

In this issue

- 1 Transgender Youth Research at Howard Brown Health Center
- 2 Massage-Relaxation Youth Study
- 3 Proyecto Latina: Homophobia in Latino/a Communities & Families
- 4 Family Environment and Division of Labor in Two-Parent, Same Gender Homes
- 5 LGBT Adolescents: Homelessness, Violence, Distress, Discrimination and Resilience
- 6 Intimate Partner Abuse and Health Among MSM
- 7 Ethnic Differences in HI V Disclosure and Transmission Risk
- 8 Clinical Counseling Group Supervision for Researchers
- 11 New roles and new faces in research at Howard Brown
- 12 Trans-Women Informing Sista Trans-Women on Topics of AIDS (TWISTA)

Special Insert: MACS News!

- MACS1 Continued participation in the MACS
- MACS2 Long-term Non Progression of HIV Infection
- MACS2 Syphilis Update
- MACS3 The MACS Study in Industry Journals
- MACS3 Did you know?
- MACS4 The CORE Center
- MACS4 Participant Spotlight
- MACS4 MACS Clinic Hours

Transgender Youth Research at Howard Brown Health Center

Amy Stauffer, MSW

“Preventing HIV in us girls is complicated. We need jobs, places to stay, doctors. HIV is just one of the many problems we deal with.”

Due to social isolation, stigma, lack of access to competent care and limited understanding of their lives, transgender individuals face many challenges to their health and overall well-being. HIV is an overwhelming social and medical issue in the male-to-female (MTF) transgender community.² To date, most research focuses on the experiences of transgender adults. Little is known about the development, resiliency and experiences of transgender youth, including participation in HIV-risk behavior.

A Howard Brown study conducted in 2003, with a convenience sample of 51 self-identified ethnic minority MTF transgender youth, provided a glimpse into the life experiences of a rarely studied sub-group of adolescents. This study was ground-breaking as it was

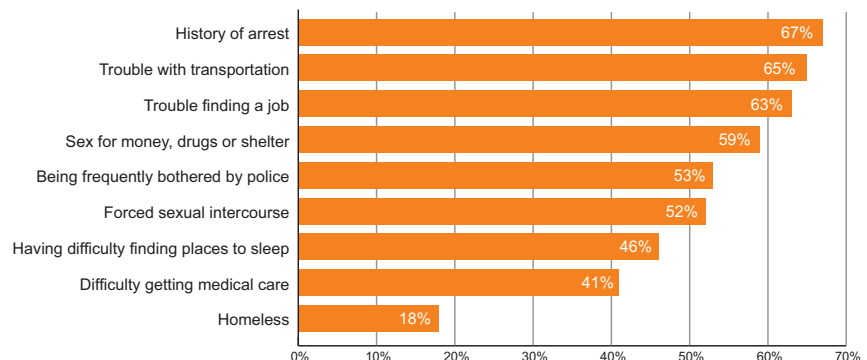
able to assess multiple dimensions of MTF transgender youth experiences, such as: social support, life stress, self-esteem, risk behavior and depression. It also included a qualitative component, of which more than 80% of participants completed. The study was developed and guided by a Transgender Youth Working Group. Additionally, the survey was piloted with transgender youth in order to ensure cultural appropriateness.

The young women in the study reported high levels of HIV-risk behavior, and 22% self-reported HIV seroprevalence rate. In addition, these youth faced multiple life stressors, such as having a history of arrest, having difficulty finding safe places to sleep, and difficulty getting medical care (see “Life Stressors” below).

Although this study cannot be generalized to all MTF youth, it does provide a strong argument for increased prevention

(see *Transgender Youth*, page 2)

Life Stressors



(*Transgender Youth, from page 1*)

efforts with transgender youth, in particular transgender youth of color. Furthermore, these data suggest that a holistic and ecological approach to HIV prevention must be taken as these youth face multiple life stressors that influence risk behavior.

In response to the 2003 study and as reported in the October 2006 research newsletter, Howard Brown was awarded two CDC grants to implement HIV prevention interventions with young transgender women (Principal Investigator: Robert Garofalo, MD); TWISTA and Life Skills. Although sharing some basic HIV prevention elements, the interventions are quite different. However, one of the overarching research goals is to learn more about young transgender women, including their life experiences, resiliency, and HIV risk-behaviors. Additionally, the efficiency of each intervention will be evaluated in terms of sustained behavioral change.

TWISTA (trans women informing sista trans women on topics of AIDS) is an HIV prevention intervention reinvented from the CDC DEBI (Diffusion of Evidence-Based Interventions) SISTA. The intervention is culturally-specific and is designed for young transgender women of color. The curriculum incorporates themes of ethnic and transgender pride with HIV prevention education. TWISTA's first cohort began the second week in February, 2008, and will continue to run cohorts four to five times a year for the next four years.

The TWISTA team conducted a pilot with 12 girls in early fall of 2007. This pilot was essential in the restructuring of the intervention, as the team learned valuable lessons concerning barriers to participation for the youth. The intervention was moved from a six-week model to a three-week model, and will incorporate aggressive retention tactics. In addition, a weekend retreat model will be used in an upcoming cycle in order to engage and retain the most at-risk youth.

Life Skills began the first group of its intervention trial in April of 2008. This groundbreaking intervention incorporated essential life skills training alongside standard HIV prevention education, with the aim to provide holistic, comprehensive and sustainable HIV prevention.

The Life Skills team has kept very busy. In their first year of funding they created a ground-up, six-session, group-based curriculum; structured individual-level interventions; conducted two focus groups; and ran a pilot group with an 86% retention rate. Each cohort of ten participants will attend six group sessions and at least one individual session over three weeks. A total of 50 transgender women between the ages of 16-24 will be recruited.

Both teams are excited to offer these two innovative interventions to the young transgender community. For more information, or to participate in the interventions, call 773-935-3151 x239.

1 Garofalo, R. et al. (2006). Overlooked, misunderstood and at-risk: Exploring the lives and HIV risk of ethnic minority male-to-female transgender youth. *Society for Adolescent Medicine* (38) 230-236.
2 Garofalo, R. et al. (2006) Environmental, psychosocial, and individual correlates of HIV risk behavior in ethnic minority male-to-female transgender youth, *Journal of HIV/AIDS Prevention in Children and Youth*, 7 (2); 89-104.

Massage-Relaxation Youth Study

May Lin Kessenich, BA

The UN-AIDS 2004 Report on the Global AIDS epidemic estimates that as many as one-half of new HIV infections occur in persons 15-24 years of age. The incidence of new HIV cases in many developing nations is increasing rapidly, in spite of conventional attempts to control its spread. On a global scale, access to antiretroviral treatment and care for HIV-related diseases care remains low. The World Health Organization estimates that nine out of ten people who urgently need HIV treatment are not being reached. More than 10 million children and adolescents are living with HIV infection, and global availability of antiretroviral therapy is extremely limited. Relatively low cost Complementary and Alternative Medicine (CAM) therapies like massage may have the potential to provide children

with a safe and sustainable form of immunostimulation while waiting for access to medication, and as an adjunct to conventional pharmacotherapy.

This ongoing epidemic reveals the need to search for cost effective therapies that enhance immune system functioning and may also prevent progression of disease while HIV-infected patients are waiting for medication. Research on non-pharmacologic interventions that have the potential to support immune function is very much needed and would likely benefit HIV-infected individuals at any stage of illness.

The Integrative Medicine Initiative at Children's Memorial Hospital, in collaboration with Howard Brown Health Center, has designed a randomized

controlled clinical trial funded in part by the NIH to investigate the effects of massage therapy and relaxation training on unmedicated HIV+ adolescents (The Massage/Relaxation Youth Study). We will conduct a multi-system assessment analyzing changes in immune measures (CD4 and CD56 counts), hormonal measures (salivary cortisol, plasma oxytocin), autonomic measures (heart rate variability) and behavioral measures (surveys and interview). This study is the focus of a NIH Career Award (K23) for Sheila Wang, PhD, Research Director of the Judith Nan Joy Integrative Medicine Initiative at Children's Memorial Hospital. Recruitment began in April, 2008. For more information, contact the project coordinator, May Lin Kessenich at 773-880-3919.

