

# *EXPLORE*

## Delivery Manual Guide



# **EXPLORE**



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This manual presents the behavioral intervention (*EXPLORE*) being tested in a randomized controlled trial conducted by the HIV Network Prevention Trials (HIVNET). The purpose of this clinical trial is to test the efficacy of the behavioral intervention compared to standard risk reduction counseling to prevent acquisition of human immunodeficiency virus (HIV) type-1 among men who have sex with men (MSM). This trial is particularly important because it is the first such study with HIV infection as an endpoint. It builds upon Phase I and II studies that have demonstrated the potential of specific behavioral interventions to reduce self-reported behavioral risk among MSM.

The behavioral intervention being evaluated in this trial is based on the extensive literature on behavioral approaches for risk reduction targeting MSM. As recommended by the literature, the intervention addresses the variety of circumstances and emotional issues contributing to unsafe sex among HIV-negative MSM. The intervention is tailored to an individual's unique problems and needs, lifestyle, and situations that contribute to his high-risk behavior. As such, the intervention responds to recent recommendations that have called for the development and evaluation of behavioral interventions to reduce HIV-related risk behaviors, including the practice of unsafe sex and sharing needles in the context of alcohol and substance use. In addition to being tailored to the individuals, the recommended behavior changes are developed with a participant-centered framework. Decisions about specific steps taken to change behavior and the pace of change are generated by active participation by the individual rather than by a prescription from the counselor. The behavioral intervention consists of 10, one-to-one 1-hour visits over a four- to five-month period, followed by maintenance visits that occur at least quarterly for the remainder of the three-year follow-up period.

The purpose of this trial is to determine whether or not the behavioral intervention is superior to the standard HIV risk reduction counseling. In order for the trial to provide a definitive answer to this extremely important question, it is essential that the behavioral intervention be delivered according to the protocol. For this reason, the Delivery Manual and Delivery Manual Guide provide detailed descriptions and implementation instructions for the standard and intervention counseling visits.



*EXPLORE* is the product of several years of hard work and the dedication of more than one hundred talented staff and researchers throughout the United States. We would like to acknowledge and thank each of them for their contribution. We look forward to working together during the coming trial.

Here's to a new challenge!

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# Introduction to *EXPLORE* Manual

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The counseling strategies employed in *EXPLORE* are based on four principles:

- The intervention is based on sound psychological theories proven effective in HIV risk reduction in previous studies;
- The counseling strategies address the individual and idiosyncratic reasons why people get exposed to HIV;
- The intervention, to be effective, is individually administered and is flexible enough to focus on the individual's needs;
- The intervention is delivered to people in ways and at places maximally convenient to them.

The intervention weaves together a strategy for addressing the myriad reasons why individuals take HIV-related risks with sound behavior change theory. Thus, it aims to address each individual's issues and reasons for risk-taking with theoretical approaches that have proven effective in motivating and maintaining HIV risk reduction.



## Theories Underlying the Counseling Strategy

The approaches that comprise the intervention are based on a culmination of research with men who have sex with men (MSM) which has defined the necessary characteristics of the interventions conducted by Kelly, (Kelly, et al., 1989, Kelly, 1995), Rotheram-Borus, (Rotheram-Borus et al., 1991), Peterson (Peterson, et al., 1996) and others conducting prevention research in HIV/AIDS (Coates, et al., 1995).

Multiple theoretical frameworks influenced the development of this intervention, including:

- (1) the information-motivation-behavioral skills model (Fisher & Fisher, 1992),
- (2) problem-posing education (Friere, 1973; Sanchez-Merki & Wallerstein, 1989),
- (3) self-management and social learning theory (Bandura, 1986),
- (4) cognitive-behavioral therapy (Beck, 1976; Persons, 1989), and
- (5) motivational interviewing (Miller, 1991; Carey, 1996).

In problem-posing education, self-management and social learning theory, participants are fully involved in the identification of their problems with risk-taking behaviors and in developing self-management strategies to impact these problems and promote behavior change. Key aspects of this approach are that behavior change is more lasting when individuals are actively involved in finding and implementing solutions to their problems and that there is no single or best solution to problems.

In cognitive and behavior therapy, the relationships between an individual's cognitions, emotional states, and behaviors are identified, problems are prioritized, and techniques to promote change are implemented.



In motivational interviewing, the focus is on helping the individual resolve ambivalence about change, aiding them in developing a behavior change plan of their own, and thus, generating a personal commitment to change.

The counseling procedures employed in *EXPLORE* use the best of each of these theoretical strategies and apply them to the issues, circumstances, and determinants of risky behavior among gay men.

### Why Do Men Who Have Sex With Men Get Exposed to HIV 17 Years Into the Epidemic?

Early HIV preventive interventions focused on knowledge and skills needed to reduce risk. Some also attempted to motivate individuals to safer sexual practices through eroticization of these practices. It would be foolish to say that these elements were not successful. Indeed, they may still be necessary elements in HIV risk reduction—for *some individuals*. Others may possess the knowledge and skills needed to reduce risk, but may fail to engage in safer practices consistently for a variety of reasons. Substance use and abuse, loneliness, low self-esteem, inexperience, lack of ability to exercise power in relationships, the desire for intimacy, feeling under-served because one is HIV negative; all of these issues may inform a highly individualized, complex pattern of risk-taking.

This required that we develop a counseling intervention capable of covering all of the issues that affect gay men's ability to practice safer sex and flexible enough to address each individual's needs. We developed 10 modules addressing the variety of issues leading to lack of safety. All participants will receive a portion of all modules, but the relative weight given to each module will vary with the participant's needs. The emphasis placed on each module will be based on each participant's pattern of risk behavior.



Substance use and abuse are especially important. The modular design of the intervention is flexible enough to focus on substance use for those participants who indicate that their risk behavior increases in association with alcohol and drug use. If alcohol and drug use predominate in an individual's risk profile, then the remaining modules will give reference to this important issue. "Track 2" of Modules 4, 6, 7, 8, and 9 provide an intensive counseling focus on substance use and risk-taking. Further, those who are in any type of abstinence-based recovery program for substance abuse will have an opportunity to transfer knowledge and skills from their recovery experience to sexual risk reduction through "Track 3."

It is also understood that the modules themselves may not address everyone's needs. Referrals remain an important option. The counselor and the individual can discuss referral needs and options and use a variety of agencies for special needs such as substance abuse, mental health, social and practical support, etc.

### Individually Administered and Flexible

Individual rather than group counseling was chosen for this intervention for several reasons. First and foremost, the intervention needs to be individually tailored to each participant. All participants will receive all modules, but in varying degrees. Individuals will vary in the degree to which they need the strategies employed in each module and we believe that we will be maximally effective by paying attention to the issues expressed by each individual participant. Put simply, an intervention for a gay men who engages in unsafe sex due to substance abuse needs to be different from that for persons whose unsafe behavior results from feeling "triggered" by certain partner types or emotionally-laden life events.

We also believe that individually administered and flexible interventions will be more transferable to public health settings where participants are seen individually and where group interventions may be logistically more difficult than individual ones.



## Convenient to the Participants

The public health generalizability of the intervention requires that the intervention be delivered to the client in a way that is maximally convenient. This means that some sessions might be held over the telephone, while others might be held off-site, at a place convenient for the participant and conducive to counseling. It may be highly cost-effective to offer services to clients in ways that use newer technologies and employ strategies that insure that our interventions are delivered to the highest risk individuals.

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## Overview to EXPLORE Delivery Manual Guide

The Delivery Manual Guide is designed to facilitate effective *EXPLORE* counseling. It may serve as a useful reference tool as counselors work with the standard and intervention counseling visits outlined in the Delivery Manual.

It will hopefully prove useful to counselors as they first learn how to deliver *EXPLORE* counseling and further in the trial when questions and problems arise. The Guide supports the Delivery Manual by explaining the purpose, goals and objectives of each module. It also provides practical suggestions for working with specific exercises and discussions. The Guide also offers recommendations for *EXPLORE* counseling challenges such as phone visits, off-site visits, and working with lower risk men.

The Guide is intended to be used in combination with the training, guidance and supervision of the Clinical Coordinator, the support of the site counseling team, and the ongoing recommendations and technical support from the Intervention Coordinating Center at UCSF CAPS.



## Structure and Delivery of Intervention Modules

The following points summarize basic principles regarding the structure and delivery of *EXPLORE* intervention modules.

### Module Delivery Order

- Modules 1, 2, and 3 are always delivered first and in order (at Visits 3.0, 4.0, and 5.0, respectively).
- Modules 4, 6, 7, 8, and 9 are comprised of Core and Focused sections. These modules may be delivered in any order during Visits 6.0 to 11.0.
- Module 10 is always delivered last, at Visit 12.0.
- See the Study Specific Procedures for guidance on delivery of Modules after Visit 12.0.

### Core Sections

- The purpose of Core sections is to assess whether further work on each topic is appropriate or desirable.
- Each Core section is designed to be approximately 30 minutes in duration.
- Every Core section is to be delivered.
- The order of delivery of Core sections is determined by the counselor.
- Core sections are to be delivered in their entirety. If a Core section is not completed during a visit it should be completed at the next visit.
- It is acceptable to stop one Core section and begin another only during the first part of a visit (that is, just after the tasks of the Core section are outlined but before work on the tasks is begun.) This may be done if it is determined that the selected topic is not appropriate at that visit. The Core section that is stopped would be delivered at a subsequent visit.



## Focused Sections

- The purpose of Focused sections is to provide advanced work on a specific topic and to set the stage for Change Work.
- Focused options are designed to be approximately 30 to 45 minutes in duration.
- The counselor may elect from which modules to deliver Focused work.
- The counselor may also choose which option or options from each Focused section to deliver.
- Once selected, a Focused section option is to be delivered in its entirety.
- If a Focused option is not completed by the end of a visit, it should be finished at the next visit.

## Change Work

- The purpose of Change Work is to help the participant to try alternative strategies or ideas that are identified during counseling visits.
- Change Work is suggested but not required in intervention counseling.
- Change Work is loosely structured so that it may be employed at any appropriate moment.
- The Change Work section of the Delivery Manual outlines options to rehearse strategies, plan for implementation of strategies, and to contract for strategy implementation. Each option is designed to suit various learning styles and needs.
- Change Work may be employed for any length of time, up to 3 hours.
- “Trigger Mix,” and “Maintenance” are considered alternatives to Change Work.





## Counseling Visit Planning

The following describes how the intervention counseling visits are delivered in Visits 3.0 – 12.0

*Intervention Counseling Visits = 50 to 60 minutes in duration.  
Module One may run approximately 30 minutes in duration.*

### 10 Total Counseling Visit Hours — Breakdown:

Time	3 hours:	
Visits	3.0 – 5.0	
Modules	1 – 3	Risk assessment, needs assessment, planning.
Time	3 hours	
Visits	6.0 – 11.0	
Modules	4 – 9	Core Sections, 30 minutes each.
Time	3 hours	
Visits	6.0 – 11.0	
Modules		Includes any combination of A. Focused Section Options, Modules 4 – 9, and/or B. Change Work.
Time	1 hour:	
Visit	12.0	
Module	10	Maintenance planning.



## Episode Exploration

### Goals

**The goals of Episode Exploration are to:**

1. Help the participant explore his behavior in a concrete, personalized way.
2. Use motivational interviewing to begin to work with discrepancies between the participant's intentions and his behavior.
3. Highlight co-factors in sexual situations (environmental, etc.) that are amenable to change and/or maintenance planning.
4. Help the participant to understand his sex life through language and the process of dialogue with the counselor.



## Guidance

Episode Exploration is grounded in traditional techniques of qualitative interviewing, yet there is one crucial difference. Information is being captured here for the benefit of the participant, not the counselor or study. Counselors reflect and help the participant tell the story as a collaborator in constructing the participant's understanding of his sexual behavior. Building this understanding and insight may be a first step toward a greater sense of choice and a readiness to employ alternative approaches.

A very important task for the counselor is to help the participant to recreate the experience as vividly as possible. Inviting the participant to “visualize” the example is a useful approach.

It may also be helpful to elicit an episode that illustrates some struggle for the participant, e.g. a time that he wanted to be unsafe but wasn't. By reflecting this “struggle” or dilemma you will produce more material to work with later. It will also prevent description of an event that was safe but where the participant played no role in making it safer. The key here is to try to highlight the participant's motivation and skill in following or crossing his risk limits.

*For instance in Module Two, some participants may describe episodes where they are the receptive partner in anal sex and “my partner just put on a condom.” While they may cast their own role as passive, work with them to see what they did to make sure that condom use happened. It may require going back in the day or even further to a time that the participant found a strategy for making sure his partner(s) knew that condoms were required for anal sex. In other words, his role is not as passive as he may initially view it. Highlight the points where he made choices and decisions which helped result in following his risk limits.*



Each counselor will develop his or her own style for Episode Exploration. This should be done with the coaching and supervision of the Clinical Coordinator. A good episode exploration resembles a good conversation where one party tells a story and the other shows genuine interest and curiosity, interjecting questions and comments to elicit more information to paint a fuller picture of the event.

**Successful episode exploration usually includes:**

- Spending time helping the participant to select an episode that is meaningful to him.
- Asking for an instance where something really stands out for him as he looks back.
- Asking for a typical episode.  
The more illustrative of the participant's "real life," the better.
- Asking for several different aspects of the episode up front.  
Giving them an idea of what is being asked for.
- Grounding the experience for the participant.



- *Tell me about the story.  
Tell me as much as you can recall...*

“Story” is a term that is used in Episode Exploration guidance. You may choose another which conveys more succinctly or sensitively what you are aiming for.

Some counselors find that it is helpful to provide a longer introduction to the episode for the participant. They find that it helps the participant to provide a fuller, richer description right off the bat.

*... where you were,*

*... what kind of mood  
were you in,*

During an Episode Exploration, some counselors may find it best to not ask questions while the participant talks. Some may find interjection to be very effective. Others (the majority) will find that different participants require different styles.

Follow the participant’s lead. Consult the clinical coordinator for guidance during supervision and coaching sessions. Listening to one’s own tapes can be a great tool for critiquing and refining one’s style!



Strive to elicit “the basics” that consist of the headings on the “*Counselor’s PROBE SHEET.*”

These include:

- Kinds of sex had
- When
- Where sex occurred
- Partner(s) description
- Participant’s thoughts and feelings related to the sex
- Spoken and Unspoken messages – i.e. communication
- Mood – A broader description of feeling states related to the sex
- Serostatus –  
what was known or unknown about the partner(s’) HIV status  
did they disclose their own serostatus?
- Condom use – including anal condom

Encourage the participant to provide details for each of these headings. It may be helpful, for participants who are resistant or who find it difficult to talk about this, to use the *PROBE SHEET* or the *Worksheet: Comparison of Examples*, as a visual to help them along.

You may adapt the content of the probes to fit your participant’s needs. Tailor appropriately. Consult your Clinical Coordinator for any guidance you may need with this.



## Trigger Modules – Overview

Modules 7, 8, and 9 are the Trigger Modules of *EXPLORE*. Each module deals with the concept of triggers to crossing risk limits from a distinct angle; module 7 from the perspective of places and events, module 8 in terms of thoughts and emotions, and module 9 from the point of view of partners as triggers.

