Nations Plaza: On the Streets of the Tenderloin

The term “neighborhood” evokes a sense of community that requires stability and comfort. On the streets of San Francisco’s Tenderloin, people struggle not only with alarming rates of HIV disease, but also with a list of problems that would destroy most communities: high rates of unemployment, homelessness, and drug use, and a huge transient population unable to put down the roots that protect communities against erosion.

The AIDS Health Project is there: on the block and in their homes. From a base at 10 United Nations Plaza, we are the city’s major provider of HIV-related psychiatric services. We offer psychiatric care to people unable to leave their homes

and psychiatric consultation to other AIDS providers serving clients who are mentally ill. And this past year, AHP became San Francisco’s citywide provider of HIV mental health crisis services.

James Washington’s immune system has remained intact since he tested HIV positive in 1990. But, for Washington, a poet and musician, depression has been unrelenting since childhood and has been accompanied by a lifelong history of drug use. AHP social worker Lori Thoemmes and her staff first reached out to Washington through individual counseling and a support group at the Ambassador Hotel. Washington says AHP has helped him restore his sense

of self-worth, kept him, “tuned in so that people can understand me—helped me feel like I wasn’t losing my intellect.”

When Marjorie Fleming was diagnosed with HIV in March 1994, she had a T-helper cell count of 20. She’d been living with her mother in San Mateo, but when Fleming got TB, her mother got frightened and Fleming had to move out. AHP’s Emily Leavitt was a safety net, providing a clinical assessment and helping Fleming secure a place to live on her own. Stability means that Fleming can build a new life: she is taking a creative writing class, exercising at the YMCA, thinking about taking college courses, and looking for a job.



“My life is brighter since
AHP helped me.
Now I can concentrate
on staying healthy.”

Marjorie Fleming

3180 18th Street: In the Mission

By the time HIV disease descends upon people who use substances, addiction has reduced them to shadows. If AIDS is overwhelming for people who are not addicted—who have built careers, friendships, and hopes for the future—it can be an insurmountable barrier for the people seen by the AIDS Health Project's AIDS and Substance Abuse Program (ASAP), people from all over the city who have hit bottom and remained there for too long.

For many years based at San Francisco General Hospital, this year ASAP moved into the nearby Mission District. At the same time, AHP strengthened ASAP's case management program—adding staff and expanding services so that we can meet clients where they are. Now, clients can receive psychosocial assessment and referral,

short-term help with issues like housing, or long-term case management right in the community.

For Randy Gonzalez, drug use resulted in an unsuccessful career and “crushed dreams.” After he was hospitalized with pneumonia and CMV retinitis in 1994, Gonzalez needed immediate assistance. AHP case manager Yvette Phillips helped him find temporary housing. Now he's been in his own apartment for two years—the longest time in his life that he's been stable and free of drugs. Each week, he meets with Phillips, and each week, she provides emotional support, helps organize his day-to-day responsibilities, and aids in arranging in-home health care and monitoring HIV-related pain medication. Without her, Gonzalez says, he's certain he'd either be using drugs or dead. “She's

like Superwoman with her super cape.”

HIV-positive since 1983, Cary Haak had long planned with his wife that she would take care of him if he became seriously ill. Haak's wife, however, entered the hospital in 1995 and later died of liver problems. This left Haak to care for himself and face the loss of his wife, while maintaining sobriety after a lifelong history of substance abuse. Fortunately, he had found AHP while in a substance abuse treatment program. Case manager Veronica Delgado has helped Haak find and maintain housing, manage his many medications for both HIV and schizophrenia, keep psychiatric appointments, and remain sober. “I would have been lost without Veronica,” Haak says. “Because of her, I go to support group meetings faithfully.”



“I want to start fresh.
With AHP's help,
I'm able to do that.”

Cary Haak

Ward 86, San Francisco General Hospital: Calm in the Eye of the Storm

Bordered to the east by sunny Potrero Hill and to the west by the vibrant Mission District, San Francisco General Hospital is one of the busiest public hospitals in the country. Hidden in one of the dozen or so brick buildings that dot the campus of the "General" is Ward 86, the highest-rated outpatient AIDS program in the United States, where in the 1980s, the AIDS Health Project pioneered hospital-based mental health services for people with HIV disease.

This year, AHP took that innovation one step further. AHP took over responsibility for Ward 86's medical social work team and reconfigured services so that all mental health staff can offer the full spectrum of services ranging from medical social work to psychiatric evaluation.

This singular approach—and it is unique to AHP—allows clients to receive a wide range of psychosocial services in a medical setting, ensuring that challenges such as employment, housing, and mental illness don't interfere with medical treatment and health maintenance.

For Roberto Avalos, Ward 86 is a sanctuary. It's where Avalos, a former drug user, visits AHP social worker Carmen Madriz, and it is where he is free from the bitterness that surrounds him in his apartment house. "Here I get help. I don't hear 'Oh, you'll be dead by the end of the week, so why bother.' I get that at home." These daily challenges affect Avalos' physical as well as his mental health.

"Carmen will listen to me. Sometimes, that's all I need to feel better."

Roberto Avalos



Dropping in for a glass of water after an appointment at the methadone clinic, getting help making a doctor's appointment, or having a heart-to-heart talk with Madriz, Avalos gets a chance to be honest and to experience his "real" feelings, regardless of how unpleasant they may be. "Real feelings are not the ones you wish you had, but the ones you have," he said. "Here, I feel okay when I'm having a hard time."

Health Center No. 1:

A Base in the Castro

HEALTH CENTER NO. 1
3850 17th STREET

Health Center No. 1—not far from one of the AIDS Health Project's newest sites, the AHP Castro Center—is a city-run community health clinic where AHP has been providing HIV antibody counseling and testing since 1985. Health Center No. 1 was AHP's first satellite and remains the site where AHP counselors see the largest number of individuals: 7,500 in the past twelve months.

In our tradition of innovative service, AHP undertook two actions in the past year. First, we began doing risk assessment and prevention counseling over the telephone. Now, when people call to

make an appointment to test, they get a counselor who helps them sort out their risks and decide what services they need. Both first-time testers and those who retest because of continued high risk get the counseling they need to help them incorporate risk reduction into their lives.

"High-risk repeat testers" are also the focus of AHP's second innovation: a National Institute of Mental Health-sponsored study of a new counseling and testing approach to help men who have sex with men stay safe.

For Gregory Myers, HIV testing may appear to be routine, but it has never been easy. "I hear the spin of the Russian Roulette wheel every time I get tested," said Myers, whose partner of 14 years died of AIDS in 1995. "It's very emotional—like waiting for the bullet to go off."

Myers has received HIV counseling and testing services nearly a dozen times, almost always at AHP sites. Each time, counselors have been there for him, and following the death of his partner, they referred him to an AHP grief support group.

"AHP teaches you to
lay your cards on the table.
To be more open."

Gregory Myers



HIV counseling and testing is the most accessible form of AIDS prevention counseling. The AIDS Health Project knows that one site is not enough to reach the thousands of HIV-negative San Franciscans who need to hear the prevention message and the hundreds of HIV-positive ones who need help dealing with HIV infection. So it's not an exaggeration to say, wherever you are, AHP is there.

Through its Roving Team, its Mobile Test Sites, and special arrangements with other AIDS organizations, AHP is able to reach out to people in the Tenderloin, in

San Francisco's Asian communities, at Cinco de Mayo, the Latin-American celebration, at Juneteenth, the African-American festival, at the Castro Street Fair and at the Folsom Street Fair—the list goes on and on.

This past year, to make counseling and testing as easy as possible, AHP created partnerships with: Walden House in the Western Addition and the Haight, the Metropolitan Community Church in the Castro, and Blow Buddies, a South-of-Market sex club for gay men. Added to existing arrangements with groups such as Asian-

American Communities Against AIDS and the Mission Neighborhood Health Center, such partnerships enabled AHP to provide counseling and testing to 3,000 people throughout San Francisco's diverse communities.

Al Jacko, Jr. gets tested for HIV about twice a year, even though he says, "All my life, I've been safe." But since 1981, nearly all of his friends have become ill or died. Each negative result

he receives reaffirms his commitment to engage in safer sex. Jacko is on the board of BG Productions, which operates the Blow Buddies sex club—designated a permanent AHP test site in 1996. He says: "AHP's presence at Blow Buddies is the greatest thing... Doing HIV counseling and testing where sex is going on sends an important message, linking the two and leading people toward safer forms of sex."

Mobile Test Sites: Wherever You Are...

"When it comes to AIDS, AHP and KMEL play similar roles in the community: both are on the front lines, both are getting the word out through education. KMEL's focus is especially on young people, who make up a large part of our audience. The level of ignorance about AIDS is incredible. AHP is a powerful source of clear, accurate, and culturally relevant information. We are proud to support them through our Summer Jam concert."

Michelle Santosuosso
Program Director, KMEL



"At Blow Buddies, people can get tested in a comfortable and protective place, and in a social environment where they're comfortable."

Al Jacko, Jr.



San Francisco and Beyond: The Lessons of 12 Years

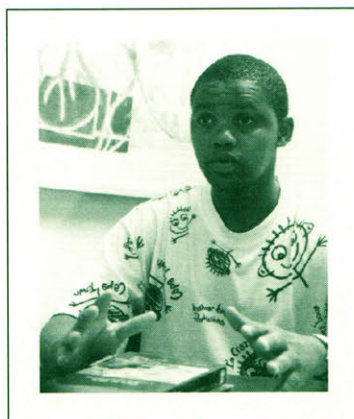


AHP trainers Robin Ortiz-Young and Ed Wolf are “dedicated, open-minded, respectful, and engaging. They want to give everything they can. This is important to a valuable training experience.”

Ligia Afu-Li

“Being at AHP has been a great learning experience. I’ve been able to work with excellent people who do excellent work, and I’m now more prepared for the clients I see in my own work.”

Lungi Hlakudi



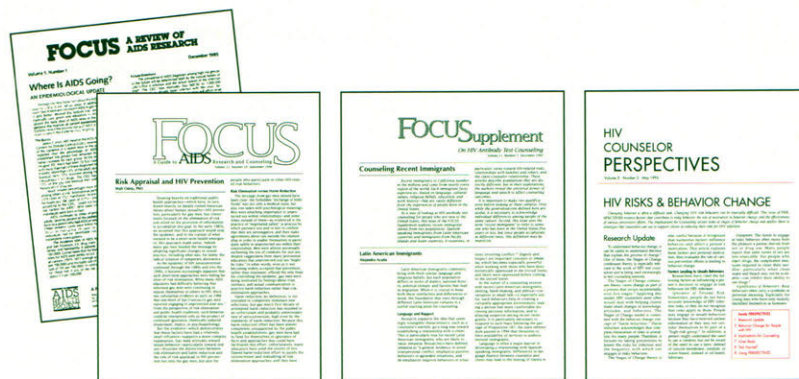
The AIDS Health Project has been lucky. We’ve been able to survive as an organization through tremendous growth over 12 years. Having pioneered and improved many of the approaches used for HIV counseling and testing, support groups, psychiatric care, and overall HIV-related mental health strategies, we believe we have an obligation to disseminate the lessons we’ve learned to other mental health and health care providers.

That is why the California Department of Health Service’s Office of AIDS has contracted with AHP for the past eight years to develop curricula and conduct training on HIV counseling and testing. This year, we developed a ground-breaking diversity training and, through the San Francisco Department of Public Health, a training for antibody test site supervisors on the difficult task of supporting HIV test counselors in an atmosphere of extreme fiscal and time constraints. AHP also pioneered tailor-made training programs on risk reduction and behavior change approaches

for more than 16 Early Intervention Program sites throughout California.

Ligia Afu-Li took AHP’s three-day training as a step toward doing HIV test counseling for the Mission Neighborhood Health Center’s Clinica Esperanza. “Before the training, I didn’t know that even with negative clients, the counselor can provide lots of helpful information.” She describes the AHP training as the best she’s ever attended.

AHP also offers training opportunities through clinical internships for counselors who have master’s degrees. Social worker Lungi Hlakudi returned to South Africa with greater understanding of the complexities of his job after a two-month training with AHP’s Mental Health Crisis Team in the Tenderloin. Hlakudi remembers one call from a suicidal client: “He didn’t want help; he just wanted to die.” Hlakudi says he will not forget how, armed with patience and a willingness to listen, AHP staff established a level of trust with the client, who agreed not to harm himself.



FOCUS: A Guide to AIDS Research and Counseling began as *FOCUS: A Review of AIDS Research* in 1985 and spawned the *FOCUS Supplement on HIV Antibody Test Counseling* and *HIV Counselor PERSPECTIVES*.

The World Over: Spreading the Word

The world has learned about AIDS only reluctantly, avoiding or discounting it until, as a burgeoning epidemic, it has become impossible to ignore. In towns across the United States, in places like Japan, India, South Africa, Brazil, and Eastern Europe, AIDS is no longer a dirty little secret. With its "discovery" has come a rush to understand HIV, particularly the mental health conundrums posed by a stigmatized and life-threatening illness.

AHP's publications—seven books, three newsletters, and numerous brochures—have taken the world as their stage. Recognizing its 10th anniversary in 1995, *FOCUS: A Guide to AIDS Research and Counseling* is

probably the longest-running AIDS newsletter in the world and one of the few addressing mental health.

Phyllis Spears—the HIV/STD Prevention Coordinator for the U.S. Indian Health Service in Tucson, Arizona—has been reading *FOCUS* for the past three years. Unlike other HIV-related publications, Spears says, "*FOCUS* is useful because it concentrates on psychosocial issues, offering a unique and *practical* perspective." Responding with limited resources to the needs of clients who travel long distances for care means that practical approaches are crucial. Spears says *FOCUS* makes such strategies clear and accessible without oversimplifying what is always complex.

This past year, AHP also prepared to publish the second in its monograph series, a guidebook on the triple threat of substance use, mental illness, and HIV. Last year's monograph—*AIDS and the Impact of Cognitive Impairment*—has been universally acclaimed, as demonstrated by a review in the *Journal of the International Association of Physicians in AIDS Care*: "The authors do a superb job... This book is an essential tool to help the mental health worker improve the quality of life for everyone who lives with HIV-related illness."



"Our resources are limited. *FOCUS* is helpful because it addresses issues that are timely and pertinent in my community, offering a perspective that many of the other newsletters do not."

Phyllis Spears

You Are Everywhere:

If the AIDS Health Project is able to be everywhere for our clients, it is only because AHP's supporters range even further. You *are* everywhere.

Relying on the kindness of friends—both contributors and volunteers—is essential. AHP has attracted more than 250 volunteers—including licensed professionals, masters-level clinical interns, and peer counselors—who undergo rigorous training to deliver HIV antibody counseling and testing, brief psychotherapy, ongoing

Businesses, Corporations, and Foundations

Academy of Friends
Bank of America
BG Productions
Blue Shield of California
Catholic Charities of Marin
The Chevron Companies
Citibank
Community Thrift Store
Corporate Scenes, Inc.
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Roberto Garcia

The Universe Is Our Oyster

psychotherapy, and support group services. Volunteers—including college interns—also help us research and write our publications, run our administrative offices, and staff our events.

