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FOCUS
A Guide to AIDS Research and Counseling

Talking about Sex in HIV-Related Counseling and Health Care Settings

Carol McCord, MSW and Stephanie A. Sanders, PhD

Talking about sex is an inherent part of the counseling and health care interactions related to HIV disease and other sexually transmitted infections. Although this may seem obvious, providers sometimes seem to lose sight of this fact, minimizing the difficulty of sexual behavior change for clients. Focusing on disease processes, treatment outcomes, and the prevention of sexually transmitted infections (STI) can lead providers to overlook the ways in which disease unfolds in the context of a person's life and the complexity of each individual's life. This focus may obscure an individual's specific barriers to behavior change—barriers that are not overcome simply by reiterating prevention or treatment messages. Providers may also feel more uncomfortable talking about sex than they realize or care to admit, or they may be confused about the place of such discussions within the context of counseling or treatment interactions.

Given these factors and the power dynamic of the provider-client relationship, it is the responsibility of mental health and health care providers—not clients themselves—to encourage the discussion of relevant sexual issues and to maintain a safe interactional "space" for such discussions. It is unlikely that clients will raise sexual issues unless they feel safe doing so, even if these issues are of paramount concern to them.

The degree to which providers can engage in the discussion of sexual matters will vary depending on the nature of each provider's role and the time available. But even if time and scope are limited, it is necessary for providers to raise the topic of sex in order to assess whether clients could benefit from referrals. Those involved in short-term interventions, in particular, have the responsibility to establish this dialogue relatively quickly. In longer term psychotherapeutic venues, the direct discussion of sexuality should more appropriately be initiated by the client. However, therapists should listen for opportunities to invite the discussion, and they should be clear with themselves that the absence of such dialogues is not the result of their own discomfort with this topic.

This article outlines three strategies to appropriately raise and respond to sexual issues in clinical settings: creating an atmosphere and dynamic that will facilitate dialogue about sexuality; recognizing the complexity of sexuality and barriers to compliance with prevention recommendations; and assessing and enhancing provider comfort in dealing with a broad range of sexual topics. Because similar issues may arise in various clinical situations, the terms "counselor" and "clinician" are used interchangeably and include therapists, health educators and counselors, and medical providers, and the term "client" includes patients.

Creating an Open Atmosphere

There are several ways providers can foster an atmosphere in which clients are most likely to address topics that are uncomfortable for them. Among these are: encouraging openness; defining a common vocabulary; providing relevant information; and maintaining sexual boundaries.

Encouraging Openness. Give clients permission to discuss relevant sexual matters. Clients are unlikely to discuss behaviors or feelings that they fear will be judged. In order to open the door to discussing sexuality, counselors must establish with clients that they are comfortable talking about the subject and can listen in a nonjudgmental manner. The primary way to do this is to raise the topic of sex and acknowledge that it can be difficult to discuss. At the least, it is crucial for coun-

Editorial: Affirming Talk

Robert Marks, Editor

All talk is not the same. Talking about sex as a mechanical, biological function—with parts identified by Latin labels—is not conducive to either effective HIV prevention or effective counseling. To get to the level of interaction where clients feel prepared to acknowledge—even more so to change—their behaviors, talking about sex must become if not a comfortable place, at least a zone in which they are willing to tarry.

Most of us cannot help but inhabit a sex-saturated world of Calvin Klein underwear ads and Madonna music videos. When sitting face to face with a stranger talking about a life-threatening sexually transmitted disease, however, any street-corner savvy about parts and acts may disappear, replaced by those Latin labels or, worse, silence. And the silent truth about health care is that many counselors, therapists, and medical providers—all human too!—share these same discomforts and can inadvertently communicate them to their clients.

Harnessing Desire

Carol McCord and Stephanie Sanders, experts in sexual health, outline some fundamental approaches to creating an atmosphere that is conducive to talking about sex. They offer a range of tools to facilitate communication and enhance ease. They also discuss the importance and willingness of providers to confront their own discomforts about talking about sex. Ed Wolf, in his article about the ways in which sex-negative attitudes can infect HIV prevention counseling, continues this exploration by discussing what he calls the "prevention counselor image" and sex-negative attitudes that have almost insidiously become habitual to HIV prevention.