Triggers for risky sex are as individual and specific as people themselves. These modules avoid over-simplifying the role of places, events, thoughts, emotions, or partners in personal prevention behavior. Rather, the modules aim to provide a framework within which the participant can contextualize elements of his risk-taking (or safety maintenance) behavior, discover alternative choices to existing trigger patterns, and work to support these choices.

The relationship between triggers and risky sex is conceptualized in two approaches in *EXPLORE*. The first is causal, wherein a given trigger causes a specific behavior. This is a simplistic, yet useful way to look at the relationship. The second is additive, where different triggers may interact synergistically to promote a behavior or pattern of behaviors. The second view also takes into account the intervening steps between initial trigger and resultant behavior: for instance how a particular event creates thoughts and feelings which prompt the person to seek a particular type of partner with whom he is ultimately likely to push or cross his risk limits. In this example, the initial event sets off a chain of triggers (thoughts, feelings, seeking a “risky” type of partner) which lead to risky sex.

For some participants it may make sense to proceed step by step; making sure they first grasp the causality of triggers, and then proceeding to the broader interactive view. For others, the second approach will be grasped more readily so the first need only be confirmed briefly. The amount of emphasis to place on both or either approach is up to the counselor.



Counselors may discover that after they do the first of the three Trigger Cores (whether it is Module 7, 8 , or 9) that in the following Cores they don't need to “start from scratch” in assessing basic understanding of triggers. Rather, they can build on the Core material to move the participant further along.

The three Cores deal mainly in eliciting examples from the participant of different types of triggers. The counselor will find that some types of examples (e.g. “places and events”) resonate more than others (e.g. “partners.”) This key information is used to plan which module to use for Focused work (if such work is deemed appropriate by counselor and participant.)

It is recommended that counselors not attempt to do Focused work in the Trigger Modules until the participant understands the basic ideas of causality explored in the Core sections. To do so may result in a swell of resistance and counterproductive struggle. Of course, the counselor's judgment, in consultation with the Clinical Coordinator, should be his or her ultimate guide (as in all of *EXPLORE* counseling.)

For participants who readily grasp (and identify with) both the causal and synergistic role of triggers, the Trigger Mix exercise, found in the Change Work section, is an excellent option for advanced work. It may complement Focused work in any of the Trigger Modules and provide a natural bridge to further Change Work.

The Focused Options of the Trigger Modules are recommended for men who are sexually active with a variety of partners and who take risks regularly or periodically. The immediacy of the trigger relationship to risky sex may be less relevant to men who are lower risk.

See “Working with Lower Risk Men” for more guidance.



# Phone Counseling Protocol

## Introduction to Telephone Counseling



### Competent practice of telephone counseling

- Need to meet the same quality of care that an in-person visit would provide.
- Need to pay special attention to confidentiality and privacy.
- Need to make up for visual cues in making assessments and in knowing how participants respond.
- Consultation with peers and supervisors is important.

### Before Ever Having a Telephone Session

- Assess whether telephone counseling could result in harm — pay special consideration to people who:
  - have histories of psychotic thinking/behavior
  - are suicidal
  - abuse substances
  - have hearing impairments
  - cannot find a private place
  - are likely to masturbate or attempt to engage counselor in phone sex during sessions
- **Definitely consider phone counseling with people who:**
  - lead very busy lives that might make attending sessions lower priority for them.
  - have mobility difficulties (lack of transportation, physical disabilities).
  - are resistant to behavior change or to self-exploration.
  - negatively and emotionally react to in-person contact.
  - may be able to more honestly disclose by phone.
- **Setting ground rules/Giving basic information**
  - Explain that occasionally a session may be done by phone.
  - No phone sex.
  - Important to not do other things while talking to counselor.
  - Importance of calling from a private place (get person to brainstorm where he could find such a place).
  - One should turn off or ignore call waiting while talking to the counselor to avoid disruption.
  - Conversations on cordless, cellular, and extension phones can be overheard so its best not to use them.



## Protocol for Conducting A Phone Session

### 1. Check-in

- Briefly ask how the person is doing in general. If there are any particular areas of concern with a person, ask about it. Things to consider asking specifically about are mood, and health if the person has health problems.
- Discuss and plan for who will call who (and what the number is) if you are cut off.
- Check that the participant:
  - Is calling from a private place
  - Has turned off call waiting or agrees not to answer it
  - Knows that if he is using a wireless, cordless or extension phone someone may overhear

### 2. Conduct visit as usual, making up for loss of visual cues

- Make auditory responses to what client is saying.
- Listen for cues about how person is reacting: sighs, changes in tone of voice, hesitations, silences.
- Check out person's reactions by asking how he is reacting (don't assume or tell).

### 3. Written materials/exercises

- If participant has a copy of the exercise, have him fill it out.
- If person does not have copy, lead him through the questions. He can write them down or just think about them if he prefers not to write them down.

### 4. Checkout

- Ask the person how he is feeling as you finish the visit, and whether he has had any other reactions to what you have discussed.
- Discuss when and where (phone or in-person) next contact will be.



## Additional guidelines

### 1. Phone sex

- Participants may get sexually aroused, especially when talking about sex.
- Participants may “test” you to see if you will engage in phone sex.
- If you suspect that someone is masturbating, don’t ignore it: reflect back to him what is making you think that or, in most cases, just ask.
- This is important to consult with your supervisors and peers about.

### 2. Self-monitoring

- Pay attention to whether your attention is drifting or you are tempted to putter. This is a sign that the session is not going well. Consult with your supervisors and peers. People can tell over the phone if they do not have your full attention.

### 3. Never use a cellular, cordless, or home extension phone as you would be compromising client confidentiality.

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## *EXPLORE* Off-Site Visits Protocol and Checklist

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### Introduction:

Since one of the goals of the *EXPLORE* project is to make the behavioral intervention available and accessible to a diverse group of participants, the protocol allows for visits 6.0 through 12.0 of the intervention arm to take place somewhere other than the study site. The following guidelines and considerations are put forward in order to help the counselors, participant and Clinical Coordinators make decisions about appropriate alternative locations for sessions.

### Setting Up the Visit:

All participants should be told at the earliest opportunity (enrollment visit or before) that an alternative to holding intervention visits 6.0 through 12.0 at the study site is possible, as long as one visit per month is conducted face-to-face.

Participants who are interested in finding alternative locations should be told that a home (the participant's or counselor's) or other intimate location is not appropriate.

In deciding what would be an appropriate location, the following factors should be considered and discussed with the participant:

- Privacy
- Safety of neighborhood
- Absence of distractions
- Accessibility
- Travel Time
- Comfortable place to cover material (both physically and psychologically)
- Table on which to set up equipment and to write

With the above factors in mind, other possible locations could include another agency or community locale, participant's workplace, etc.

Alcohol or other drugs should never be consumed during a visit.



## Off-Site Visits Checklist

- Pick a place to have the visit.
- Schedule it in the Master Appointment Book. Include name and address of location, phone, and other contact information. Make sure the supervisor or other staff know where you are and when you expect to return. Let this person know when you return to the site.
- Pack! Include:
  - Appropriate manual pages
  - Worksheets (include copies for participant)
  - Tape recorder
  - Microphone for tape recorder
  - Fresh batteries for tape recorder
  - Labeled, blank audio tape
  - Pens, notebook, clipboard (if needed)
  - Your appointment book, to set up next appointment
  - Other: \_\_\_\_\_
- Conduct the visit.
- Complete and Data Fax "Intervention Counseling Form".
- Make counseling notes, per routine.



## Working with Lower Risk Men

Lower risk men pose a special challenge yet they may still benefit from *EXPLORE* counseling..

Maintain your “intent to treat,” the participant. That is, all participants should receive a full measure of “prevention treatment” or intervention, regardless of what is presented as their current risk.

This makes sense in the long run because the participant’s sexual activity and development will change over his life span. Further, one can never predict how future events (e.g. the advent of more effective anti-retroviral therapies or a effective vaccine) will impact this participant’s risk-taking. So maintain an open, balanced view, and keep in mind that although he may not seem to directly benefit now, he may well benefit in the long run.

In addition, the trial runs for three and a half years. Each participant’s behavior may change over that time period as well. By establishing yourself (and your site) as a credible, reliable source of support and information, the participant may more readily seek your help if he really needs it at a future point. Working with the material in the first ten visits – with full effort and fidelity to the material – demonstrates a level of integrity, consistency, and credibility that may prove vital at a later date.



**The following are recommendations for tailoring material for lower risk men.**

Module 4, Focused Option 1, offers the chance to look at challenging communication situations. This may be tailored to look at previous challenges and ways they were addressed. Possible future challenges may also be applied.

Module 6, Tracks 1 and 3 also offer opportunities tailored for lower risk men.

Modules 7, 8, and 9; the Trigger Modules, may be more challenging in terms of tailoring for lower risk men. The premise of triggers is such that the immediacy of relationships between external elements (places, events, people) or internal elements (thoughts and feelings,) is grasped by the participant. While the “theoretical” or “hypothetical” approach may be a way to tailor for the lower risk participant, these Focused options tend to rely on recent, real experience as a point of reference. This may be a real struggle for lower risk men to come up with, however well intentioned.

Use the hypothetical situation option selectively and thoughtfully (as you do all the material in *EXPLORE*.) One participant from another HIVNET study once commented on how his relationship with his partner felt diminished when his counselor said “You’re in a relationship now, but what if you break up? What would you do then – in terms of risk?” Projecting a break-up may not be the kind of hypothetical situation to suggest to a participant who is in a committed relationship.

It may be helpful to introduce or highlight the concept of “temptations” or “close calls” for the participant who is currently not taking HIV-related risks. The two terms (and you may come up with ones that better suit you and your participants) help open the examination to include areas of potential risk-taking.

Work closely with counseling team members and the Clinical Coordinator to devise further strategies for working with lower risk men in *EXPLORE*.







### Purpose

This visit aims to conduct pre-antibody test counseling and to establish or reinforce a risk reduction plan.

### Goals

The Visit will enable participants to:

- ◆ Make a decision regarding having antibody testing at this time.
- ◆ Assess current risk for HIV infection.
- ◆ Assess current risk-reduction strategies.
- ◆ Make a new plan for risk-reduction, if needed.
- ◆ Reinforce existing risk-reduction plans, as needed.

### Objectives

By the end of the Pre-Test Counseling Visit, participants will:

- ◆ Identify personal costs and benefits of antibody testing.
- ◆ Articulate behaviors that may have put them at risk for infection in the past 6 months.
- ◆ Identify which risky behaviors are amenable to change at this time.
- ◆ Make a realistic plan for change.
- ◆ Identify promoters and barriers for change.
- ◆ Receive referral information about resources for support in issues and needs relevant to HIV risk-reduction.
- ◆ Review condom and injection works risk reduction measures.



## General Principles for Screening Visit

While the screening counseling visit occurs in a relatively short period of time (20 to 30 minutes,) much can be accomplished with a focused effort by the counselor.

The primary task of the counseling in this visit is to place the antibody test within the larger context of sexual risk-taking.

Going beyond the simple transfer of information, the counselor walks the participant through the fundamental steps in creating a change plan.

For participants who are randomized to the standard arm this visit may be a key part of their risk reduction for the next 6 months. For those who are randomized to the intervention arm, this counseling will set the stage for the work to follow in the remaining counseling visits.

Counselors should ask just one or two questions in each section while maintaining a very specific focus on what is the goal of that section.

One key to success in this segment is to actively engage the participant in the task at hand. Explain the time constraints and the need for focus. Ask for support in doing this.



During the visit communicate at the participant's level of understanding, avoiding technical terms, jargon, or words beyond the comprehension of the participant (e.g., "window period," "non-reactive").

Use every opportunity presented to reinforce positive steps the participant has taken or will take toward change. Self-affirming statements and a positive tone are a key element in this segment.

Attend to the participant's feelings and emotional reactions during this segment. There may be little "trauma" which the participant expresses at this stage or he may be quite anxious about this process. Sadness, grief, or anger may also surface as reactions to examining how HIV has created a need for risk-reduction in the participant's life.

Maintaining a positive tone throughout the segment, gently highlight the participant's contradictions. Use appropriate Motivational Interviewing strategies to help the participant begin to argue for change.



## A) Introduction

Briefly introduce yourself and inquire about the participant's visit thus far.

- *Hi, my name is \_\_\_\_\_.  
I'll be your counselor today.*

Note that for Latino men (Spanish-speaking specifically) the word “counselor” may imply an imbalanced power dynamic. Other choices are “health promoter,” etc. More details in Spanish Language Manual.

*How has the visit been going so far?*

Don't open a “can of worms” by asking about life in general, etc.  
The goal here is to break the ice and to quickly get focused.



## B) Overview

Explain the purpose of this counseling segment and enlist the participant's buy-in.

- *Let me tell you what we are going to do in the next 20 minutes.*

Actually, 20 to 30 minutes are allowed for this segment. Stating 20 minutes as the limit may help focus the visit.

- Help you examine the COSTS AND BENEFITS of getting tested today.
- MAKE A DECISION ABOUT BEING TESTED based on that examination.
- See WHAT'S BEEN HAPPENING since your last antibody test THAT MAY BE RISKY FOR HIV INFECTION.
- Talk about WHAT YOU'VE BEEN DOING TO REDUCE YOUR RISK of getting infected.
- REINFORCE WHATEVER IS WORKING for you to reduce risk.
- MAKE A NEW PLAN FOR REDUCING RISK, if needed.
- Give you any REFERRALS YOU MIGHT NEED at this time.
- Provide basic information on CONDOM USE AND CLEANING INJECTION NEEDLES.



## C) Testing

Review the participant's comprehension of basic terms.  
Assess their ability to technically understand results at the next visit.

Pace this according to the participant's first response.  
It may be quite a quick review or it may require a bit more time.

Ask the questions directly, without apology.  
This will help the participant to understand your role  
as information provider and the need to let you do your job.

In all instances during the term review, give plenty of  
positive reinforcement for what the participant knows.

- *Let's go over some information related to HIV and testing.*

*Do you know what a negative test result means?*

*How about a positive test result?*

Avoid mentioning false-positive and/or false-negative results unless the participant has a higher comprehension of the basic facts. It could take the rest of the visit to explain just these two things!

*Indeterminate result?*



Again, downplay this with participants who have a less firm grasp of the basic terms “negative” and “positive.” This may just confuse and worry them more. Additionally, the likelihood of such a result is low AND if one occurs, it will be explained fully at that time (when the result is disclosed and the blood re-drawn.)

*What are some ways  
HIV can be transmitted?*

An excellent question for participants with whom you are uncertain of their grasp of the basics.  
Review sexual transmission: anal, oral, vaginal as well as injection risk.

Offer sincere praise for their knowledge level (whatever that may be.)



## D) Costs and Benefits of Testing

Help the participant resolve ambivalence about the decision to have the antibody test. Note that the purpose is NOT to make the argument for testing.

Let them arrive at their decision on their own terms.

If the costs outweigh the benefits, they may choose to not be tested at this time (and therefore be screened out for *EXPLORE*.)

Tip: If the participant is fine with testing, move along through this segment quickly. Pace accordingly.

- *When was the last time you got tested for HIV antibodies?*

Essential information that helps you assess further their familiarity with the process itself. Plus it offers a chance to begin risk assessment.

- *How are you feeling about being tested today, in general?*

Contain the discussion here. Avoid the “can of worms syndrome.” (Too much information that may not be relevant.)