Proyecto Latina: Homophobia in Latino/a Communities & Families

Nicole Perez, MA

In 2007, Amigas Latinas conducted a survey of the Latina lesbian, bisexual, transgender, genderqueer, and questioning (LGBTQQ) community in the Chicagoland area. The survey, Proyecto Latina: Descubriendonos (Project Latina: Discovering All of Us), ran from January, 2007, through Summer 2007. The survey tool for this project was modeled after the Affinity Community Services Take Charge! survey project in 2002. It involved the marketing and distribution of an extensive survey tool (299 questions) available on paper and online in English and Spanish. Survey questions asked women about demographics, sexuality and gender identity, parenting, physical health, health behaviors, medical services, emotional well-being, and overall satisfaction with services provided by Amigas Latinas.

The literature on the lives of Latina LGBTQQ women reveals this is an underserved and neglected population in research studies and publications despite an increase in data about Caucasian gays and lesbians. Proyecto Latina: Descubriendonos documents the experiences of Latina LGBTQQ women in the Chicagoland area, thus making visible the unique life experiences and challenges of this population.

Participants were recruited through email blasts, distribution of informational flyers, and through information released to members of Amigas Latinas and to local newspapers. Snowballing also helped the success of this project.

A total of 305 people between the ages of 13-60 years old completed the survey

(262 in English and 43 in Spanish). Respondents varied in terms of racial/ethnic identity, sexual or gender identity, education, employment, income, relationship status, immigration or citizenship status, age, and geographic location. Although efforts were made to ensure that the survey reached all types of LGBTQQ Latinas, the survey was class-biased and skewed towards more educated women with access to computers and telephones. The sample also lacked a significant number of respondents who identified as bisexual, transgender, queer, or genderqueer, and is therefore more representative of the experiences of lesbian women.

In this article, the experiences of Latina LGBTQQ women were examined with regard to the reported prevalence of homophobia/heterosexism in Latino families. The analyses were conducted by Nicole Perez, MA of Howard Brown and Alicia Matthews, PhD of UIC and Howard Brown. Research on homophobia and heterosexism among Latino communities and families reveals the prevalence of such attitudes and behaviors among these populations. Many Latino theorists identify the discriminatory treatment that Latina queer women experience from their Latino communities and families, particularly when they are trying to “come out” and be open about their sexuality, or when engaging in forms of social and political organizing.¹⁻⁴

The data from the Proyecto Latina survey project reveals that Latina LGBTQQ women experience much homophobia/heterosexism from their Latino

with other Latinos on sociopolitical issues. For example, of the 32% of Latina LGBTQQ women who were born outside the United States, 6% immigrated for reasons related to their sexual orientation or gender identity. Five-percent said they immigrated in order to explore their sexual orientation in a way they could not in their native country, and 2% because they feared for their safety as LGBTQQ women in their native country.

Latina queer women also struggle with coming out to family. Nearly 20% are not out to their mothers, and of those who are, 38% did not receive a positive reaction when they came out; 26% are not out to their fathers, and of those who are, 25% did not receive a positive reaction; 24% are not out to all of their siblings, and 27% who did disclose did not receive a positive response; 6% are not out to all of their children, and 6% received a negative reaction when their children became aware of their sexual orientation or gender identity. Twenty-seven-percent are not out to all extended family members, and of those who are, 23% did not receive a positive response.

The survey asked women to identify the reasons why they are not out to all friends and family. Table 1 lists the reasons LGBTQQ Latinas reported withholding the disclosure of their sexual orientation or gender identity.

Forty percent of Latina LGBTQQ women stated they lack emotional support from family members. Latina LGBTQQ women also reported unfair treatment when trying to access services in Latino communities on sociopolitical issues. One-quarter of respondents replied (either slightly, moderately, or strongly) that they feel discriminated against because of their sexual orientation in places servicing the Latino community. Similarly, 54% of women revealed that they feel most Latinos do not accept LGBTQQ women.

(see *Latina*, page 9)

Table 1
Reasons for NOT Coming Out

Most people know, just don't talk about it	31%
Fear of rejection from family & friends	23%
Family & friends' negative attitudes about LGBTQQ women	21%
Private matter	14%
Fear of verbal or physical violence	8%
Goes against their religion	7%
Have tried to come out but no one listens	6%
To protect children/family from harassment	5%
Fear losing children	2%

Family Environment and Division of Labor in Two-Parent, Same Gender Homes

Blase E. Masini, PhD

The 2000 U.S. census was the first census to track households with same gender adults. The results showed a striking statistic – same gender couples are raising children in at least 97 percent of all U.S. counties.¹ The density of LGBT-led families with children is likely even higher since some are reluctant to report a same-gender partner;² furthermore, this figure does not include single LGBT parents raising children.

In spite of the prevalence of children being raised by LGBT parents, there is limited scientific research on the environment of their homes and how this may differ from heterosexual-led homes. Reviews of studies looking at children of LGBT parents showed that child outcomes were the focus of the research;^{3,4} little was reported on the family environment or other functional aspects of the home.

Howard Brown is currently running a national online survey for LGBT parents to assess the family functioning and the psychosocial, academic, and social development of children. To date, 264 parents have responded. The sample is predominately White, educated, and upper middle class. Sixty-nine percent of the respondents are female, 25% are male, and 1% is transgender.

Two aspects of the home are analyzed, the family environment and the division of labor among the parents. The Family Environment Scale⁵ is a well known, normed instrument designed to measure the environment of families. Subscales used in this study include cohesion, expressiveness, conflict, independence, achievement orientation, intellectual-cultural orientation, active-recreational orientation, and moral-religious emphasis. Each subscale score is the sum of 9

true/false items where 1=true and 0=false, with subscale scores ranging from 0 to 9.

Division of labor among the adults in the home was assessed across eight household tasks: cooking, cleaning, laundry, household chores, childcare (hygiene), childcare (academics/entertainment), and elder care. The respondent was asked to “estimate how much you and the other adults contribute to each” in percentages. (This analysis is based on 199 same gender couples with one member of each couple responding.)

Table 1 compares the mean FES scores for two-parent, same gender homes against national norms, both for normal families and distressed families. Mean scores did not differ significantly between male-led and female-led homes, so the two were combined. Significance tests were run comparing each sample mean to corresponding national norms.

For all but Achievement Orientation, same-gender led families differed significantly from national norms on the FES scales. For some of the scales, the statistical difference was an artifact of the large national samples, namely Independence (6.3 vs. 6.6/5.9) and Moral-Religious Emphasis (4.2 vs. 4.7/4.4). While these differences between same gender led homes and national norms may truly exist in the population, the differences are not substantial.

On the other hand, same gender led families were statistically and substantively different on five scales. Same gender led families scored higher on Cohesion, Expressiveness, Intellectual-Cultural Orientation, and Active-Recreational Orientation. These families were also lower in Conflict. See Table 1 for specific means.

(see Family, page 8)

Table 1
Family Environment: LGBT Sample vs. National Norms

	LGBT N=262	National Norms	
		Normal N=1,125	Distressed N=500
Cohesion	8.4***	6.6	5.0
Expressiveness	6.9***	5.5	4.6
Conflict	2.1***	3.3	4.3
Independence	6.3***	6.6	5.9
Achievement Orientation	5.3	5.5	5.3
Intellectual-Cultural Orientation	7.8***	5.6	4.5
Active-Recreational Orientation	6.3***	5.4	4.3
Moral-Religious Emphasis	4.2***	4.7	4.4

***Significantly different from national norm at p<.001.

Table 2
Division of Labor in Two-Parent Homes: Average Percent of Time Spent

	Two Female Household		Two Male Household	
	Parent reporting Average %	Second parent Average %	Parent reporting Average %	Second parent Average %
Cooking	55*	43	50	45
Cleaning	45	41	38	35
Laundry	47	49	51	37
Shopping	57**	41	54	44
Household Chores (yard work, repairs)	45	51	50	43
Child Care: Hygiene	57**	39	56**	37
Child Care: Academics/Entertainment	55**	40	55**	39
Elder Care	39	32	20	22

*Significantly different at p < .05, **Significantly different at p<.01.

LGBT Adolescents: Homelessness, Violence, Distress, Discrimination and Resilience

Laura C. Hein, PhD, RN, NP-C

Victimization and homelessness have been associated with sexual minority status for youth. D’Augelli, Grossman and Starks’ found 11% of lesbian, gay and bisexual youth have been physically victimized and 9% sexually victimized. Furthermore, youth who were more gender atypical as children experienced more victimization and consequently more current mental health symptoms. Homelessness is one form of victimization, sometimes associated with coming-out to one’s family. Homelessness is not without health consequences. The mortality rate of homeless youth is 11 times that of youth in the general population.²

Methods

An ethnically diverse sample of 16-24 year old LGBT youth (n=88) from Chicago and Indianapolis participated in a study funded by the Health Disparities in Underserved Populations training grant at the University of Illinois, Chicago College of Nursing. The specific aim of this study was to identify relationships between demographic factors, experience of violence, discrimination, distress and resilience.