By reminding readers that sex is natural and wonderful—well-kept secrets even in sex-saturated Western culture and even in the ideally sex-positive HIV counseling world—both articles suggest to me a tool that providers can use to move from consciousness to action. This tool is curiosity, which may reside at the core of counseling practice: curiosity about the whole client, including his or her sexual attitudes, beliefs, and desires.

But it is not curiosity alone. It is curiosity about the wonder of sex. As something natural and wonderful, sexual behavior can become the route toward HIV and STD protection—rather than the barrier to it. By cultivating this attitude, counselors are better prepared to invite clients to uncover and explore their innate desires to be both sexual and life affirming. Since these desires, themselves, are likely to be the strongest motivators of self-protection, harnessing them is likely to lead to the most effective prevention interventions.

selors to avoid communicating discomfort when clients raise sexual issues.

It is also imperative for counselors to think about the words they use, their body language, and their facial expressions as conveyors of judgment. Avoid questions or statements that imply assumptions regarding sexual orientation or specific sexual behaviors. Instead, ask questions that allow for a wide range of possibilities. For example, asking "Are your sexual partners men, women, or both, …" introduces the topic of sexual orientation without suggesting a "correct" answer. Asking "How many times have you had anal sex in the past three months? 0, 5, 50, 500?" implies that a provider would not be shocked by any of these answers. If a client reacts negatively to a question because he or she thinks it presumes he or she is gay or has engaged in a behavior he or she finds offensive, explain that the question allows for a wide range of possibilities specifically because the counselor assumes nothing about the client. It is all right if a client does not want to talk about sex. Raising the issue opens the door for clients to feel more comfortable talking about sex later in the session or during future interactions. When seeing a client repeatedly, it may be necessary to raise the topic more than once.

Defining a Common Vocabulary. Although using the words a client uses to describe his or her sexuality, behaviors, or partners can be helpful, it is important to ascertain what the client means. Even the meaning of terms such as "having sex" may vary by individual[1] and across situations.[2] If a client uses a word a counselor does not know or which has ambiguous meaning, the counselor should ask about the specific meaning.

In response to clients who are reticent about talking about sex, consider modeling by using words for sex and sexual parts, and ways to talk about sexuality. It may help to explain that people use many different words to describe sexual acts and sexual parts. The words will vary depending on cultural background, family experience, and personal comfort. Using a range of words offers the greatest opportunity

for a client to understand sexual concepts and gives the client permission to use the words that are most familiar. Counselors might start by using more medical terms—identifying these as medical words that not everyone knows or uses—and then move on to more vernacular terms. This encourages clients to choose their language and enables the pair to establish a common vocabulary, which is crucial to counseling.

Providing Relevant Information. It is important to remember that clients do not "owe" providers information about their sex lives, but providers owe clients accurate, relevant information about sex and an opportunity to discuss sexual matters. Giving information before asking the client questions about sexual issues is one of the easiest ways to begin communication about sex. For example, saying "Some people have trouble using condoms all the time. Are you having trouble with that?" establishes that sexuality-related vocabulary can be used comfortably in the clinical setting. Conversely, in many settings, it is necessary to offer information even if a client does not want it. It is important to confirm that clients have appropriate information and to offer them the opportunity to ask questions.

People are unlikely to adopt safer sex behaviors unless they see a way to do so without thwarting their sexual desires and goals.

Maintaining Sexual Boundaries. Talking about sex must not sexualize the clinical situation. The counselor is responsible for maintaining the clinical and consultative context of the session, especially when discussing sexual matters. Regardless of the topic of interaction, of course, clients may become physically attracted to their clinicians. Failing to recognize this or dealing with it ineffectively can compromise the clinical relationship.