While there are moments when government money is uncertain or staffing is thin, we know there is a community into which AHP fits, like a hand in a glove, that ensures we are not living hand-to-mouth. Thank you: without your help AHP would be...nowhere.

Robert Glavin
David Greenberg
Gary Grossman
Scott Gursky
Joseph Guydish
John Hulse
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and Dennis Murphy
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Trefethen Vineyards
John Smith,
UCSF Campus Planning

UCSF AIDS Health Project

1995/1996 Annual Financial Report

Operating Revenue	Revenue		Subtotal	Total
Government Grants and Contracts				
Federal Government	\$2,000,037			
State of California	855,925			
San Francisco Department of Public Health	597,707		\$3,453,669	
Publications and Educational Materials				
FOCUS Newsletter	\$36,149			
Other	9,514		\$45,663	
Private Contributions				
Individual Donations	\$68,064			
* Fundraising Benefit	41,513			
Foundations and Corporations	174,993		\$284,570	
Total Revenue 1995/1996				\$3,783,902
Operating Expenses		Expenses	Subtotal	Total
Program Services				
SFGH Services		\$895,616		
Counseling and Testing Services		707,789		
Education and Training		635,816		
Prevention and Psychosocial Services		661,903		
Community Psychiatric Consultation		589,259		
Publications		86,596	\$3,576,979	
Supporting Services				
Management and General		\$197,464		
Operating Reserve		9,459	\$206,923	
Total Expenses 1995/1996				\$3,783,902

* Support for this event received prior to fiscal year 1995/1996 is not reflected in this figure.

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James W. Dilley, MD *Executive Director*
Joanna Rinaldi *Deputy Director*

Barbara Adler, MA
Dymond Austin
Miriam Garfinkel, MFCC
Michal Longfelder
Robert Marks
Helen Prince
Patricia Sullivan, MFCC

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Daniel Hernandez *Vice-Chair*
Timothy Schott *Secretary / Treasurer*

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Gerald Tucker, MBA

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Robert Marks *Editor*
John Tighe *Writer*
Kelly Costa *Designer*
Sari Kasper *Interviewer*
Cathy Hultin *Interviewer*
Laurie Stuhlbarg *Interviewer*
Pamela Pappas *Interviewer*
Tania Lihatsch *Proofreader*
Shauna O'Donnell *Proofreader*

Acknowledgements

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AHP clients, volunteers and friends who told us what AHP has meant to them:

Ligia Afu-Li	Lungi Hlakudi
Noah Alper	Al Jacko, Jr.
Roberto Avalos	Luke Mauerman
Marjorie Fleming	Gregory Myers
Carlos Gonzales	Michelle Santosuosso
Randy Gonzalez	Phyllis Spears
Cary Haak	James Washington

Volunteer photographers giving time and talents especially for this report:

Brian Duncan
*p. 5 15th and Folsom; p. 6 AHP Castro Center;
p. 7 10 United Nations Plaza; p. 8 3180 18th Street;
p. 9 San Francisco General Hospital; p. 10 Health Center #1;*

Jim Sheahan
*p. 6 Luke Mauerman; p. 8 Cary Haak; p. 11 Al Jacko, Jr.;
p. 12 Ligia Afu-Li*

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Asa Mathat
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John Tighe
p. 10 Gregory Myers; p. 12 Lungi Hlakudi

Judi Parks
p. 11 Mobile Test Site

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*Historical map on page 4 courtesy of the
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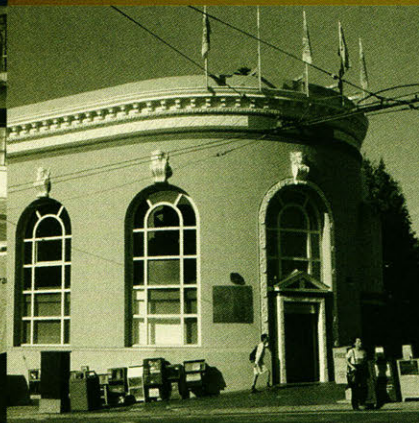




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e-mail: main_office.ahp_mcb@QUICKMAIL.ucsf.edu
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UCSF AIDS HEALTH PROJECT

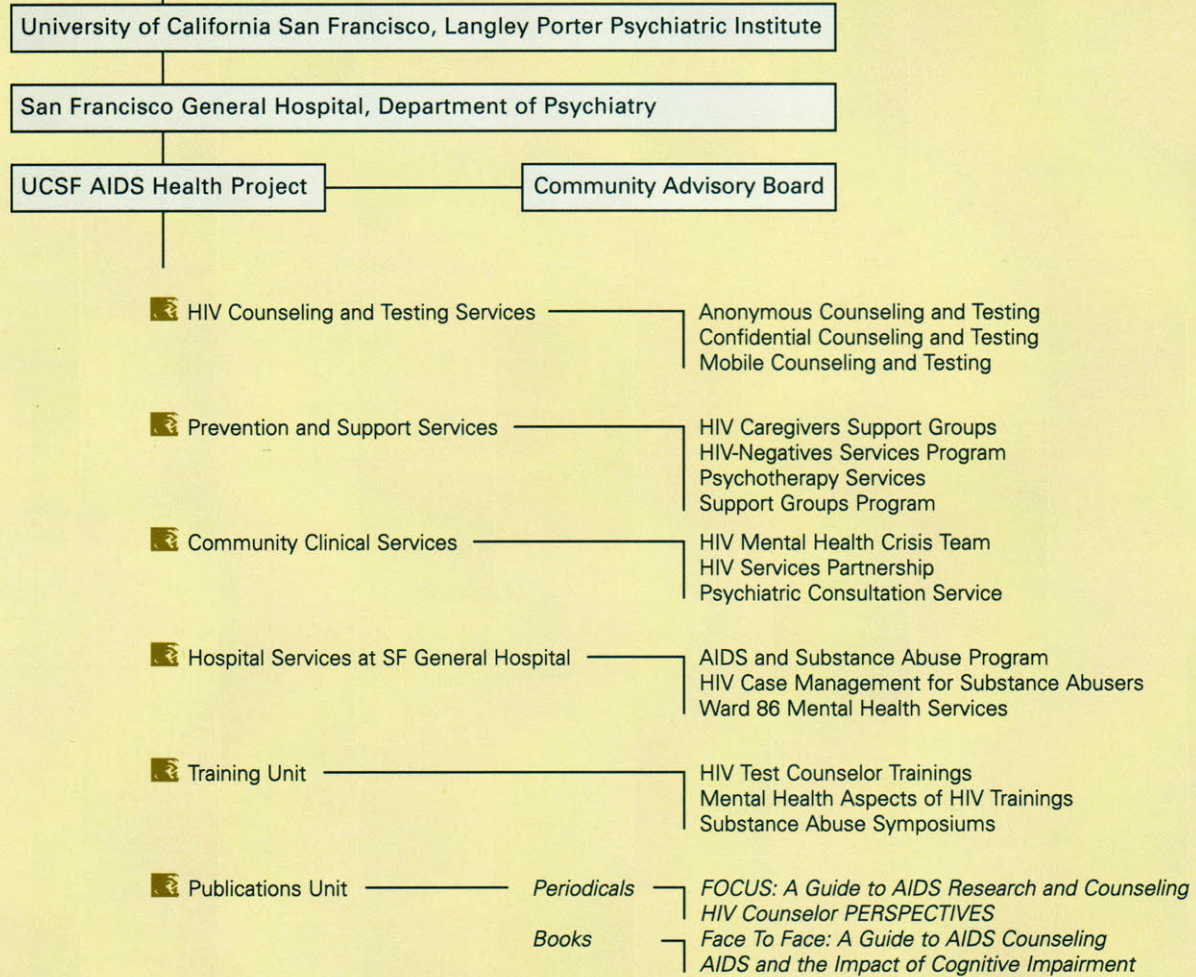


annual report

1994/1995

Organizational Chart

The AIDS Health Project is affiliated with the University of California San Francisco. While UCSF provides no funding to AHP, it does contribute administrative support and the resources of a world-renowned medical school.



14 years into the epidemic

270,000 people in the United States have died from AIDS;

14,000 in San Francisco alone.



14 years into the epidemic

more than one million people in the United States are infected with HIV;

in San Francisco, 28,000 people are infected.



14 years into the epidemic

San Franciscans witness 1,700 HIV-related deaths and 1,000 new infections annually.



14 years into the epidemic

AIDS remains the leading cause of death among people between the ages of 25 and 44.



14 years

and the UCSF AIDS Health Project is still here,

still one of the premier AIDS mental health agencies in the country.

We'll be here as long as we're needed.

Over the years, the AIDS Health Project has served thousands of clients, justifying its reputation as the leading HIV mental health agency in San Francisco—a reputation achieved because of our commitment to anticipating and responding to the challenges of the epidemic. The timeline on this page illustrates just a few of our accomplishments of the past year; the pages that follow offer a sense of the breadth and depth of AHP's services.

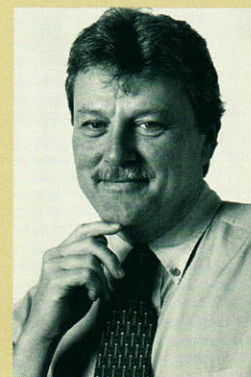
In the past year, AHP has taken dramatic steps to address the most pressing concerns in the fight against HIV disease. First, in response to the most critical HIV prevention challenge we face, AHP has expanded our programs to help people who are immersed in the despair of the epidemic to feel motivated to protect themselves from HIV. To accomplish this task, AHP has hired an HIV-Negatives Services program coordinator, developed a new psychotherapy program for HIV-negative people at risk of infection, and expanded our Negatives Being Positive social programs.

Second, AHP has designed an innovative approach for assessing client needs as part of our new collaboration with the San Francisco AIDS Foundation and the Shanti Project. Not only has this made it easier for clients throughout the city to obtain services that meet their needs, but also AHP's thorough "intake" interview has revealed like never before the magnitude of the challenges our

clients face, ranging from isolation and fear of intimacy to the complex combination of HIV disease, substance abuse, and mental illness.

Finally, AHP's successes have always been based on our ability to develop efficient ways to serve our clients, and in response to our strategic plan, we have streamlined our administrative structure, enhanced our capacity to evaluate the effectiveness of our programs, and are seeking ways to adapt to the increasingly uncertain health care and AIDS funding environment. Furthermore, while our affiliation with UCSF's Department of Psychiatry provides access to the best AIDS medical and research programs in the country, it offers no financial support for AHP programs.

To achieve its goals, AHP depends on the expertise of a seasoned staff and the active involvement of our Community Advisory Board: a dedicated group of mental health professionals, corporate leaders, activists, and others who have been working to meet the needs of disenfranchised communities for years. With all these exciting changes, one thing remains the same: our mission to provide culturally sensitive counseling and education to stop the spread of HIV infection, and to help people face the emotional, psychological, and social challenges of living with HIV disease. We defined this mission in 1984; until it is fulfilled, the AIDS Health Project will be here.



James W. Dilley, MD
Executive Director
UCSF AIDS Health Project

James W. Dilley

July 1994

AHP joins a city-wide prevention collaboration with nine leading AIDS agencies.

July 1994

The HIV Services Partnership—a collaboration of AHP, the Shanti Project, and the San Francisco AIDS Foundation—officially opens, streamlining the way clients access HIV services in San Francisco.



July 1994

AHP establishes a cutting-edge program aimed at providing cost-effective, short-term psychotherapy.

October 1994

AHP becomes the primary substance abuse intake and assessment site at San Francisco General Hospital, one of only three such sites in the city.



October 1994

AHP marks its 10th anniversary on the frontlines of the epidemic by staging a spectacular show—*Facing The Future Together*—featuring Robin Williams, Brian Boitano, and many others.



Katherine Bella

Katherine Bella
Chair,
Community Advisory
Board



Serving as chair of AHP's Community Advisory Board during 1995, I have been continually inspired by the many people—staff, volunteers, and supporters—who are dedicated to delivering the highest quality services to people affected by the AIDS epidemic. This dedication and cooperation goes to the heart of AHP's mission: with proactive planning enhanced by input from researchers and clients, we've developed cutting-edge programs that have changed the direction of the local epidemic and averted crises.

As has been true throughout the first 11 years of the agency's existence, AHP continues to use our unique expertise to respond early to emerging challenges as the epidemic moves through its second decade. Our AIDS and Substance Abuse Program has played a central role in helping San Francisco maintain one of the lowest rates of HIV infection among drug users in the country. AHP was also the first AIDS agency to offer ongoing, peer-led support groups where seropositive people could explore their feelings about HIV disease. And, AHP's Psychiatric Consult program provided crucial expertise to health and mental health care providers when the frightening

phenomena of "multiple diagnoses"—HIV disease combined with substance abuse and mental disorder—first emerged.

AHP has recently completed a strategic planning process that will help shape the agency's future work in meeting the changing needs of those affected by AIDS through the year 2000 and beyond. Crucial to this process will be the ever-stronger involvement of community members as volunteers, advisors, and financial supporters. As health needs change and become more complex; as public funding sources decrease while the need for them does not; and as AIDS agencies work to coordinate their diverse services, the need for your help will increase.

One of the major events of the past year was the grand opening of the AHP Castro Center, which has led to greatly increased access to care. We all look forward to a time when new facilities and expanded care are no longer needed, and instead of celebrating increased services, we can celebrate the end of the epidemic. Until that day comes, we hope to count you among the friends who will help make that celebration possible. We thank you for your support of our work.

"At AHP's ten year event, Jim Dilley encouraged everyone to 'Take two hours off from the epidemic and enjoy the show.' And that was essential for everyone to hear, because, unfortunately, HIV disease would still be there at the end of the evening. I was proud to have been a part of making that evening so special for those who give so much to the community."

Carole Shorenstein Hays, Philanthropist

November 1994

Underwritten by Pacific Bell, AHP publishes the first issue of *AHP Faces*, a newsletter that helps AHP to stay in touch with our circle of supporters and friends.



April 1995

AHP's Volunteer Appreciation Party, hosted by Wells Fargo Bank, Bank of America, and The San Francisco Marriott, honors over 400 volunteers for their tireless dedication.



May 1995

The AHP Castro Center opens as the first mental health service agency to be located in the heart of the HIV epidemic since the epidemic began 14 years ago.



May 1995

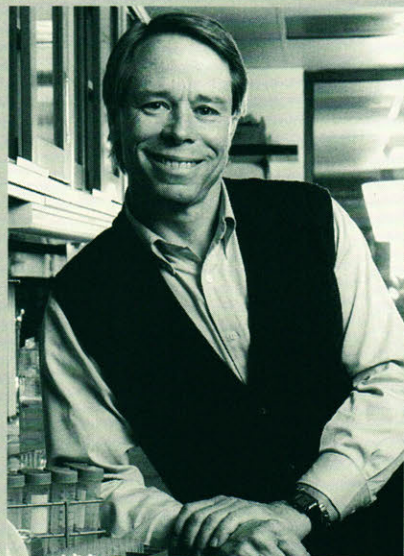
AHP adds confidential HIV counseling and testing to its anonymous testing program.