Results

Demographics

The mean age of participants was 20 years old (SD=2): 66% were male; and 34% female. Racially, 59% were White, 31% Black, 27% Latino, and 10% other. Overall, 68% had completed high school, a General Educational Development certificate (GED) or more, and 5% were still in high school.

Homelessness

From this community-based sample of LGBT youth, 57% reported having been homeless in the past, and 46% were currently homeless. Being homeless in the past was predictive of 69% of current homelessness (OR=5.05; 95% CI=2.0-12.7; p<.001).

Perceived lack of physical safety at their parents’ home predicted both previous

(OR=1.02; 95% CI 1.00-1.03; p<.005) and current homelessness (OR=1.03; 95% CI 1.01-1.05; p<.001). Additionally, rape was associated with homelessness: 65% of youth with a history of homelessness had been raped.

Income Securing Behaviors

Youth were asked about how they secured goods and income: “What have you done to take care of yourself – get food, money, a place to stay, etc.” Youth could use more than one strategy, and they did. Income securing behaviors

reported by youth included pimping, being a houseboy/girl (a young person who lives with an older person, with the understanding that lodging, money, and clothes are offered in exchange for sexual relations), panhandling, dumpster diving (going through trash for food or other items), robbing/stealing, drug work (making drugs, dealing drugs or being a drug courier-mule), sex work (prostitution/survival sex), working, and asking friends and family for money. (See Table 1)

(see *Adolescents*, page 9)

Table 1
Income Securing Behaviors

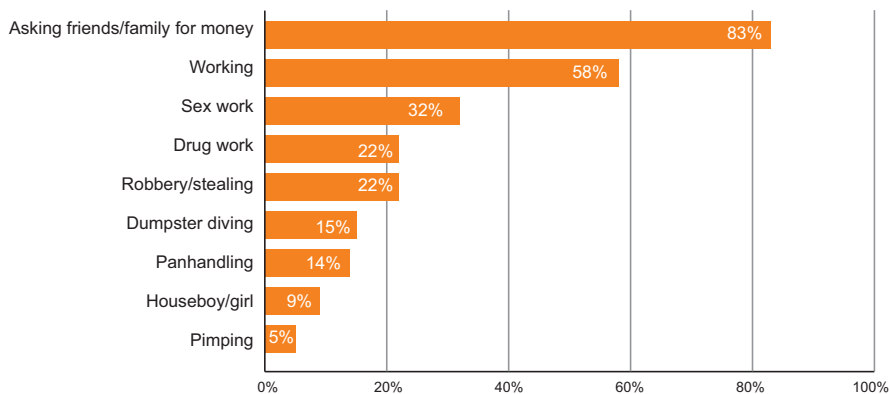
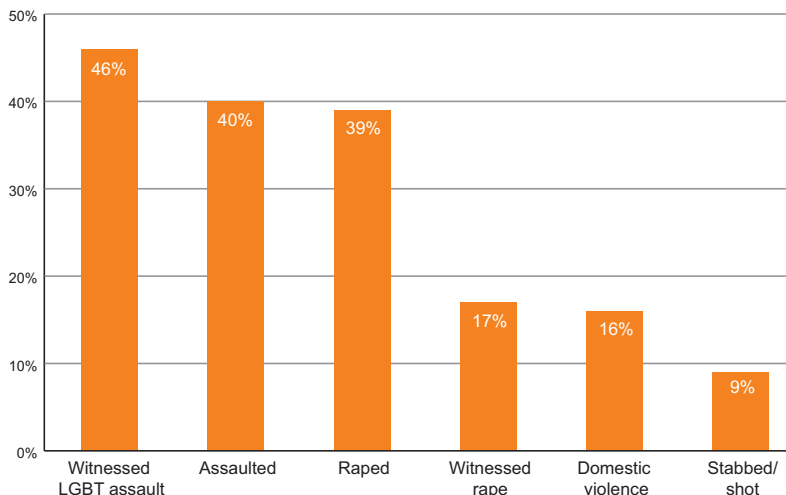


Table 2
Violence



Intimate Partner Abuse and Health Among MSM

Eric Houston, M.A. and David McKirnan, PhD

The following are excerpts from the peer reviewed article, Intimate Partner Abuse among Gay and Bisexual Men: Correlates and Health Outcomes (2007) which appeared in the Journal of Urban Health: Bulletin of the New York Academy of Medicine, 84, 681-690.

Men in same-sex relationships experience abuse rates similar to those faced by women in heterosexual pairings, and by as much as three times higher than those reported by men involved with women. Despite this high prevalence, few studies have focused on abuse in same-sex male relationships. This lack of attention occurs in the face of growing evidence that intimate partner abuse among gay and bisexual men may pose a significant threat to health outcomes, including sexually transmitted diseases and HIV.

In a convenience sample of 817 men who have sex with men (MSM), 32.4% (n = 265) of respondents reported any form of relationship abuse in a past or current relationship; 20.6% (n = 168) reported a history of verbal abuse (“threatened physically or sexually, publicly humiliated, or controlled”); 19.2% (n = 157) reported physical violence (“hit, kicked, shoved, burned, cut, or otherwise physically hurt”); and 18.5% (n = 151) reported unwanted sexual activity (see Table 1).

This study is one of the first to focus on a diverse sample of urban MSM. It is based on survey data collected by Howard Brown Health Center and the Chicago Department of Public Health. Findings also showed that more than half of the men who reported experiencing any

history of abuse reported more than one form. Depression and substance abuse were among the strongest correlates of intimate partner abuse. Men reporting recent unprotected anal sex were more likely to also report abuse. Age and ethnic group were unrelated to reports of abuse.

Intimate partner abuse has become so intertwined with health problems that some researchers consider this pattern of coercive behavior a health problem itself. This issue was highlighted in an examination of the survey data, showing a significant relationship between a range of health problems and intimate partner abuse. Abused men were more likely than nonabused men to report problems such as hypertension, heart disease, obesity, smoking-related illness and, in some cases, sexually transmitted infections (see Table 2). There were no statistically significant differences between abused and nonabused men concerning HIV sero-status. Men in abusive relationships were more likely to report depression or other mental health problems, and to engage in unhealthy behaviors such as substance abuse, combining drugs with sex, or unprotected sex.

Table 1
Percentage of total sample experiencing different forms of abuse, by time frame

Type of abuse	Any current	Relationship time frame		Any time
		Any past	Past + current	
Sexual	5.8% (n=47)	14.6% (n=119)	1.8% (n=15)	18.5% (n=151)
Physical	6.2% (n=51)	15.5% (n=127)	2.6% (n=21)	19.2% (n=157)
Verbal	6.5% (n=53)	17.0% (n=139)	2.9% (n=24)	20.6% (n=168)
Any form	12.5% (n=102)	27.3% (n=223)	7.3% (n=60)	32.4% (n=265)

Table 2
Relationship between abuse status and health outcomes

	Percent of participants reporting abuse	Percent of participants not reporting abuse	Wald, OR (95% CI)
Behavioral health and sexual risk			
Alcohol intoxication	53	42.5	4.87, OR = 1.43 (1.04 - 1.96)*
Substance use problems	26.4	15.6	9.32, OR = 1.84 (1.24 - 2.73)*
Substance use with sex	33.5	23.6	6.8, OR = 1.8 (1.16 - 2.79)*
Hard drug use	18.3	15.2	0.69
Unprotected anal sex	43.6	31.9	9.02, OR = 1.61 (1.18 - 2.21)*
Transmission risk	23.3	16.9	3.8, OR = 1.74 (1.0 - 2.16)**
Number of sexual partners	18.3	15.2	0.59
Smoking	42.5	37	1.62
Physical and mental health			
Physical health problems	37.2	28.1	7.35, OR = 1.59 (1.14 - 2.21)*
STIs	19.2	13.2	5.3, OR = 1.4 (1.04 - 1.76)***
Mental health diagnosis	20.3	13.1	5.89, OR = 1.66 (1.10 - 2.51)*
Psychosocial factors			
Safety burnout	50.9	47.6	0.3
Depression	43.9	30.2	8.45, OR = 1.59 (1.14 - 2.21)*
Social support/isolation	22.9	29.9	2.56
Self-esteem	53	51	0.41
"Outness" as MSM	49.5	41.8	3.48

* p < .05, controlling for socioeconomic status, age, and ethnicity

** p < .051 (marginally significant), controlling for socioeconomic status, age, and ethnicity

*** p < .05, controlling only for socioeconomic status

With regard to health seeking behaviors, the study found that abused men were more likely than nonabused men to report ever seeing a mental health professional. Although abused men were more likely than nonabused men to seek help at gay/bisexual health centers, there were no other significant differences between the two groups with regard to the specific types of places where they sought care (e.g., county hospital, emergency room, community, or free clinic).