Sometimes a client directly expresses his or her attraction to the counselor. The counselor may acknowledge feeling complimented, at the same time assuring the client that the boundaries of the professional relationship must be maintained. It may help to diffuse this situation by telling the client that it is not unusual for people receiving care to develop feelings of attraction to the provider. Reassuring the client that the counselor prioritizes sustaining the firm boundaries of the relationship will help create a safe environment for the client to discuss and work through feelings of attraction.

At the same time, it is crucial for clinicians to recognize when they, themselves, are attracted to clients and to evaluate the degree and pervasiveness of these feelings. The fundamental question is whether the clinician can keep these feelings separate from the interaction and remain objective about the client and the clinical objectives of the situation. If a provider is in any way unclear about this, it is necessary for him or her to seek supervision. Sexual interaction with a client is prohibited by codes of ethics for medical and mental health providers, and such interactions can cause significant damage. If the attraction is strong or if the clinician finds him or herself "falling in love," he or she must step back, get advice from a supervisor, and most likely facilitate the transfer of the client's care to another provider.

In this case, citing the attraction as the reason for termination is generally unwise. Instead, a clinician might explain to a client that the clinician has reached the limit of what he or she has to offer the client. This is a true statement, but it does not put the client in the inappropriate role of worrying about the clinician's feelings.

Recognizing Barriers to Behavior Change

People are unlikely to adopt safer sex behaviors unless they see a way to do so without thwarting their sexual desires and goals. For example, telling someone to always use condoms is likely to meet with noncompliance if a client experiences erection problems when using condoms. Further, clinicians should avoid making assumptions about the barriers a client is facing: a recent study reported that 32 percent of college men reported such erection problems despite their relative youth.[3] Helping people find ways to overcome barriers to safer behaviors may require referring them elsewhere for assistance; in this case, a referral to a sex therapist might be appropriate.

Successful treatment may also require discussing and addressing sexual side effects of medications ranging from HIV

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2. Bogart LM, Cecil H, Wagstaff DA, et al. Is it sex? College students' interpretations of sexual behavior terminology. Journal of Sex Research. *2000; 37(2): 108–116.*

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antiviral drugs to antidepressants. For example, the fact that a medication reduces libido may lead to a client's nonadherence with a medication regimen. Clients have the right to full information about all potential side effects of medications and about treatment alternatives, sex therapy, or counseling to alleviate these effects.

It is crucial to convey safer sex messages and discuss treatment nonadherence in a non-judgmental manner. This can be difficult if a person is putting him or herself—or someone else—at risk. However, being perceived as judgmental will undermine effective communication with clients. If clients feel that they must defend their behaviors to their clinicians, they may end up justifying these behaviors to themselves, making it more difficult for them to change.

Further, it is important to empathize with the difficulty of behavior change and treatment adherence. Finally, it is useful to assume that clients want to behave in healthy and responsible ways: exploring specific barriers with them will help them decipher how to achieve these goals.

Assessing and Enhancing Provider Comfort

A clinician's own discomfort with sexuality or sexual topics may impede his or her ability to work effectively with clients. It is the clinician's responsibility to assess personal discomfort with the topics that need to be dealt with in interactions with clients and to decide whether he or she is willing and able to ensure a safe, comfortable, and non-judgmental atmosphere for clients. Clients will not be honest if they sense discomfort or judgment. It is unacceptable for a clinician's lack of awareness of his or her own feelings and beliefs about sex to undermine client interactions.

There are a number of ways to enhance the ability to listen to clients in a comfortable and non-judgmental manner. Among these are: addressing one's own uneasiness, and negative feelings and beliefs; obtaining training in discussing sexuality with clients; using professional supervision and collegial discussions to seek advice on how to deal with specific feelings; and practicing talking about various sexual issues with supervisors or colleagues.

Introspection and reflection can help clinicians assess their limitations more realistically, overcome some personal biases, and enhance their ability to work with clients. Family history and values, positive and negative sexual experiences, being pushed beyond a person's comfort level in a sexual situation, sexual assault, and previous errors in judgment can all affect reactions to client experiences.