June 1995

AHP launches the UCSF AIDS Health Project Monograph Series with the publication of *AIDS and the Impact of Cognitive Impairment*.



Donald P. Francis, MD, DSC
AIDS prevention pioneer,
Centers for Disease Control
and Prevention
Currently the researcher directing
the gp120 AIDS Vaccine Clinical Trials
for Genentech, Inc.



"The first step in controlling an epidemic is discovering how it is transmitted and who is infected, especially when there is no cure or vaccine. But HIV antibody testing must be accompanied by information and emotional support. AHP literally wrote the book on HIV testing and counseling, developing the first large-scale counseling and testing program in 1985, a time when few sane minds prevailed. To this day, the AHP approach is a model for HIV counseling and testing nationwide, and AHP continues to improve this process in creative ways that ensure quality and appropriate care."

The mission of the UCSF AIDS Health Project is to provide culturally sensitive counseling and education to stop the spread of HIV infection,

HIV Prevention Services

- AIDS AND SUBSTANCE ABUSE PROGRAM
- HIV COUNSELING AND TESTING SERVICES
- HIV-NEGATIVES SERVICES PROGRAM

The AIDS Health Project's commitment to HIV prevention is the natural response to frightening statistics about rates of new infections in San Francisco. In each of the past several years, an estimated 1,000 people in San Francisco have become infected with HIV. In an atmosphere of overwhelming rates of HIV infection, AHP has undertaken the critical task of helping people who are uninfected fight the psychological pull towards despair and risk.

For many, HIV prevention is not about information; it's about overcoming emotional barriers to behavior change. As a mental health agency, AHP is a natural leader in HIV prevention efforts, particularly for those who have the most trouble adopting safer behaviors. In the past year, we've redoubled our commitment to protect uninfected gay and bisexual men by making this issue one of our top funding priorities.

AHP has provided group emotional and social support to HIV-negative gay and bisexual men for many years. In 1995, AHP successfully secured funding to hire a coordinator to oversee our existing programs for uninfected gay and bisexual men and to create new services. For example, AHP has started a cost-effective, short-term psychotherapy program for HIV-negative clients, an innovative approach that allows clients to confront personal obstacles to safer sex. Some people ask why it is so hard in this day and age to practice safer sex, but people—whether they are straight or gay—have always had trouble changing sexual behaviors, failing to avoid unplanned pregnancies or serious and life-threatening sexually transmitted diseases. In the gay and bisexual

and to help people face the emotional, psychological
and social challenges of living with HIV disease.

"One of the major focuses of the Levi Strauss Foundation's grantmaking is HIV prevention. Everyone in the community has lost close friends and companions to HIV disease. It is of vital importance to inspire the "survivors" to maintain healthy behaviors. Keeping healthy people healthy is an important part of the prevention program being conducted by the AIDS Health Project and the reason we felt it was so important to underwrite its work.

Myra Chow, Manager of Contributions, Levi Strauss Foundation

community, where people are stricken by grief, it is not unusual for helplessness and hopelessness to lead to a fatalistic attitude toward unsafe sex and AIDS.

Using the HIV antibody counseling and testing process as a prevention tool—an approach AHP pioneered in 1985—AHP's team of multicultural, multilingual counselors works one-on-one with clients who seek testing to help them assess their risks and change unsafe behaviors. This past year, AHP's HIV Counseling and Testing Services program reached out to more than 10,000 people, offering confidential as well as anonymous testing for the first time. AHP provides counseling and testing—including pre-test counseling, drawing blood samples for testing, and disclosing test results—at five different clinic locations throughout the city.

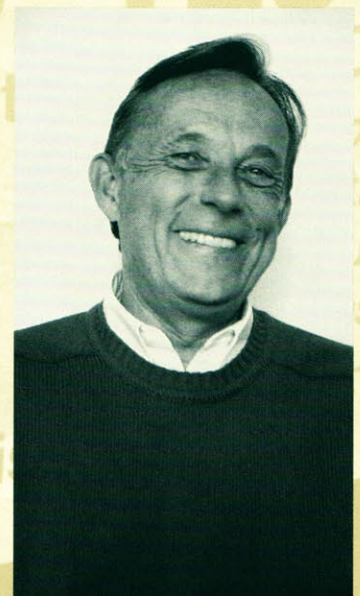
AHP's Mobile Counseling and Testing Program places a special emphasis on increasing access and visibility to communities at risk. It provides testing to hundreds of clients at neighborhood street fairs and sex clubs, clients who are traditionally "underserved" and overlooked. In the past year, AHP reached out to African-American clients at the Juneteenth festival, to Latino clients at Cinco de Mayo, to Filipino clients at the South of Market Health Fair, and to youth at City College and the KMEL Summer Jam.

"In 1993, all four of my best friends were living with HIV disease, and all I could think about was that they were going to die. Essentially, I stopped functioning as a human being: it had become very difficult for me to focus on work and I was afraid to make new friends for fear that they too would die.

At the insistence of worried friends, I joined a group for HIV-negative men at AHP. It changed my life and enabled me to care for myself and my friends."

Bill Lorton

Former AHP support group participant and Member of AHP's Community Advisory Board



Support for People with HIV Disease

PSYCHOTHERAPY SERVICES

SUPPORT GROUPS PROGRAM

"The opening of the AHP Castro Center was literally a historic occasion, truly a dream turned into reality. At Pacific Telesis, we have long supported AHP's work in the community."

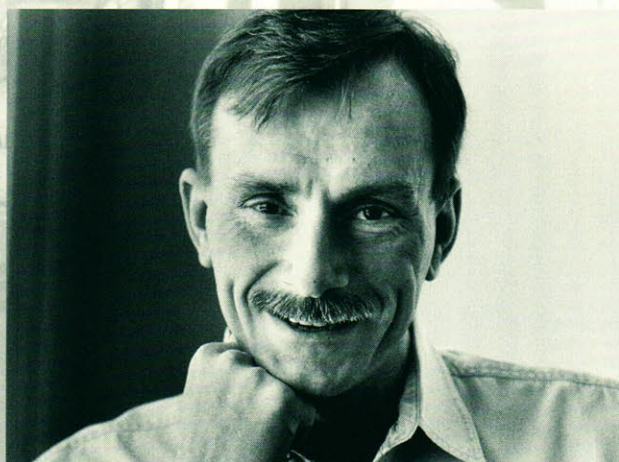
Will Rigney, Pacific Telesis

"Coming to my PWA support group every week is like being with family—the good kind of family. I've just gotten a new diagnosis and I know that when I tell the group they will actually listen and understand. Sometimes, it's a struggle to get there, but somehow I do because it's important to me and the group members."

While the phrase "living with HIV disease" has become a cliché, it is the essence of the AIDS Health Project's support services. While HIV disease is life-threatening, there is plenty of life ahead after a positive antibody test result.

Maintaining quality of life while "living with HIV," however, can seem out of reach when a person feels isolated and overwhelmed by financial, medical, and personal concerns. AHP services for people with HIV focus on a combination of support and problem-solving—a combination that ensures that "living with HIV disease" is more than a catchy slogan.

Over the past year, AHP anticipated an increased demand for services and, in response, strengthened its support programs. We joined in a collaborative effort with the San Francisco AIDS Foundation and the Shanti Project to



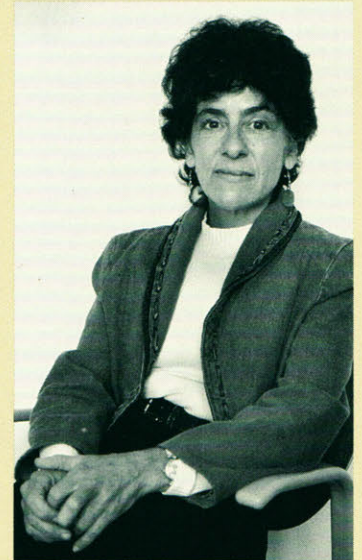
Jim Orban
AHP support group participant

All of us at AHP are saddened by the recent passing of Jim Orban.

and to help people face the emotional, psychological and social challenges of living with HIV disease.

"Our clients deal with perpetual loss of ability, community, livelihood, and dignity. Helping them to find meaning in their suffering stretches me as a therapist and as a human being. Through the Volunteer Therapist and Clinical Internship Programs, AHP provides a supportive container for this vital and challenging work."

Jan Spector, MA
AHP Clinical Intern



create the HIV Services Partnership, implementing a coordinated "client intake" system for all three agencies. By providing all three agencies with a more thorough and individualized profile of our clients and the community, the system has enabled AHP to better assess client needs and help clients better identify the services they need. Most importantly, in April 1995, we opened the AHP Castro Center, the first AIDS multi-service center in the heart of San Francisco's HIV epidemic.

These changes have increased the visibility of our programs and access to AHP's services. AHP has matched these improvements with expansions in the types of mental health services we provide. One approach doesn't fit every client, and we have continually reexamined our programs in light of community needs, current research, and clinical innovations. For example, in late 1994, AHP began

our Psychotherapy Internship Program which provides graduates of clinical training programs with supervised professional experience, employing a brief psychotherapy model to help those adjusting to the emotional roller coaster of HIV disease. Combined with our Volunteer Therapist Program—run with local therapists in private practice who donate their time to treat our clients—AHP was able to provide ongoing individual psychotherapy to hundreds of people who might not have otherwise received help.

In recognition of our mental health expertise, AHP is now the primary provider of emotional support groups in the city. Each week, we run more than 45 support groups, ranging from groups for HIV-positive people and people with AIDS to more focused groups for people with Kaposi's Sarcoma, younger men and women, and African-American men.

"Without my therapist, especially during the tragedies of this past year, I believe that I would have had a nervous breakdown or much worse. She has maintained my sense of dignity and reminded me of my strength when it seemed like there was nothing left. Most importantly, she has always given me a sense of hope when I felt there was none."

AHP Client, (anonymous)

Acute Mental Health Services for People with HIV Disease

- HIV MENTAL HEALTH CRISIS TEAM
- PSYCHIATRIC CONSULTATION SERVICE
- WARD 86 MENTAL HEALTH SERVICES

JB Molaghan, RN, NP,
Head Nurse,
UCSF AIDS Program,
pictured here with
Yvette Cortez, MEd,
AHP's Coordinator of
Mental Health Services on Ward 86.



"Sometimes, the psychological and social problems faced by people with HIV disease are more devastating and disabling than the medical complications. AHP's services on Ward 86 are a vital component of our efforts to enhance patient care."

JB Molaghan, RN, NP

Many people with HIV disease also have serious mental health problems and need psychiatric attention. The AIDS Health Project, as a program of San Francisco General Hospital's Department of Psychiatry, is one of the only agencies tending to the needs of people with these difficult mental health concerns. Without AHP programs like our Psychiatric Consultation Service and Ward 86 Mental Health Services (located at San Francisco General Hospital's AIDS Clinic), many of these people would receive little or no support from a mental health system that has historically been unprepared to care for them.

AHP's Psychiatric Consultation Service was one of the first psychiatric programs in the country to deliver coordinated care for HIV-infected clients with mental health needs. The program is a crucial element of the city's home-based care system, providing psychiatric care to clients who are unable to leave their homes. In addition, AHP clinical staff advise providers at other agencies to help them deal with their clients' acute mental health conditions and psychiatric concerns. This past year,

The mission of the UCSF AIDS Health Project
is to provide culturally sensitive counseling
and education to stop the spread of HIV infection,
and to help people face the emotional,
psychological and social challenges of
living with HIV disease.

AHP's Psychiatric Consultation Service staff saw clients in their homes, in homeless shelters, in hospices and other residential settings, and in community-based clinics across the city, providing mental health or substance abuse assessments, clinical consultation, psychiatric medical evaluation and monitoring, as well as links to substance abuse treatment and other services.

The need for specialized acute mental health care is especially high at San Francisco General Hospital. At SFGH, AHP has developed a web of services dealing with patients who suffer from HIV infection, substance abuse concerns, and mental disorders—patients who represent the most significant mental health challenge in the epidemic.

AHP's Hospital Services Program, in the vanguard of care since 1984, is an integral part of Ward 86, providing the mental health services at SFGH's world-renowned and pioneering outpatient HIV clinic. This past year, AHP's Ward 86 team provided psychiatric and mental health services, including substance abuse services, to hundreds of patients at Ward 86.

"When the clients I see need mental health services, their needs are urgent. The great advantage of AHP is that it provides access to immediate, quality mental health care. Ultimately, AHP offers support and relief to those clients who are least equipped to negotiate San Francisco's otherwise saturated system of mental health services."

Susan Canavan
Housing Caseworker,
San Francisco
AIDS Foundation



The mission of the UCSF AIDS Health Project is to provide culturally sensitive counseling and education to stop the spread of HIV infection, and to help people face the emotional, psychological and social challenges of living with HIV disease.

HIV-Related Substance Abuse Services

- AIDS AND SUBSTANCE ABUSE PROGRAM
- HIV COUNSELING AND TESTING SERVICES
- PREVENTION AND SUPPORT SERVICES
- PUBLICATIONS UNIT
- TRAINING UNIT

"ASAP does what most other agencies don't. We meet our clients where they are. Whether they have serious psychiatric difficulties, whether they are confronting their addictions, whether they are homeless, we help them make decisions about what they need and how to make it happen."



Olivia Baldain
ASAP Substance Abuse Counselor

Thus far, the HIV epidemic in San Francisco remains centered in the gay and bisexual communities, but it is no secret that the epidemic's direction has changed. It is only a matter of time before people who have become HIV-infected through substance use will comprise a more significant proportion of the city's caseload. The AIDS Health Project was the first AIDS service agency in the city to anticipate this second wave of the epidemic by developing specific programs targeting substance users and their sexual partners, and every one of AHP's programs, from HIV-related trainings to HIV test counseling, includes a focus on substance abuse.

At the core of AHP's substance abuse services is the AIDS and Substance Abuse Program (ASAP), which operates out of San Francisco General Hospital and provides care to HIV-

infected inpatients who are addicted to drugs or alcohol. ASAP was one of the first hospital-based substance abuse programs in the United States to deal with issues of HIV infection. The program provides assessments, referrals, and emotional support groups to clients with substance abuse and HIV-related concerns. ASAP is a crucial part of the city's health care infrastructure because of the large number of substance abusers with HIV disease who enter the medical care system through public hospitals such as San Francisco General.

Through its case management program, ASAP provides comprehensive services to HIV-infected substance-abusing clients, ensuring that these clients make it through the complex health care and drug treatment systems. ASAP staff also make monthly visits to sites such as the Salvation Army and Walden House to provide HIV prevention education to clients at early stages of substance abuse recovery.

Reconciling substance abuse services with HIV-related mental health and medical care is a daunting challenge. By cultivating capability in both areas, AHP has successfully managed to provide effective services to this underserved population. Our efforts have not gone unnoticed—providers throughout the city rely on AHP and ASAP for our unique expertise in helping them to help clients struggling under the worst conditions.