The study highlights several challenges for researchers and healthcare providers in meeting the needs of abused men. For example, because intimate partner abuse among MSM does not receive the same attention as it does among heterosexual

(see Abuse, page 9)

Continued participation in the MACS

John P. Phair, MD

The MACS began recruitment in April of 1984 and completed the first wave of enrollment in March of 1985. Eleven hundred and two men volunteered for this study initially. To increase the participation of African-American men, recruitment was reopened in 1987 and 250 men were added to the cohort.

In 2001, the MACS opened enrollment again to recruit younger men and to represent more accurately the continuing evolution of the HIV epidemic. By December 2003, an additional 239 younger, primarily African-American, men entered the study. The MACS investigation began before it was possible to detect the HIV antibody, so approximately 60 percent of the original cohort in Chicago were uninfected. However, more than ten percent of these antibody negative participants became infected during the first few years of the study. Thereafter the rate of new infections decreased dramatically, and the NIH decided to reduce the number of uninfected men in the study. Some of these administratively censored participants came back into the study between 2001-2003.

In the first 12 years of the study, many of the men who entered the MACS with infection and those with new HIV

infections progressed to AIDS. Approximately 90% of those men with AIDS died. Then in late 1995, infected men began using effective antiretroviral therapy, or HAART. At present more than 85% of men with HIV infection are receiving HAART. The progression to AIDS has decreased dramatically, reducing the number of deaths. The proportion of illnesses which occur due to classical AIDS-related conditions is dropping, and diseases associated with aging such as heart disease, diabetes, high blood pressure and non-AIDS related cancers are increasing.

The current focus of the MACS is to understand if men with HIV, or men who receive HAART age more rapidly, and if the diseases of aging are more prevalent. The study is well positioned to investigate this issue because in addition to the infected men, the MACS continues to follow the uninfected men who have approximately the same lifestyle. In Chicago 187 uninfected men and 295 infected men remain active in the study. The age range of the uninfected men is 36 to 75, and the infected participants range from 24 to 69 years. Thus, it will be possible to compare health and disease in infected and uninfected men over a wide age range. The MACS can also evaluate racial differences in the occurrence of

health problems as 184 of the 505 active participants are African-American. The effects of gender can be studied by comparing the results of the MACS with those in the women's study (Women's Interagency HIV Study – WIHS) which is conducted in Chicago at the CORE Center, Rush and Northwestern. Five other cities also conduct the WIHS.

To accomplish our goals over the next year and in the renewed MACS which will run until 2014, the MACS will depend upon the active participation of its men at the current high levels. The MACS is not a study without the immense generosity of its men, some of whom have faithfully donated time and blood to this investigation for more than 24 years. In addition to the previous contributions to the MACS, we are now dependent upon receiving accurate records of hospitalizations and illnesses that develop over the next six years. The men will be asked by the clinic nurses and coordinators to share such information and records with the MACS database. The attitude of the men in the MACS and their generosity have provided very important information to the progress made in dealing with HIV infection over the past 24 years. The continuation of this type of participation will ensure that the next six years will be just as productive.

25 Years with The MACS Study:

Chicago, Baltimore, Los Angeles, and Pittsburgh

The MACS commemorates the 25th anniversary of funding since April 1983.

In April 2009, we will celebrate 25 YEARS of participant enrollment.
The MACS has enrolled 6,973 participants since April 1984.

Thanks to all of you for your continued loyalty to the MACS!

Long-term Non Progression of HIV Infection

John P. Phair, MD

The progression of HIV infection varies from individual to individual. Age and differences in host genetics have been identified as influencing the rate that the virus impacts the immune system, and in time leads to the complications which are used to identify clinical AIDS. Infection which occurs in younger persons progresses on average more slowly than it does in older individuals. Eighteen host genetic variations have been shown to influence the course of HIV infection. However, it is estimated that the known genetic variations account for a minority of the differences in progression of this viral infection. In the MACS we have identified 53 infected individuals who have been AIDS-free for more than 15 years with no need for treatment. This contrasts with the usual AIDS-free time of approximately ten years in the absence of antiretroviral

therapy. These so-called long term non-progressors (LTNP) were compared with 191 participants who developed HIV infection while in the MACS, and who developed AIDS in less than 12 years. The MACS has just begun an analysis of the differences found in these two groups of participants. The preliminary findings are summarized below.

Control of many viral infections has been shown to be better if an individual has a variety of HLA genes which control the immune response. If the parents of an individual have many of the same HLA genes, the child will have less variation or be homozygous for HLA genes, A, B or C. The LTNP were slightly less likely to be homozygous for HLA. The LTNP also were more likely to be African-American, 21% as opposed to 4%, more often

CCR5 heterozygous, 38% vs 15%, and more frequently had cleared an infection with hepatitis B, 53% in contrast to 21%. An earlier study of the MACS participants in Baltimore also demonstrated that African-Americans appear to progress less rapidly than Caucasian men. The CCR5 heterozygous state is a genetic variant known to slow the progression of HIV infection. Such individuals have fewer receptors on their T-cells which are required by the virus to enter and infect the cell. The increased clearance of the infection with Hepatitis B may reflect the variation in the HLA genes of the LTNP as well.

The next newsletter will follow with more information about the underlying causes of the varying responses to HIV.

Syphilis: An Update

Margarita Verano, MA, MS

Syphilis is a curable infection caused by the bacteria *treponema pallidum*. It is usually acquired through sexual transmission, although it can be contracted congenitally from mother to child. Syphilis was once difficult to diagnose, but modern diagnostic tests have high accuracy.

Contemporary screening tests for syphilis include the Rapid Plasma Reagin (RPR) and the Venereal Disease Research Laboratory (VDRL). These tests may show false positives, so they are followed up with a confirmatory test. Syphilis is easily treated with antibiotics, usually with an intramuscular injection of benzathine penicillin in the buttocks. Individuals allergic to penicillin may receive oral antibiotics for 14 or 28 days. Individuals with syphilis are two to five times more likely to give or receive HIV. Indeed syphilis sores can create pathways for HIV to enter or leave the body. A suppressed immune system due to syphilis can also make it easier for HIV to infect T-cells. Syphilis can also increase the viral load in an HIV positive individual.

Primary syphilis, which usually manifests as a single painless sore that is open and crater-like, may appear like a cold sore on or near the genitals, on or inside the anus, on the lips, tongue or in the mouth, or in the vagina. Primary syphilis can last 1-5 weeks, will go away without treatment, and is sometimes mistaken for zipper cut or burn. Secondary syphilis lasts 2-6 weeks, with symptoms which may include an itch-free rash on the hands or soles of the feet, a bilateral (both sides) rash on the body, patchy hair loss on head and body, mucous patches in the mouth, and a general sense of malaise. As with primary syphilis, symptoms clear up, while the disease continues to thrive in its human host. Latent syphilis occurs 1-30 years after infection, and can include complications like chronic nervous system disorders resulting in blindness, insanity and paralysis, problems with heart and blood vessels, and the appearance of gummas (small bumps or tumors on skin, bones, or any organ). Untreated syphilis may lead to serious, sometimes fatal, damage to the heart,

aorta, brain, bones and eyes. Individuals with HIV, in particular, more commonly show neurosyphilis, which is an infection involving the central nervous system. Neurosyphilis treatment involves intravenous antibiotics for 10-14 days.

The MACS Study at HBHC offers MACS participants complimentary, confidential, in-house testing for syphilis. Testing for syphilis is not part of the regular MACS protocol, and this service is provided to MACS participants as a courtesy procedure. Testing for syphilis will require that participants complete non-MACS related forms that identify the participant by name and with other demographic information. This information is kept confidential.

The CDC reported a rise in syphilis rates in the US in 2007, and especially among homosexual and bisexual men. *The New York Times* reported that less than 40 percent of non-HIV-positive gay men are

(see *Syphilis*, page MACS3)

The MACS Study in Industry Journals

John P. Phair, MD

The MACS in Neurology

HIV-associated brain dysfunction is most often diagnosed in patients with AIDS. Generally such patients have high levels of HIV in the central nervous system. It is not clear whether chronic HIV in persons who have no HIV-related problems leads to brain function abnormalities. A recent study from the MACS published in the journal *Neurology* provides new information regarding this question.