If a clinician realizes that he or she cannot deal with an important topic for a particular client, it is appropriate to refer the client to someone who can and explain that it would be best for the client to speak with someone who has more expertise or experience dealing with such issues. But if, on a regular basis, a clinician feels uncomfortable handling sexual topics or finds him or herself being judgmental about clients' behaviors, professional responsibility requires that the clinician take action to enhance his or her abilities to work constructively with sexual issues or reconsider his or her suitability to address clients dealing with STI- or HIV-related concerns.

Conclusion

Talking about sexuality may be difficult initially, but it need not be intimidating or awkward, and it gets easier with practice and experience. Ultimately, by creating an open atmosphere for self-examination and discussions of sex and sexual barriers to behavior change, clinicians can more effectively meet both the needs of their clients and the challenges of the epidemic.

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Clearinghouse: Talking about Sex

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Talking about HIV Prevention without Demonizing Sex

Ed Wolf

Talking to clients about sex and exploring the context of their sexual activities are central to achieving the goals of HIV prevention counseling and risk reduction. Providers who are uncomfortable with this may sabotage the nonjudgmental atmosphere that helps clients discuss their behaviors, risks, and feelings. Much has been written about how to talk to clients about sex, but less has been written about the ways in which the risk reduction goals of HIV counseling may, themselves, lead some counselors to focus only on the harm of sexual activity, and shut clients down by essentially denying the pleasure and meaning people naturally ascribe to sexual activity.

To stay true to client-centered counseling and harm reduction, counselors need to avoid talking about sex only in terms of harm.

The UCSF AIDS Health Project, which develops trainings for HIV prevention counselors, and mental health, social service, and medical providers, has designed several approaches to address this challenge. One training, *Supporting Human Sexuality in the Context of HIV Counseling*, focuses on helping providers talk about sex in ways that help clients constructively confront the meaning of sex in their lives.

Being Sex-Positive

There is often laughter during the training when someone points out the obvious: none of us would be here if unprotected sex had not occurred. However, many of the approaches providers use to help clients understand how they might reduce HIV risk demonize all unprotected sex. These approaches also deny the "hierarchy of risk," the ranking of sexual activities, which acknowledges that some have greater risk than others.

Many sexual behaviors that a provider might define as "risky" are motivated by personal meanings and desires. Decisions to change these behaviors are influenced by a mix of psychological make-up, personal history, the beliefs of friends and role models, media images, and social, economic, and life circumstances. It is precisely because these behaviors are complex—and because so much of sexuality is life affirming—that a nonjudgmental and sex-positive approach to counseling is crucial. The training's primary message is that to remain true to the tenets of client-centered counseling and harm reduction, counselors need to shift from talking about sex only in the context of harm. The fact that unprotected sex may be dangerous does not negate its essentially positive and meaningful nature.

Leaving Prevention at the Door

The Human Sexuality training begins by asking participants to leave their "prevention counselor image" at the door. It goes on to explore the meaning of sex for individuals, the process people go through to define the risks they are willing to take to do the things they value, and the skills and attitudes that enable counselors to help their clients decipher the meanings of their sexual behaviors and achieve a healthy sexuality. Chief among these skills is the ability to develop sensitivity and neutrality towards other people's sexual behaviors and choices, and to notice how a counselor's own judgments and values might express themselves during HIV counseling sessions.

Early in the training, participants engage in an activity to define and explore the extraordinary range of sexual expression.

ing sexual transmission of HIV from those who know they are infected: The need for personal and collective responsibility. *AIDS*. 1999; 13(3): 297–306.

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See also references cited in articles in this issue.

While clients often talk about oral sex, vaginal or anal intercourse, and masturbation, there are many other sexual activities they may also engage in—whether or not they disclose these. Clients may also feel a variety of emotions during sexual activity, including love, frustration, anger, shame, fear, anxiety, happiness, and accomplishment. There is no "right" way to have sex or to feel during sexual activity.

What makes a behavior sexual is its ability to physically and emotionally excite or arouse an individual. What stimulates one person might bore or even offend another. Counselors who understand this principle are better prepared to listen openly to their clients' sexual histories and questions. Clients who feel acceptance from their counselors are more likely to be forthright in return, sharing not only the details of their sexual activities, but also the context of sex in their lives: the set of circumstances and experiences that influence the emotional, erotic, and psychological significance of the sexual encounter.