"A lot of our clients come to us with broken hearts and spirits. HIV, drug use, and homelessness have taken their toll. We offer hope. As a case manager, my role is to know what services are out there and to negotiate systems to make those services accessible. If I'm successful, I can make my clients' lives a little easier, to make sure that something goes right. This can be a big victory in lives that are often forgotten."

Yvette Phillips
ASAP Case Manager



"AHP was one of the first AIDS programs in San Francisco to adopt a harm reduction philosophy. We help clients get off substances, but we do not punish them for continuing to use drugs. Instead, we try to empower them by redefining success. The ability to make it to medical appointments, to stay clean and sober for 30 days, to use condoms some of the time rather than never: all of these are successes that protect substance users and their partners and improve the quality of their lives."

Miriam Garfinkel, MFCC
Director of AHP's Hospital Services

Services for HIV Providers and Caregivers

"Clients need more than traditional health education when they come in for anti-body testing; they need hope, support, and compassion. Their counselors need to be better at listening, better at supporting, better at helping clients understand their own needs. Seasoned by years of experience, AHP does such important work in preparing trainers such as myself to help counselors reach these goals. With the foundation AHP provides, I can pass this gift on to the people I train and, ultimately, to the thousands of clients who test."



Alejandra Acuña
California Office of AIDS
Consultant Trainer

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education
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HIV CAREGIVERS SUPPORT
PUBLICATIONS UNIT
TRAINING UNIT

Affiliated with the University of California San Francisco, one of the premier medical schools in the nation, the AIDS Health Project is steeped in a tradition of teaching and healing. That's the spirit behind AHP's decade-long commitment to training and publications for mental health professionals, a spirit that compels us to reach out to providers on the frontlines—particularly providers new to the epidemic and those in rural areas—and to share the lessons we learn from each day's work.

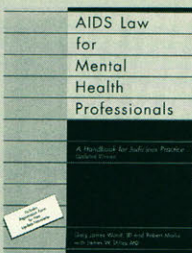
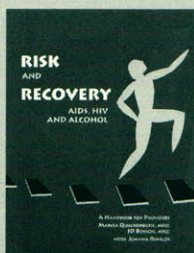
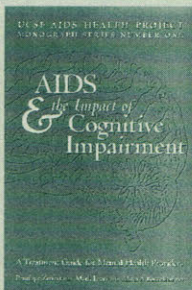
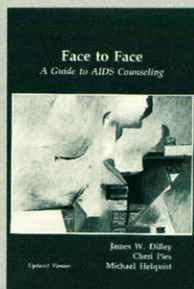
AHP developed its training programs early in the epidemic as we recognized the need to establish and communicate standards of care for HIV-related mental health services. We've conducted trainings across the city, state, and country—services that participants applaud as improving their skills and renewing their energy.

In the past year, AHP staff provided continuing education training to more than 600 anti-body test counselors, and through a program unique to AHP, trained nearly 400 health care providers about counseling and testing in the substance-using community. In addition, AHP provided ongoing support and consultation to a state training program for HIV test counselors who provided counseling and testing to more than 400,000 people this year alone. Finally, the state of California has entrusted AHP to develop training curricula

that are used in all state-sponsored antibody counseling and testing training sessions.

In the early years of the epidemic, it became clear that training alone was not enough to get information about this rapidly changing epidemic to frontline providers. Even with all the HIV-related material published during the past 10 years, there remains a need for clear, accessible, and practical information about the mental health implications of HIV disease. In 1985, AHP founded *FOCUS: A Guide to AIDS Research and Counseling*, one of the first and longest-running AIDS newsletters. Perhaps the greatest tribute to *FOCUS* is not simply that it goes out to 2,000 mental health professionals a month, but that it has reached close to 200,000 others over the past four years through reprints in other publications.

AHP is one of the leading AIDS and mental health publishers in the country. We have published seven books and regularly publish three newsletters. This past year, AHP inaugurated the UCSF AIDS Health Project Monograph Series with the publication of *AIDS and the Impact of Cognitive Impairment*. Also in 1995, we reprinted *Face to Face: A Guide to AIDS Counseling* for the third time. First printed in 1989, this anthology remains a standard in the field in both the United States and throughout the world. Last year, Harcourt Brace Japan issued a Japanese-language version (we've also been translated into Greek!).



Leanne Porterfield
Executive Director,
Lancaster AIDS Project

"Lancaster County, the 'Amish Country,' is a rural, insular community, where we don't have the support for AIDS work that exists on the coasts. New information from New York or San Francisco may take months to reach our 'heartland.' Our limited funding requires me to carefully consider all our options for educational resources. AHP's *FOCUS: A Guide to AIDS Research and Counseling* is one of the journals that I would not want to be without. In fact, *FOCUS* is required reading for all my service delivery staff."

Volunteers

Kean Tan
AHP Counseling and
Testing Services
Site Supervisor



"Without volunteer counselors, AHP couldn't keep up with the ever-increasing demand for counseling and testing. Our volunteers have brought with them training, cultural sensitivity, language capability, and passion. Working side-by-side with people who steal time from their busy lives is a powerful reminder of the importance and value of our services, of my work. I'm thankful that AHP is able to nurture our volunteers so that they feel that our work is their work and our rewards are their rewards."

Where would the AIDS Health Project be without volunteers? At best, we could only reach about half the number of people we now serve. By relying on 400 volunteers, AHP is able to overcome the pressures of limited funding and remain linked to the communities we serve.

To ensure that our clients consistently receive the very highest quality of care, our volunteers undergo intensive training and are closely supervised by AHP's licensed professionals. Volunteer counselors see more than half of the clients who use our HIV Testing Service and the facilitators of our 45 support groups are all volunteers. The people who plan the social programs for our Positives Being Positive and Negatives Being Positive social programs are also volunteers. We have recruited 80 licensed therapists who provide counseling to our clients through our Volunteer Therapist Program. And our

publications program relies on volunteers to write and review materials and to design and proofread them.

AHP also runs two internship programs. One is for college students who get the opportunity to work full-time for a year doing everything from researching and writing to evaluating the needs of clients who call AHP for HIV testing. AHP's second internship program provides HIV-related clinical experience for mental health providers who have completed graduate training; these interns provide short-term psychotherapy to our clients.

Finally, volunteers are a crucial component of our special events. People like actor Robin Williams and Olympian Brian Boitano, the technical crew from *Phantom of the Opera*, and the scores of people who work behind the scenes have volunteered to ensure that AHP events are successful.

"AIDS care is all about people coming together in innovative ways. AHP's program is a great example of this: more than 400 volunteers donated their time last year (the equivalent of almost \$1 million worth of staff hours). It was appropriate for Bank of America and Wells Fargo to join together to create a very special evening to recognize AHP's work and the contribution made by a group of very special people: AHP volunteers."

Tim Hanlon, Wells Fargo Bank, **Dave Studach**, Bank of America

Donors

"There are so many HIV/AIDS organizations that it is often difficult for an individual to know which organization to support. I did some research and discovered that the AIDS Health Project not only provides crucial services to those affected by HIV disease, but also to those who are often overlooked by other agencies. I am confident that my contributions support a most worthy organization."

Steven Sams, Member of AHP's Community Advisory Board

We often think of the HIV epidemic in terms of the terrible toll it has taken upon our community and the efforts of those who work on the "front lines." But just as crucial to the AIDS response are the donors who are committed to fighting this modern day plague. Donors make up a special vanguard, delivering the fuel that powers the effort, and this vanguard has become increasingly important in light of the reductions in government funding.

Today, and in the coming year, the only certainty for the AIDS Health Project and other organizations serving the community is the uncertainty of future government support. To ensure that AHP continues to meet the needs of the thousands who seek out our services, we reach out to those in our community who are as committed as we are to fighting HIV disease.

While AHP is affiliated with

UCSF, the University provides no financial support for AHP programs and invests AHP with the responsibility of securing funding to support all of its programs. Every AHP program is supported by a combination of public monies and individual, foundation, and corporate funding. No AHP program can function without this vanguard's efforts.

AHP is fortunate in that hundreds of people—too many to list here—are willing to make both small and large donations in support of our work. Every contribution is important. Every donor—from the anonymous client who gives a few dollars in appreciation for our services to the corporations and foundations who underwrite AHP programs—provides significant support.

A few of these hundreds are listed here, who in the last year have provided major support towards AHP's efforts to stop the spread of HIV disease.

Anderson Consulting

Bank of America

Diagnostic, Inc.

Mr. Charles Gould

Graham and James

Health Net

Hennessy Martini

Mr. Stephen Herman

IBM

Ms. Jill Lambert

Mr. George McCauslan

The Niagara Trust

Pacific Gas and Electric Company

Pacific Bell

James Rosenfield & Associates

Mr. Bob Ross

Mr. Steven Sams

San Francisco Foundation

Levi Strauss Foundation

The Tides Foundation

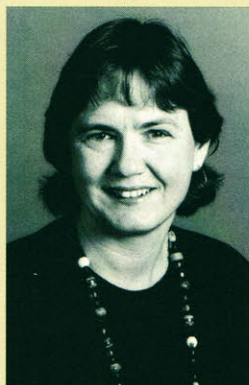
Wells Fargo Bank

Annual Financial Report

Fiscal Year 1994/1995

"Many of the funding criteria guidelines of the San Francisco Foundation emphasize agencies with programs that address a serious need in the community and have a demonstrated record of success. In particular, we are interested in supporting programs that focus on mental health issues. AHP is such an organization, and we are proud to have funded a strategic plan to aid them in planning for the future. The truth is that AIDS will be with us for a long time, and the community will continue to need the services of AHP."

**Ruth Tebbets
Brousseau**
Program Officer
San Francisco
Foundation



	Revenue	Subtotal	Total
Operating Revenue			
Government Grants and Contracts			
FEDERAL GOVERNMENT	\$1,664,371		
STATE OF CALIFORNIA	806,609		
SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH	655,538	\$3,126,518	
Publications and Educational Materials			
FOCUS NEWSLETTER	42,444		
OTHER	24,434	66,878	
Private Contributions			
INDIVIDUAL DONATIONS	47,302		
* FUNDRAISING BENEFIT (NET)	24,426		
FOUNDATIONS AND CORPORATIONS	192,636	264,364	
Total Revenue 1994/1995			\$3,457,760

	Expenses	Subtotal	Total
Operating Expenses			
Program Services			
SFGH SERVICES	\$997,102		
ALTERNATIVE TESTING SERVICES	691,157		
EDUCATION AND TRAINING	586,466		
PREVENTION AND PSYCHOSOCIAL SERVICES	564,736		
COMMUNITY PSYCHIATRIC CONSULTATION	264,901		
PUBLICATIONS	80,804	\$3,185,166	
Supporting Services			
MANAGEMENT, DEVELOPMENT AND GENERAL	204,805		
CAPITAL RESERVE	67,789	272,594	
Total Expenses 1994/1995			\$3,457,760

* Support for this event received prior to fiscal year 1994/1995 is not reflected in this figure.

AHP Management Team

James W. Dilley, MD *Executive Director*
 Joanna Rinaldi *Deputy Director*

Barbara Adler, MA
 Dymond Austin
 Ed Diaz, MA
 Miriam Garfinkel, MFCC
 Michal Longfelder
 Robert Marks
 Helen Prince
 Patricia Sullivan, MFCC
 Carl Yoshimoto, MSW, MPH

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 Victor Murphy, Esq *Vice-Chair*
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The AIDS Health Project gratefully acknowledges the tremendous generosity of the Pacific Telesis Group/Pacific Bell which has underwritten printing and production costs of this report.



A Pacific Telesis Company

Acknowledgements

Production of this UCSF AIDS Health Project Annual Report would not have been possible without the generous donation of time and talents from the following:

The many AHP clients, volunteers, friends, and staff members who agreed to write about what AHP has meant to them:

AHP Client (anonymous)	JB Molaghan, RN, NP
Alejandra Acuña	Jim Orban
Olivia Baldain	Yvette Phillips
Ruth Tebbets Brousseau	Leanne Porterfield
Susan Canavan	Will Rigney
Donald P. Francis, MD, DSC	Steven Sams
Miriam Garfinkel, MFCC	Jan Spector, MA
Tim Hanlon	Dave Studach
Carole Shorenstein Hays	Kean Tan
Bill Lorton	

Volunteer photographers giving time and talents especially for this publication:

Kevin Dwarka
pp 5 Bill Lorton; 7 Jan Spector; 14 Kean Tan

Lori Eanes
pp FC, 10-11 Bleach, needles and condoms

Elizabeth Manglesdorf
pp 2 Jim Dilley; 2 Olivia Baldain with client; 6 Jim Orban; 8 JB Molaghan and Yvette Cortez; 9 Susan Canavan; 10 Olivia Baldain; 11 Miriam Garfinkel and Yvette Phillips

Judi Parks
pp 3 Kathy Bella; FC, 5 HIV Testing Booth at Folsom Street Fair; FC, 6-7 AHP Castro Center; FC, 8-9 George Harrison

Other photography

Christina Gaglio	<i>pg 3 AHP Castro Center Opening pg 3 Volunteer Appreciation Party</i>
Marcia Quackenbush	<i>pg 3 Castro Theatre Marquee pg 14 Facing the Future Volunteers</i>
Kelly Van Noord	<i>pg 12 Alejandra Acuña</i>

Annual Report Staff

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John Tighe	<i>Writer</i>
Kelly Van Noord	<i>Designer</i>
Kathy Barr	<i>Proofreader</i>
Jennifer Cohen	<i>Proofreader</i>

AHP Services Meet Changing Needs

Over the past few years, there have been major shifts in the impact of the HIV epidemic in San Francisco and in the interventions that are available for treating someone with HIV disease. In response to these changes and in anticipation of the future direction of the epidemic, the AIDS Health Project has implemented several changes in the focus and scope of its services that include:

Multi-Cultural Services Development. Say the word culture and most people think of racial and ethnic traditions. While this meaning is actively in place at AHP, the term multi-cultural services has a broader meaning for us and is used to represent services that are designed to meet the needs of any population group that presents special service requirements.

Services and materials are in place and being developed that address the specific needs of members of racial and ethnic groups, youth, women, IV drug users, persons subject to relapse to unsafe sex behaviors, and members of sexual minority groups.

This customization of AHP services to meet different needs of special population groups is not unlike the adjustments that any large provider of products or services makes in response to the differing needs of the marketplace. However, when the services are HIV services and when the members of the "marketplace" are people in urgent need of vital services, the challenges are special.

Offering a single service in a single manner doesn't meet the HIV service needs in the nineties. A broader cross-section of staff and volunteers must have at their disposal a wide range of services and materials from which to pick if clients' needs are to be met successfully.

Positives Being Positive. Although the Positives Being Positive Peer Support Groups continue to be very popular, many clients have expressed a need for groups that are led by facilitators. AHP

has conducted a training of facilitators in collaboration with Black and White Men Together/Men of All Color AIDS Task Force and with the involvement of Mano a Mano.

