

# The Effectiveness of Project RESPECT in Reducing Sexual Risk Behaviors of Male-to-Female Transgender Patients

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## ABSTRACT

**Objective:** The purpose of the present study was to determine the effectiveness of Project RESPECT in reducing sexual risk behaviors of male to female transgender patients.

**Methods:** In an interventional, quasi-experimental and case-control study, 30 transgender patients (male to female) with high-risk sexual behaviors were selected and divided into two experimental and control groups. Transgender patients in experimental group received a four-session intervention conducted one session per week individually, but control group received no intervention. The instruments include demographic and Sexual Risk Behavior questionnaires. Data were analyzed using independent t-test, chi square and percent differences.

**Results:** Although frequency of sexual risk behaviors did not change significantly in experimental group, higher sexual risk behaviors were reduced significantly ( $P \leq 0.01$ ).

**Conclusion:** Project RESPECT is more effective in reducing higher sexual risk behaviors than frequency of sexual risk behaviors among male to female transgender patients.

## 1. Introduction

The Male To Female (MTF) transgendered community comprises of individuals who desire to live as a woman despite their male gender at birth (Operario & Nemoto, 2005). The unusual behavior and appearance of transgender patients often lead to their loneliness and social isolation at very young age. Transsexual and transgender individuals are victims of stigmatization and humiliation in society and in their families, which force them to deny their feelings and want them to adapt their behaviors to their birth sex, just to be like others.

Besides, they frequently experience hardships in finding jobs, career and housing. They are often abused or harassed because of their physical appearance and confronted with pervasive discrimination in restaurants, stores and the other public places. Exposure to stigma

and transgender-related discrimination lead them to feel guilty, ashamed and depressed. Such discrimination can also lessen their self-esteem and increases trading sex, drug use and suicide (Scott & Lines, 1999; Ellis & Eriksen, 2002).

There are different reasons for engaging in sex industry. The gender confirmation surgery is a very expensive procedure. Being deprived from family and social support, the transgendered tends to earn the money through sex trade (Nemoto et al., 1999) especially because the employment barriers usually prevent them from finding other ways to provide for the surgery. Sex trade is the most applicable choice to meet their survival needs (Scott & Lines, 1999; Ellis & Eriksen, 2002). However, the trouble does not end there. The additional money paid for unprotected sex and their demands lead them to engage in unsafe sex. Transgender patients are prone to HIV through both vaginal and anal intercourse after sur-

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gical reassignment surgery. Most of the transgender sex workers are both drug and hormone abusers and injectors. In addition, by taking amphetamines they engage in sex working for longer hours. Thus, those transgender patients who involve in commercial sex work and or injecting drugs or hormones are at higher risk for HIV infection (Nemoto et al., 1999).

Prior studies have shown that sexual high-risk behaviors are prominent among male to female transgender patients. Javaheri & Koochakian (2006) found that 60% of transgender patients among 40% of transgender patients in Iran had sexual high-risk behaviors. Another study of transgender patients in Iran (Mehrabi, Moshtagh, & Eftekhari, 2007) indicate that these male to female transgender patients are at high risk for HIV infection because of their sexual risk behaviors.

A study by Nemoto et al. (1999) revealed that female transgender patients were more likely to engage in risk behaviors such as having several sexual partners in the past 30 days and the past 6 months, working in the sex trade industry and having stable partners who injected drugs. Edwards, Fisher, and Reynolds (2007) believed that engaging in unprotected sex for earning money and reusing the needles were among the main causes of HIV infection in transgender patients. Despite this context, there are limited (if any) prevention programs aimed at sexual high risk behaviors of this vulnerable and marginal group.

“Enhanced counseling intervention”, one of the Project RESPECT conditions, the longest and most intensive intervention, seems to be suitable for using in public clinic settings and prevents HIV by changing behaviors and reducing new Sexually Transmitted Diseases (STDs) (Centers for Disease Control and Prevention, 1993). The intervention includes four-session prevention counseling that is based on an Integrative Model (IM), Reasoned Action Theory, the Health Belief Model and Social Cognitive Theory (Rhodes et al., 2007). The Project RESPECT has been shown to reduce the unsafe sexual behaviors, STDs and increased condom use over the next 12 months after implementation (Kamb, Fishbein, & Douglas, 1998).

In a study by Rhodes et al. (2007), they found that Enhanced Intervention significantly increased condom use for both men and women with respect to both stable and casual partners. Kamb et al. (1997) investigated the efficacy of Project RESPECT in reducing HIV and STDs infections among 5801 heterosexuals. They concluded that in 3-6 months follow up, Enhanced Counseling In-

tervention could effectively increase condom use and decrease the number of sexual partners among both men and women.

Although transgender patients are at significant risk for HIV (Bockting, Robinson, & Rosser, 1998), there is a dearth of information and research on these communities in Iran. In this study, we evaluated the effectiveness of the enhanced counseling in reducing the intensity and frequency of sexual high-risk behaviors.