- *What do you see as the benefits of being tested now?*
- *What are the costs?*

DO NOT use Decisional Balance sheet at this visit! Restricted to intervention participants only. BUT the principle of helping them to weigh both sides is very much in play here. Use skillfully.





## E) Coping with Test Results

- *What do you think will be the outcome of the test?*

This question can start the risk assessment section (Section F)  
BUT make sure that the remaining bullets in this section are covered.  
One approach may be to say “Keep that thought – about your recent sex risk-taking – in mind. We’ll come back to it in a minute.”

- *How do you think a negative test result could affect your risk behavior?*

It may have no effect or an enormous one. It’s up to the participant. This may be a good chance to find out (and highlight) the participant’s beliefs regarding his behavior and his serostatus. Luck, magical thinking, etc. may all be at play. Listen for this and highlight (through reflection) for the participant’s benefit.  
DON’T CONFRONT.



- *If you test positive  
how will you react?*

Pay attention to the possibility that the participant may suffer strong adverse reactions to a positive result. This means even more than the grief, sadness, anger, etc. that may accompany a positive result. Look especially for intention to hurt oneself as a reaction. Consult with and follow the guidance of the Clinical Coordinator as soon as possible.

For a less clinically challenging participant, coach them on how they may cope with a positive result. Help them plan what they will do, who will support them, etc. in the event of a positive result.

- *What will waiting for the results  
of your test be like for you?*

Again, coach appropriately. Offer yourself as a resource during the wait period. (Check with your Clinical Coordinator for guidance.)

This may be an appropriate point to ask:  
“ARE YOU READY TO BE TESTED?”



## F) Risk Assessment

- ***When was the last time you did something risky for HIV?***

*Tell me about that time.*

Probe for the following:

When it occurred (window period considerations.)

What happened sexually.

What happened injection drug use-wise.

Focus on ONE aspect of the risk-taking as an area for possible change planning later in the visit. Avoid “can of worms syndrome.”

This is not an “Episode Exploration” or any variation of it. This must be kept simple and short. Lengthy examinations of participant’s risk-taking and co-factors will bias the visit toward the Intervention Arm, which must be avoided.

- ***What are you currently doing to avoid infection?***

*What would you like to do to reduce your risk?*

If they are already reducing risk:

*What can you do to stay at low risk?*

An opportunity to do two things:

1. Reinforce the positive steps they’ve made.
2. Probe for ambivalence and readiness to make change plans.



## G) Condoms:

Employ the collaborative tone of *EXPLORE* counseling. The questions “How consistently do you use condoms” may sound judgmental if not asked in a collaborative tone. Reinforce that you are an empathic, neutral helper. While your work is not “agenda free,” the agenda (to reduce HIV infection) does not compromise your ability to listen and align with the participant. Not to collude, but to support.

- *How consistently do you use condoms for anal sex?*
- *What about for oral sex?*

This is a good opportunity to find out if the participant engages in these types of sex. Re: anal sex – distinguish between “receptive” and “insertive”. Do they have different patterns for the two?

This is also a good chance to address oral sex risk. Frame it in terms of how risky they see it for themselves. If they ask “how risky is it?”, first ask them what they know. Then fill in the facts. This approach is consistent with the collaborative tone of *EXPLORE*.

Let the participant define the term “consistently.” Avoid argument or quibbling about the term. How do you define “consistently” may be a helpful response to “What do you mean by consistently?”



*Do you have sex with women?*

*If yes, how consistently do you use condoms for vaginal sex?*

If yes, see “men who have sex with women” in the Delivery Manual Guide.

## Working with Men who have Sex with Women

### Rationale:

*EXPLORE* counselors should be prepared to address the needs of men who have sex with women. Men who have sex with women are a diverse group, and this section of the Delivery Manual Guide talks about their needs and explains the rationale for why it is important to effectively counsel these men.

As we know, one of the eligibility criteria for the study is to have had anal sex with a man at least once in the past year. Many men who meet that eligibility criteria will also have had, and will continue to have, sexual experiences with women, including vaginal, anal, and oral sex with women. Some of those men will identify as bisexual, and see themselves as part of a bisexual community of people who have sex with both men and women. Others will identify as gay men, but occasionally have sex with close female friends, including their lesbian friends. Others will not identify as a sexual orientation at all, but have sex with partners of more than one gender.

Creating a welcoming environment in *EXPLORE* for men who have sex with women is an important tool in recruitment for the study. *EXPLORE* sites can actively recruit volunteers in the local bisexual community. In many *EXPLORE* cities, the bisexual community is sizable. Since historically so few studies have targeted bisexuals, self-identified bisexuals are eager to participate in research that validates their sexual experiences and orientation. Allowing space to speak about sex with women reassures bisexual men that they don't have to leave a piece of themselves at the door when they come to *EXPLORE*.



For all men who have sex with women, regardless of their sexual orientation, addressing penile-vaginal intercourse is an important aspect of risk reduction, considering that penile-vaginal intercourse is a major route of HIV transmission in this country and internationally. Also, research shows that penile-vaginal intercourse among the *EXPLORE*. target populations is not uncommon. One study found 21% of young gay men have had sex with a woman in the past three months; two-thirds had had sex with women in their lifetimes. Another study found that among men who have sex with men and women, the men were less likely to use condoms with their female partners than their male ones. By not addressing vaginal sex, *EXPLORE*. runs the risk of perpetuating the myth that only anal and oral sex with men is risky for HIV.

## Implementation:

### A. Guiding principles:

#### 1. Avoid Assumptions.

As a general rule, don't make assumptions and each person's experience is valid. For example, don't make the assumption that all the men who join *EXPLORE*. are gay men or are in the process of becoming gay men. Also don't assume that all self-identified gay men in the study are having sex solely with men. Some men identify as bisexual their entire lives, and other men, regardless of their sexual orientation, will have sex with women that may put them or their female partners at risk for HIV.

#### 2. Create Space for Discussing Sex with Women.

Likewise, each person's experience of their sexuality is valid grounds for discussion in *EXPLORE*.. If a man wishes to talk about his sexual experiences with women in the study, to allow space and time for that is part of the *EXPLORE*. commitment to addressing the whole person and all the aspects of their sexual lives which may put them at risk for HIV.

#### 3. Focus on Man to Man Sex, as Appropriate.

We do not want to send a mixed message to bisexual participants that *EXPLORE*. is designed to address risk reduction for sex with women. It is not. While many of the principles may apply, the specific psycho-educational goals and objectives for a risk reduction intervention for sex with women would be, necessarily, quite different than those in *EXPLORE*..



So it's important to create a space for the man who has sex with women as well as men to talk about these experiences. This will create a context within which he will be seen as a whole person by the counselor. Further, his sexual relationships with women may be referenced as his motivation for risk reduction is explored and ambivalences therein enhanced.

It's important for the counselor and the Clinical Coordinator to make careful judgment about how much risk reduction counseling re: sex with women is appropriate or warranted. The ICC believes that the best way to work with this complexity, as with many that arise in EXPLORE, is on a case-by-case basis. Clinical Coordinators can consult Patrick Barresi at CAPS for any specific guidance on tailoring modules, should this need arise.

Counselors' knowledge and comfort level with bisexuality may vary, so *EXPLORE* sites are encouraged to seek resources and training. The Bisexual Resource Guide 2000 (ISBN #0-9653881-2-3) is a 304-page book of information about bisexuality, including local resources throughout the country. It can be purchased for \$12.95 from the Bisexual Resource Center, P.O. Box 400639, Cambridge, MA 02140. (617) 424-9595. [www.biresource.org](http://www.biresource.org). [brc@biresource.org](mailto:brc@biresource.org).

[NOTE TO FENWAY/LHI Explore staff — I have a copies of this book for any of you who want one (free).]



## B. Specific Delivery Manual Guidance

### 1. Screening Visit (p. 23)

Questions about sex with women and use of condoms for vaginal sex have been added. It's probably wise to ask the first, "Do you have sex with women?" of all screeners. Focus on the present or recent past (6 months to a year.) If someone replies "I did years ago," ask "How about more recently?" or "Do you see yourself doing so now or in the near future."

### **Condom demonstration:**

If the screener has sex with women as well as men, refer to both vaginal and anal sex when discussing penile condom use. When discussing the Reality Condom, refer to the instructions in the Reality packaging for guidance on vaginal sex use.

### 2. Module Two, p. 57

Include risk limits for sex with women. Doing so may help point out any double standards the participant may have about risk reduction with men vs. women. It could make for some very productive MI!

### 3. Modules Two, p. 62

Okay to focus on an example of sex with a woman, if participant prefers. See comments above on creating a space for the participant to be seen in. It's important (despite previous *EXPLORE* experience with this Module and Module Three) to not force the participant to talk about sex with a man if he can not or will not do so. To foster rapport, allow him to talk about the experience that he wants to talk about. Maybe add a question after the episode exploration and probes (around p. 65) "How is sex with men different than the sex you described in this experience?"

### 4. Module Four, p. 98

Where appropriate, ask how this is different with women partners. Again, take the opportunity to probe how communication differs for women and what, if any, 'double standards' might apply. Another angle: Is communication clearer with one gender than the other? What are strengths/skills that you can transfer from one to the other?"





- *Let's briefly review some condom information.*

Use the Info Sheet to help this section along.  
Don't read the sheet to the participant verbatim.  
Highlight key points and ask for their input.



## H) Injection

- *What experience do you have with cleaning works (needles, syringes, spikes, etc.?)*

Some resistance may be provoked by this question. Ask it directly, without apology. Explain that covering this information is consistent with the study's intent to look at how to best reduce HIV infection. Injectors are an important audience for our efforts, so we include them.

- *Let's briefly review some information about cleaning works.*

Frame this review as a chance to learn something that may be helpful to the participant or a friend at a later time.

## I) Change Planning

- *What are one or two things you can do between this visit and the time that you get your results to reduce your risk?*

Stress the time frame here. Coach the participant to pick a task that they can try in the next 2 weeks. Use the *EXPLORE* notesheet to write down the details.



## I) Change Planning - continued

*Is there anything you've been thinking about trying?*

*Any new ideas you'd like to try?*

These questions broaden the timeframe to include cognitions which occurred before this visit. They expand the range of Change Work goals to include “trying ideas”, i.e. thinking about topics of concern as an alternative to attempting concrete action.

- ***Is this...***

- ... *something new?*

- ... *something you currently do?*

- ... *or something you have done in the past?*

Build on their familiarity with the task they choose.

Stress how past success predicts future success (in many cases.)

- ***Can you anticipate any problems following through on this plan? If so, what?***

These may be temporal (don't have sex by next visit) or inter-personal (partner resistance) or intra-personal (lack of self-efficacy, resolve.)

Allow the participant to name the possible problems. Don't try to solve them.



## I) Change Planning - continued

- *What will you do if you run into problems?*

Build on the last question, the identified problems.

Try to avoid being an authority for the participant, i.e. telling them what to do. Rather, let them have the experience of coming up with the answers themselves.

## J) Conclusion

At this point, wrap up the segment. Offer condoms, lube.

Also offer any referrals that may be relevant.

Set up the next counseling appointment and direct the participant to the next step in the Screening Visit.

*Thank You!*

NOTE: Tell the participant that there is a chance they may be meeting with someone else either when they get their results or just afterwards. This may be done to “balance the load” of participants among counselors.



a) Welcome - Greet the participant

- *Hi. Welcome back.*

*Are you ready  
to get your results?*

Move immediately to results disclosure.

b) Results disclosure

- *Your antibody test result is negative.*

Deliver the result in a direct, neutral tone.  
Don't anticipate the participant's reaction. It could be negative or mixed.

Allow a few moments of silence  
for the participant to absorb the news and to react.





### c) Processing Test Results

- ***Any thoughts or feeling about getting a negative result today?***

Avoid “can of worms syndrome,” again.

Deal with the feelings that present themselves.

Don’t probe or dig for more. There will be time for that later.

- ***What does this test result mean to you?***  
( *In a technical sense...*)

Check comprehension. Especially regarding the window period, antibody development, and infectiousness.

Be prepared to address any responses such as:

“It shows that I can’t get it, I’m immune;”

“That means that I’m just lucky because I took so much risk;”

“Maybe being a top without a condom isn’t as risky as I thought.”

Talk with the counseling team at your site about how you would deal with each of these types of responses. Avoid judgment and allow the participant to have misinformation, even for just the time-being. The opportunity to gently correct it will present later in this or subsequent visits.





- *Any questions about your results?*
- *We are now going to break briefly to call the Statistical Center and get your assignment.*

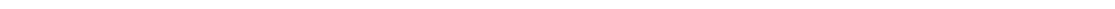
The procedure for making the Randomization call is determined at your site.

Consider the need to briefly explain the 2 arms of the study and the meaning of the terms “random” and “randomization,” if needed

*Random:* By luck; a 50-50 chance of getting in one arm or the other.

*Randomization:* A process that puts you in one of the 2 arms completely by chance, based on 50-50 odds or chance.







# Visit 2.0 Enrollment and Randomization Visit

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## Delivery Manual Guide



### Standard Arm Counseling

#### Purpose

To help participants re-visit the plan which was drawn up in the Screening Visit.

#### Goals

The goals of the Counseling Visit are to:

- ◆ Talk about further reactions to their antibody test result
- ◆ Ask questions about their study participation in the Standard Arm
- ◆ Examine the change process, as initiated at the Screening Visit
- ◆ Refine change plans, as needed

#### Objectives

By the end of this part of the Counseling Visit, participants will:

- ◆ Further process their feelings and thoughts about testing negative
- ◆ Resolve questions about the randomization process and being in the Standard Arm of the study
- ◆ Talk about their change plan (or lack of one) from the Screening Visit
- ◆ Trouble-shoot aspects of the plan that didn't work OR may seem unrealistic or un-feasible at this time (approximately one week later.)
- ◆ Revise the plan to make it more realistic and more likely to succeed
- ◆ Anticipate problems that lie ahead that may threaten intentions to enact risk reduction



Following randomization, participants in the standard arm receive a counseling segment which aims to help them firm up their plans to practice risk reduction.

Due to time constraints, it is key for the counselor to frame the segment clearly.

Following discussion of reactions to the test result and randomization, direct the participant immediately to the plan devised at the previous visit.

Briefly review Session (SOAP) notes from the Screening Visit (particularly if this is a new participant for you!) Review information about change steps that were discussed at that visit.

The counselor acts as a coach to help the participant enact parts of the change plans that are feasible. The counselor also coaches the participant in having realistic expectations for the change process.

A copy of the plan from the screening visit is a key visual cue.

## Audio-Tape Recording Notes:

It's helpful to "voice slate" the tape before the participant enters the room.

For example:

"This is counselor 234. Participant ID 99-88888-0.

Date is January 31, 1999.

Today we are going to cover Core of Module 4  
and part of the Focus of Module 7, Option 2."

This will help the QC reviewer get started efficiently.

## Microphone Procedures

- Clip on all mics and start recording as you greet the participant.
- Be careful not to start the content of the visit (Check In) until recording has begun.
- For phone visits, start recording as the phone is ringing. You may wish to remind the participant that the phone visit is being recorded (as a courtesy.)



### **A) Disclose Randomization**

Following the randomization call, inform the participant that they are in the Standard Arm.

- ***You are in the “Standard Arm.”***  
***This means we’ll take about another 10 to 15 minutes to talk about your test results and plans for the next six months in terms of staying safe and avoiding HIV.***

### **B) Further Reactions to the Test Result**

Further process their feelings and thoughts about testing negative.