Bay Area Youth Positives. Marching with AHP in the Gay Freedom Day Parade were several members of the Bay Area Youth Positives group. This special peer support group for young people with HIV (age 25 and younger) is run collaboratively by AHP and the Accept program.

Street Fair and Community Outreach. As part of its Alternative Test Site (ATS) Outreach program, AHP has expanded its presence at street fairs throughout the city. In September, test site staff provided information about the test at both the 24th Street and Folsom Street Fairs. Culturally-specific materials and services were implemented at the fairs for the Latino and Leather communities. Special meetings were held with the "South of Market" community prior to Folsom Street Fair to gain input on how ATS services could be modified to meet the Leather community's needs.

The program has also appeared at the recent *Mujeria* (a gathering of Latino Lesbians), the Tenderloin AIDS Fair in Boddeker Park, the San Jose State University Health Fair and the SF State University AIDS Services Fair. Numerous other

continued on page 3

INSIDE NEWS...

- Funding Update
- A Word from Our Director
- CAB Program Committee
- Benefit for Womens Services and more...

Funding Update

As anyone who reads the front page of the newspaper knows, virtually every level of government is facing a budget crisis. The impact of these crises has had a riptide effect on HIV providers and the AIDS Health Project. The importance of private sources of funding as a stabilizing factor in such times is apparent.

Government funders balance their reduced budgets by making funding cuts. AHP has suffered cuts in most of its program components - most devastatingly in the Training Unit which lost its City of San Francisco training contract. This program taught SF health care providers how to give HIV antibody test results and educated about the mental health issues that surround the AIDS epidemic.

The Training Unit cut was part of a general tendency of funders to cut "soft" services as opposed to direct client services.

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- ◆ **AIDS Law: A Training Manual for Mental Health Professionals** (\$9.95) and **Judicious Practice**, our AIDS law update (free with purchase of the **AIDS Law** book).
- ◆ **Resource Compendium (Fall/Winter 1990)**
A 100+ page listing of vital information on San Francisco HIV service agencies. Courtesy copy provided to all agencies listed. (\$9.95).

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AHP Services Meet Changing Needs

Over the past few years, there have been major shifts in the impact of the HIV epidemic in San Francisco and in the interventions that are available for treating someone with HIV disease. In response to these changes and in anticipation of the future direction of the epidemic, the AIDS Health Project has implemented several changes in the focus and scope of its services that include:

Multi-Cultural Services Development. Say the word culture and most people think of racial and ethnic traditions. While this meaning is actively in place at AHP, the term multi-cultural services has a broader meaning for us and is used to represent services that are designed to meet the needs of any population group that presents special service requirements.

Services and materials are in place and being developed that address the specific needs of members of racial and ethnic groups, youth, women, IV drug users, persons subject to relapse to unsafe sex behaviors, and members of sexual minority groups.

This customization of AHP services to meet different needs of special population groups is not unlike the adjustments that any large provider of products or services makes in response to the differing needs of the marketplace. However, when the services are HIV services and when the members of the "marketplace" are people in urgent need of vital services, the challenges are special.

Offering a single service in a single manner doesn't meet the HIV service needs in the nineties. A broader cross-section of staff and volunteers must have at their disposal a wide range of services and materials from which to pick if clients' needs are to be met successfully.

Positives Being Positive. Although the Positives Being Positive Peer Support Groups continue to be very popular, many clients have expressed a need for groups that are led by facilitators. AHP

has conducted a training of facilitators in collaboration with Black and White Men Together/Men of All Color AIDS Task Force and with the involvement of Mano a Mano.

Bay Area Youth Positives. Marching with AHP in the Gay Freedom Day Parade were several members of the Bay Area Youth Positives group. This special peer support group for young people with HIV (age 25 and younger) is run collaboratively by AHP and the Accept program.

Street Fair and Community Outreach. As part of its Alternative Test Site (ATS) Outreach program, AHP has expanded its presence at street fairs throughout the city. In September, test site staff provided information about the test at both the 24th Street and Folsom Street Fairs. Culturally-specific materials and services were implemented at the fairs for the Latino and Leather communities. Special meetings were held with the "South of Market" community prior to Folsom Street Fair to gain input on how ATS services could be modified to meet the Leather community's needs.

The program has also appeared at the recent Mujería (a gathering of Latino Lesbians), the Tenderloin AIDS Fair in Boddeker Park, the San Jose State University Health Fair and the SF State University AIDS ServicesFair. Numerous other

continued on page 3

INSIDE NEWS...

- Funding Update
- A Word from Our Director
- CAB Program Committee
- Benefit for Womens Services and more...

Funding Update

As anyone who reads the front page of the newspaper knows, virtually every level of government is facing a budget crisis. The impact of these crises has had a riptide effect on HIV providers and the AIDS Health Project. The importance of private sources of funding as a stabilizing factor in such times is apparent.

Government funders balance their reduced budgets by making funding cuts. AHP has suffered cuts in most of its program components - most devastatingly in the Training Unit which lost its City of San Francisco training contract. This program taught SF health care providers how to give HIV antibody test results and educated about the mental health issues that surround the AIDS epidemic.

The Training Unit cut was part of a general tendency of funders to cut "soft" services as opposed to direct client services.

Government funders utilize other criteria for determining the cuts to be made. In 1990-91, one of the key criteria was the ability of the contractor to deliver collaborative, multi-ethnic services.

AHP is pleased that it received continuation of its Alternative Test Site Ethnic Community Outreach Contract and the City-funded Prevention contract - both of which have heavy multi-cultural service requirements.

The AIDS Walk continues to be a major source of private funds for AHP. Our AIDS Walk receipts totalled \$70,000 in 1990. The importance of the AIDS Walk to people with HIV disease and those at high risk is unequalled in northern California.

The Community Thrift Store has just expanded and provides an easy way to make small but meaningful contributions to AHP. Since opening in 1984, the Store has donated almost \$400,000 to community services with nearly 75% going to AIDS/HIV services. The AHP account number is 201 - please use it when donating goods to the Store. Located at 625 Valencia at 17th, their phone

number is 861- 4910.

The Future is not bleak - but it is challenging. New federal funds, in the form of the Ryan-White (Kennedy-Hatch) legislation will help. However, we all need to continue to make HIV funding a priority in the eyes of our elected representatives.

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We'd like to hear from you.
Please send your comments and suggestions to:

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SPOTLIGHT ON



Cab Program Committee

The AIDS Health Project's Community Advisory Board (CAB) provides assistance to AHP in a variety of ways, including fund raising, volunteer participation at large events, and idea generation.

The involvement of the Program Committee is of a slightly different nature and provides an opportunity for CAB members to work directly with staff on program design.

The Committee, chaired this past year by Jerry Polon, meets monthly. The typical agenda usually includes a presentation by a member of the AHP program

staff, as well as feedback from Committee members on topics discussed at previous CAB meetings.

The involvement of the Program Committee in the planning of the recent presentation of Alternative Test Site (ATS) services at the Castro Street Fair provides an example of the Committee's invaluable activity.

The Committee was consulted during the project's initial feasibility discussions. After agreeing in concept with the project, member and current committee chair Larry Fuller volunteered to serve as an ongoing liaison to staff

for the purpose of providing a community perspective during planning. Mr. Fuller attended all meetings, contributed to the overall planning effort, and was so taken with the project that he "worked the crowd" passing by the test site booth on Fair day.

The Committee is involved in similar efforts with several other AHP program components, too.



a word from Our Director

The AIDS Health Project has declared being a multi-cultural agency as one of its goals. I would like to explain what this statement means to us.

As a relatively large organization that provides a range of services, we are fortunate to have a very talented staff and many different vehicles for providing services. We provide direct services, train professionals, develop publications, perform research, and contribute to the development of public policy.

It is our belief that this multiplicity of services must be provided in a manner that reflects an acknowledgment of the cultural diversity in our city, state, and nation. With this orientation, we are not content to provide services

in a culturally-neuter fashion. While we recognize the commonality that binds us all together, we also recognize the importance of individual group differences. It is our intent to reflect this recognition in the design and presentation of our services.

Most agencies focus on the provision of services to one population group, be it an ethnic group or sexual preference group. Unfortunately, large agencies, which often have the greatest potential for providing culturally diverse services, often tend to homogenize services - especially if they feel they are the only source for the services. This is the "I am the only provider, therefore my way must be right" form of program administration.

We ask our staff to think along special population lines. We would rather take the time to develop four variations of one service than

NEWS & NOTES

AIDS
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to try to fit people into a common mold. And, we regularly evaluate the efficiency of each approach.

We are not there yet, but we are headed in that direction. One of the keys, of course, is staff. We must have a culturally diverse work force (which we do) that is empowered to act in that fashion (which it is), and that is provided with a program planning vehicle that facilitates such effort (which we are working on).

The other key is input from the community - people like, you, our *News & Notes* reader, other service providers, and receivers of HIV services. *News & Notes* is an important communication vehicle for us. If we are not speaking to *you*, please let me know.

James W. Dilley, MD, Director

AHP Services Meet Changing Needs

continued from page one

small group workshops are presented regularly by the ATS Multi-Cultural Outreach staff.

Training Unit Goes to Jail!

In preparation for the development of a training program for correctional officers, the AHP Training Unit toured San Quentin in early October. Among other impressions, staff were pleased with the dedication of many correctional officers working in the ward for prisoners with HIV. The Corrections Facility training contract will allow AHP to provide expertise to this underserved arena.

Asphalt Testing - Mobile Testing. October 7th saw the unveiling of the new mobile Alternative Test Site testing service in a 1,000 square foot tented area at the Castro Street Fair. Pre-test sessions and blood draws were done *on the spot* - with test results provided two weeks later at nearby

SF DPH Health Center #1. This "first in SF" was planned with multi-ethnic and multi-lingual members of the gay and lesbian community.

As we go to press, the ATS program is in the middle of its second Mobile Testing Service. Upon the invitation of the Glide Memorial Church AIDS Project, testing services are being offered at Glide October 23rd and November 6th.

These two activities are the first of an ongoing effort to take anonymous HIV antibody testing out of the cinder block-walled institutions and into the streets.

Conclusion. These are only a few of the many special activities that have been set up in the past year to diversify the presentation of AHP services and to enhance their cultural acceptability.

Benefit for AHP

World-famous illusionist Jim Bailey has offered the proceeds of the last night of his 1990 San Francisco run to the AIDS Health Project's Womens Services Program. He will perform a special two-hour presentation of his "An Intimate Evening with Judy Garland" for the benefit on Wednesday, November 14 at the Plush Room Cabaret at the York Hotel, 940 Sutter, at 8:00 pm.

Mr. Bailey will tour AIDS services at SF General Hospital after lunching at Ivy's Restaurant as the guest of AHP Community Advisory Board member Andrew Foxwell. AHP provides crisis counseling, psychiatric evaluations and HIV antibody testing and counseling at SFGH and on Wards 86 and 5A.

For those interested in tickets, please call the York Hotel at 885-6800. Mr. Bailey's show opens on November 3 and runs every night through the benefit on the 14th. See you there!

Thanks to...

- ◆ **Larry Cichosz** for designing *News & Notes* and serving as its founding editor.
- ◆ **Brenda Patterson** for coordinating the UCSF AIDS Walk Team.
- ◆ **Rick Slick**, Castro Street Fair, for donating 10 booth spaces for the Asphalt Testing Program.
- ◆ **Karen Staller**, Pacific Presbyterian Medical Foundation, for tickets to the Macy's Passport Fashion Show for staff and volunteers.

C A L E N D A R

- ◆ **Nov. 14 - Jim Bailey Benefit**
A benefit performance for the AIDS Health Project of Jim Bailey's Nov. 3-14 San Francisco run (at the Plush Room). Call for tickets and details: 885-6800
- ◆ **Dec. 1 - World AIDS Day 1990**
(Focus on Women and AIDS)
- ◆ **Dec. 18 - Women's Services Party**
Our annual cooperative holiday event for women with HIV and their families.

New Educational Materials From AHP

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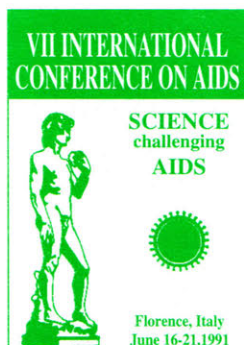
FOCUS

A Guide to **AIDS** Research and Counseling

Volume 6 Number 10 September 1991

Report from the International AIDS Conference: Hope and Apprehension

James Dilley, MD, Michael Helquist and Robert Marks



In this special issue, *FOCUS* examines the Seventh International Conference on AIDS, held in Florence, Italy, in June. More than a decade into the pandemic, many of the "facts"—about transmission, replication, and pathogenesis—continue to be valid. We emphasize here those aspects that are most quickly evolving and most likely to be of interest to counselors, for example, the changing populations of infected people, vaccine research, combination antiviral therapy, and neurological findings.

Interpreting conference presentations is

as much an art as a science, requiring knowledge, intuition, and energy. More than 10,000 people attended five days of presentations, including two plenary sessions each morning, sessions emphasizing issues for "Communities Challenging AIDS," and a choice of 500 oral and 3,000 poster presentations divided into four tracks: A-Basic Science; B-Clinical Science and Trials; C-Epidemiology and Prevention; and D-Social and Behavioral Science. In this issue, references to conference abstracts are cited in parentheses within the text: the first part indicating the day, the second indicating the track, and the last indicating the number of the presentation. This month's Clearinghouse (see page four) offers information on how to order conference abstract books and professional publications that provide further commentary.

Epidemiology

The HIV pandemic continues to spread inexorably, especially in the developing world. James Chin, Chief Epidemiologist of the World Health Organization (WHO), predicted that in the industrialized world, where the average duration of time from infection to disease is 10 years, the number of diagnosed AIDS cases will remain high well into the middle of the 1990s, but will level off after that. The infection rate in the developing world, however, will continue to rise.

Millions of new infections are projected in Asia, Latin America, and Africa. Overwhelmingly, new infections throughout the developing world are transmitted through heterosexual contact, although the roles of infected blood supplies and male-to-male transmission are difficult to determine in some countries. While some 10 million people worldwide are currently infected, by the turn of the century the

figure is expected to rise to between 25 and 30 million. Yoweri Kaguta Museveni, President of Uganda, stated that by that time, the developing world will account for 90 percent of the diagnosed AIDS cases compared to 50 percent in 1985.

Rates Vary among Drug Users

Some industrialized nations report increased seroprevalence among injection drug users. For example, in London, a study of 534 injection drug users in and out of treatment programs found a seroprevalence rate of 13 percent in 1990 compared to 6 percent in 1989 (M.C.48). In a study of Argentinean injectors in treatment programs, seroprevalence rose from 0 percent in 1986 to 38 percent in 1990 (W.C.3326).

On a more positive note, seroprevalence rates have been stable for one year in Bangkok (34 percent), and for six years in New York (47 percent). Most users in both cities claim to have adopted behavior change consistent with HIV prevention

This is the first issue of the redesigned FOCUS. We hope you'll find it easier to read, and with its Editorial and Clearinghouse, more comprehensive and useful.