Another training exercise asks participants to formulate sex-positive responses to a wide range of sexual activities. Everyone in the group wears a label with a sexual activity written on it. When one participant encounters another, each asks him or herself, "Why would I enjoy this activity?" This exercise asks participants to challenge the HIV counseling approach to quickly identify risk by underscoring what is pleasurable or positive about the full range of activities.

The Experience of Judgment

Portraying sexual behaviors only as a series of risky events is ineffective because it usually contradicts a client's experience of pleasure and meaning, making it irrelevant to his or her life. To highlight this dynamic, the trainer leads the group through a guided visualization. This exercise touches on the balance between the risks we take to do the things we value.

The visualization begins as the trainer reads the following statement: "Take a moment to think about a sexual activity (or activities) or sexual experience that you really enjoy doing, knowing that you won't have to tell anyone here what it is [pause]. Think about how it feels to engage in this behavior . . . how much pleasure it gives you . . . how much you look forward to doing it [pause].

"Now, imagine that you are speaking to an HIV prevention counselor who has just told you that this behavior is risky [pause]. Because of the way the counselor is speaking and acting, you sense that she/he feels your sexual behavior is bad and that it is essential that you stop doing it [pause]. Imagine that you say to the counselor, 'This is difficult. I really like doing this behavior' [pause]. How does the counselor respond to you?"

The trainer brings the visualization to a close and asks the group to share their reactions. Past participants have responded strongly, making comments such as: "I felt pathologized by the counselor and was afraid to talk further"; "I withdrew when they said what I was doing was dangerous"; "I got defensive and fought back; a few options would have been more helpful"; and "They had all the power and I felt hopeless." The debriefing makes it clear that the counselor's focus on the harm of the behavior translates to the client as judgment and lack of understanding. The outcome is that the client disconnects from further interaction, including the risk reduction intervention.

This debriefing leads into the final activity, which is a role-play. With the judgmental counselor of the visualization still resonating in their minds, counselors are asked to counsel a fellow participant. The goal of this exercise is not to talk "the client" into safer sex, but to bring openness, interest, and acceptance into the counseling session.

Conclusion

People rarely change complex, highly personal behaviors such as sexual practices simply because someone tells them they must. Rather, successful prevention counseling goes beyond informing clients about risk, instead helping them examine the broader personal and social context in which their behaviors occur. This process communicates a counselor's genuine presence, engaging a client in an exploration that includes explicit details about sexuality and leads toward an acknowledgement of risk. As clients understand the bigger picture, they are better prepared to take the kinds of steps necessary to achieve effective and long-lasting change.

Authors

Ed Wolf is a trainer and senior curriculum writer with the UCSF AIDS Health Project. His writing has also appeared in Christopher Street Magazine, Art and Understanding, *and the* James White Review.

No FOCUS Next Month

As of this past January, the *FOCUS* publication schedule changed: *FOCUS* is now published 10 times a year, with no issues in December or June. This will sustain *FOCUS* over time in an era of rising costs and decreasing HIV funding. If you have any questions, please contact Jennifer Jones at jejones@itsa.ucsf.edu or 415-502-4930.

Recent Reports

A Model for Sexual Health

Robinson BE, Bockting WO, Rosser BR, et al. The Sexual Health Model: Application of a sexological approach to HIV prevention. *Health Education and Research*. 2002; 17(1): 43–57. (University of Minnesota Medical School, Minneapolis.)

A sexological strategy for implementing HIV prevention emphasizes the importance of addressing emotional, physical, and spiritual aspects of sexual health. The Sexual Health Model seeks to increase people's knowledge of and comfort with their own sexuality in order to enable them to make informed and healthy sexual decisions.

Researchers at the University of Minnesota developed this holistic seminar approach to sexual health and HIV prevention based upon characteristics of a series of sexuality education seminars from the 1970s, as well as the authors' research on the sexual attitudes and practices of various populations.