Men in the MACS have completed two tests of brain functioning for many years, the Symbol Digit Modality and Trail Making. This study demonstrated that the ability to perform these tests did not decline over an extended period of time in HIV infected asymptomatic men as compared to the uninfected men in the cohort. This suggests that people can live for a long period of time with low levels of HIV without experiencing significant brain dysfunction.

In an editorial in the journal which accompanied the paper, it was stated that the significance of the study was reinforced by the size of the MACS and the careful follow up over many years. The evidence from the study indicates that without high levels of HIV, lack of progression to AIDS and maintenance of CD4+ T-cell above 200 brain function

is preserved. Chronic HIV infection by itself is not enough to cause loss of brain function.

The editorial also pointed out that this study was carried out in the original MACS cohort. The original MACS cohort is a unique group of primarily Caucasian men with strong intellectual abilities, who on average have a high educational level and a relatively low level of recreational drug use. Thus it is unknown if the same findings would be present in other populations who are HIV infected in the US or in the rest of the world. Furthermore, only two tests were used for this study which is why the MACS has asked for more complete testing in the past several years. These additional tests are more sensitive and will provide more information regarding the problem of the impact of HIV infection upon brain functioning.

The MACS in Science

In January 2008, investigators from Harvard reported in the journal *Science* the results of a large scale genome-wide RNA interference screen designed to identify host factors or proteins necessary for HIV-1 replication. They identified 281 so called HIV-dependency factors, or proteins found in human cells. These proteins play a role in many

cellular functions, and the authors demonstrated that knocking out these proteins prevented the virus from replicating or reproducing in the test tube or culture. They also found the possibility that identifying new pathways in the viral life cycle would result in new therapies for HIV infection.

The necessary step to confirm the importance of the Harvard findings was to show that polymorphisms or variants in the genes controlling some of the HIV dependency factors had an influence on clinical HIV infection. Scientists at Duke used a method called genome-wide scanning to look for genes which had an impact on clinical disease using MACS specimens. They identified variants or polymorphisms in 23 of the 281 genes which in fact control the level of HIV/RNA in blood and the clinical progression of the infection. The absence of associated variants in most of the factors identified by the Harvard study does not mean that these host factors are unimportant. Many genes do not have functional variants, and thus would have not been identified by the method used by the Duke investigators.

The association of plasma viral load and progression with some of the factors implies that these genes have direct effect upon the host control of HIV-1.

Did You Know?

Compiled by Michelle Johns, BA

- The smallest bone in the human body is the stapes or stirrup bone located in the middle ear. It is approximately .11 inches (.28 cm) long.
- The longest cells in the human body are the motor neurons. They can be up to 4.5 feet (1.37 meters) long and run from the lower spinal cord to the big toe.
- The human eye blinks an average of 4,200,000 times a year.
- Human jaw muscles can generate a force of 200 pounds (90.8 kilograms) on the molars.
- The Skylab astronauts grew 1.5 - 2.25 inches (3.8 - 5.7 centimeters) due to spinal lengthening and straightening as a result of zero gravity.
- The heaviest human brain ever recorded weighed 5 lb. 1.1 oz. (2.3 kg.).
- The average person falls asleep in seven minutes.
- Our eyes are always the same size from birth, but our nose and ears never stop growing.
- The human brain is 80% water.
- Everyone's tongue print is different.

(*Syphilis*, from page MACS2)

routinely tested for syphilis. To help reduce syphilis, use condoms, limit the number of sex partners, ask partners about their sexual history, and check partners for symptoms. It is recommended that you get tested twice a year. For more information, contact Daniel Pohl, Disease Intervention Services, at 773-562-6976.

Sources:

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Sex Diseases in Many Gay Men Go Unfound, Experts Say (2008). The New York Times. Retrieved March 28, 2008. from http://www.nytimes.com/2008/03/13/health/13std.html?_r=3&ex=1363060800&en=f81cdf42407b4c50&ei=5088&partner=rssnyt&emc=rss&oref=slogin&oref=slogin&oref=slogin

The CORE Center

P.M. CORE VISITS (PMCV) because... It's Your Night!

Carmon Houston, RN, MA

The men at CORE Chicago are very diligent in returning for their biannual visits, with a consistent participation rate of at least 80%. At CORE we want to make the visits as complete as possible, obtaining important information from our participants, as well as collecting valuable facts, patterns and trends.

While our participants make an excellent effort to attend each wave, things can interfere with, or prevent participants from completing the Tuesday and Thursday morning MACS visits at CORE. Some of the barriers you may encounter when scheduling a MACS visit may include the following situations:

- Do you have early morning work hours?
- Are you unable to delay your starting time?
- Are you denied sick time for appointments?
- Do you have conflicting schedules?
- Must you report every Tuesday and Thursday morning for work?

When a participant misses a visit or the visit occurs at a time other than the Tuesday and Thursday morning visits, loss of data occurs as a result of missing blood draws and the physical examination. This can compromise the study and hamper the individual's HIV management, limiting the monitoring of viral load and CD4 status.

We have worked diligently to implement a solution for our participants who may have difficulty scheduling on Tuesday or Thursday mornings. In February the CORE Center launched PMCV (P.M. CORE Visits). The CORE Center plans to hold two visit days per wave from 3:00 pm to 5:00 pm, with three appointments available. The number of appointments is capped at three because the blood has to be processed on the same evening it is drawn.

Our staff has been very cooperative in this effort. Cheryl normally leaves at 4 pm, and has volunteered to stay late. Our physician has agreed to come in to see those attending the late clinic. Landra has also jumped in, drawing and managing the blood.

These special accommodations may assist you:

- If you are unable to get in to get your blood drawn in the morning;
- If your job demands morning presence every Tuesday and Thursday;

Call 312-572-4552 to leave your contact information, and to register your need for PMCV. Remember our priority is fasting blood specimen and doctor examinations with each six month visit.

MACS Participant Spotlight:

George Manning

Amy N. Miller, BA

George Manning is treasured at Howard Brown and with the MACS Study for his continued commitment since



1990. He was inspired to join the MACS at the request of a friend who died from an AIDS-related illness. They suspected that George's exceptional health may have been indicative of his immunity to HIV, and that he may be genetically impervious to the virus. It seemed that with the MACS being the longest-running longitudinal HIV/AIDS study in the world, George would be a perfect fit for the study.

George has never missed a MACS visit. In addition to his time and blood contributions with the MACS, he is well-liked for his inspirational demeanor and interesting stories. He coined the phrase, "Kindness is a language that the deaf can hear and the blind can see." George embodies this commitment to improving the world. He has worked in mental health services for 38 years, serves on the board of several non-profit organizations, and is the founder/ president of a variety of community groups. He is accomplished in playing and composing on the piano and organ. In fact, George has played the organ for three US Presidents.

George is especially proud of his youth mentoring program at his church. As group leader, he teaches youth test-taking and interview techniques to help them prepare them for college. He also teaches them practices related to hygiene, etiquette, safe sex, and the importance of community service. Every four years, George presents 40 young scholars in a gala Scholarship Cotillion each year, and estimates that 90% of his "Cotillion Kids" enroll in college. He expresses his joy that his Cotillion Kids "are serious in their roles to be producers rather than consumers, and understand the importance of their unique role in our global community."

Howard Brown MACS Clinic Hours

Mondays: 4-7 pm

Tuesdays: 8-11 am

Wednesdays: 8-11 am

The MACS has one special Sunday clinic (8 am – 1 pm) per wave, usually during the last month of the wave. Please call ahead if you wish to reserve an appointment during that time. You can call the Scheduling Line anytime to request an appointment at 773-388-8889. When calling, please identify yourself with your MACS ID#, mother's maiden name, and your date of birth. We will confirm your appointment date and time

with you. You can reach the MACS Team via phone or email anytime. We look forward to hearing from you!

The MACS Team:

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Ethnic Differences in HIV Disclosure and Transmission Risk

Jason D. P. Bird, MSW and David D. Fingerhut, MS, MA

The following are excerpts from a poster presented at the American Public Health Association Conference in November, 2007.