- ***Do you have any other thoughts, feelings, or ideas about testing negative?***

***Mixed feelings?***

Invite the participant to say anything more about thoughts, ideas, or feelings about getting a negative test result.

Reinforce statements the person makes about wanting to stay negative.

Use reflections to acknowledge and amplify any ambivalence that the participant may have about testing negative.

Help them see that it is normal to have mixed feelings about testing negative and to get them thinking about how this ambivalence may inform their actions.



### C) Reactions to randomization

- *What reaction, if any, do you have to being randomized to the Standard Arm?*

*Tell me more...*

- *Do you have any questions about being a Standard Arm participant?*

Clarify what “Standard Arm” means and probe what questions they may have. (Refer to the Study Participant Packet as a reference.)

Reinforce that the Standard Arm is in no way “superior” to the Intervention Arm. We don’t know if one is better than the other. Their participation will help us find out!



## D) Revisit Risk Reduction Plan

Talk about their change plan outlined on the *EXPLORE* Note Sheet from the Screening visit.

- ***Did you get a chance to try anything we talked about at our last visit?***

Be prepared to point out any key steps you glean from looking at the *EXPLORE* Note Sheet or from your review of the SOAP notes.

*What happened?*

*What did you think?*

*What were your reactions?*

*Was it what you expected?*

*Were you happy with how it went?*

*How do you feel about it now?*

Reinforce that you are there as a collaborator, not a judge.

The participant may feel defensive if he thinks parts or all of the plan failed.

Be ready to reinforce the positive aspects of the process for him – while maintaining enough distance to let him have his feelings.

For instance, *“Though it didn’t go as planned, sounds like the progress was just in trying something new. That’s a big step.”*

Emphasize any success the participant experienced.

If they seem to be ready to try more change steps, use Motivational Interviewing to elicit self-motivational statements about areas of the plan that did not succeed. Set up a context for contracting next steps.



If the participant did not work with the plan since the last visit:

- ***So you didn't get a chance to work with the plan or think about it? Why was that?***

*Did you get to think about any aspects of it?*

A non-judgmental, neutral tone may help the participant to see past any feelings of guilt or shame and view not taking action from a more objective point of view.

If no plan was discussed at the Screening Visit:

- ***Do you have any ideas about things you want to do to continue to avoid getting HIV?***

Use Motivational Interviewing to elicit self-motivational statements and move toward a change plan, as appropriate.

Use the **EXPLORE** Note Sheet to capture details of the plan.

Use questions on page 41 to outline the plan.



## E) Revisions to the Plan

If ready, invite the participant to take more change steps or to re-commit to those already identified.

Per Motivational Interviewing theory, a reduction in resistance (as evidenced by participant statements and actions) signals readiness to move forward with change planning.

- *Would you like to make any changes to the plan?*

How realistic the plan looks to the participant is a spring-board to a closer examination. The question is intentionally strongly-worded to elicit a position from the participant and promote self-motivational statements (without provoking resistance.)

*Does it reflect your real life?*

*(Or is it “what I think my counselor wants to hear-/-what is the ‘right’ thing to do...?)*

This is a good chance to acknowledge the potential “Hawthorne Effect” of a study. That is, when people know they are being observed it is likely they will change their behavior to please or impress the observer.

It’s not necessary to lecture the participant about sociological theory and research, but mention that wanting to please you (or the site) is a common side-effect of participation.



Two things to emphasize during this discussion:

1. Personal choice – the participant has power and choice in his behavior.
2. Change is made up of individual, seemingly small factors.

Attention to one or two of these factors can produce movement in all of them.

Provide an opportunity to make changes to the plan:

What do you want to change?

What parts of the plan sound the best to you?

*What parts of the plan sound “do-able” to you?*

*Which parts sound most difficult or challenging?*

*Is that something you can do in the coming weeks?*

Make revisions on a new *EXPLORE* Note Sheet.

Provide a photo-copy to the participant, if desired.

File both Note Sheets in the chart for future reference.





### E) Closure

- *Do you have any other questions?*
- *You will meet with another counselor at your next visit.*

Explain that the participant will see a different counselor next time. This is to simulate what happens in the counseling and testing sites as much as possible.

Also explain any other procedures for locator and follow-up, as appropriate.

- *Thank you and Good Luck!*



# Visit 3.0/Module One

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## Being HIV Negative and Participating in EXPLORE Delivery Manual Guide



### Purpose

The purpose of Module One is to begin to establish a rapport with the participant and to help them explore their motivation for staying HIV negative. It is also to help the participant identify how this intervention may help him to achieve his goal of staying sero-negative

### Goals

The goals of Module One are to:

- ◆ Examine what being HIV negative means to the participant.
- ◆ Explore the participant's reaction to receiving negative antibody test results.
- ◆ Begin to identify areas for subsequent intervention visits.
- ◆ Clarify the roles of counselor and participant.
- ◆ Address potential retention problems.
- ◆ Build rapport with the participant.
- ◆ Explore ambivalence about test results, being negative, sexual behavior.

### Objectives

This module will help the participant to:

- ◆ Make self-motivational statements about their desire to remain HIV negative.
- ◆ Articulate their motivation to participate in the intervention as a means to change their behavior.
- ◆ Clarify their role in, and expectations for, participation in the study.
- ◆ Begin to trust the counselor.



## Audio-Tape Recording Notes:

It's helpful to "voice slate" the tape before the participant enters the room.  
For example:

"This is counselor 234. Participant ID 99-88888-0.

Date is January 31, 1999.

Today we are going to cover Core of Module 4  
and part of the Focus of Module 7, Option 2."

This will help the QC reviewer get started efficiently.

## Microphone Procedures

- Clip on all mics and start recording as you greet the participant.
- Be careful not to start the content of the visit (Check In) until recording has begun.
- For phone visits, start recording as the phone is ringing. You may wish to remind the participant that the phone visit is being recorded (as a courtesy.)



## A) Overview

*We're going to spend  
the next 50 minutes:*

Overviews are offered consistently to help frame the visit.  
Make a practice of telling the participant what is going to happen in the visit.

It's important to specify what you'll be doing to assure them  
you are making good use of their valuable time.

- *Any questions for me  
as we get started?*

Stay on track and be mindful of pacing.  
There's time to handle most issues in the next three and a half years!!



## B) Reactions to the Test Result and Randomization

---

- *In the past, what effects has HIV testing had on your sexual decisions or behavior?*

*How do you think this result will affect your willingness or ability to protect yourself?*

Explore the connection between testing and sexual behavior for this participant. Look at how testing encourages prevention behavior or possibly enables risk-taking (by providing apparent evidence that previous behavior did not result in infection.) Consider the participant's "highly personalized logic" about testing and risk-taking. Let this logic emerge slowly and naturally – don't correct or confront! As you establish rapport, the participant will give you permission to challenge him on some of his ideas and notions.

- *How do you feel about being randomized into this arm of the study?*

Some participants may be disappointed that they are randomized to the Intervention Arm! Acknowledge the participant's willingness and generosity!



**EXPLAIN** that this arm is not necessarily better.

Refer the participant to the *EXPLORE* Participant Packet for more information. Keep one handy to refer to during counseling visits.



### **C) Impact of HIV on Participant's Sense of Future**

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This discussion deals with “concerns in general” to provide the broadest possible point from which to begin the discussion.

The participant will reveal, probably quickly, how much he wants to “go into” his feelings about being HIV negative, etc. So, as always, follow his lead. Notice that the questions get increasingly “charged” as the discussion continues.

- *What's it like for you to be HIV negative?*



## D) Guidelines

### • Introduce this section:

Use this section to shift the focus off of the participant and on to the printed guidelines.

*“I want to review a few guidelines for you before we continue. The guidelines will help us to work together smoothly and make this a safe space for you to talk about your experiences.”*

## Guidelines

- *Confidentiality*

Re-emphasize that his name and participant ID are kept separated for security purposes. Auditing of counseling – via audiotape review and chart review – is done by study staff who are also under the rules (and ethics) of confidentiality.

- *OK to Pass*
- *Take Risks*

“Risks” refers to challenging oneself in counseling. Sexual risk-taking is another matter...

- *Ask Questions*





- *Say What's on Your Mind*
- *I'm Not Your Therapist*

Make your role very clear.

Talk with other team members about ways to convey this effectively to participants.

- *Do you have any questions about these?*
- *Do you want to add any items to the list of guidelines?*

If so, write on an *EXPLORE* Note Sheet.

The first time you use a Note Sheet, explain the fields (Counselor ID., Participant ID., etc.) to the participant so they will understand all the little spaces, etc.

### A Note on Retention

- *"It's important to the study that we complete our 10 meetings within four months. The best way to accomplish that is for us to meet weekly.*

*Does that sound like something we could do?*

Be direct and non-apologetic about regular attendance. It's a commitment that you, as a counselor, are there to help the participant keep. Set a tone of collaboration in helping him do so.



## E) Expectations for Counseling

- *Let's talk about what you may want from this study.*

 WRITE participant's responses on Note Sheet

See note on “first use of *EXPLORE* Note Sheet,” above.

For “roll-over” participants:

“Roll-over” refers to participants who have enrolled in other studies at your site.

For all:

*How do you think this study will help improve your quality of life?*

Help the participant clearly make the connections between quality of life, staying HIV negative, and having a good sex life clear!

Reflect and highlight any self-motivational statements made at this point. Participants may express dissatisfaction with current risk-taking, a desire to “learn more,” or hope that they will “be safe more consistently.”

When such statements are made, note them and return to them to build motivation in later visits.

If it helps, write the statement on an *EXPLORE* Note Sheet and keep handy for future visits.



- *What questions do you have about the study?*
- *Feelings about participating?*

*What mixed feelings do you have about being in this kind of study?*

Throughout the Delivery Manual, references to “mixed feelings,” or “costs and benefits” cue you to use Motivational Interviewing techniques. They will become second nature with time. But initially, these prompts may help.

*Mixed feelings about talking about sex?*

*Mixed feeling about talking about HIV?*

Again, with each question, the stakes are raised slightly. Let the participant set the pace for a discussion that is beneficial but also feels safe for him.



## F) Closing

- *Any other questions for me before we close?*

*Next week, we'll start talking more about your sex life. We'll talk specifically about times you followed and times you crossed your risk limits.*

Emphasize that looking at sexual episodes is a strategy you'll use repeatedly over upcoming visits. Help reduce discomfort about this by setting it up as the norm in advance.

Encourage them to think about various sexual episodes before the next visit.

- *See you next time!*

*Thank You!*

You will, of course, develop your own style of closing visits. Always remember to thank the participant.

Remember to not turn off the tape recorder until the visit is completely finished.

# Visit 4.0/Module Two

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## Risk: What's Acceptable for Me?

### Delivery Manual Guide



## Purpose

The purpose of this module is to facilitate a discussion of the participant's personal definition(s) of acceptable risk and guide an exploration of factors which support adherence to that definition (via Episode Exploration.)

## Goals

The goals of Module Two are to:

- ◆ Convey the concept of “acceptable risk limits” as a personalized definition of risk-taking behavior.
- ◆ Introduce the range of co-factors for their sexual behavior and risk-taking . Help them to develop a greater appreciation for the complexity of their sexual behavior.
- ◆ Provide experience in one approach for understanding sexual episodes.
- ◆ Stress the flexibility of the counseling visits to meet their individual needs.
- ◆ Further build rapport.

## Objectives

This module will enable the participant to:

- ◆ Articulate his personal definition(s) of acceptable risk for HIV.
- ◆ Describe an episode that illustrates co-factors which support his acceptable risk.
- ◆ Start to select which areas he wants to focus on in future visits.



## A) Check In

Greet the participant when you see them! Be natural and say hello, make small talk as you get the mics clipped on and recording begins.

- *How was your week in terms of taking care of yourself around sex?*

But beware of letting the “chatty” part of the visit run on for longer than a minute or two. Longer “chat” segments may seem to build rapport but there’s a distinct possibility that the participant is nervous about the topic and chatting is enabling him to put off the harder work. Find a balance. Also, note that the sex-focused question may not be appropriate in early visits. A brief “How are you doing?” may be a better strategy in early visits - until frank discussion of the participant’s sex life is more routine.

## B) Overview

*We are going to do the following tasks today:*

Overview may be a way to “rein-in” a real talker!

*“Well, we DO have some things to do today...”*



### **C) Section One: Overview**

A quick orientation to how we examine sex in *EXPLORE*.

#### **Main points to convey include:**

1. Risk limits are defined by the participant according to what they deem to be “acceptable” for themselves.
2. Acceptable risk does not mean “socially acceptable” or “acceptable to others.” It’s a highly personal definition.
3. Risk limits are not fixed or rigid. They vary and change over time, across partners, in various settings, during different events (both personal life events and larger holidays or social events,) etc. What a person defines as acceptable risk depends on their own development and understanding of their world and a host of additional factors.
4. *EXPLORE* operates on the principle that men who have sex with men can make informed, responsible choices for themselves. These choices can support them to both protect themselves from HIV (if they so choose) and maintain a good quality of life.

The key is to take a few minutes to see that the participant understands this principle. Use the visual on page 59 to aid his comprehension.



## Things to Note:

We'll talk frankly about sex in our sessions  
(as you may have guessed!)

Stress to the participant that you will mirror (follow their lead on) their language and comfort in talking about sex. Acknowledge their discomfort but reinforce the safety of the counseling visits as a place to talk openly and candidly about sexual matters which concern them.

Write what's acceptable to them (within their risk limits) inside the circle  
(Worksheet: The Riskiest Things I'll Do, pg. 58.)

One counselor suggested placing "more risky" behaviors closer to the edge of the circle and "less risky" ones toward the middle.

You can write the behaviors that CROSS their risk limits outside the circle.

You may choose to use this visual again, in later visits, if the participant clarifies or changes his risk limits.

- *What are currently your acceptable risks – the riskiest things you will do, your "Risk Limits?"*





## D) Acceptable Risk Example

Segue into this section straight from the last question.

- *Think about an example of a time that you followed your acceptable risk or risk limits.*

### Acceptable Risk Example.

This Episode Exploration is the first time the participant is asked to “tell a story” about his experience.

Refer to General Topics - Episode Exploration, for further direction.

Okay to focus on an example of sex with a woman, if participant prefers.

The goal of focusing on sex with a woman, if the participant prefers, is to help him talking about sex and his risk limits. Letting him explore an episode with a woman may help put him at ease to address his behavior with men in the next module.

If it's comfortable for the participant after the episode is told, ask him which aspects of the example may apply to his sexual experience with men.



## WORKSHEET: Comparison of Examples

WRITE notes in the Acceptable Risk Column 

Ask the participant if it's OK to take notes on the Worksheet while he talks. Or you may want to wait and use the Worksheet to summarize, writing the notes as you do so.

Follow the participant's lead. If they become more engaged in the Worksheet than with describing the episode, that's a sign that it may be best to wait to make notes.

Some participants may feel uncomfortable if you make notes while they talk, like you're transcribing every word.

**Adherence Tip: Revisit at least 7 items/areas for full credit.**

“Adherence” refers to Audio Quality Assurance scoring.



## E) Module Mapping — Overview for Future Visits

- *Introduce the visual:  
Topics for Upcoming Sessions*

HIGHLIGHT the areas they referred to in their story.

You may find it helpful to use a hi-liter here to circle topics that interest them.