The model outlines 10 aspects of a healthy sexuality—including sexual health care, fantasy, intimacy and relationships, and safer sex—that are covered during one- to two-day seminars. A key component of the model is teaching individuals to feel comfortable communicating about their sexual desires, in this way achieving both pleasure and safety. Seminars often include exercises on the use of sexual language to express these desires. The model fosters a sex-positive attitude, celebrating the variety of sexual expression and desires among different people. This can be especially useful in HIV prevention: increased comfort often leads to greater ability to set sexual boundaries and decrease risk.

Seminars are tailored to fit the beliefs and practices of their members. A seminar with Latino men who have sex with men addressed the common belief that the insertive partner is not "gay" and thus not at risk for HIV. Seminars with transgendered individuals discussed body dysphoria, hormones, surgery, and disclosure of trans identity to partners.

Two controlled trials of HIV interventions using the Sexual Health Model are underway, with preliminary results showing a reduction in HIV risk. Both interventions consist of one- or two-day intensive seminars, with follow-up interviews after nine or 12 months. One group of 422 men who have sex with men reported an 8 percent increase in the use of condoms during anal intercourse over the period of the year. The 218 African American women in the second trial reported positive changes in attitude towards the female condom and an increase in non-risky sexual activities. While the model provides a useful tool for prevention interventions, the authors recommend further trials to determine the components and ideas that apply most to HIV prevention.

Prevention Discussions at Health Clinics

Marks G, Richardson JL, Crepaz N, et al. Are HIV care providers talking with patients about safer sex and disclosure?: A multi-clinic assessment. *AIDS*. 2002; 16(14): 1953–1957. (U.S. Centers for Disease Control and Prevention; University of Southern California; and Santa Clara Valley Medical Center, San Jose, Calif.)

A survey of 839 HIV-positive men and women receiving medical care revealed that health workers often had not initiated discussion around HIV prevention measures. Twenty-nine percent of those interviewed had not discussed safer sex with clinic providers and 50 percent had not discussed serostatus disclosure to partners with their providers.

Because of perceptions of stigma and judgment, African American female teens were unlikely to disclose sexual behavior to health care providers.

Researchers recruited participants from six public health clinics in California. All participants had tested HIV-positive at least three months prior to the study and reported some sexual activity in the previous three months. Thirty-nine percent of people interviewed were White, 36 percent Hispanic, 17 percent African American, and 8 percent of other ethnicities. Seventy-two percent were men who have sex with men, 15 percent heterosexual men, and 13 percent women who have sex with men.

There was an even distribution of education levels, with roughly one quarter

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having completed some high school, all of high school, some college, or having graduated from college. One-quarter of participants had an annual income of $20,000 or more; the rest made less than $20,000 a year. Sixteen percent had visited the clinic less than five times, 28 percent between six and 20 times, and 56 percent 21 or more times.

The majority (67 percent) of discussions about safer sex were with physicians; the rest were with other health workers, including nurse practitioners, health educators, social workers, and psychologists. There was notable variation in the number of patients reporting discussions across the six clinics. One clinic had a rate of 94 percent for discussion of safer sex and 78 percent for discussion of disclosure, while at three clinics less than 60 percent of patients reported safer sex discussion and less than 40 percent reported having talked about disclosure with their providers. The study did not find a correlation between the number of patients seen at a clinic (ranging from 500 to 2,500 per clinic) and the likelihood that providers would undertake prevention discussions.

Discrepancies in prevention counseling practice across clinic populations suggest that providers make broad assumptions about who needs this education. African American and Hispanic patients were more likely to receive messages about safer sex and disclosure of status than White patients, as were patients with lower household income and less education. Gay and bisexual men were less likely to receive messages about safer sex and disclosure than heterosexual men and women. Providers may have assumed that White patients are better informed about HIV prevention than patients of color or that men who have sex with men are more likely to be more comfortable than their heterosexual counterparts disclosing their HIV status to partners. Finally, patients who had been to a clinic no more than five times were far less likely to have discussed safer sex or disclosure than patients with more of a history at a particular clinic.