Background

The recent rise in HIV infection rates has been accompanied by a renewed effort to find innovative and effective avenues for HIV prevention. Moreover, as effective treatments lead HIV-infected persons to live longer, healthier, and more sexually active lives, HIV prevention efforts are shifting towards routine HIV testing and increased HIV prevention interventions

among HIV-positive individuals (e.g. "Prevention for Positives" effort of the Centers for Disease Control and Prevention).¹⁻⁴ These intervention shifts will inevitably direct greater attention and debate towards the relationship between HIV disclosure and sexual risk. While research has shown that African-American Men who have Sex with Men (MSM) are generally less likely to disclose their same-sex sexual behavior than Whites⁵, little is known about specific HIV serostatus disclosure patterns to sexual partners and the relationship

between disclosure and HIV transmission risk among African-American MSM. Therefore, researchers with the Treatment Advocacy Program (TAP) sought to examine disclosure and its relationship to risk through an analysis of the TAP baseline data.

Methods

The Treatment Advocacy Program, a behavioral intervention for 317 ethnically diverse (White=47%, African-Americans=32%, Hispanic=17%, Other=4%), HIV-positive MSM, was conducted through Howard Brown, the University of Illinois at Chicago, the Chicago Department of Public Health, and Saint Joseph Hospital. Participants completed intensive baseline, 6-month, and 12-month questionnaires, which included questions about sexual

behavior, substance use, HIV-medication adherence, mental health, exercise behavior, social support, and disclosure. For these analyses, we assessed disclosure, which was defined as disclosing one's HIV-positive status to sexual partners 50% or more of the time, and transmission risk, which was defined as any unprotected anal sex with an HIV-negative or -unknown partner. We further analyzed the differences in disclosure patterns based on the known or perceived HIV-status of the participants' sexual partners.

Results

The results of this analysis suggest three important patterns. Table 1 presents the first pattern – TAP African-American participants were significantly less likely than White participants to engage in HIV sexual transmission risk (21.8% v. 36.7%, $\chi^2(1, n=251) 6.29, p=.012$). Table 2 highlights the second pattern – African-American participants were significantly less likely than White participants to disclose to their sexual partners, regardless of their partners' HIV status (HIV+, $\chi^2(1, n=225) 12.79, p<.001$; HIV-, $\chi^2(1, n=221) 24.95, p<.001$; and HIV-unknown, $\chi^2(1, n=224) 3.91, p=.048$) (Table 2). Finally, among African-American participants, disclosure to HIV+ partners ($r=-.205, p=.048$) and HIV- partners ($r=-.290, p=.006$) was related to decreased unprotected anal intercourse; whereas, disclosure to HIV-unknown partners was not significantly related to sexual risk taking behavior. In contrast, among White participants, disclosure to HIV+ and HIV- partners was unrelated to risk; while the disclosure to HIV-unknown partners was related to decreased sexual risk taking ($r=-.193, p=.026$).

Discussion

Overall, disclosure and sexual risk taking among African-Americans and Whites followed distinctly different patterns in the TAP sample. This suggests that while

(see *Ethnic*, page 10)

Table 1
HIV Transmission Risk

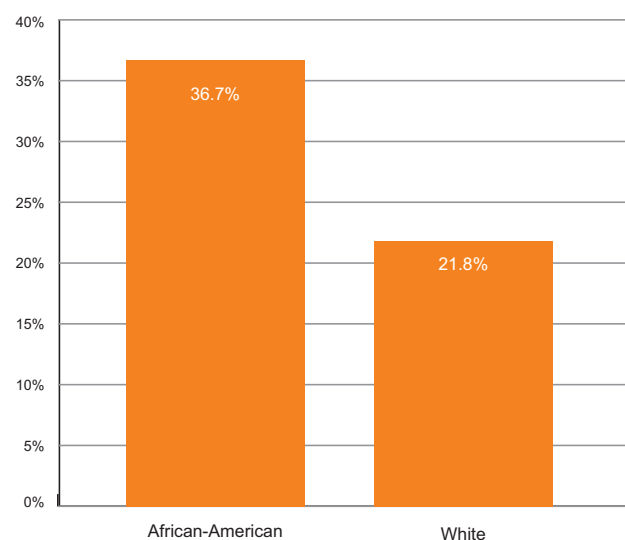
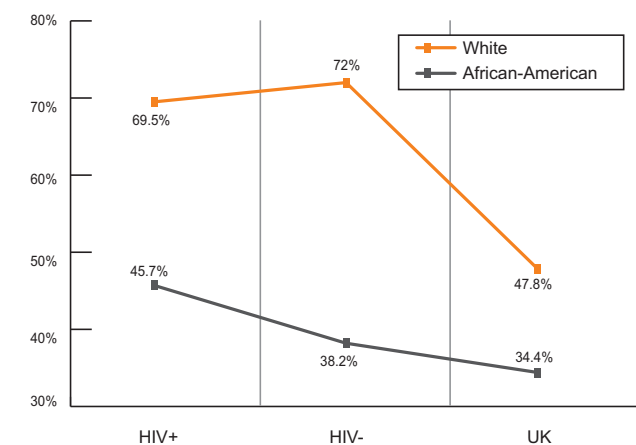


Table 2
Disclosure to at Least 50% of Sexual Partners by Sero-status



(Family, from page 4)

Table 2 presents the results of paired sample t-tests, comparing the mean percent of labor between each parent; tests were run separately for male-led and female-led homes. For females, one parent carried significantly more of the cooking, shopping, and child care. Labor was more evenly divided between the males; only for childcare, did one parent carry significantly more of the labor. There were no significant differences in all other household labor for males.

There are clear differences in the environment of same gender led homes compared to national norms. In all cases, these differences were positive, like more cohesion, more expressiveness, and less conflict. Overall, these families are tight knitted and expressive, with an achievement, intellectual, and recreational orientation. Lesbians and gay men are very purposeful in their quest to become parents – they can go to extraordinary lengths to become pregnant or adopt. They are also likely to face discrimination in a largely heterosexual society. These are some of the reasons that may explain why same gender led families are more cohesive. The intellectual and achievement orientation is likely an artifact of the high socioeconomic status of the sample.

When it comes to division of labor, same gender led families look very different from what is known about opposite gender families where males work for pay outside the home, and females handle the child care and domestic chores.⁶ The same gender families in this study divide much of the labor evenly. Yet there was still an imbalance in

childcare as compared to earlier research in lesbian homes.⁷ In this study, there was clearly one parent who took the lead on childcare, but other household labor was more equitable, particularly for the males.

It is also important to look at the association of the family environment and division of labor with child development. Family systems theory states that systems within a family impact each other, and as such, the environment of a home can affect the development of children. Yet, consider this: a review of eight studies⁸ looking at gender role behavior found few differences between children raised by same gender parents and those raised by opposite gender parents; in only one study did differences emerge, with girls of lesbian mothers preferring some boy-typical activities. So in spite of the fact that children of lesbians see their parents take part in traditional (childcare and cooking) and non-traditional (yard work, home repairs) labor, these children end up not differing from children raised in opposite gender homes in gender role behavior. In this case, perhaps societal and peer influences are overriding familial influences.

Legal obstacles remain for LGBT parents to co-adopt. More evidence is needed to show the normalcy of same gender led families and more specifically, how children in these families develop. The Howard Brown LGBT parent study will allow for further analysis as well as serve as a spring board for future studies with greater external validity.

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4. Patterson, C. (1992). Children of lesbian and gay parents. *Child Development*, 63, 1025-1042.
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Clinical Counseling Group Supervision for Researchers

Nicky Martin, MS, LCPC

Howard Brown's Department of Research began an official department wide meeting to help ensure we conduct the best, most appropriate, and comprehensive research with our participants as possible. We modeled this meeting after the traditional Clinical Group Supervision model used by counselors and therapists in clinic settings.

Training is designed to:

- expose researchers to several different supervisors and peers to enrich our learning experience.
- provide general training experiences and professional growth.
- provide case presentations, give peer feedback, and discuss general clinical issues.
- help us to check in on and follow ethical and legal guidelines.
- promote a challenging yet supportive environment which examines the dynamics of the participant, the researcher, and the interpersonal interaction between them.

The supervisor helps provide a framework for considering alternative therapeutic models and strategies, become more sensitive to the implications of cultural differences, hone the sense of professional responsibility and values, and incorporate the various components of the training experience.