Document Participant ID, Counselor ID, Initials, and Visit Date, if the map is placed in the participant's chart.

## F) Closing



# Visit 5.0/Module Three

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## Crossing Acceptable Risk Limits

### Delivery Manual Guide



### Purpose

Module Three further examines what promotes risk-taking or risk reduction maintenance in the participant's individual experience. Co-factors for risk reduction or maintenance were identified in Modules 1 and 2. Module 3 further explores key co-factors, suggesting direction for the remaining counseling visits. Also, the role in risk-taking of alcohol and other drugs is examined through the Substance Use + Sex Screen.

The participant and counselor engage in a collaborative process which culminates in a preliminary plan for visits 6.0 – 11.0. This may include a decision to look more closely at drinking and drug use in its relation to crossing or maintaining risk limits.

### Goals

The goals of this module are to:

- ◆ Continue to explore the concept of acceptable risk.
- ◆ Examine co-factors for risk-taking behavior (or risk reduction maintenance).
- ◆ Consider the relevance of these co-factors to current life circumstances.
- ◆ Look at what role alcohol and other drugs play in the participant's sexual life.
- ◆ Identify preliminary direction for remaining counseling visits.
- ◆ Continue to build the counseling relationship.
- ◆ Establish norms for extracting insight and meaning from in-depth discussion of sexual episodes.

### Objectives

This module will help the participant to:

- ◆ Continue to articulate his personal definition(s) of acceptable risk for HIV.
- ◆ Identify factors which contribute to risk-taking or risk reduction maintenance.
- ◆ Examine ambivalence about risk-taking or risk reduction maintenance, as applicable.
- ◆ Consider the need for a closer look at how drinking and/or using drugs impacts maintaining or crossing risk limits.
- ◆ Feel increased ownership of the intervention counseling process.



## A) Check In

## B) Overview

*This visit builds on the last one.*

It's a good point to reinforce with the participant that each visit builds on the last one.

## C) Example: A time I crossed my Acceptable Risk Limits

Pull out the participant's Worksheet: Risk Limits – The Riskiest Things I'll Do (pg. 58) if it will help start this discussion. It may make the concept of “crossing risk limits” clearer through its visual depiction.

- *Think about an example of a time that you crossed your acceptable risk limits.*

*The idea is to really examine what it was like – what supported, and what made difficult, your choices in that moment.*

*So I want you to think about an example that really stands out for you.*

“Really stands out for you,” implies that it is significant to the participant in some way.



*It may be an example from a recent time or from many years ago.*

Immediacy is the value of a recent episode. But one that is older may have the value of serving as a turning point for the participant. Ultimately, the value of the participant's choice will come clear as you work through the example together.

If the participant begins an episode and starts to struggle with it (can't recall details, too emotionally painful, etc.) let him stop, pick a different episode, and start again.

*Pick one that you are willing to tell me with as much detail as possible.*

Avoid a tone of interrogation! "Give me as much detail as possible," could be misconstrued as pressure.

See Episode Exploration Guidance for more details (pp. G-18 to G-22).



## D) Comparing the Two Examples - Looking for Patterns

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- *Any reactions to talking about that?*

Reactions may be emotional, cognitive, or both. The participant may ask for clarification on this, (e.g. what do you mean by “reactions?”).

- *Let’s review some key points from the second story:*

### Two steps here:

1. Review the key points from the “crossed risk limits” episode.
2. Compare the two and look for patterns.

Use the **Worksheet: Comparison of Examples** that you started filling out in Module 2 (p. 64) to facilitate this discussion.





lower risk men:

- *What most tempts you to go out of your acceptable risk?*

This is a good time to introduce or strongly reinforce the concept of “temptations” or “close calls” for the participant who is currently not taking HIV-related risks. The two terms (and you may come up with ones that better suit you and your participants) help open the examination to include areas of potential risk-taking.

all:

*what about those examples represent larger patterns for you?*

“Patterns” is a term that needs tailoring to the participant. Have some ideas ready should he ask “What kind of patterns?” Brainstorm these with your clinical coordinator and counseling team.

*What stands out for you when you compare the two?*



## **E) Introduction: Substance Use + Sex Screen**

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Abstinence-Based Recovery includes but is not limited to 12 step programs (like NA, AA, MA, CMA.) May also include a private, individual or group-therapy based approach that the participant is using to address a drug and/or alcohol dependence problem.

It's not advisable to inform a participant "You're in Track 3" or "Track 2!" It will probably raise more questions than it will answer and it may cause undue anxiety. This classification system is for the benefit of the study staff only.

Pull out the "Response Scale" as a visual aid for this segment.

### **The Substance Use + Sex Screen aims to:**

Determine if alcohol or drug use is related to sex or sexual safety  
Screen participants for one of the three tracks.

Track 1 = General Intervention

Track 2 = Alcohol and/or Drug Focus

Track 3 = Abstinence Based Recovery Focus

### **For Track 2, the Screen:**

Assesses the degree that substance use affects sexual safety

Assesses points in the modules where alcohol or drug use is most relevant or important.

May help enhance the participant's motivation to address substance use and sex in the next visits



### **Substance Use + Sex Screen Procedures:**

Administer the “core” screening questions to all participants. (pgs. 78 – 80.)  
Follow the directions in the Delivery Manual.

If a participant answers “Never” to the question at the top of pg. 80, confirm with the second question and then move to Module Mapping, pg. 86.

If a participant answers “Occasionally, Often, or All the Time,” to the question at the top of page 80, proceed to the complete Substance Use + Sex Screen, pg. 81.

Complete EVERY item on the Screen. DO NOT SKIP ANY.

You may wish to hold discussion to the end of the Screen. At that point, you may want to go back and discuss those answers the participant “endorsed” with a 2 (Often) or 3 (All the Time.) Use questions on pg. 82 to guide this discussion.

Pg. 83 essentially asks the participant to endorse his participation in Track 2 in future modules. It may be helpful to “preview” the Track 2 material by saying,

“The material that looks more closely at alcohol and drug use as it relates to sex:

1. Really doesn't push you into trying anything you don't want to;
2. Doesn't promote not drinking or using drugs;
3. Gives us a perspective from which to look at how drinking and using drugs interacts with sex to either help you stay within or cross your risk limits.

Ultimately, it's up to you. You also can decide to look at this later.  
You don't have to make that decision right now.”



## F) Module Mapping — Overview for Future Visits

- *Introduce the visual:  
Topics for Upcoming Sessions*
- MAKE DECISIONS FOR FOCUS AT THIS VISIT.

Also, highlight Special Topics at this time ( Offer verbally...).



## Purpose

The purpose of this module is to provide a format to launch into one of the major topics in *EXPLORE*: Communication.

In this regard, Module Four helps establish basic terms for discussion of communication in situations related to sex: those where sex is sought and/or negotiated, and those where sex actually occurs. It builds upon that base to help the participant assess his skills and consider alternative strategies. The Module looks first at the participant's "style" of communication as an "icebreaker" to get the conversation going on this topic. From there, Focus Options offer paths to look at actual skills assessment and building.

*EXPLORE* emphasizes both Spoken and Unspoken messages.

## Goals

The goals of this module are to:

- ◆ Focus the participant's attention on his style of communication in situations related to sex.
- ◆ Move the participant toward skills assessment and rehearsal, if needed.
- ◆ Examine how the context of a sexual situation predicts or relates to the success of communication.
- ◆ Support the participant to commit to strategies that may be beneficial in adopting and maintaining safer sex strategies.

## Objectives

This module will help the participant to:

- ◆ Identify strengths and weaknesses related to communication.
- ◆ Gain insight into factors which enable or impair communication.
- ◆ Identify areas for further work.
- ◆ For Track 3, identify skills learned in recovery that may apply to communication in sexual situations.
- ◆ For Track 2, examine the effects of substance use on sexual communication.



**A) Check In**

**B) Overview**

**Introduction**

Module Four injects a key idea: that we are continually sending and receiving messages in sexual situations, whether or not a word is ever spoken.

The core worksheet identifies elements of the participant's communication style. It also provides an opportunity to learn more about how the participant describes his experience in words. This helps the counselor plan future modules to suit the participant's verbal style and skills.

Use the worksheet to negotiate terms. Spend time finding out exactly what the participant means by a word. Find out why a phrase in the worksheet doesn't fit him. Which phrase fits better?



## C) Sexual Communication: What's Your Style?

### 1. Introduce Exercise

*We are going  
to do 2 things here:*

- *1. Talk about how you communicate about what you want to happen (and don't want to happen) in sexual situations.*
- *2. Look at how your "style" of communication supports your choices around sexual safety.*

Use the following warm-up questions to get the topic rolling. Aim for the ideas in the forefront of the participant's mind. Don't probe yet. Save that for the worksheet (and Focused work, if elected.)

- *First, tell me what makes you successful at communicating (or telling) your sexual limits.*
- *What makes you less successful?*



## 2. Complete Worksheet

- *This worksheet will help us understand what we're trying to get at in this module.*

Choose or fill in a response to each of the following items.

Either one of you can do the writing. The key is collaboration.

For the purpose of this discussion assume each question applies to you.

If it's helpful, tell the participant that the worksheet was designed with sexually active men in mind.

Use the hypothetical approach eluded to here. Another tact is to have some questions apply to how the participant communicated in the past – when these circumstance might have been more relevant to his life.

As a guideline, attempt to complete at least seven of the questions.

Do more if you have time. Skip questions, as appropriate.





**Words to look at closely:**

Risk limits	Sexual situation	Having sex
Partners	“Feels comfortable”	prefer
body language	communicate	best
face to face	talking during sex	safe sex
talking about using condoms		aroused state – really turned on
sexy	sexy enough	really into sex
ability to tell	some drinks	talked into
too assertive	dating situations	up front

**Worksheet: Sexual Communication**

**1. TALKING ABOUT MY RISK LIMITS WHILE I’M IN A SEXUAL SITUATION**

- a. Feels very comfortable
- b. Feels sometimes comfortable
- c. Feels uncomfortable
- d. I don’t do it

*Sexual situation* could include looking for partners, meeting partners, being in a place where others are having sex, or engaging in sex oneself.

**2. WHEN IT COMES TO HAVING SEX WITH PARTNERS I DON’T KNOW THAT WELL,**

- a. I prefer to talk about what we’ll do.
- b. I prefer to use body language rather than talk about what we’ll do.

Body language needs to be defined by the participant. Include things beyond gestures, posture and stance, or facial expressions. Clothing, piercing, tattoos, hair style, etc. may also be important ways unspoken messages are communicated.

**3. I COMMUNICATE BEST**

- a. when I’m not face-to-face with someone  
(i.e., on the phone or over internet).
- b. when I’m face to face with someone.

Stick to sex-related communication.



4. WHEN I'M HAVING SEX WITH A PARTNER AND HE OR SHE STARTS TO DO SOMETHING I DON'T LIKE,

I \_\_\_\_\_.

5. TALKING DURING SEX IS
- Sexy and fun
  - Annoying and tacky
  - Neither

Talking may consist of telling one's partner what feels good or is desired. Or it may be "dirty talk", whatever that means for the participant.

6. THE LAST TIME I HAD SAFE SEX, I TOLD MY PARTNER MY LIMITS BY

\_\_\_\_\_.

Explore how a man in a monogamous, non-condom using relationship negotiated this.

7. FOR ME, TALKING ABOUT USING CONDOMS
- Is a turn off
  - Is just something you do, even if it isn't sexy
  - Can really be a turn on, if it is done right
8. I COULD BE "TALKED INTO" CROSSING MY ACCEPTABLE RISK LIMIT
- By a partner that is sexy enough
  - By a partner that is sexy and persuasive
  - By a partner that is very persuasive
  - By no one at all



**9. IN SEXUAL SITUATIONS, I AM MORE LIKELY**

- a. To bring up safe sex first
- b. To wait for my partner(s) to bring it up first
- c. It depends on the situation
- d. other \_\_\_\_\_

This is a good point at which to ask the participant,  
“When is the best time to bring it up?”

**10. WHEN I AM REALLY INTO SEX WITH A CERTAIN PARTNER , I**

- a. am more clear about my limits
- b. am less clear
- c. the same
- d. other \_\_\_\_\_

Is it harder or easier to communicate when highly aroused?

**11. THINGS THAT SOMETIMES INTERFERE WITH MY ABILITY TO “TELL” MY PARTNER(S)  
MY RISK LIMITS INCLUDE (CIRCLE ALL THAT APPLY)**

- a. having had some drinks
- b. being in a really aroused state – really turned on
- c. being afraid that the partner won't want to have sex if I am too assertive
- d. being in places where talking is discouraged
- e. my wanting to have sex with this partner more than wanting to be safe at that moment.
- f. other \_\_\_\_\_

**12. IN DATING SITUATIONS, I WOULD BE MORE LIKELY TO BE UP FRONT ABOUT MY RISK LIMITS**

- a. during the first date
- b. after a few dates
- c. after a longer time dating


**13. A GOOD EXAMPLE OF HOW I USE BODY LANGUAGE WITH A PARTNER IS**

\_\_\_\_\_.



### 3. Process the worksheet

Summarize key points that came up in the worksheet:

Offer your own observations 

Use Motivational Interviewing to contrast what the participant's goals are for staying negative with how his communication strategies do or do not support that.

### E) Focus Option 1 Worksheet: Challenging Situations

This option is recommended for the participant who has a clear idea of how communication works in various sexual situations. Further, it's clear that communication plays a role in risk-taking (or maintaining safety.)

This option may also be appropriate for the participant who is ambivalent about the role of communication.

It would probably not be productive to attempt this option with a participant who does not see communication as a factor in risk-taking. Its structure and pointed direction may provoke undue resistance.



**Guidance for all *EXPLORE* Worksheets:**

The counselor places the worksheet so that both parties can look on.

The counselor reads the guidance as outlined in the Delivery Manual while the participant focuses on the worksheet/chart.

Either the counselor or the participant can write on the worksheet/chart, depending on individual preference.

For phone counseling, follow guidelines for “Phone Counseling Worksheets.”

**1. Introduce the worksheet/chart.**

- *We’re going to use this worksheet to identify situations where communication of your sexual limits is difficult for you.*

Bridge from Core. The discussion began at that time.

*We’ll then talk about things you can do that may improve communication in each situation.*



## 2. Guide the participant through chart:

Attempt to complete a minimum of all the columns of a single row.  
A thorough exploration of one co-factor may be preferable to rushing through the whole worksheet.

Pick the co-factor that pertains most to the participant.  
(E.g., he may have expressed that “*Places*” are likely to cue risk-taking.  
Start with that row.)

Keep the goal in mind. The goal is to arrive at ideas for alternative strategies –  
to set the stage for Change Work if possible.

*With what partners (or types of partners)  
is it harder to communicate your risk limits?*

*In which places that you have sex  
is it harder to communicate?*

*What aspects of these places  
make it more difficult?*

*How is communication  
more difficult when drinking  
or using recreational drugs?*

*Which moods, thoughts, or feelings make  
it harder to communicate your risk limits?*

*Work across each row,  
addressing each column.*



## 2. Worksheet: Communication

Some counselors asked about “How Does It Help Communication” on the worksheet. Basically, this column asks for any positive sides of partners, places, etc. - i.e., acknowledging that a given factor is not ‘all good’ or ‘all bad,’ but rather that there is both, recognizing balance.