Editorial: Towards a New Conference

Robert Marks, Editor

The International AIDS Conference continues to fulfill a valuable role by focusing worldwide attention on the pandemic and by bringing together the international AIDS community. Psychosocial and prevention presentations, in particular, are useful in three ways: they provide an international forum for prevention and social support strategies; they encourage medical and social science professionals to exchange ideas about an epidemic that has blurred lines between these disciplines; and they introduce the media to aspects of HIV disease that may be overlooked in the rush to cover every, and often every insignificant, medical finding.

In the hodgepodge of hundreds of oral and poster presentations, the conference format, designed for the exchange of scientific information, failed to actively facilitate the development of innovative ideas. Most social science and prevention presentations confirmed what has been known for several years, not surprising in the context of a scientific conference where replication is a high art. Many of these presentations were data-based, so that the exchange of ideas was limited even further to concepts that could be tested and proven

statistically significant using the scientific method.

Oral presentations offered little opportunity for substantive discussion, rarely extending beyond a recitation of methodology and basic findings. Since the oral presentations in a given session were often only peripherally related to each other, limited discussion never led to useful conclusions about the implications of a body of work. The oral sessions, which this year were fewer and thus more accessible, could have provided opportunities for dialogue and synthesis to guide future research and program development; instead they became little more than talking posters.

A New Approach

It would be wrong to criticize presenters simply because their reports did not contribute to global answers: the enthusiasm and intelligence of HIV workers worldwide is perhaps the most impressive aspect of the conference. Likewise, each year organizers improve on the previous year's model, making information more accessible. It is time, however, to experiment with approaches that go beyond the limitations of the scientific approach.

To do this, there should be

greater autonomy between psychosocial and medical aspects. During the first two or three days, the conference could focus on psychosocial, prevention, and public policy issues; for the final two or three days, it could focus on medical and basic science. In between, there could be a one- or two-day session, designed to identify and discuss the most important areas of common interest for attendees of the two larger sections.

The new format should be matched by a new approach. Using this approach, organizers would define the key HIV-related social science, prevention, and public policy topics. They would write position papers—defining the state of current knowledge and research—about these topics and would suggest a range of unresolved questions that presentations could address. Panel participants, chosen on the basis of their responses, would be those who organizers believed were the best equipped to challenge the limits of current knowledge through their presentations and discussion.

Sessions should include a healthy amount of audience participation and culminate in the development of a statement detailing points of agreement, and suggestions for future discussion. The product of the conference, the compiled statements from each session, would form a coherent guide for future research and program development.

guidelines and, consistent with these data, new seroconversions tended to cluster among those who are new injectors. (M.C.I). WHO has undertaken a five-year seroprevalence study of drug use in 11 major cities throughout the world, and this data should provide an assessment of the success of behavior change programs.

Women and Young Gay Men Vulnerable

The numbers of women infected with HIV is rapidly growing in Western industrialized countries. In a comprehensive

study of Centers for Disease Control (CDC) case reports, researchers found women to comprise 55 percent of all U.S. cases reported since January 1989 (W.C.100). While 51 percent of these cases occurred among injection drug users, in 1990, 31 percent were the result of heterosexual contact, and this category has had the highest rate of increase.

An ongoing observational study of HIV-infected women in 18 U.S. cities reported that, of the first 222 women enrolled, the average age of participants was 35; 65

percent were African-American, 21 percent were Latino/Hispanic; and the most often reported risk exposures were injection drug use and heterosexual contact (M.B.2442). Fifty-nine (27 percent) had a history of vaginal candidiasis.

One of the most disturbing epidemiologic reports came from the San Francisco area, where a survey of six sexually transmitted disease (STD) clinics assessed HIV seroprevalence among 1,688 young gay and bisexual men. Overall, 27 percent of White men, 54 percent of Black men, and 11 percent of Latino men were antibody positive. In San Francisco County alone, 49 percent of this group of young men were infected (W.C.3010).

Natural History

From early in the epidemic, researchers have studied the natural history—the development over time—of HIV infection in hopes of defining routes of transmission,¹ recognizing cofactors that facilitate disease progression, identifying biological markers that indicate or predict disease progression, and distinguishing disease progression among groups of people.

Cofactors: Age, Stress, and Unsafe Sex

Researchers have considered everything from diet to popper use as cofactors for progression to AIDS. But, while many of these seem intuitively related to health and the body's ability to fight disease, none have been shown to have a direct relationship to disease course. The only consistent conference finding regarding the role of cofactors was age at time of infection. Numerous studies agreed that those who become infected later in life, especially after 35, tend to progress more rapidly to AIDS and showed that this effect existed in various populations.

Other possible cofactors, however, continue to be investigated. Findings from the U.S. Multicenter AIDS Cohort Study (MACS) suggested that more rapid progression to AIDS is related to repeated exposure to multiple and perhaps more virulent strains of HIV, or to some other sexually transmitted factor (M.C.95). Researchers studied 32 men who progressed to AIDS within five years of seroconversion and seropositive controls who had not progressed to AIDS. Those with AIDS reported more frequent bouts of STDs prior to seroconversion, and receptive anal intercourse with more partners before and after seroconversion.

Other studies found that stress may reduce T-killer cell levels (TH.B.91), and that continuing heroin injection does not accelerate disease progression. (TH.C.48).

Progression Similar in All Groups

The standard data about progression from HIV infection to AIDS comes from four large San Francisco cohorts of gay White men, which have found that less than 3 percent progress to AIDS during the first few years, but 6 or 7 percent progress annually during subsequent years. This results in an infection rate exceeding 50 percent by the end of the 10th year. The United Kingdom Hemophilia Cohort and the Italian Hemophilia Group, both large studies of seropositive people followed for five and six years, found nearly identical rates of progression (M.C.3131).

Surprisingly similar findings were reported among injection drug users. One large Italian study assessed the rate of progression of disease among 539 injectors, plotted initial five year results, and found the "natural history of HIV infection in injection drug users does not seem to differ from that of gay men in the U.S." (W.C.3354). A second study of 358 injectors in Rome replicated the AIDS Clinical Trials Group (ACTG) 019 study that assessed the use of zidovudine (ZDV; AZT) in gay men with T-helper cell counts of less than 500. Progression to AIDS and advanced symptomatic disease was "similar to that reported for gay men in ACTG 019" (M.C.3183). Of particular interest was that progression rates for men and women were essentially equal. A third study from Baltimore, Maryland, demonstrated that while a rapid decline in T-helper cells follows seroconversion among injection drug users, after a plateau is achieved, the decline continues slowly and "resembles that seen in other risk groups" (TU.C.44).

As more and more women become infected, there is greater interest in the effect of pregnancy on disease progression. French researchers studied seropositive pregnant women, none of whom had AIDS, to see if there was a difference in disease progression between those who carried their babies to term and those who aborted in the first or second trimester (W.B.2046). Interestingly, they found no difference between the two groups in terms of T-helper cell levels.

50 T-Helper Cell Threshold

Finding surrogate markers that predict or indicate disease progression has been a research priority since early in the epi-

1. The conference offered no major findings on routes of transmission. Boston researchers, however, incited controversy when they stated that the dendritic cells, found in the mucous lining of the mouth, the anus, the urethra, the vagina, and other parts of the body, had extremely high concentrations of HIV (W.A.70). One of the researchers added, at a press conference when questioned about the risk of transmission from kissing, that the CDC has always cautioned against any exchange of bodily fluids, including saliva. Other scientists, educators, and epidemiologists assert, however, that while transmission may be theoretically possible, there is no evidence that such transmission has ever occurred, and current safer sex guidelines remain valid.

demic. The U.S. National Cancer Institute (NIH) reviewed the records of patients who had participated in antiviral therapy studies and found that only one of 51 patients who died of AIDS had a T-helper cell count of more than 50. The study also found that the median survival time of patients after their counts had fallen below 50 was only 9 months (M.B.37). The researchers concluded that a count of 50 may be an important benchmark for defining stage of illness, and Samuel Broder, Director of NIH, suggested at the conference's closing that keeping counts above 50 may be the goal of therapy.

Treatment

Conference data continued to support the efficacy of early antiviral treatment² and offered new evidence about the use of combination therapy as disease progresses. Researchers presented evidence that ZDV was well tolerated in early use and that the development of anemia, which was often seen at the previously recommended doses of 1,500 milligrams per day, was a rare complication at doses less than 500 milligrams per day. Furthermore, they found that if patients had not developed anemia within the first six months of treatment, it was unlikely that they would.

ZDV Comparable in Women and Men

The number of presentations on the treatment of women—not including the many studies on vertical transmission of HIV to the fetus—could be tallied on a hand or two. Studies that were reported, however, begin to define the differences between manifestations and treatment of HIV disease among women. Two studies,

both from Canada, examined ZDV use in women. The first, comprised of 58 subjects followed for a mean of 45 weeks, found that the low rate of progression to AIDS—6.1 percent for the sample—was comparable with predominantly male samples treated with higher doses (W.B.2068). Anemia and leukopenia (depressed white blood cell count) seemed more prevalent in this sample, particularly for women receiving more than 600 milligrams per day, than in male samples. The second study found that, of the 289 female subjects, 89 percent survived after 12 months and anemia was the most common side effect (W.B.2085).

Combination Therapy Reduces Toxicity

Combining ZDV with other drugs to enhance efficacy, and to reduce toxicity and the development of resistance, is an area of continuing research. Strategies include using ZDV with drugs that interfere with different aspects of the HIV life cycle, for example, alpha interferon (TH.B.35), as well as using drugs from the same chemical family, for example, dideoxycytidine (ddC) and dideoxyinosine (ddI). In the laboratory, ddC and ddI have shown additive effects against HIV when combined with ZDV (W.B.2110), and several studies supported this strategy.

Margaret Fischl of the University of Miami reported on data from the ACTG 106 phase I/II study using constant doses of ZDV with variable doses of ddC. The study found that in the higher-dose ddC group, T-helper cell counts increased at rates greater than would have been expected with ZDV alone. Perhaps more importantly, the increase persisted for as long as one year, and there was no increase in ZDV- or ddC-associated com-

2. Results confirming the positive effects of early treatment with ZDV were reflected in a number of presentations (W.B.2001, W.B.2125, W.C.41).

Clearinghouse: AIDS Conference

We surveyed 30 professional journals and newsletters to find out in which would appear summaries of the Seventh International AIDS Conference. The following is a compilation of those offering special coverage. We have tried to include ordering information and pricing when this was available.

Conference-Specific Publications

Official conference abstract books are expected to be available for purchase. To receive more information, write: Seventh International AIDS Conference, General Secretariat, Laboratory of Virology,

Instituto Superiore di Sanita, Viale Regina Elena, 299, 00161 Rome, Italy.

Audiotapes of conference presentations are available for \$8.00 each from InfoMedix. To receive a list of presentations or to order, call: (800) 367-9286.

AIDS 91 Florence Summary, abstracts the conference findings. Send \$64.75 before December 1, or \$90.75 after this date to: Philadelphia Sciences Group, Order Fulfillment Department, 12908 Acorn Hill Court, Midlothian, VA, 23112, or call (804) 744-5233.

Journals and Newsletters

AIDS, a monthly journal, plans to publish a special edition focusing on the Florence conference and reviewing 1991's HIV-related medical and psychosocial advances. To order the hard-bound edition, to be released at the end of 1991, write: Current Science,

**Keeping
T-helper cell
counts
above 50
may be the
goal of drug
therapy.**

plications in the combination group. Researchers obtained similar results in a dose-ranging study of the combined effects of ZDV and ddI (TU.B.2). Following 24 weeks of therapy, no unexpected toxicities were seen and all groups showed a rise in T-helper cell counts.

Several presentations reported on HIV resistance to ZDV (TU.B.81, W.A.78, and others) and clarified this issue. First, on average, drug resistance emerged more slowly in patients treated early than in patients treated late in their disease. This finding is consistent with what is known about the natural history of the disease: as T-helper cell counts decrease, viral replication increases, and it becomes more likely that a drug-resistant form of HIV will emerge. Second, resistance occurs progressively and may be the result of several viral mutations. One study showed, in four patients with ZDV resistance, that ddI decreased HIV levels and led to renewed ZDV sensitivity (TU.B.91).

Researchers presented the results of a Phase I human trial on a relatively new class of drugs, the Tetrahydro-Imidazo-Benzodiazepin-2-One (TIBO) derivatives, which were first discussed at last year's conference when they were shown to have potent anti-HIV activity in the test tube (TH.B.86). Tested in 22 patients with AIDS or severe symptomatic illness, the derivative, called R82913, caused no adverse side effects, including no bone marrow suppression, and led to a statistically significant drop in p24 antigen. Researchers will soon begin human efficacy trials on the TIBO derivatives, which, like ZDV, are reverse transcriptase inhibitors.

The Vaccine Solution

Following the disappointments of last year's conference, when advancing research served only to emphasize the challenges facing vaccine development, this year's conference offered evidence that those challenges might be overcome. Thirteen vaccines are in human safety trials and, within the next three years, should enter efficacy trials. While research is moving rapidly, none of the vaccines presented meets two of the key criteria for a successful model: that is, the ability to raise antibodies that will kill free-floating HIV and to induce a T-killer cell response that will eliminate cells that are already infected. However, even data that demonstrated failed attempts suggested that these criteria can and will be met during what Dani Bolognesi, a leading researcher from Duke University, dubbed the "Decade of the Vaccine."

"Post-exposure" vaccines, those that stimulate the immune system to overcome HIV after it has infected the body, generated the greatest enthusiasm among conference participants. Dr. Bolognesi noted that the array of post-exposure vaccine findings shared similar results: stabilization of T-helper cell levels, stabilization of weight loss, reduction in opportunistic infections, and increased survival. The relatively uniform success of these approaches is expected to lead to rapid and greatly expanded trials.

Opportunistic Conditions

Conference presentations reported on a range of treatment developments for opportunistic conditions. According to *AIDS Treatment News*, "Most of the clinical information [on opportunistic conditions] came from relatively small confirmatory

Subscriptions, 20 North 3rd Street, Philadelphia, PA, 19106-2113, or call (800) 552-5866.

AIDS Care (Volume 3, Number 4), a quarterly journal, presents summaries of the conference in its final 1991 issue. Write Carfax Publishing Company, P.O. Box 25, Abingdon, Oxfordshire OX 14 3UE, United Kingdom.

AIDS Treatment News devoted two issues to the conference: Number 129 reports on treatments for opportunistic infections, and Number 130 analyzes vaccine presentations presented at the

conference. Publisher John S. James will send a sample issue of the twice-monthly newsletter free of charge; additional issues cost \$2.00. Call (800) 873-2812.

Bulletin of Experimental Treatments for AIDS (BETA), published four times a year by the San Francisco AIDS Foundation, includes news from the conference in its August 1991 issue. Call (800) 327-9893.

CDC AIDS Weekly, features conference reports on psychosocial topics and summaries of conference abstracts in successive weekly issues, dated from June 17 to July 15, 1991. To receive

copies (two issues will be sent free of charge), call: (800) 633-2931.