## 2. Methods

### Intervention

Each session of Enhanced Counseling includes individual face-to-face HIV prevention strategies and builds on materials from the preceding session. In addition, it depends on each individual's personal risk. Particularly, this intervention focuses on increasing consistent condom use for vaginal and anal sex with all partners. According to IM theory, Enhanced Counseling is directed at changing determinants of intentions. These components are attitudes, perceived norms and self-efficacy.

Session 1 lasted 15-20 minutes and focused on a personalized assessment of risk and establishment of risk reduction plan. The remaining sessions lasted 60 minutes. The purpose of session 2 was to change self-efficacy of condom use. Session 3 involved HIV testing and identifying situational barriers to condom use. Besides, it focused on condom use attitudes. At the final session, perceptions of norm regarding condom use were recognized and a long-term risk-reduction plan for avoiding HIV and STDs in the future was developed. The same counselor conducted sessions but she did not collect the participants' posttest data.

### Subjects and procedure

Participants were recruited through two private and public clinics of sexual disorders in Tehran. At first, these clients were interviewed by two psychiatrists and one clinical psychologist. General eligibility criteria for the survey were:

- (1) To be identifying as a transgender woman;
- (2) Having 18 to 35 years old;
- (3) Having sexual behaviors during the past month; and
- (4) Having a history of sexual risk behaviors including multiple sexual partners, irregular condom use and both injecting and non-injecting drug use during intercourse

**Table 1.** Comparison of demographics among each group condition.

	Experimental n=15	Control n=15	$\chi^2$	Independent
Age				-0.6 (NS)
Mean	23.67	24.47		
Education %			0.79 (NS)	
High school	33.3	6.7		
Diploma	46.7	80		
Associate's	20	13.3		
Means of income %			0.15 (NS)	
Student loan	13.3	33.3		
Part-time job	40	26.7		
Full-time job	33.3	26.7		
Family	0	13.3		
Sex-working	13.3	0		

\*\*  $P \leq 0.01$ .PRACTICE in  
CLINICAL PSYCHOLOGY

NS: Not Significant.

The clients were excluded if they did not have sexual intercourse during the past month, having one stable sexual partner at least during last year or using condoms regularly with their partners. Then, 30 male-to-female transgender patients who had high-risk sexual behaviors were selected and randomly divided into experimental and control groups. Subsequently, participants completed the demographic and Sexual Risk Behavior questionnaires. Experimental group received 4 intervention sessions within 4 weeks and completed Sexual Risk Behavior questionnaire each session after the enrollment. Although participants assigned to control group received

no intervention condition, they completed Sexual Risk Behavior questionnaire per week just like the experimental group.

### Measures

The questionnaires collected demographic data and evaluated sexual risk behaviors. The Sexual Risk Behavior questionnaire indicated occurrence, frequency and number of sexual partners, specific sexual acts with each partner, the use of condoms during each of sexual acts and the use of drugs during sexual behaviors.

**Table 2.** Risky sexual behaviors among experimental and control group during past month.

	Experimental		Control		$\chi^2$
	No	%	No	%	
Partner type					3.28 (NS)
Casual	6	40	11	73.33	
Stable & casual	9	60	4	26.66	
Sex under drug use	2	13.33	3	20	
No condom use					1.62 (NS)
With stable partner	9	100	4	100	
With casual partner	10	66.66	13	86.66	

\*\*  $P \leq 0.01$ .PRACTICE in  
CLINICAL PSYCHOLOGY

NS: Not Significant.

**Table 3.** Frequency and risk level of sexual behaviors in both experimental and control groups during previous month at pretest.

	Experimental n=15	Control n=15	Independent t test	Percentage differences
Risk level of sexual behaviors			0.88 (NS)	
Mean	2.09	2.37		
SD	1.08	0.55		
Frequency of sexual behaviors (%)	78.32	82.12		0.21 (NS)

\*\* P≤0.01. NS: Not Significant.

### 3. Results

Demographic characteristics of 30 clients are presented in Table 1. As it shows, there were no significant differences at the baseline in the demographic background factors such as age, education and means of income.

As outlined in Table 2, among the 30 MTF transgender patients, no one has merely a stable partner during last month. Furthermore, 40% of the experimental group had casual partners and 60% had both casual and stable partners. In control group, 73.33% had casual partners and 26.66% had casual and stable partners both. On the other hand, in participants who had both stable and casual partners, no one had used condoms in sexual behaviors with stable partners. However, 33.34% of experimental group and 13.34% of control group who had both stable and casual partners had used condoms regularly during intercourse with their casual partners. In addition, 13.33% of experimental group and 20% of control group consumed drugs while they had sexual behaviors. There were no significant differences at the baseline in sexual risk acts among the experimental and control group.