### 3. Process the Worksheet

Focus on the strategies column with the following questions:

- *Which strategy is most attractive to you?*

“Most attractive” is one way to measure the appeal or desirability of a strategy. You can stage the discussion so it starts at the “most attractive” and progresses to the “most important” and on to the “most immediate.” This approach may help warm up the participant toward considering change (along with appropriate Motivational Interviewing.)

Add the following 2 questions  
for men in abstinence-based recovery (Track 3):

*How has communicating about sexual safety been different while you've been in recovery than it was while you were drinking and/or using?*

It may be helpful to refer back to key parts of the worksheet and ask “How is this different now than before you got clean and sober?”





## **F) Focus Option 2 Discussion: Communication Strengths and Weaknesses**

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Option 2 is recommended for the participant who emerged from the Core of Module 4 with some ambivalence or concern, but is not ready to do the “head-on” work called for in Option 1. Since this option refers back to the Core worksheet, it is grounded in work already done. For some participants this may seem less daunting.

This option is designed to resolve ambivalence and move the participant toward Change Work or toward the next module or more Focused Module 4 work.



## 2. Questions

Frame this discussion, if needed:

“We may already have touched on this, but let’s go deeper now.”

- *What strengths did you recognize in your communication styles from the worksheet?*
- *What are some of the weak areas?*

Track 3:

- *What things that you’ve learned in recovery apply to communicating in sexual situations?*

How do “recovery skills” transfer to sexual risk reduction?

All:

- *Are there alternative approaches you would like to try?*

The questions here move the participant toward Change Work.



## G) Focus Option 3, Track 2 Discussion: Substance Use

### 2. Discussion:

The first part of this discussion deals generally with sexual communication and substance use – without direct links to risk-taking. It helps build the foundation by illustrating the importance of substance use in sexual situations.

Link this discussion to the Core. Although the questions refer to “talking,” broaden appropriately to include non-verbal cues and body language.

*Example...lowers inhibition, creates rapport, etc.*

Only cite these examples when the participant can think of none himself.

- ***When does drinking or being high make talking about sex more difficult.***

*In what ways does it make it challenging?*

### 3. Example

A full Episode Exploration is NOT called for here. Pull for the basics of the example (where, when, what type of sex, partners) and move to the probe questions, below.

- ***Give me an example of a time when drinking or being high stopped you from communicating well and you ended up having sex outside your acceptable limits.***

*Let's focus on the parts of this example that deal with communication.*



#### 4. Probes:

The probes deal with the major areas of how substances may impact sex:

- Motivation to protect
- Physical impairment in ability to protect
- Affiliation with “outlaw” aspects of substance use and culture and impact on protection behavior
- Emotional enhancement of some drugs – such as Ecstasy’s empathy-promoting effects.

All four are rich areas for detailed discussion. Pursue it at the participant’s lead.

- *Any concerns about any of this?*

Asking for concerns is one approach. Employing Motivational Interviewing statements and reflections may further enhance this strategy.

#### 5. Discuss possible strategies:

Think of these questions (page 108 and other sections like it that appear at the end of Focused options) as warm up to Change Work.

They do not replace the detailed process that would be used in Change Work (to work out every possible glitch in potential change steps.) Rather they can serve to prepare for change.

Early in the visits, they may help to educate the participant about the many considerations involved in change.

#### H) Closing

Summarize key learnings or ideas.  
Use Motivational Interviewing techniques as appropriate.

See Miller (1991), pp.78-80 for a discussion of how Summarizing is used as an effective strategy in building motivation for change (and specifically, eliciting self-motivational statements.) Also, check the index (p.348) for a complete list of references to Summarizing as a tool in Motivational Interviewing.

# Visit 6-11.0/Module Five

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## HIV Status and Sex: Exploring Ideas and Actions

### Delivery Manual Guide



### Purpose

Module Five acknowledges that many men make decisions about safer sex based on knowledge of their partner's HIV status. The module strives to help participants identify the strategies for how they gather and use information about serostatus (their own and that of their partners) to assert their risk limits and avoid HIV infection. Helping the participant to look at how effective these strategies really are is an important aim of the module.

This module builds upon information gathered in earlier sessions. By this time, the counselor should have some sense of the following:

1. How does the participant know or find out the serostatus of his partner(s)?
2. Whether or not the participant discloses his serostatus to sex partners or attempts to learn his partner's serostatus as a prevention strategy.
3. If so, how does discussing serostatus affect his sexual decisions and his taking chances.

Module Five is comprised solely of a Core segment.

### Goals

The goals of this module are to:

- ◆ Assess how important serostatus is to the participant in following his risk limits.
- ◆ Gain further insight regarding the degree of concern the participant has about the threat of HIV infection.
- ◆ Gain insight into the participant's perceived ability and motivation to avoid exposure to HIV.



## Objectives

This module will help the participant to:

- ◆ Identify how much he relies on knowledge of serostatus information as a prevention strategy.
- ◆ Assess his comfort in relying on serostatus information as a prevention strategy.
- ◆ Consider improving his techniques for gathering serostatus information, if needed.
- ◆ Consider adopting other prevention strategies in addition to knowledge of serostatus.

### A) Check In

REFER to Change Work,  
as appropriate

Begin to include in Check-In the processing of any Change Work done at previous visits. Be prepared with Change Plans from earlier visits.

### B) Overview

#### Core Segment Tasks:

Be attentive to the need to clarify the participant's comprehension of terms such as HIV status, HIV transmission, etc. Review these as needed.  
*See Delivery Manual, Screening Visit, for more guidance.*



### C) Introduction

- *We're going to discuss how much time and energy you spend thinking about your HIV status.*

"Time and Energy" are one way to frame this discussion.  
Tailor appropriately.

It may help to frame this in the following manner: *"We want to look at how much HIV figures into the sexual choices you make. One way to begin thinking about this complex topic is to discuss how much time overall you spend thinking about HIV."*

*This discussion will help us begin to look at how your general thoughts influence your day to day decisions about sexual behavior.*



## D) Discussion

Aim for a measure of how great the threat of infection is for this participant. What's his sense of vulnerability to HIV? What's his perception of risk? Highlight any inconsistencies with earlier stated concerns and goals. (Use Motivational Interviewing appropriately.)

- *Roughly speaking, how much time do you spend thinking about your HIV status?*

*How comfortable are you with that?*

*How do you strike a balance between constant worry and complete denial?*

Alternately, "How do you maintain a *healthy fear* of the virus; of getting infected?"





## E) Worksheet: HIV Status and Sex

### • 1. Instructions

Aim to complete a minimum of 8 of the 16 items.

**The following suggestions are offered  
as probes for further discussion of each item.**

1. What's easier about not talking about HIV status, sometimes?
2. How do you define "don't know very well?"
3. How does this assumption make you feel toward sex?
4. How do you define "safer sex?"
5. What does "trust" mean to you?
6. How do you know when you are with someone you trust?
7. What choices would be different?
8. What sexual situations, specifically?
9. What's the testing process like for you?
10. What does it say about his status – the kind of sex he's willing to have?
11. Say more about cues...
12. Do you feel less threatened? Less afraid?
13. How does that make you feel?
14. What kind of support would you like to see for negative men?
15. What can you do to maintain that confidence?
16. What about being a bottom (receptive?)



# Visit 6-11.0/Module Six

## Sex, Drinking and Drugs

### Delivery Manual Guide



## Purpose

The purpose of Module Six is to help participants examine how alcohol and drug use play into taking sexual risks around HIV. The module offers views from two perspectives:

- 1.) How a sex partner's drinking and drug use affects the ability to practice safer sex for the person who is not using alcohol or drugs; and
- 2.) How the ability to practice safer sex is affected in the drinker and/or drug user himself.

Track 2, the Substance Use Track, is designed for men who find that alcohol and drug use interferes with their safer sex plans or guidelines; it is not limited to men with diagnosable chemical dependency or addiction, and may be inappropriate for such men without the support of formal treatment. Track 2 materials adopt a "harm reduction" approach which is presented in this module. For some men, abstinence from alcohol or drugs is the only approach that will lower sexual risk. For many others, alcohol or drug use will continue. Rather than only encouraging abstinence, the counselor and participant work together to curtail the harm of substance use, via three central principles:

- 1.) Be realistic,
- 2.) Recognize the positive,
- 3.) Change is an active process.

Track 3, the Abstinence-Based Recovery Track, is designed for men who have been in "recovery" for a minimum of six months (although some men with less time may benefit from the material.) In this module, Track 3 gives the participant a chance to describe his experience as a recovering person and to make initial comparisons between staying clean and sober and consistently practicing safer sex.



## Goals

The goals of this module are to:

- ◆ Continue a dialogue with the participant about drinking, drug use and sexual behavior.
- ◆ Examine the impact of the participant's social environment upon his practice of safer sex and his use of alcohol and other drugs.
- ◆ Examine personal patterns of substance use and risky sex or safety maintenance.
- ◆ For Track 2 participants, consider harm reduction strategies.
- ◆ For Track 3 participants, explore the similarities between the recovery process and the practice of safer sex.

## Objectives

This module will help the participant to:

- ◆ Assess the role of substances in their social environment and its impact on their personal sexual safety.
- ◆ Look at patterns of behavior in places where there is substance use and in sexual interactions with substance users.
- ◆ For Track 1 participants, examine his pattern for any concerns and the potential need for further examination or Change Work.
- ◆ For Track 2 participants, further examine patterns of use and begin to consider harm reduction strategies.
- ◆ For Track 3 participants, look at how his recovery may help maintain his risk limits and how to avoid sex-related relapse into drinking and/or drug use.



## A) Check In

## B) Overview

The discussion in this section aims to elicit concerns from the participant, ranging from concerns about friends' patterns of unsafe sex under the influence to his own behavior. It is designed to first address friends' drinking, drug use and sexual risk; then risk associated with partners who may use drugs or drink; then the participant's own drinking, drug use, and risk-taking behavior.

## C) Discussion: How Alcohol and Drug Use Affects Sex (Risky and Safe.)

### 1. Introduce Discussion

Alcohol and/or drugs are frequently combined with sex.

State the above assumption in your own words.

The focus here is about links between substances and sexual safety.

- *How big a role does alcohol play among people you know or socialize with?*

Ask about drug use as well.

- *How much of a concern is HIV and safer sex for people you know?*



## 2. Discussion

- *Are you aware of any times that friends had unsafe sex while drinking or using drugs?*

Clearly state that the intention of the above question is to examine what it's like for him to be aware of (or not aware of) sexual risk-taking among friends who drink and/or use drugs.

- *How often are you in situations where there is drinking and/or drug use AND people are meeting sex partners?*

You may choose to re-phrase this question. The gist of it is, "Do you frequent places where alcohol, drugs, and sex are being mixed?" Probe about places where men meet potential partners (e.g. bars) and then go elsewhere to have sex.

*What substances are usually being used?*

*How much support is there for having safer sex?*

The key concept above is the participant's perception of support for safer sex in these places.



- *Can you think of any instance when you crossed your risk limits (or were tempted to) in such a place?*

Open the discussion to include instances of meeting partners where there is drinking and/or drug use in one place and then going elsewhere to have sex. When this occurs, there may be clear communications at the meeting place that unprotected sex is what's desired. Probe for this appropriately.

- *How comfortable are you having sex with partners who have been drinking or using drugs?*

Ask the participant to consider how power dynamics (who's in charge) shift during sex with a man who is drunk or high. Discuss who has the power to assert safer (or unsafe) sex under these circumstances.

- *At the end of Module 3 you answered some questions about your alcohol and/or drug use and risky sex.*

### **BRANCHING**

“Branching” is the term used for “placing” the participant in the appropriate Focus Track. The “Substance + Sex Screen” is used to guide this process.



## Focus, Track 1

Focus, Track 1 is designed for the occasional mixer of substances and sex. The goal is to probe for any underlying concerns which may indicate the need for more focused work.

This option may also work for the Track 2 participant who expresses some concern regarding mixing substances and sex but is still reluctant to take a direct look at the topic. Employed with effective Motivational Interviewing, this option may help tip the balance toward more focused Track 2 work in future modules.

- *You mix alcohol or drugs and sex occasionally.*

Clarify what the participant means by “occasionally?”

- *Is doing this occasionally something that is consistent, or has it changed over time?*

Discuss his pattern over time.

*Are you comfortable with your current pattern or would you like to look at doing some change work around this?*





## Focus, Track 2

Focus, Track 2 is designed for men who scored “often” or “all the time” on a number of items on the Substance Use + Sex Screen. The assumption is that the participant has agreed to the importance of looking at this pattern.

### 1. Let’s talk about your alcohol or drug use...

- *Where and when do you use alcohol or drugs?*

Probe for “any special days” or “favorite places?”

*Are there drugs that you tend to use before or during sex?*

Don’t forget poppers! And, of course, Viagra (if not prescribed to them...)

*(are there “sex drugs?” – they enhance sex, somehow make it better?)*

Each user or drinker may have their own “sex drugs.” Sex drugs are highly individual. Don’t assume that drugs like valium or klonopin (depressants) or marijuana (hallucinogenic) are not sex drugs for the participant. The amphetamine family is a likely candidate (speed, crystal, crank) as are certain other hallucinogens like ecstasy (or MDMA.) Some may even find alcohol (including beer and wine) to be a sex drug. Their perception of what are their sex drugs is the key factor here.



*Are there feelings or moods  
that you are trying to achieve  
by getting high before sex?*

This question may elicit key insights for the participant.  
Avoid a confrontational or “blaming” tone.

*Are there sex partners  
you tend to get high with?*

Include partners with whom the participant has sex in order to obtain drugs or alcohol.

- *Do you see  
any patterns here?*

Alternately, “What patterns do you see here?”



## 2. Episode Exploration

A full Episode Exploration is required. Include coverage of 6 of the 9 main domains on the *Counselors' PROBE SHEET* and the additional questions on page 138. If time is short, you may want to break before the Episode Exploration and pick up with it at the next visit.

- *Could you describe a recent time when you drank or used drugs and had sex?*



- Use the Counselor's PROBE SHEET

Refer to the guidance for Episode Exploration and Probes, pages G-18 through G-22

The questions on page 138, Delivery Manual, elicit costs and benefits of drinking and/or using in the episode. You may note these as they talk and summarize at this point, aiming to heighten ambivalence and elicit concerns.



### 3. Harm Reduction

It's important to convey the meaning of harm reduction without giving a lecture to the participant. Lecturing endangers the balance of the counseling relationship, making you the teacher and the participant the student. Work with your Clinical Coordinator and team members to devise ways to convey the harm reduction ideas effectively.

- *Let's talk for a minute about some specific skills or strategies to reduce the risk of harm.*

Stressing the material below may avert the problem of a harm reduction lecture. Keep the explanation of harm reduction very brief and then let these questions help illustrate it for the participant.

*Let's say you don't want to get too high when you're out...*

*Use "selective abstinence."*

Use "designated driver" idea as an analogy, if appropriate.

*How realistic and positive are these approaches for you?*



### Focus, Track 3

This option is designed for men who have been in any abstinence-based recovery “program” for 6 months or longer. It is not exclusive of those with less than 6 months of recovery time. However, men with less than 6 months may benefit more from a tailored form of Track 2, since the experience of sex and substance use is more recent. Track 3 looks at supporting the participant to maintain recovery and apply those skills to adopting and/or maintaining safer sex.

#### 1. What My Recovery/Sobriety Looks Like

This section provides a chance for the participant to describe in his own words his experience of abstinence.