Treatment Issues (Volume 5, Number 6), published by the Gay Men's Health Crisis in New York, reports on conference presentations in its August 1991 issue. Future issues will include more information from the conference. In addition, *Treatment Issues* has prepared a special conference report. To receive a copy of the newsletter or the report, write: GMHC, Department of Medical Information, 129 West 20th Street, New York, NY 10011, or call (212) 337-3556.

studies of treatments already in use." Some of the highlights include:

- reports that Acyclovir, commonly used to fight herpes virus infections, may be used to *prevent* infections caused by the herpes simplex, varicella zoster, and Epstein-Barr viruses (M.B.2248);
- the finding in several small studies that while the *Pneumocystis carinii* pneumonia (PCP) prophylactic, aerosolized pentamidine, may cause fewer side effects, the systemic oral treatments—dapsone and co-trimoxazole (Septra or Bactrim)—may be more effective and may prevent toxoplasmosis, and *Pneumocystis carinii* infections in organs other than the lungs;
- reports that the incidence of drug-resistant tuberculosis worldwide is growing (M.B.2174, W.B.2302, W.B.2356).

Psychosocial Issues

Conference reports offered few new insights into psychosocial issues. Some interesting studies, however, reaffirmed the clinical experiences of mental health providers. The importance of social support for people with HIV disease was shown in studies of hemophiliacs (W.B.2399), injection drug users (W.D.4026), gay men (W.D.4212), and both gay men and injection drugs users (W.B.2385). Most notably, in a study from a semi-rural setting in the U.S., fewer social supports predicted the development of major depression in a group of 75 people with HIV disease (W.D.4276).

A San Francisco study presented data on multiple loss, grief, and depression (W.D.2). Responses from 430 gay men revealed significant increases in depression as AIDS deaths or diagnoses of friends or acquaintances increased from a median of one in 1984, to three in 1986,

to seven in 1988. Seropositive subjects showed significantly higher levels of depression in response to losses.

A study of long-term survivors in New York attempted to determine the psychological consequences of prolonged illness, and to identify factors associated with the maintenance of hope and quality of life (TU.D.105 and M.D.105). "Long-term" was

defined as having an AIDS diagnosis for 36 months, twice as long as the CDC survey's 1990 median survival time.

Participants were generally pragmatic and realistic about their illnesses. They were highly informed about their disease and "superb medical consumers" who worked in partnership with their physicians and reported high satisfaction with their doctors. They were optimistic, tenacious, and determined, and most reported a sense of accomplishment about their lives. They used denial as a coping mechanism only minimally; while these men were acutely aware of their foreshortened lives, they did not believe they would "beat" their illness.

Women and the Politics of Sexuality

Attention to issues affecting women with HIV disease was more noticeable this year than in the past, but research progress was limited. Much of the psychosocial discussion emphasized the shortcomings of the CDC AIDS case definition, which does not include gynecological manifestations of HIV infection, the failure of sexual behavior change programs to target men in heterosexual relationships, the lack of research on safer sex methods that, unlike condoms, women can control, and the poor, although improving, access of women to clinical trials.

At a community session on women, Columbia University researcher Zena Stein noted that only a handful of conference presentations addressed safer sex methods over which women have control, for example, a vaginal virucide or the female condom. There was agreement among participants that energy must focus on changing sexual power relationships throughout the world, and research must seek safer sex alternatives that compensate for this imbalance.

A study of women's participation in clinical trials found that the recruitment of women in ACTG trials has increased over time but is leveling off. Women have accounted for a total of 6.7 percent of all ACTG subjects (TU.D.114). In addition, women in trials are not necessarily representative of the bulk of women with HIV: women of color comprise 73 percent of women with AIDS but only 52 percent of trial participants; women injection drug users comprise 51 percent of women with AIDS but only 23 percent of participants.

Approaches to Prevention

Reports on prevention programs generally fell into two categories: the first

Long-term survivors are 'superb medical consumers'; optimistic, tenacious, and determined; and use denial only minimally to cope with illness.

Next Year's AIDS Conference

In response to U.S. travel and immigration policies regarding AIDS, organizers of the Eighth International Conference on AIDS have decided not to hold the 1992 event in Boston. At press time, they were seeking a site outside the U.S.

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represents the application of basic prevention activities in communities around the world. These reports indicated the huge effort underway to implement such programs, but failed to provide new insights for most other programs.

The second category involves a more thoughtful approach to the fundamental challenges of human behavior change. Researchers in a few sites applied basic theories of behavior change to program development. Thus, some new studies attempted to create social norms to influence behavior while others focused on perceived personal efficacy as a primary factor for risk reduction. Other studies relied heavily on the principles of commercial marketing to develop the most effective messages for specific target populations. The variety of approaches in this second category reflects the fact that there is no clear agenda for behavior change research or programming. Without this agenda to serve as a context for interpretation, valuable lessons from the field get lost in the thousands of repetitive studies conducted each year.

The fact that behavior change researchers are seeking to identify factors that move people from "being aware" to "willing to try new behaviors" or from early adoption of behavior to sustained behavior changes reveals that many researchers and programmers recognize that the "easy" part of AIDS education is over. The worldwide public is, for the most part, knowledgeable about HIV disease. The challenges in AIDS prevention now are to define an effective prevention theory, to establish priorities and an agenda, and to obtain the resources necessary to implement comprehensive programs for behavior change.

Neuropsychiatric Aspects

In what is perhaps the most important neurological report since the beginning of the epidemic, Leon Epstein of the University of Rochester in New York announced the successful development of an animal model for studying HIV infection in the brain. Epstein made the presentation in Padua, Italy, at the Neuroscience Satellite Symposium, which preceded the International Conference. The process involves grafting human fetal tissue into the anterior chamber of an adult rat's eye, which, since it is free from normal immune system response, does not reject the implant. The fetal tissue grows nor-

mally, develops a blood-brain barrier, and differentiates into specific human nerve cells. Dr. Epstein and his colleagues are currently attempting to infect the graft with HIV to study the process of primary infection. Other studies may include examining effects of other organisms on brain function.

Also at the symposium, Steven Wolinsky of Northwestern University in Chicago reported that HIV "env" gene sequences vary by as much as 11 percent in the blood and brain of a single individual. These differences may be responsible for producing in the same person strains of HIV that are more effective at infecting either nervous tissue cells or systemic immune cells, and may arise because of differences in pressure on either side of the blood-brain barrier.

Neurological Impairment

At the International Conference, reports from a variety of countries continued the debate on whether asymptomatic seropositives are subject to cognitive impairment. The majority of the evidence continues to suggest that asymptomatic individuals are not significantly more likely than uninfected controls to be impaired.

Several presentations, however, did suggest that seropositives had slower "central conduction times," that is, their brains processed electrical impulses more slowly than the brains of seronegative controls (M.B.2070, M.B.2118, M.B.2086). This finding is consistent with the accepted fact that HIV infection of the brain and spinal cord occurs early in the course of the illness and that this infection can and at times does lead to problems in thinking. However, infection does not seem to lead consistently to poor test results on formal neuropsychological examinations.

Other neuropsychiatric conference presentations included:

- a case report of mania in two people with AIDS being treated with a daily dose of 750 milligrams of ddI (M.B.2031). The patients had no history of mania, and the episodes resolved within 10 days of stopping treatment.
- a study of 64 children whose cognitive impairment improved six to 12 months after treatment with ddI (W.B.2051). There was no additional improvement after 12 months.
- a study of 350 consecutive psychiatric admissions to an acute inpatient ward in New York showing a 7 percent seroprevalence rate, much higher than in the general population (M.B.2114).

FOCUS

A Guide to AIDS Research and Counseling

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Summary

Epidemiology. In industrialized nations, the populations affected by the epidemic continue to broaden from gay White men to women, people of color, and injection drug users, and professionals who wish to continue to respond will need to know more about these populations in order to address their needs. In the near term, gay men will remain dominant in the statistics, and the need for support for gay men with HIV infection will be matched by the need for support for gay communities dealing with years of cumulative, long-term loss.

Natural History. Research continues to fail to discover a magic cofactor that people with HIV disease can avoid or embrace to remain healthy. In fact, the emerging correlation between progression, STDs, and HIV reinfection supports the stance, disappointing to some, that safer sex is as central to HIV treatment after infection as it is to HIV prevention before infection.

Conference data suggest that the course of disease is far more similar across transmission categories than it is different. The identification of a 50 T-helper cell threshold strengthens arguments for antiviral treatments, which may be valuable in extending life even if they fail to restore full immune function. Armed with information that may give people with HIV disease the sense that they have more time available to adjust and to make decisions, counselors can help clients deal with the overwhelming demands of infection in a more deliberate way. At the same time, counselors should be prepared to deal with the heightened concerns of people whose T-helper cell counts fall below 50 and who interpret these results as a death sentence.

Treatment. Treatment decisions for most medical conditions are usually confined to the physician's office, but for HIV disease, mental health practitioners frequently work with their clients to sort out these questions. While it is disappointing that ZDV and its analogs, ddC and ddI, remain the only real choices for treatment, the emergence of the TIBO derivatives and the post-exposure vaccine promise potent alternatives. Conference data suggest that lower doses and combinations of antivirals may lead to fewer and less toxic side effects, and may make treatment choices less intimidating.

Who would have thought, after last year's gloomy outlook, that vaccine

research success would have dominated the Florence conference? An effective vaccine could fulfill four goals: protection for the uninfected; treatment for those already infected; a potentially affordable treatment for developing nations where poverty has made even basic health care, much less high-priced antivirals, the stuff of legend; and hope, particularly in those communities hardest hit by the epidemic. While optimism seems justified, the implementation of a widespread vaccine program remains distant.

Psychosocial and Neuropsychiatric Issues. Conference studies confirmed the importance of social support and suggested factors that might lead to long-term survival. While some studies offered insights into risk reduction, the lack of a foundation for behavior change continues to complicate prevention, even in the face of the global success of HIV education.

Jonathan Mann, Director of the Harvard International AIDS Center, reflected on the hope and apprehension we face: "Our own 'status quo' frightens us. A revitalization, a creative renewal of efforts is needed—building upon success, yet capable of facing the evolving circumstances and even greater challenges of the 1990s."

Next Month

The prevailing mythology is that drug users lack the competence and their communities lack the existing structure to organize effective prevention and social support efforts like those of the gay and lesbian communities. In the October issue of *FOCUS*, **Samuel R. Friedman, PhD**, Senior Principal Investigator at Narcotic and Drug Research, Inc. in New York, explains the importance of drug user organization for HIV risk reduction and offers a critique of two drug user organization experiences, one in Amsterdam and one in New York.

The stuff of myth also enters into the debate regarding syringe exchange, perhaps the most potent risk reduction intervention for injection drug users. Also in the October issue, **Holly Hagan, MPH**, Principal Investigator of the Tacoma Syringe Exchange Study, reviews the data on syringe exchange to determine whether such programs increase drug use among current injectors and attract new injectors.

FOCUS A GUIDE TO AIDS RESEARCH

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October 1988

Communicating about AIDS

Mark Hochhauser, PhD

Limited progress towards a vaccine and effective treatments has made prevention crucial to stopping the AIDS epidemic. Despite repeated recommendations from health care professionals that education should be the focus of this effort, very little is known about effective techniques to provide information that will change behavior.

The challenge of educating the public is so great because misinformation about the threat of HIV and its routes of transmission is far more widespread than the virus itself. A December 1987 National Health Interview Survey (NHIS)¹ of 5,597 adults in the United States found considerable misunderstanding about AIDS, particularly among those with less than 12 years of education—an estimated 41 million Americans.

Among those in the study at this educational level, 68 percent said that they knew little or nothing about AIDS. Many incorrectly thought HIV could be contracted through a variety of routes: 34 percent by donating or giving blood, 35 percent by using public toilets, 39 percent by being coughed or sneezed upon by someone with AIDS, and 38 percent by being bitten by mosquitoes or other insects.

These individuals—the poorly educated and the functionally illiterate, as well as the mentally ill and the homeless—may represent significant “high-risk” groups for transmission of HIV. Their lack of information about AIDS will not prevent them from contracting or transmitting the virus.

Educational programs for this group, as well as other sectors of the general public, must go beyond the crude risk group categories identified by the Centers for Disease Control (CDC)—gay and bisexual men, I.V. drug users, hemophiliacs, and sexual partners of members of other risk groups—in order to be effective. These programs must consider key demographic characteristics such as education, socioeconomic status, and cultural factors. They must also acknowledge the fact that cultures seen as uniform, such as Native Americans, Blacks or Asians, are not, and may differ in a variety of ways, including country of origin, language, values and religion.

Information Techniques

The most common method for providing information about HIV transmission is anonymous distribution, in which there is no direct contact between the source and the recipient of the information. Television, radio, brochures, pamphlets and booklets, for example, have become primary sources of information. While these methods are convenient, there is little evidence to show that they are, in fact, effective in changing behavior. Information may play a role in increasing knowledge, and perhaps in affecting attitudes, but information alone appears to

have little impact on behavior change. A national health education campaign in Great Britain, based on whole-page newspaper advertisements in the national press, caused some increase in information, but no change in misconceptions about AIDS or alteration in attitudes or behaviors.²

The NHIS found that most people in the United States report getting AIDS information from television (84 percent). Other sources were considerably less influential: newspapers (55 percent); magazines (28 percent); radio (10 percent); brochures (9 percent). Only about 6 percent of the sample reported getting most of their information about AIDS from a doctor or health provider. Sources in other countries may vary considerably, for example, radio may play a major role in health communication in developing countries.

Brochures, despite the fact that they have been widely

Instead of assuming that you know what your audience needs to know, ask your audience what they want and try to meet that need.

distributed and may be effective informational tools for specific groups such as gay men, have had little impact upon the knowledge of the general public. In order to reach this constituency, educators must emphasize television and newspapers as sources of AIDS information.

AIDS Brochures: Separating Fact from Fiction

Despite their limited use up to now in educating the general public, brochures may be particularly effective when targeting a specific audience. In these cases, however, information must be clear, accurate, unambiguous, relevant to this targeted group and geared toward their reading level.

Relatively little has been published about the evaluation of AIDS educational efforts. A recent review³ of selected AIDS programs by the congressional Office of Technology Assessment found virtually no documentation of evaluation of the behavioral change that might result from these programs. It should be noted, however, that most early prevention campaigns in the United States were developed before the government started to provide funding for education and evaluation.

A review of 22 safe sex brochures from the United States, that evaluated 13 areas, identified significant limitations in the content of specific educational materials. These included: lack of a rationale for why a particular practice was considered risky; focus on prevention of AIDS, without mention of other sexually-transmitted diseases; evocation of fear as a way to encourage preventative measures, without advice on how to deal with the fear; and ambiguous recommendations to “reduce or limit” the number of sex partners without specific numbers.

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A Publication of the AIDS Health Project University of California San Francisco

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Communicating . . .

continued from cover

In those studies that have reported significant changes in sexual behavior among gay men, the motivation for such changes often cannot be identified. These changes have occurred in environments where knowledge of AIDS has come from a variety of sources, including discussion among peers and the personal experience of knowing people who have died of AIDS. Written materials clearly have some role in promoting behavior change. The challenge is trying to identify the specific impact of particular interventions. The conclusion is that we do not yet know what information presented in which ways works for whom to change what behaviors.