Stigma, Shame and STD Disclosure

Cunningham SD, Tschann J, Gurvey JE, et al. Attitudes about sexual disclosure and perceptions of stigma and shame. *Sexually Transmitted Infections.* 2002; 78(5): 334–338. (Johns Hopkins School of Medicine; University of California San Francisco; and Indiana University School of Medicine.)

A study of African American adolescents in San Francisco found that perceived stigma around having a sexually transmitted disease (STD) had a negative influence on health-seeking behaviors for females but not for males. Female participants were unlikely to disclose sexual behavior and past STDs to health care providers, and unlikely to regularly test for STDS due to perceptions of stigma and fear of judgment.

The sample of 142 sexually active adolescents, ages 13 to 19, was 56 percent female and 44 percent male. Sexual orientation of participants was not specified. Forty percent of the males and 73 percent of females had received STD-related care in the prior year. The females interviewed were more likely than the males to anticipate judgment around disclosure of sexual behavior (42 percent versus 33 percent).

Forty-four percent of female participants reported elevated feelings of STD-related stigma, defined as the belief that other people would think badly of and avoid them. This stigma was significantly related to negative perceptions about disclosing sexual behavior and negatively affected their willingness to test for STDs. More than half of the male adolescents reported similar feelings of STD-related stigma, but these feelings did not lead to anticipation of negative reactions from nurses or doctors.

Seventy-three percent of females and 64 percent of males associated shame with STDs. Shame, however, was not correlated with negative attitudes toward the disclosure of sexual activity in the clinic for either females or males.

Next Issue: July 2003

HIV and substance use are inextricably linked, however, there remains an uncomfortable union between the two in care settings. In the July issue of *FOCUS,* **Mindy Domb,** the Director of the Statewide Partnership for HIV Education in Recovery Environments (SPHERE) in Amherst, Massachusetts, talks about the integration of HIV-related issues into substance abuse treatment and of substance abuse-related concepts into HIV care.

Also in the July issue, **Michael Gorman, PhD** of San Jose State University in California, and **Perry Halkitis, PhD** of New York University discuss the ongoing relationship between stimulant use and HIV risk, particularly among men who have sex with men.

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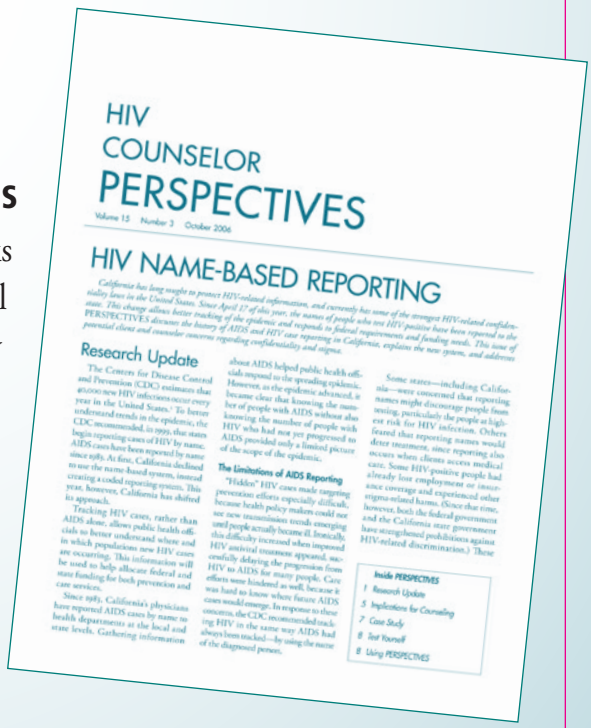
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ABOUT UCSF AIDS HEALTH PROJECT PUBLICATIONS

The AIDS Health Project produces periodicals and books that blend research and practice to help front-line mental health and health care providers deliver the highest quality HIV-related counseling and mental health care. For more information about this program, visit http://ucsf-ahp.org/HTML2/services_providers_publications.html.

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