- *How long has it been since you last had a drink or drug?*
- *Briefly, tell me what your drug and/or alcohol use was like.*

Emphasize “briefly.” You don’t want the full chronicles. Just the big picture. [If it helps, tell the participant to break the time into periods of 5 to 10 years, or phases. (E.g. “my pot phase,” “my speed phase,” “my speed plus bath house phase,” etc.)]

As they talk, note costs and benefits.



You may summarize statements in lieu of posing the following questions, as appropriate.

*What was good about drinking or using?*

*What did you get from it?  
(benefits)*

*How did alcohol or drugs turn on you, or stop working for you?  
(drawbacks)*

- *The terms “recovery” and “sobriety” mean different things to different people –*

*On a scale from 1 to 10, 10 being most important, how important do you rate your recovery?*

*Has this changed over time?*

Acknowledge that priorities change as length of recovery grows.

- *Briefly, describe what makes it possible to sustain your recovery?*

The aim here is to highlight the strengths and resources used in recovery. From that point, guide the participant toward a discussion of how these same strengths and resources can be used to support adopting and maintaining risk limits.



- *Tell me a little bit about how you spend your leisure or free time?*

A discussion of leisure time may help illuminate what choices the participant recognizes in how he spends his time.

- *How often are you in situations where people around you are using or drinking?*

Aim for discussion about how these situations support or undermine adherence to risk limits.



## 2. Sex, Partners, and Sobriety

- *When you drank or used drugs, were alcohol or drugs a trigger for sex?*

Alternately, “How were drugs and drinking related to sex for you?  
How did that connection change over time?”

- *When you drank and used, what was your ability to practice safer sex and protect yourself from HIV infection?*

Note that some men got sober or clean before the advent of HIV.  
Tailor appropriately.

- *Have you ever had a “slip” associated with a sex partner who was high?*

Alternately, “Ever had a slip that involved sex as well?”

- *Do you ever experience urges when you’re around people who are drinking and/or getting high (urges to use..?)*

Discuss how coping skills can be transferred to maintaining risk limits.





## Purpose

The purpose of this module is to examine places and events as distinctive triggers to unsafe sex for gay and bisexual men. Despite individual differences, an examination of each man's patterns of behavior can help to reveal how certain places and events may play a role in risk taking. From there, the participant may identify choices, triggers may be modified, or alternative coping strategies may be adopted.

## Goals

The goals of this module are to:

- ◆ Provide a basic framework within which to explore the concept of triggers to risky sex.
- ◆ Assess the participant's understanding of the concept of triggers and plan further related work accordingly.
- ◆ Assess the relevance of places and events as triggers for the participant and the need for further work (including Focused options, Change Work, or other alternatives.)

## Objectives

By the end of Module Seven, participants will be able to:

- ◆ Gain an understanding of how different people, places, and times can act as triggers to unsafe sex for participants.
- ◆ Identify specific triggers and how they're activated.
- ◆ Build a framework to begin to develop new skills for dealing with these triggers.



A) Check In

B) Overview

C) Briefly define triggers

Use the below definition or personalize one for your participant.

Tailor the definition to reflect your local area - places and events specific to your locality. The following steps summarize the habituation process:

- a. A single or repeated exposures to a trigger  
(whether external or internal, positive or negative.)
- b. which triggers cue a sexual event or chain of events.
- c. which reinforce the original trigger(s.)

It's hard to find a word or words which best fit this highly personalized process. Trigger has its baggage. Sites may work to build a vocabulary that better captures the essence of the process.

Some alternatives:

Active ingredients  
On-ramps  
Cues  
Antecedents

The intent is to define triggers by example – avoid an “instructional” tone.

The best teacher in this case is example and personal experience.



NOTE: Offer a few of the following examples  
to clarify the concept of triggers, if needed.

Focus specifically on places and events at this point. The fact that feelings and thoughts may mediate the sexual result is a key idea in Module 8. If you've done Module 8, work those ideas in during this module. If you have also completed Module 9, work in the impact of partners as factors in places and events that act as triggers.

If not, save the closer examination for the appropriate module. If a participant wants to talk about the mediating feelings and thoughts now, acknowledge the connection and offer a response like, "Your insight on this is really good. I'd like to keep us focused on the externals for now – just to take a really close look at them. Then Module 8 will give us a chance to get into your ideas about thoughts and feelings. Does that sound OK?"

If you start this module and it's abundantly clear that the participant wants to talk about feelings and thoughts instead, do not proceed with this content! Go to Module 8. Come back to Module 7 at a later point. However, do not stop mid-way in the Core of Module 7 to move to another Core. The opportunity to make that choice is as you get started in a Core, not once you are under way.

The list of examples of *Events and Places* should be tailored to your local area and "scene." Also, consider diversity – for instance, events and places that may be more relevant to Native American men, African American men, Asian men, or Latino men. Bisexual men may also have specific places and events. The team can work together to build a list of these to enhance delivery of this module at your site.

For example:

Events:

Places:



## D) Exercise: List Triggers

Use the following worksheet to list ideas of places and events that may act as triggers or cues to safer or unsafe sex.

Note that the terms “safer” and “unsafe sex” are used here (as opposed to “crossing risk limits” or other terms used in the Delivery Manual.) A variety of terms are offered to choose from. Use what works for the individual participant. Sometimes varying terms may help reduce redundancy and avoid monotony.

### 1. Places

- *Let’s brainstorm places where you might have risky sex or where you might seek risky sex, or where you may have “close calls” or be tempted to have risky sex.*

The language above is cast broadly to capture a variety of individual experiences; “Have risky sex,” and “might seek risky sex,” may apply for those who are currently sexually active (particularly with multiple partners;) “Where you may have ‘close calls’ or be tempted to have risky sex,” may be more relevant for those who may currently be at lower risk (but have taken risk in the past or may do so in the future.)

Choose the terms that are most relevant to the participant in an effort to engage him in this discussion of trigger places and events.

If the participant doesn’t see the relevance, encourage them to stay with the process; that it may benefit them at some point in the future.



*Include all the possible places,  
even potential ones you haven't  
yet experienced but might like to.*

Examples:

Give the participant a chance to list any ideas they have first. If needed you may wish to pull from examples and experiences that the participant has described in earlier visits.

2. Events

- *Now let's brainstorm events during which you may have risky sex or seek risky sex.*

Some participants may take literally the phrase “events during which you may have risky sex.” Explain that this means “events where sex is actually taking place (like a sex party or at a sex club,) or events where there is a lot of cruising for sex.”

“Events” can be broadened to include personal events such as birthdays or difficult periods in one’s life.

Examples:



## E) Discussion

- *How do you think each of these things may trigger risky sex?*

Allow the discussion to take on the level of complexity that meets the participant's interest and needs. As stated earlier, for some participants, the discussion will focus on one to one causality. Others may already grasp the interplay of places, events, thoughts, feelings, and partners.

The main aim is to

1. Examine the “essence” of the places and events – i.e. what makes them triggers.
2. Help the participant recognize where he may have choices not previously recognized.

Compare costs and benefits of each trigger.  
Focus on key ones for this participant.

Costs and benefits is offered here as one way to facilitate the discussion of how triggers work. For some, the cost/benefits discussion may not be appropriate.

- *What alternative choices might you have?*



### F) Recent Example

- *Can you think of an example that illustrates how these places and events act as triggers for risky sex for you?*

One effective approach may be to refer to a good example discussed in an earlier visit and discuss further how the places and events described may have acted as triggers.

### G) Segue to Focus or Next Module

- *Would you like to explore this further?*

Summarize what's been said and heighten any concern or ambivalence that arose during the discussion. This alternative approach may produce a better result.



## H) Focus Option 1: Episode Exploration

Focus, Option 1 is designed for a participant who is currently sexually active with more than one partner. Episode Exploration is most effective when the participant has a number of episodes to describe. In this case, the participant should be able to talk about an episode where a place and/or event stands out as a trigger. Episode Exploration may be a less useful tool with men who have fewer episodes to describe.

- *In this section our goal is to:*
  - *1. Look at a specific story where places and events acted as triggers to sex.*
  - *2. Examine the triggers to see how they worked in the episode. What made them act as triggers for you?*
  - *3. Consider if you'd like to do anything differently in future situations.*
  
- *We'll use a similar technique to the one we used in Modules 2 and 3 where we looked at a specific sexual episode.*
  
- *This time we are going to map the details on paper as you describe the episode. I'll interrupt to make sure I get as much detail as possible (related to triggers.)*





Tell the participant that you will write the key places and events on the worksheet, as he mentions them. Do so in a way that keeps the episode moving forward but is not too disruptive. (Interrupting too much may be a barrier for some participants; particularly because it may be challenging for them to discuss sexual events such as this and interruptions may increase their discomfort.)

### 1. Describe the Episode

- *Since the focus of this exercise is to look at the places and events in a sexual story - pick a story where the place(s) and events really stand out.*

Prompt them to describe the entire episode for an example mentioned earlier during Check-In, the Core section, or in another visit.

**Places:** All the places involved in the episode – before, during, and after sex. Places means physical locations where action took place.

Again, note that “where action took place,” may include places where cruising occurred but not actual sex. (Although you want to hear about the “sex places” too!)

**Events:** All the events or situations related to the episode. What events were taking place before, during and after? (example: parties, good day at work, fight with friend, holiday... Use “events” as the participant defines it. Refer to what they said in Core...)

**Show the finished chart when the episode is finished**  
– avoid distracting them or cutting it short.



## 2. Rating and Discussion

- *Which Places and Events were Triggers? Why?*

Highlight those that they identify as triggers.

### 2a. Rating

The goal of rating is to narrow the focus to those triggers that are most relevant for the participant by ruling out the ones which aren't part of a larger pattern.

- *Thinking about times you've had sex, how often is each place or event a trigger for unsafe sex?*



**2b. Discussion – Process the rating**

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- *Let's talk about the ones you rated 1 or 2.*

Take time to help them to get at the essence of how triggers work. Per *EXPLORE* design, begin with one of the questions on the following three pages of the Delivery Manual, and then follow the participant's lead.

*Had you been to these places before? If so, How did your experience this time resemble past experiences?*

A fuller examination of costs and benefits, using Motivational Interviewing, may ensue from this question.

Track 3:

*Do you have the same expectations about sex?*

For men in recovery, expectations about sex may change greatly. This question may facilitate a rich discussion of how different expectations lead to new challenges to maintaining safer sex.



Resume:

*What was the “mood”  
of the place or places?*

*How loud or quiet?  
How crowded or empty?  
Fun or serious?*

Discussion of the objective aspects of the example may be a way to start the discussion. Matters of more personal relevance may then be raised to the participant.

*What appealed to you  
about the places and events?*

*What were positive  
aspects of them?*

*What about them did you like?*

Cost/benefits discussion may employ the Decisional Balance Sheet, if appropriate.

*What aspects of them  
gave you the most “charge?”*

Resume:

*Did the places and events  
affect your sense of self-control?*

This could be an effective question for a participant who is ready to look directly at the impact of triggers on his self-control.



2c. Assess for further work

- *Any concerns when you look at this worksheet?*
- *Anything you'd like to add or elaborate on?*

Another approach would be to summarize the concerns that you heard, a la Motivational Interviewing, to help the participant “argue for change.”



## I) Focus Option 2: Track 2 - Alcohol and Risk

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The Track 2 option is designed to move from a general discussion of the role of places and events in drinking and/or drug use, to the specific connection between such places and events and sexual risk-taking.

### 1. Place and Events + Alcohol/Drug – General Use

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Have the participant describe how places and events may act as triggers to drinking and drug use. Use the questions to help them describe the highly personalized patterns that may exist for them.

- *In what places or events are you most likely to use alcohol and/or drugs?*
- *Do you ever use sex to obtain drugs or alcohol?*

“You mentioned earlier that sometimes you’ll go home with a guy that you know has some pot or an extra 12 pack; that that’s a strong draw as well as how attractive he is. Does that sound right?”

- *Do you ever use alcohol or drugs to help a partner “loosen up” sexually? (i.e. do the things you want them to do?)*

“Poppers seem like a pretty good way to ‘loosen up’ a partner for you. Is that right? But this concerns you too, you mentioned earlier.”



## 2. Looking at a Place

*Now I'm going to ask you to think specifically about a place or setting where alcohol or drug make it difficult for you to practice safer sex.*

This is NOT an Episode Exploration. Use the questions on page 170 to explore how this place may act as a trigger.

A discussion of costs and benefits is also offered as an approach, with Motivational Interviewing as the guiding technique.

## 3. Sex and Safety in Drinking or Using – Participant Specific

This series of questions are designed to concretize the connection for the participant (between risky sex and alcohol or drug use in these places and events.)

Discussion:

- *How likely is it you'll have sex while in these drinking or using events and/or places?*

Use Motivational Interviewing to offer some of these points as reflections, via summarization of earlier statements by the participant.

Here are examples of restatement of the following questions as observations:



### 3. Sex and Safety in Drinking or Using – Participant Specific- continued

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- *How does using or drinking in these events or places affect your sexual safety?*

“So drinking in this bar with the back room makes it pretty likely you’ll have risky sex, even if you go there intending just to have a few beers – as you said you often do. Is that accurate?”

### 4. Move toward Change Work

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*Now thinking about  
the risky place or circumstance  
that we have just discussed...*

Summary observations may be appropriate here as well (as opposed to posing new questions.) Statements can be made and concerns elicited in a non-confrontational manner.





## Purpose

The purpose of this module is to examine the role of feelings and thoughts as triggers to risky sex. It aims to ground the participant's understanding of feelings and thoughts as triggers, assess if such triggers play a role in risk-taking for the participant, and proceed with Focussed work appropriately.

## Goals

The goals of this module are to:

- ◆ Assess the participant's ability and comfort in talking about feelings and thoughts. Work with their comfort level accordingly.
- ◆ Explore the participant's understanding of feelings and thoughts as triggers.
- ◆ Determine the relevance to the participant of these types of triggers.
- ◆ Guide deeper exploration of how feelings and thoughts operate as triggers; identify the "active ingredients" for the participant.
- ◆ Explore and enhance the participant's motivation to try alternative approaches to existing triggers.
- ◆ Provide a foundation for Change Work in this area, as appropriate.

## Objectives

This module will help the participant to:

- ◆ Articulate his thoughts and feelings related to risky sex.
- ◆ Understand the potential connection between risky sex and thoughts and feelings.
- ◆ Explore how these connections work and examine where alternative choices may exist.
- ◆ Form motivation to work on these triggers, as needed.
- ◆ Outline the initial steps toward Change Work.



A) Check In

B) Overview

Core Segment Tasks:

- *In this module we will talk about feelings.*

A definition of “feelings” is offered to make sure the counselor and participant have basic agreement.

Site counseling teams are encouraged to customize this list, as appropriate.

C) List and Discuss Feelings

- *Let’s identify some feelings you’ve had recently (e.g., in the past week) or feelings you associate with sex. (Before, during and after.)*

Define the connection to sex in broad terms – seeking sex, having sex, wanting to have sex, missing sex, regretting sex, etc.



LIST these

Don’t push for an exhaustive list. A few items (2 to 4) will suffice.  
Go for quality, not quantity in this examination.



- *Tell me about each feeling we've listed.*

Ask for a brief example.

Use the remaining questions to assess their coping with each feeling and any possible connection to risky sex. Probe for temptations to cross risk limits, even remote ones (to engage lower risk men.)