Researchers differ from traditional clinical counselors:

- Supervision is not necessarily meant to be a monitoring tool
- The main objective in research is to collect data, which differs from clinical counselors who aim to build therapeutic relationships.
- Researchers strive to keep a balance

(see *Counseling*, page 10)

(Adolescents, from page 5)

Victimization

Many youth had experienced victimization. Females (53%) were more likely than males (32%) to have been raped ($p < .048$). When compared to national youth data³ for rape, the prevalence of rape in this study was five times the national average for females; and eight times the national average for males. Additionally, 40% of the sample had been assaulted, and 9% had been stabbed or shot. (See Table 2)

Distress

Non-specific psychological distress (a composite of anxiety and depressive symptoms) was measured in this study. Distress was correlated to lack of perceived physical ($r = -.31, p < .006$) and emotional safety ($r = -.34, p < .002$) at their parent's home; and frequency of homelessness ($r = .35, p < .005$). Having a history of homelessness was associated with higher levels of distress ($F = 6.89, df = 1, p < .01$).

Discrimination

Discrimination was measured as the frequency with which LGBT individuals experienced specific heterosexist discriminatory events. Lifetime discrimination ($r = .44, p < .001$) and the stressfulness of the discrimination was correlated to distress ($r = .41, p < .001$).

1 D'Augelli, A. R., Grossman, A. H., & Starks, M. T. (2006). Childhood gender atypicality, victimization, and PTSD among lesbian, gay, and bisexual youth. *Journal of Interpersonal Violence, 21*(11), 1462-1482.

2 Roy, E., Haley, N., Leclerc, P., Sochanski, B., Boudreau, J. F., & Boivin, J. F. (2004). Mortality in a cohort of street youth in Montreal. *JAMA, 292*(5), 569-574.

3 Youth Risk Behavior Survey. (2005). 2005 National Data Files. Retrieved January 2, 2008. from <http://www.cdc.gov/HealthyYouth/yrbs/data/index.htm>

Resilience

Resilience is a process of rebounding from adversity. Resilience was predicted by higher perceived safety at their parent's home and low distress ($F = 6.91, df = 3, p < .001$), and was inversely correlated to distress ($r = -.33; p < .004$). Youth with some college had significantly higher levels of resilience than youth with other levels of education. Surprisingly, the lowest levels of resilience were found among those youth still in high school ($F = 3.48, df = 3, p < .02$).

In summary, high rates of homelessness, several dangerous income securing behaviors and experiences of victimization were common in this sample. These findings lend support for the need for supportive services for LGBT youth – offering preventative programming to potentially avert some victimization as well as offering services to those youth who find themselves homeless and/or victimized. Additional research is needed to identify the circumstances leading to victimization and the specific services youth desire and feel would be helpful to them.

(Latina, from page 3)

With these data, Amigas Latinas plans to engage community members in conversations about the experiences and needs made apparent in the survey. Amigas Latinas also aims to empower LGBTQQ Latinas to address community needs. The organization is committed to developing intensive programming around the most pressing discoveries from survey results, and will encourage and support the emergence of leadership teams to address issues brought to light in the survey results. Together with the leadership teams, Amigas Latinas will facilitate the development of an action plan to address the important issues highlighted by the survey. In this regard, the ongoing goals of the organization involve encouraging mainstream Chicagoland Latino communities to address the needs of Latina LGBTQQ women within their communities, and to pressure the mainstream GLBT community to address the needs of queer Latinas.

Amigas Latinas anticipates that the dissemination of survey results and the ensuing activism inspired by the survey findings will contribute to breaking silence, reducing feelings of isolation, fostering feelings of empowerment, sparking community dialogue and action, and creating a safer and more just world for Chicagoland Latina LGBTQQ women.

1 Anzaldúa, Gloria, ed. 1990. *Making face, making soul hacienda caras: Creative and critical perspectives by feminists of color*. San Francisco: Aunt Lute Books.

2 García, Alma, ed. 1997. *Chicana feminist thought: The basic historical writings*. New York: Routledge.

3 Moraga, Cherrie. 1983. *Loving in the war years: Lo que nunca pasó por sus labios*. South End Press.

4 Yadira Ortiz, Rosa. 2002. *¿Soy a dyke y qué? A quest for identity and sacred space*. *Dialogo 9*: 12-17.

(Abuse, from page 6)

couples, many MSM who need help may not be recognized unless the health care provider is appropriately trained and takes time to assess for abuse.

Another challenge lies in reaching men who experience abuse, and ensuring that those who seek help are effectively served. Study findings indicate that this may be made more difficult by the help-seeking behaviors of abused men. Despite their heightened rates of health problems, the rate of medical visits by

abused versus nonabused men did not differ significantly, according to results reported in the study. The finding that abused men were more likely to seek care from a mental health professional suggests that medical providers may want to routinely screen gay and bisexual men for depression, given its association with intimate partner abuse. The connection between abuse and a range of physical health problems also suggests that health providers should pay closer attention to men reporting

these health problems. Gay/bisexual health centers may play a heightened role in this area, as these sites often provide both medical and mental health services. It is imperative that future research focuses on ways to assess abuse and to examine strategies designed to improve outreach to bring these men out of danger and to improve their overall health outcomes.

(Ethnic, from page 7)

African-Americans may disclose to significantly fewer of their sexual partners, they are also engaging in less transmission risk. One hypothesis for this pattern is that African-American MSM may be avoiding sexual risk instead of disclosing, thereby avoiding the stigma and negative social consequences associated with HIV disclosure. If this hypothesis is accurate, then it illuminates a larger issue regarding HIV stigma, namely, that African-American MSM may view HIV infection as a more stigmatizing experience than White MSM.

Finally, it is important to note that the impact of disclosure on sexual risk was inversely related within the two groups. In other words, African-American participants who disclose to sexual partners 50% of the time or more, were less likely to engage in sexual risk with HIV+ and HIV- partners while White participants, who disclose to sexual partners 50% of the time or more, were less likely to engage in sexual risk with partners whose HIV status was unknown. This suggests that interventions specifically targeting disclosure should

take into account racial and ethnic differences. Moreover, this data show a continuing need for culturally tailored HIV prevention interventions that target sexual risk taking behaviors.

Conclusions

The TAP data cannot fully evaluate the reasons why these risk and disclosure patterns are different; however, they highlight the need for greater quantitative and qualitative research exploration of these group differences. Howard Brown seeks to examine issues of HIV disclosure and the relationship between disclosure and risk through current and future studies, including Project MIX and ICARE. It is our hope that future research will further define the particular patterns of sexual risk and HIV disclosure and increase our understanding of the challenges and barriers associated with disclosure. This information is essential to assess accurately the impact of interpersonal communication on HIV interventions, safer sex negotiation, and HIV testing among groups at high risk for HIV infection.

- 1 CDC. (February 1, 2007). Fact sheet: HIV/AIDS among African Americans. <http://www.cdc.gov/hiv/topics/aa/resources/factsheets/aa.htm>.
- 2 Crepaz, N. & Marks, G. (2003). Serostatus disclosure, sexual communication, and safer sex in HIV-positive men. *AIDS Care*, 15(3), pp. 379-387.
- 3 Gorbach, P.M., Galea, J.T., Amani, B., Shin, A., Celum, C., Kerndt, P., Golden, M.R. (2007). Don't ask, don't tell: patterns of HIV disclosure among HIV positive men who have sex with men with recent STI practicing high risk behavior in Los Angeles and Seattle. *Sexually Transmitted Infections*, 80, pp. 512-517.
- 4 Sullivan, K. M. (2005). Male self-disclosure of HIV-positive serostatus to sex partners: A review of the literature. *Journal of the Association of Nurses in AIDS Care*, 16(6), 33-47.
- 5 Millett, G.A., Peterson, J.L., Wolitski, R. J., & Stall, R. (2006). Greater risk for HIV infection of Black men who have sex with men: A critical review of the literature. *American Journal of Public Health*, 96(6), pp. 1007-1019.

(Counseling, from page 8)

with participants. Data collection and retention are effected by keeping participants engaged and by building relationships with them.

- Researchers also refrain from intervening on participant issues.
- The purpose of each study will dictate the level of interaction between researchers and participants, necessitating a constant need for balance. Study procedures can range from pen and paper data collection, to intimate specimen collections, to behavioral intervening and everything in between.
- Perhaps supervision for researchers may, at times, mean more problem solving for the researchers rather than for the participants.
- In addition to legal and ethical guidelines, researchers must adhere to research protocols, Human Subjects Protection guidelines and any guidelines set forth by funding institutions.

A typical meeting agenda may include the following elements:

- I. Review the purpose of the meeting for new members
- II. Introduce new members
- III. Review group guidelines, which describe maintaining confidentiality for participants and staff in a supportive, respectful atmosphere.
- IV. Case Presentation(s) using non-identifiable participant information
- V. Staff Concerns/Issues
 - a. Particular stresses
 - b. Other issues/concerns

For the past 18 months this meeting has proven to be very helpful in getting ideas and feedback from others to help us conduct sound quality research as a team, and we plan to keep it up.