Two tools are helpful in developing and evaluating brochures: readability formulas and focus groups. Readability formulas assess characteristics of the text of a brochure including: word length and mix, sentence length, use of common words, and the unnecessary use of difficult words. From this data, an index of reading difficulty is calculated and expressed as the reading grade level required to understand a particular document.

In a review last year of 16 AIDS educational brochures from the United States, Hochhauser⁴ found that the average reading level of these brochures was grade 14 (second year of college), with some written as high as grade 17 (first year graduate school). Some of these brochures are likely to be beyond the understanding of large segments of the population. The recent "Understanding AIDS" brochure, published by the U.S. Public Health Services and mailed this summer to every household in the United States, was written at an eighth-grade reading level.

There are approximately 40 readability formulas and their results are not always consistent. Experts suggest that three or four formulas should be used together to make a determination. Critics say that readability formulas produce materials that are readable, but which may also be choppy, oversimplified, condescending and boring. In the end, readability formulas should be used as one, but not the only tool in developing brochures.

While readability formulas have many limitations, the concept of "readability" is an important one in AIDS education. Without addressing issues of readability, much AIDS information is likely to be misunderstood by much of the public. As an alternative to overemphasizing readability formulas, focus groups can be used to pre-test written materials and ensure that the information and its presentation is relevant and understandable to the intended audience.

A focus group is comprised of eight to 12 people who represent this audience. With the help of a moderator, the group

discusses the topic in question and offers researchers answers to questions such as: What kind of information about AIDS do you want to know? Does this brochure provide this information? Is it understandable? What do you understand? What don't you understand? Is this brochure persuasive? Would you change your behavior if someone gave it to you?

Focus groups must be carefully planned. The moderator should be knowledgeable about the topic and the audience, and should be clear about the goal of this particular focus group, the areas it will cover, and how much time will be spent discussing each area. There should also be a plan as to how information gained in the focus group will be organized for analysis. It is wise to involve people trained in marketing in these efforts.

Facts about AIDS

The presentation of AIDS information is often inaccurate. Much of what passes for AIDS information, particularly in the mass media, is incorrect or at best misleading. The following concepts are misrepresented most often.

The AIDS test. There are a number of tests that detect the presence of HIV or are correlated to a suppression of the immune system. The most common among these is a test for the presence of antibodies to HIV, to which the media consistently refers as the "AIDS test." Not surprisingly, the NHIS found that 40 percent of the general public believe that the HIV antibody test reveals whether a person has AIDS, despite the fact that a person can be asymptomatic for years after infection with HIV. Combining "AIDS" with "test" compresses in the minds of many the time frame for the development of AIDS from an average of seven years to however long it takes to get the test results back. One can only guess the number of Americans who have not been tested because they do not want to find out if they "have AIDS."

"Getting" AIDS. AIDS is a clinical description based on the presence of certain opportunistic infections and cancers, and usually, but not always, a positive HIV antibody test. Strictly speaking a person does not "get AIDS"; he or she contracts HIV. References to "getting AIDS" are too similar to "getting a cold," and may help perpetuate the myth that HIV can be spread through casual contact.

The AIDS virus. AIDS is only one of the manifestations of infection by HIV, the virus believed to cause AIDS. The mass media emphasis on the end stage disease (AIDS) rather than the beginning stage cause (HIV) implies that AIDS itself is infectious. AIDS is not communicable; HIV is.

High-risk groups. Despite the efforts of many, some brochures still refer to high-risk groups, rather than high-risk behaviors. The danger in this representation is that as long as people do not identify with those "groups," they may not perceive themselves at personal risk for HIV infection.

Some Practical Suggestions for Developing Educational Materials

Objectives. What do you want the materials to accomplish? Do you want to change knowledge, attitudes or behaviors? Can this be accomplished in a single brochure or booklet, or might a series of materials be more appropriate? How will you evaluate the impact of your materials?

Marketing Tools. Produce materials that are intriguing, readable and understandable to your target audience. Consult with marketing experts and become familiar with basic marketing and advertising terminology and practices. Instead of assuming that you know what your audience needs to know, ask your audience what they want and try to meet that need. Work closely with representatives from your intended audience and use formal focus groups to test messages. Ask yourself, focus group members and other advisors, such as experts in AIDS, communication and education: What are the benefits and risks of this material? Does it empower the listener? Does it complement previous messages?

Identify barriers. Political factors may dictate the content of your materials and require compromises. The most common barrier is reluctance to approve sexually-explicit information. One way to answer this objection is to emphasize the life and death nature of AIDS and ask, "What is more offensive, sexually-explicit material or death?" Another way is to marshal support for your materials from well-respected individuals, including public health officials, physicians, health educators and government administrators.

Recognize developmental differences. The presentation of information for 16-year-olds should be different from the presentation for 26-year-olds. Knowing how your audience thinks is vital. For example, one of the most difficult problems in educating adolescents and young adults is their perception of immortality: their belief that illness and disease happen to other people. Developmental differences among various cultural, socioeconomic, and ethnic groups may complicate this even more.

AIDS carriers. People with AIDS do not carry AIDS; they are infected with HIV. Some politicians are concerned about irresponsible individuals who they say are spreading AIDS to the general public. This suggests that the virus is more communicable than is actually the case. More importantly, it omits the fact that it takes one person to contract the virus as well as one to transmit it. Political solutions that overemphasize incarcerating transmitters of HIV, without acknowledging the responsibility of the potential receivers of the virus, again mislead the public.

These points are more than an exercise in semantics. As long as misinformation about HIV and AIDS is disseminated to the public, individuals will not be able to make truly informed choices about their behaviors. At the very least, people will be confused by the contradictory messages they receive.

Mark Hochhauser, PhD is the former Director of Health Education at the University of Minnesota student health service and is now a consultant on AIDS issues.

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Diagnosis/Treatment/Prevention

The Effect of AIDS Education on Mental Health Professionals

Thomas M. Irish, PhD and Nancy Gourash Bliwise, PhD

A survey of mental health practitioners before and after a training workshop conducted by the AIDS Health Project showed a positive shift in the attitudes of participants toward people with AIDS, I.V. drug users and gay men. At the same time, it demonstrated an increase in participants' concerns about dealing with sexually-explicit material, death and dying and the stress of working with people with AIDS.

Results such as these are particularly significant as the numbers of AIDS educational programs for health professionals grow. This report documents both the positive and negative effects of the workshop and offers insights into the way educational efforts must be packaged to be most beneficial.

Survey of Participants at AHP Training

In the fall of 1987, the AIDS Health Project conducted an intensive, three-day training workshop for clinicians from a southeastern state department of mental health. Seventy-four clinicians attended the training. The workshop presented a comprehensive overview of HIV-related health care and mental health issues.

Using both didactic and experiential components, the training covered the following areas: basic medical information about AIDS, including a description of HIV disease and how it is treated; the epidemiology of AIDS; how to prevent transmission; the relationship of substance abuse to the spread of HIV; how to take a sexual history; and the psychiatric assessment of clinical syndromes such as AIDS dementia. The workshop also provided training in pre- and post-test AIDS antibody-test counseling.

Psychological issues discussed by participants included stages of coping with AIDS, stigmatization, family issues, and typical reactions of people affected by AIDS. The training made

use of many small group discussions, in which clinicians were asked to express their personal feelings about death and dying, drug use, homosexuality, and human sexual behavior. These exercises led to the exploration of the key issue of clinicians' countertransference reactions and the importance of being aware of these reactions when providing AIDS care.

An attitudes survey developed by the authors was administered directly before and after the workshop. The survey assessed clinicians' attitudes towards populations at highest risk, contagion, sexuality, death and other AIDS-related issues, using an 80-item self-report questionnaire. Subjects chose one of six responses ranging from strongly agree to strongly disagree. Among the statements tested were: I would not mind counseling the lover of an AIDS patient; I.V. drugs users only waste time and resources; Hispanics and Blacks should be especially concerned about catching AIDS because it is all around them; My fear of catching AIDS would keep me from working with AIDS patients.

Results of Attitudes Survey

The results of the survey indicated that a significant change in attitude did occur over the course of the workshop. The pre- and post-training surveys showed that clinicians' attitudes shifted significantly toward greater acceptance of gay people. Twenty percent changed their answers from disagreement to agreement in response to the statement, "I would feel at ease at a party where many guests were homosexual." Thirty percent changed from agreement to disagreement in response to, "Homosexuality is not as good as heterosexuality." Other shifts in attitude included greater confidence in counseling the lover of a person with AIDS and a greater agreement with the idea that people with AIDS often have close interpersonal relationships.

The survey also revealed that clinicians became significantly less afraid of physical contact with people with AIDS and of contracting HIV while working with AIDS patients. Clinicians also saw I.V. drug users as more deserving of professional time and 23 percent changed their answers from agreement to disagreement in response to the statement, "It is difficult to be sympathetic to I.V. drug users." Racist attitudes towards Blacks and Hispanics also decreased during the workshop.

Of equal importance are the areas about which clinicians' anxieties significantly increased. Some saw themselves as less likely to work with people with AIDS because of the stress involved in patient care. This anxiety also increased when clinicians discussed sexually-explicit matters. Twenty-seven percent changed their answers from disagreement to agreement in response to the statement, "It is hard for me to ask patients about their sexual practices." Clinicians also expressed a disinclination to discuss the subject of death with a dying person, and 29 percent changed their answers from disagreement to agreement in response to, "I am very much afraid to die."

Conclusion

The survey indicated that the workshop had a significant impact on the attitudes of practitioners working in more rural states where AIDS is not as prevalent as it is in cities such as New York or San Francisco. Their concerns about contagion and negative attitudes towards those groups at risk for AIDS decreased as clinicians considered individuals at-risk less as stereotyped external threats and more as people in an understandable and dire situation. As these fears decreased over the course of the workshop, however, personal and internal fears increased.

It should be remembered that this training addressed an audience of clinicians who had little experience in providing AIDS care. Most in attendance were probably hearing the concrete details of AIDS care for the first time and probably felt anticipatory anxiety when they imagined themselves faced with the real-life experience of working with AIDS. In addition, such intimate, personal concerns as sexuality and mortality are still beyond the comfort level of many professionals.

Educators should consider these reactions when planning workshops and should expect that initial trainings, while reducing

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some fears, may actually accentuate others. While AIDS trainings can force professionals to confront, perhaps for the first time, issues such as sexuality and working with the dying patient, educators and administrators should be aware that becoming comfortable with these issues is a process that requires time and experience. After some experience is gained, additional, long-term educational strategies can be developed to help professionals improve their skills in these areas.

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BRIEFS

In Review

Strategies for Survival: A Gay Men's Health Manual for the Age of AIDS. Martin Delaney and Peter Goldblum, PhD, MPH, with Joseph Brewer. St. Martin's Press, New York, NY, 1987; 320 pages, paperback, \$10.95 U.S.

The AIDS crisis has placed gay men in a new relationship to the medical profession. Already a marginal population whose health concerns fall outside the sphere of traditional medicine, gay men now find themselves dependent upon a professional group that often cannot provide them with clear or unbiased answers. Some medical providers question the gay lifestyle, mix facts with fiction, or unwittingly give homophobic advice under the guise of "safer sex" counseling.

Strategies for Survival provides a gay-affirmative "insider's" approach to the issues confronting gay men today and validates gay male sexuality in the face of existing dangers. Coping, making choices, evaluating one's approaches to the variety of decisions that need to be made—these are some of the tools offered in this manual directed at gay men and written by gay men. The authors use a broad definition of health that considers physical, intellectual, social and emotional well-being. They take the concept of exposure to HIV and use it as an opportunity to discuss various layers of gay identity and sexuality.

In general, the book avoids the *whys* and focuses on the *hows*. How can I build an integrated health plan? What goals should I set for myself? Which goals for myself are currently outdated or self-destructive? How do I achieve these goals? This approach implies that some control over the health crisis can be attained. But, the book makes no false promises, and places responsibility for behavior change and for making informed choices onto the reader's shoulders and not in the hands of the doctor.

The authors recognize the powerful role of internalized homophobia in shaping responses to the epidemic, and shun stereotypic morality, providing instead a refreshing chorus of self-acceptance. Facts, commentary and workbook exercises are interwoven through each of the chapters.

Occasionally, the book lapses into a cookbook tone such as, "Listen to your friends more." No mention is made of the significant, fledgling, self-help movements for sex and love

addicts, and an insufficient amount of the book addresses the subgroups of gay men who continue to put themselves and others at risk in spite of knowing the facts. A few more *whys* are in order. These are minor faults, however, in a book that encourages gay men to re-examine old assumptions and to transcend aspects of the epidemic.

James Fishman, LCSW is the Coordinator of Men's Services at Operation Concern, San Francisco's gay and lesbian mental health agency and is also a psychotherapist in private practice.

Recent Reports

HIV Infection and Genital Ulcer Disease. A marked increase in the risk of HIV infection occurs among gay men with genital ulcers caused by herpes simplex and syphilis, according to scientists at the University of Washington School of Medicine.

The study, published in the *Journal of the American Medical Association* (September 9, 1988), included two populations of gay men: 200 patients who presented with acute rectal or gastrointestinal infection at a sexually transmitted diseases (STD) clinic and 111 who sought HIV-antibody testing and counseling from a local health department. The STD subjects were tested for a variety of infections including HIV disease, herpes simplex and syphilis. The HIV-antibody test subjects were also tested for herpes and syphilis.

The study concluded that historical or serologic evidence of herpes simplex or syphilis, the two most common causes of genital ulcers among gay men, resulted in a threefold to eightfold increased risk of HIV infection. These statistics persisted even after adjustment for amount and type of sexual activity and are supported by prior research on female prostitutes and heterosexual men, both in Kenya. The study also concluded that a history of non-ulcerative STDs, such as gonorrhea and chlamydia, was not associated with HIV infection.

Next Month

As a greater consensus forms about the utility of HIV-antibody testing and as experts advocate its wider use, counselors are confronted more often by clients who ask for help in deciding whether to be tested. In the November issue of **FOCUS**, **Peter Goldblum, PhD, MPH** will discuss the pros and cons of antibody testing and the approach a therapist should take with clients who are trying to make this decision. The article will cover issues such as the significance of testing, the accuracy of the test and the importance of anti-discrimination measures. Goldblum is a therapist in private practice, the former Deputy Director of the AIDS Health Project, and a member of the AIDS Task Force of the Pacific Graduate School of Psychology.

Also in this issue, **Judith Wilber, PhD**, a virologist at the San Francisco Department of Public Health, will review from a scientific perspective the variety of tests that are used to study HIV infection, including antibody tests, DNA amplification (PCR), antigen tests and T-cell assays.

FOCUS A GUIDE TO AIDS RESEARCH

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The amount of research information now appearing in the medical and lay press staggers most AIDS health care and service providers. The goal of **FOCUS** is to place the data and medical reports in a context that is meaningful and useful to its readers.

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