If lower risk men don't find this personally relevant, frame the discussion in terms of "Do you see the potential connection? If not for yourself, for others? How might that work for them?"

#### D) Thoughts and Feelings

- *Sometimes feelings are associated with certain kinds of thoughts that often become connected. We call these "automatic thoughts" or "self-talk."*

Be prepared to present this idea concretely and concisely. Have examples ready (as done on pg. 181.) Work with your Clinical Coordinator and team members for best approaches to present this.

Key ideas:

1. Events or other factors trigger feelings.
2. These feelings prompt thoughts or self-talk.
3. When this happens repeatedly, it gets reinforced, becomes a habit of thought, or "automatic."

- *Look at the feelings we listed earlier.*



- ***What kind of thoughts did you have connected to the feeling(s)?***

*That is, things you said to yourself or “automatic thoughts” you had when you felt this.*

- ***What are some other things that you say to yourself, related to risky sex?***

Keep referring to the list of feelings made in the first section. Highlight the ones the participant tied to risky sex (having it, wanting to have it, regretting it, etc.) In this way, you build on the ideas raised earlier in the module.

You may need to draw on feelings and thoughts that the participant described during other visits.



**E) Assess participant's ability to articulate thoughts and feelings.**

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- ***What's it like for you to talk about feelings?***

Check in with the comfort level of the participant. This will help assess his ability or readiness to work in Focused options of this module.

Not every participant will be used to talking about his feelings. Explore this issue and ways to handle it as a counseling team.

**F) Looking at a Risky Time:**

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It may help to use the **Worksheet: Comparison of Examples** (pg. 64, completed in Modules 2 and 3) as a visual.

Refer to notes on what the participant described in Module 3, risky episode, for the following discussion.

- ***Think of the episode we discussed in Module 3 (where you crossed your risk limits...)***
- ***What feelings and thoughts were you having?***



It may be helpful to first ask these questions to the participant. If needed, you may then wish to offer your observations, based on your notes from the visit.

For example, "You've *said you felt bored and sort of anxious before you picked up the guy at the bar who later fucked you without a condom. And you also said that you thought to yourself, 'What the hell! It won't hurt just this once. I need some excitement.'* You sounded concerned at the time. Sounds like the boredom made you more prone to take risk. Say more about that..."

- *How did your thoughts and feelings cause you to have risky sex?*
- *How did they help you set limits?*

Process the relationship of feelings and thoughts to risk-taking or limit-setting, as appropriate.

- *Would you like to continue this discussion on how thoughts and feelings act as triggers for you?*

It may help to first summarize what's been said and highlight concerns. Then ask if the participant wants to do more work.



## G) Focus Option 1

Focus, Option 1 is designed for participants who want to further explore the dynamic of feelings and thoughts as factors which affect behavior. This option breaks the dynamic down into “equations” to show the role each separate part may play. Also, the elements of the equations may help illustrate where alternative choices exist. Appropriate Motivational Interviewing can then help move them toward Change Work in pursuing these alternative choices.

### 1. When Thoughts and Feelings Combine

*Feelings or thoughts can be strong triggers all by themselves.*

*Let's review the discussion from the Core.*

The goal is to help summarize learnings from the Core of Module 8. Or, if that Core has not been done yet, to capture key ideas to frame the rest of the Focused option. Use summary statements, as appropriate.

- **SUMMARIZE** How feelings and thoughts caused the participant to take risks or tempt them to take risks.

Track 3:

The Track 3 questions examine the similarities of feelings and thoughts as triggers to drinking and using AND feelings and thoughts as triggers to present sexual behavior. Recovery skills in re-framing old thought patterns and dealing with feelings may be drawn upon to address current risk-taking behavior.



- **SUMMARIZE** How are feelings and thoughts are connected for the participant.

Use this question (or summary statements) to reinforce connections the participant made during the Core. Aim specifically for the “self-talk” and “automatic thoughts” framed in Core.



#### LIST

- *Do you find that your feelings and thoughts can combine to create a stronger trigger?*

Probe for their understanding of how the two can interact for a synergistic, or stronger, effect.





## 2. Combination Exercise – Thoughts and Feelings Combined

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Aim to complete at least one equation.

- *What we want to do here is look at how triggers combine and affect your actions related to crossing your risk limits.*
- *We can also discuss which parts of the combinations you feel you have more control over and which parts you feel you have less control. Then you may wish to explore working on alternatives further.*

An alternative to “control” is to use the term “choices.” For those who are ready and willing, use “control.” Discuss these two approaches and their implications with the Clinical Coordinator.

- *Let’s look at the list of thoughts and feelings we were working on in Core and put together a combination or a string of feelings and thoughts that might represent a pattern for you.*
- *We can also fill in the results, rewards, and consequences.*



### 3. Process Equations

An alternative for processing below is to summarize what was said and move toward concerns. *“It looks like these combinations show some connection. Like when you feel this you think that. What do you think?”*

- *Do these combinations help show how feelings and thoughts may cause unsafe sex?*

*How much control do you feel you have over how feelings and thoughts influence your sexual actions?*

Again, “choice” is a viable alternative to “control.”

- *How do you feel talking about all this?*
- *Would you like to do some more work on putting these equations together?*

These questions can be re-framed as summary statements which end with elicitation of concerns (per Motivational Interviewing.)

One approach might be to highlight a particularly significant pattern and use summaries and double-sided reflections to elicit self-motivational statements.



## H) Focus Option 2: The Chain of Events

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Focus, Option 2 is designed for the “advanced student” of triggers – specifically thoughts and feelings. It is a more abstract, less concrete (and visual) approach that would suit the learning style of participants who fully understand the synergistic properties of triggers and are likely candidates for Change Work in this area.

Here’s an example of a chain of events:

### 3. Discussion

- *Any reactions?*
- *How do you feel talking about this?*
- *Look at some feelings and thoughts you had “between” events. Look at the next event.*

The aim is to highlight how feelings and thoughts between each event represent “choice points.” Alternative choices can be explored in Change Work.



**I) Focus Option 3: Track 2 Alcohol, Feelings, and Thoughts**

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- *Now I would like to talk about how feelings and thoughts may mix with alcohol or drugs to make sexual safety more difficult.*

**Thoughts and Feelings Examples:**

The examples may be useful at earlier points in the Module as well.



## 1. Example

- *Let's work through a (recent) time when you had sex while drunk or high.*

An example discussed earlier in this visit or others may be useful to draw on here.



## PROBE SHEET

Do not use “Episode Exploration” (Counselors’ Probe Sheet) here.  
Move directly to the probes on pp. 202-203.

The temporal focus of these probes may be useful since they place feelings and thoughts within a concrete context. A “chain of events” is constructed through the narrative.

Use all three time periods – before, during, and after – for maximum effect.

## 2. Introduce “Self-Talk”

Some of these points were covered in the Core.  
Re-frame questions as summary statements, as appropriate.

The remainder of this option is quite clear and concise.  
Use Motivational Interviewing, as prompted, on pages 203 – 206 to move the participant closer toward Change Work.



# Visit 6-11.0/Module Nine

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## External Influences: Partners as Triggers

### Delivery Manual Guide



## Purpose

The purpose of Module Nine is to facilitate in-depth exploration of how the participant's safer sex boundaries are supported or challenged in different partner contexts. It looks at how various "rules" may apply for different types or characteristics of partners and for varying levels of involvement.

## Goals

The goals of Module Nine are to:

- ◆ Assess the relevance of particular partners as a trigger for unsafe sex for the participant.
- ◆ Guide deeper exploration of how partners operate as triggers; identify the "active ingredients" for the participant.
- ◆ Explore and enhance the participant's motivation to try alternative approaches.
- ◆ Provide a foundation for Change Work in this area, as appropriate.

## Objectives

This module will help the participant to:

- ◆ Explore in depth how his sexual partners affect his ability to practice safer sex.
- ◆ Look at how different "rules" may apply to different types of partners.
- ◆ Explore how varying types of involvement with a particular partner affects his choices regarding safer sex.
- ◆ Look at the impact of sexual fantasies on sticking to his risk limits.



A) Check In

B) Overview

C) Types of Partners

- *In general, what are the labels you and your friends use to name the various types of sex partners you might have?*

The discussion begins with a free-listing of all possible partner types.



LIST on note sheet

*What are the benefits of each type of partner?*

*What are the drawbacks of each type of partner?*

*Is sex better with some than with others?*

Benefits and drawbacks are offered as terms for the discussion. “Likes” and “Dislikes” or “Pluses” and “Minuses” are alternatives that get at the same idea (and may be more concrete for the participant.)

- *How do different type of sexual relationships trigger risky sex?*





Different types of relationships may trigger risky sex for a variety of reasons. These may include:

**COMMUNICATION:** ‘rules’ or styles which differ by type (e.g., the anonymous partner where there is total silence; the new casual where some negotiation of limits may take place; the internet partner where limits are discussed on line before the meeting takes place - but not in person, once the partners meet for sex; etc.);

**POWER DYNAMICS:** Some relationships differ in power intentionally according to sexual scripts (such as S/M, B/D) and some are more ‘equal’ in power. For some, power (which may play out as the ability to assert limits in the sexual moment) may be a function of age differences, gender role (effeminate/butch) or race;

**PURPOSE OF THE RELATIONSHIP:** Is it to just ‘get off’ or to make a deeper connection, enhance intimacy, etc.? Is this a lover that their person lives with and depends upon for financial and practical support, or a fuck buddy, where the main goal may be to have some fun and “get off”?

Along with these and other possible types of relationships, how does HIV status play into the equation (refer to Mixed Status/Serodiscordant Couples Special Topic for more ideas about this)? How about drugs and/or alcohol? How do these and other factors that you may have or will explore with the participant “mix” (i.e., do these different areas work together somehow? What is the result in terms of sexual safety?

- ***Partners can also have characteristics that strengthen the trigger.***

Characteristics serve as another dimension of “power” (temptation to have risky sex) that a partner may have. Used here, the term offers the participant another dimension of partners with which they may identify. Type and characteristic are portrayed as interactively enhancing triggering partners.

Regarding the example chart, prepare further examples that better reflect the diversity of your participants.



**D) Explore relationships and safer sex:**

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- *Tell me about how you think your safer sex limits may change if or when you are in a relationship that has the prospect of becoming “long term” or serious?*

This question serves to open a discussion of when and how some MSM may elect to stop using condoms for anal sex during a relationship. The participant may already be in a relationship, in which case ask about if and how he and his partner made this decision.

Elicit first what the participant knows about Negotiated Safety and then fill in the information with the *EXPLORE* Info Sheet.



### E) Focus Option 1 – Partners

The aim of this discussion is to elicit a concrete example of a partner who is a trigger. Elicit as much detail as possible. Help to point out choices as they may appear. (I.e. points where he can still experience the thrill of this partner AND maintain his risk limits.)

### F) Fantasy Partners: Impact on Safety

This section is based on the premise that some gay and bisexual men may base their expectations and standards about what's sexy and hot on what they learn from watching erotic videos, reading erotic magazines or books, etc. Much as heterosexual people may take their cues from relationships portrayed on mainstream TV (or erotic videos as well,) gay men may pattern their views on what they watch or read.

It may be helpful to explore this with the participant and see how much support for safer sex he perceives from the sexual fantasies that he gleans from the media.

### H) Focus Option 2, Track 2: Substance Use, Sex and Social Network

This exercise is a strong visual approach to having the Track 2 participant examine his concerns about the partners in his social networks.

Reinforce the positive elements that stand out and enhance the inconsistencies and concerns, as they arise.



### 1c. Summary of the Worksheet

- *Look at the partners with whom you drink or use drugs:*

A good way to bring in ideas from Modules 7 and 8, as appropriate.

The option to concretize patterns with a specific example:

*Describe your typical alcohol and/or drug use with one of these types of partners:*

- *Concerns?*

Use summary statements and Motivational Interviewing as appropriate.

# Visit 6-11.0/Module Ten

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## Planning for Maintenance Delivery Manual Guide



### Purpose

The purpose of Module Ten is to provide closure to the initial, ten-session portion of the intervention. The module provides guidance for helping the client plan how he will use what he's learned in the coming months.

### Goals

The goals of this module are to:

- ◆ Review and reinforce learnings.
- ◆ Revisit risky situations and plans for dealing with them.
- ◆ Obtain feedback on the counseling experience to date.

### Objectives

This module will help the participant to:

- ◆ State what they got from the nine sessions with the counselor.
- ◆ Express concerns about the coming months and “risky” situations that may arise.
- ◆ Plan practical strategies for dealing with “risky” situations by drawing on previous learnings.
- ◆ Plan for maintenance of any changes that have occurred as a result of the project.



### A) Check In

Inquiry about the participant's week before proceeding.

- *So this is our last visit in the 10 visit series. We won't be seeing each other for \_\_\_\_\_ months. (specify next visit)*
- *Any reaction or feelings about this change in gears?*

### B) Counselor's Overview

Outlined clearly are the 2 options for this module: One that includes a discussion of Change Work and a second that does not. Deliver one of the two options.

Do not review this page with the participant!



C) Section A: Participants who have done any Change Work.

- *First let's look at the work we've done since we started.*

Be prepared to facilitate this discussion with any notes that were made regarding change efforts by the participant. If they cannot name the things they attempted or intended to attempt, be prepared to name these things for them (to facilitate their learning process.)

Review the changes worked on. "Changes" is broadly defined to include ALL work done with the participant, whether an actual Change Plan was drafted or not.

The term "changes" may be too intimidating or strong for some participants.

Motivational Interviewing is the recommended approach for the questions on pp. 235 – 236. Praise any progress steps made while holding the ambivalence of un-addressed concerns as "steps yet to be taken."



2. Review progress:

- *Looking at your efforts so far...*

*...How do you feel  
about your progress?*

3. Highlight strengths:

- *What personal strengths helped?*
- *What other things helped?*

These items provide a chance to focus the discussion on positive aspects – the experience of making progress and the strengths the participant identifies in himself. Capitalize on the positive tone of this segment.





#### 4. Examine upcoming situations:

The worksheet provides a chance to map out any possible situations that might arise in the coming months that could prove challenging.

Offer ideas but skip the chart if the participant cannot think of any upcoming situations, even with prompting.

It may be helpful to suggest a possible upcoming situation based on situations described in previous visits. But don't appear to be setting up the participant to fail.

The term "relapse" may be too clinical, with negative connotations. Use appropriately.



## D) Section B: What I Learned from this Project

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*Let's give you a chance to say what you've learned as we've worked together.*

- *What positive things did you get from being involved?*
- *What drawbacks were there to being involved?*

May summarize what was expressed at the start of the visit.

Set the tone for the following as the time when the participant can be as candid as possible. Encourage him not to avoid hurting your feelings. State that this is an important part of the study and the learning process for all staff involved.

Emphasize, in closing, that the participant may be able to think about things he gained from participating later, when he's not "on the spot." He may want to think about this more and jot notes down for his own benefit.

No visit closing format is prescribed! You'll most likely see each other in less than 3 months. Emphasize that.

Talk with the Clinical Coordinator before this visit about any considerations that should be conveyed to the participant if staff changes are projected before he returns.

Also, stress that you may notify him by phone or mail to remind him of his visit. You'll respect his confidentiality. But emphasize that getting a call or card from you does not mean anything negative (like he sero-converted.) It's just a reminder!