Table 3 demonstrates the sexual risk behaviors frequency and risk level of these behaviors among experimental and control group during a previous month. Frequency of sexual risk behaviors were the number of sexual risk acts during last month. In assessment of the risk levels of sexual behaviors, receptive unsafe anal sex

was considered as more risky than oral unprotected sex. On the other hand, intercourse with casual partners was considered as more risky than intercourse with stable partners. Therefore, sexual risk behaviors were given scores from 1 to 4 with respect to their riskiness in this way: unprotected anal sex with casual partner got score 4, unprotected anal sex with stable partner got score 3, unsafe oral sex with casual partner got score 2 and unprotected oral sex with stable partner got score 1. For assessing the risk level of sexual behaviors, frequency of these sexual behaviors were multiplied by their score values and then they were divided by number of all types of sexual behaviors.

Percent differences and independent t-test did not show significant differences at the baseline in experimental and control groups when assessing the frequency and risk level of sexual behaviors.

Table 4 shows frequency of sexual risk behaviors in both experimental and control groups at pre and posttest. There were no significant differences between pre and posttest of control group. Although frequency of sexual risk behaviors decreased in posttest of experimental group by RESPECT intervention, there were no significant differences were found between pre and posttest in experimental group.

Table 5 displays the risk level of sexual behaviors. Independent t-test revealed that the risk level of sexual

**Table 4.** Frequency of risky sexual behaviors in both experimental and control groups at pretest and posttest.

Frequency of risky sexual behaviors (%)	Pretest n=15	Posttest n=15	Percentage differences
Control group	78.32	77.66	0.05 (NS)
Experimental group	82.12	68.54	0.66 (NS)

\*\* P≤0.01.

NS: Not Significant.

**Table 5.** Intensity of risk level of sexual behaviors in both experimental and control groups at pretest and posttest.

	Experimental		Control		Independent t-test
Risk level of sexual behaviors	0.61	0.59	-0.49	1.42	2.78**

\*\* P≤0.01.

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NS: Not Significant.

behaviors was significantly reduced at posttest in experimental group. The risk level of sexual behaviors in control group did not change significantly at posttest.

#### 4. Discussion

This study suggests that Project RESPECT can effectively reduce the risk level of sexual behaviors in male to female transgender patients. This is consistent with previous data by Kamb et al. (1997, 1998). In spite of 13.58% reduction in frequency of sexual risk behaviors in experimental group, there were no significant differences between experimental and control group. Implicitly, the data suggests that Project RESPECT is more effective in decreasing higher sexual behaviors such as unsafe sex with casual partners than stable partners.

Some limitations might have led the frequency of sexual risk behaviors to not be influenced by Project RESPECT. Primarily because of the limited sample size, we were not able to examine the efficacy of Project RESPECT in reducing the frequency of sexual risk behaviors definitely. Besides, inaccessibility of participants' partners while conducting Project RESPECT may likely affect assessing the efficacy of this project.

Many studies have shown that interpersonal aspects of condom use, specially the type of the sexual partner, have a great influence on their decisions in condom use (Sacco et al., 1991; Vrungos, 2002; Rhodes et al., 2007). It seems that frequency of sexual risk behaviors in transgender patients also depends on the type of their partners. Interpersonal aspects and type of the partners may affect the other components of condom use (Nemoto et al., 2004).

Some studies have indicated that transgendered women who engaged in sex work may more likely use condoms in sexual behaviors with their casual partners than stable partners because of the intimacy and emotional connections of stable relationships (Nemoto et.al, 2004; Operario & Nemoto, 2005). Additionally, those who have stable partners have more difficulty to change their behaviors with their stable partners when they are at risk of catching HIV (HIV infection) (Vrungos, 2002). Bauman and Siegel (1987) found that gay men who had sex with one sexual partner or stable partners underestimated

their sexual risk behaviors more than those who had sex with casual partners (Sacco et al., 1991).

Besides, the perceived and imagined negative reaction of the partner when suggesting the safe sex may be another component to the failure of using condoms. These thoughts led them to avoid assertive communication with their partners (Gaies, Sacco, & Becker, 1995). Since women are more dependent on their male partners to buy and carry condoms, they are not more likely to use them (Sacco et al., 1991). Therefore, partner attitudes towards condom use and relationship status play an important role in sexual behaviors (Vrungos, 2002).

Devisser & Smith (2001) reported that condom use in persons with stable relationships depended more strongly on established behavior patterns like prior agreement of both partners whereas in individuals who have casual partners, condom use was related to the interactions like partner intentions to use condoms or their self-efficacy (Vrungos, 2002). As previously noted, there were no access to larger sample of transgender patients and specially their partners. Since the study was based on self-reported measurements, the results could have some biases. Because of the cultural taboos related to discussing sexual behaviors, sexual partners or drug use, participants might minimize their risk behaviors.

In addition, clients may not remind or estimate their sexual risk behaviors accurately while reporting their sexual behaviors. Further studies on larger sample of transgender patients can provide additional insight into this community in Iran. It may be more effective to conduct this project on individuals and their partners. While we evaluate the effectiveness of Project RESPECT, studies focused on different components of IM associated with condom use can extend research knowledge on HIV risk among transgender patients.

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