Are you an LGBT parent?

If yes, please participate in an anonymous Internet survey about the family and peer relations of children raised by LGBT parents.

The online survey will take approximately 30 minutes to complete. Participants may enter a drawing for \$50.

To find out more about the study contact Blase Masini at survey@howardbrown.org

To participate, visit www.howardbrown.org



Principal Investigator:
Blase Masini, PhD of
Howard Brown Health Center



New roles and new faces in research at Howard Brown



Nicole Perez comes to the Department of Research from BYC case management. She now divides her time coordinating two studies: TWISTA, an intervention for young transgender women, and a colorectal

cancer screening study for LGBT adults testing tailored messaging. Nicole completed her Master's degree at DePaul University in Interdisciplinary Studies with a focus in Women and Latino studies in sociology. She served as the principal investigator for a campus climate survey for DePaul and Project Latina for Amigas Latina. She plans to get a PhD in the social sciences and devote her life as "a fierce scientist in queer research." Oh, and if you see her tumbling around the department, it may be because she was a gymnast for 10 years.



Jessica (Jessie) Lefebvre was promoted from Clinical Research Assistant to Clinical Research Coordinator. In her new role, she will take charge of clinical research trials, starting with Gilead 0130, a study testing an HIV

medication, GS-9137 (Elvitegravir), an experimental integrase inhibitor under development by Gilead Sciences. She is also slated to coordinate new studies, beginning with a device study for a rapid flu test. This promotion brings Jessie a little closer to her goal of completing nursing school since solid clinical research experience is an asset to incoming students. She remains committed to a variety of outdoor activities, but few know she loves road trips on a motorcycle.



Arnaldo Vera is the Research Assistant for youth research and an administrative assistant for Michael Cook, Howard Brown's CEO. He is also serving as interim Project Coordinator for a new study developing an HIV

prevention intervention for young MSM. Arnaldo arrived in Chicago five years ago from Puerto Rico to attend college. He is a graduate of the University of Chicago where he obtained a BA in Biological Sciences. He has worked on research projects addressing racial disparities in medicine and accessibility to health care. Arnaldo was recently accepted into medical school in Puerto Rico. He is also an Eagle Scout.



Selket Lewis is a Recruitment and Retention Specialist on Project ICARE, an HIV prevention study for African American MSM. She recently completed a PhD program in counseling psychology at the University at Albany

and is currently writing her dissertation. She comes to us from Northwestern University where she completed a one-year pre-doctoral internship. She plans to work in service delivery and substance abuse. When you have time, join Selket for a veggie burger – she has been a vegetarian for 13 years.



David Moore transferred from HIV/STD Prevention to work as a Group Facilitator on Project ICARE, an HIV prevention study for African American MSM. Prior to working at Howard Brown, David was the manager of a health

club. He studied history at Northern Illinois University. Eventually David would like to use his experience to establish a community based organization devoted to providing housing and job skill training to gay African American youth. In the meantime, he's planning on running with the bulls in July!

Michael Maloney has been a research volunteer extraordinaire for the last year. He recently accepted a part time position to collect program evaluation data for our smoking cessation program, Bitch To Quit, and also serves as IRB assistant. Michael studied psychology at Marquette University in Milwaukee, completing his BA in 2005. He is currently applying to Master's programs in psychology with plans to complete a PhD. When he is not here or at his other part time job at Borders Books, Michael is out and about playing the clarinet for The Lakeside Pride Music Ensemble and the Gay Marching Band.



Carl Streed is the new Clinical Research Coordinator for SENEKA, an observational study of a non-invasive assay monitoring liver disease in participants co-infected with Hepatitis C and HIV. Prior to coming to Howard

Brown, Carl worked at Sidetrack and the Princeton Review. Carl completed his BS in biochemistry /chemistry at the University of Chicago. He plans to attend medical school and complete a master's in public health. He is also taking tango dance classes which may live up his step around Howard Brown.



Julia Brennan is a nurse practitioner working on clinical trials under the Adolescent Trials Network. Before coming to Howard Brown, she completed her Master's in Nursing with a focus of HIV/AIDS at the University of California at

San Francisco. In 2003, she completed a 2-year tour in the Peace Corps in Nepal. Her professional goals are to continue providing HIV clinical care and to do more international work. Speaking of international, she is planning a trip to Antarctica since that is the only continent she has yet to visit.



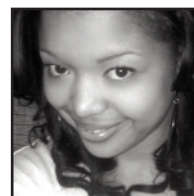
Chandra Matteson is the new Clinical Research Manager. She comes to us with over 5 years experience running clinical trials as a research nurse. Now she is moving into management and has set her mind to growing our

clinical research division. She studied nursing at City Colleges, completing an Associates Degree in nursing and biotechnology. Someday she wants to devote herself to full time volunteer work to provide HIV care. In the meantime, she is helping us build a solid clinical research program. Oh, and she can breathe fire – perhaps to entertain us at our next social gathering.



Besheer Mohammad is a part-time Interviewer on our Cultural Predictors study of adolescents and HIV risk. Under the direction of Rob Garofalo, MD at Howard Brown and Steven Eyre, Ph.D. at UCSF, Besheer is conducting qualitative

interviews with at-risk youth. Besheer is a full time doctoral student at the University of Chicago, studying sociology of religion in the sociology department. His goal upon completing his PhD is to secure a tenure-track position at a research university. He told us he underwent a career change not so long ago – in a former life he was a software developer. He has a wife and beautiful 15 month old daughter.



Frankia (Kia) Granberry is a part-time Interviewer on our Cultural Predictors study of adolescents and HIV risk, conducting qualitative interviews. She completed her Bachelor's degree in psychology at Clark Atlanta University in

Atlanta. She is now working on a Master's degree in anthropology, with plans to earn a PhD in a social science discipline. Her goal is to secure a university faculty position in the social sciences. When she is not interviewing youth or cramming for finals, she paints portraits in oil, acrylic and watercolors and has exhibited her work in the past.

Trans-Women Informing Sista Trans-Women on Topics of AIDS (TWISTA)



Howard Brown

**4025 North Sheridan Road
Chicago, IL 60613
773-388-1600**

Services at the main location include all medical services, behavioral health and social services, research, youth services, case management, and the Walk-in Clinic. This location serves the community as the preeminent source for LGBT health care. Most HMO/PPO plans accepted.

**TRIAD Health Practice
3000 North Halsted Street,
Suite 711
Chicago, IL 60657
773-296-8400**

TRIAD Health Practice provides all of our medical services, including primary care, gynecological services, family planning, and health screenings and check-ups. TRIAD accepts both HMO and PPO plans, and provides on-site parking.

**Broadway Youth Center (BYC)
3179 N. Broadway
Chicago, IL 60657
773-935-3151**

BYC is a program of Howard Brown and our community partners, offering comprehensive services to all youth 24 and under. Services include: case management for youth who need help with housing, job placement or basic needs; HIV testing and STD screening and treatment; medical services and education; individual and group counseling; and drop-in services including computer and internet use, laundry, food, and shower facilities.

Trans-Women Informing  Sista Trans-Women on AIDS

TWISTA

A Howard Brown Health Center Program

Twista is a CDC DEBI 'SISTA' adaptation taking place at the Broadway Youth Center (BYC). TWISTA is open to youth between the ages of 16-24 who self-identify as transgender women

of color. The TWISTA curriculum includes transgender and ethnic pride, HIV/AIDS education, harm reduction and safer transitions, assertiveness skills training, coping, and a review/peer teach-back session. TWISTA also includes a research evaluation component. The TWISTA program recently finished its second cycle. Nine young transwomen of color entered the program and ALL nine graduated. The TWISTA program is unique in adaptations for transgender populations because it is peer-based and peer-led. It was created by a transgender woman, and three young transgender women of color are the program facilitators. Above, members of the TWISTA team.

SAVE THE DATE!!

Rob Garofalo, MD, MPH presents

HIV Prevention Research in Transgender Youth

Friday October 3, 2008

Look for details this fall.

Dr. Garofalo is affiliated with Children's Memorial Hospital
and Howard Brown Health Center

www.howardbrown.org

**Lakeview: 3651 N. Halsted
Andersonville: 5404 N. Clark
Wicker Park: 1459 N. Milwaukee
Oak Park: 217 Harrison
Schedule your pick up online at
www.howardbrown.org
or call 773-549-5943**