Personalized Cognitive Counseling

Implementation Manual

University of California, San Francisco
AIDS Health Project
in collaboration with
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How to Use This Manual

This manual provides an overview of the ***Personalized Cognitive Counseling (PCC) Intervention***, the important steps needed to implement the program successfully, and the resources you will need to conduct the intervention. The following overview explains the arrangement of the manual content to help you use material from the manual.

This manual complements a CDC-sponsored training of counselors, which is a prerequisite for individuals to attend before implementing ***PCC***. Implementing agencies will benefit from referring to this manual in the planning, implementation, and maintenance stages of the ***PCC*** intervention.

There are six sections in the manual:

1. Overview and Background
2. Getting Started
3. Pre-Implementation
4. Implementation
5. Maintenance
6. Appendices

Overview and Background

The *Overview and Background* section provides information an agency needs to understand the conceptual basis for the ***PCC*** intervention and the research that determined its efficacy.

In this section, you will find:

- An overview of ***PCC***
- A description of the intervention's goal
- A description of the science that supports ***PCC***
- An explanation of the Core Elements and Key Characteristics of ***PCC***
- A ***PCC*** Behavior Change Logic Model

Getting Started

The Getting Started section addresses the primary concerns your agency may have while becoming familiar with ***PCC***. These include:

- Agency capacity issues
- Budget development
- Engaging key stakeholders
- Checklists and tools your agency can use when getting started

Pre-Implementation

The Pre-Implementation section addresses practical issues involved in preparing your organization to implement ***PCC***. Topics covered include:

- Implementation planning timeline
- Implementation summary
- Staffing needs

This section also contains information on other things you need to consider before implementing the intervention and helpful reminders your agency can use during the pre-implementation phase.

Implementation

The Implementation section addresses things your agency needs to address when conducting ***PCC***.

In this section, you will find:

- An overview of the five steps of ***PCC***
- A detailed guide on how to implement each step of the ***PCC*** intervention
- The ***PCC*** *Questionnaire*, which is a Core Element and necessary for implementation of ***PCC***.

Maintenance

This section provides information and ideas on how to integrate ***PCC*** into your organization's ongoing prevention services. Topics include:

- How to keep the ***PCC*** intervention going
- Tools for monitoring adherence and client satisfaction

Appendices

There are six appendices in this manual. One of the most immediately useful appendices for the reader to review is *Appendix 2. Glossary and Guide to Abbreviations; however*, all the appendices provide useful reference material.

Appendix 1. Original Research Articles

Appendix 2. Glossary and Guide to Abbreviations

Appendix 3. *PCC* Questionnaire

Appendix 4. Supplemental Material: Using Probing Questions

Appendix 5: References

Appendix 6. CDC Required Materials

- CDC Statement on the ABCs of Smart Behavior
- CDC Fact Sheet for Public Health Personnel: Male Latex Condoms and Sexually Transmitted Diseases
- Program Review Panel Guidelines for Content of AIDS-related written materials, pictorials, audiovisuals, questionnaires, survey instruments, and educational sessions in (CDC) Assistance Programs (Interim Revisions June 1992).
- Program Review Panel Instructions for Form 0.113
- Form 0.113
- CDC Statement on Nonoxynol-9 Spermicide, May 10, 2002
- CDC Statement on Study Results of Product Containing Nonoxynol-9

OVERVIEW and BACKGROUND

Introduction to the Personalized Cognitive Counseling Intervention

Personalized Cognitive Counseling (PCC) is a single-session counseling intervention designed to reduce unprotected anal intercourse [UAI] among men who have sex with men (MSM) who are repeat testers for HIV. ***PCC*** focuses on the person's self-justifications (thoughts, attitudes, and beliefs) used when deciding whether or not to engage in sexual behavior that can transmit HIV. This 30- to 50-minute intervention is conducted as the counseling component of *Counseling, Testing, and Referral Services* (*CTRS*) for MSM who are screened eligible for ***PCC***. Male clients that present for HIV counseling and testing who screen eligible to receive ***PCC***, are those who:

- Previously tested for HIV,
- Result showed seronegative on that test,
- Had UAI since their last test,
    - with a male who was not their primary partner, and
    - that partner's serostatus was positive or unknown.

PCC is for those who already have a basic understanding of how HIV is transmitted. Additionally, while a moderate degree of denial of risk does not mean a client cannot participate in ***PCC***, men who truly do not feel at risk or know how HIV is transmitted are not suitable for ***PCC***. An educational or other behavioral intervention like *RESPECT* or prevention case management like *CRCS* would be more appropriate in these cases.

The goal of ***PCC*** is to help clients avoid future episodes of unprotected anal intercourse with partners of unknown or positive HIV status. ***PCC*** encourages the client to explore his reasons or self-justifications (thoughts, attitudes, and beliefs) for engaging in risky sexual behaviors and to develop strategies to avoid future episodes of UAI with partners of unknown or positive HIV status. The process of ***PCC*** is to identify the specific thoughts used by the client when he decided to engage in UAI, aid him in reconsidering those thoughts, and create an opportunity for him to plan for safer ways to think about and behave in future sexual situations.

Once the client is determined eligible for ***PCC,*** the counselor assists the client in selecting a recent memorable episode of UAI (Step 1). With this specific episode in mind, the client is asked to complete the ***PCC*** questionnaire, which generally assists the client in recalling thoughts related to the UAI episode (Step 2). After the client completes the questionnaire, the counselor helps the client talk about the UAI episode in detail, including his thoughts before, during, and after the UAI episode (Step 3). Throughout this narrative, the counselor asks questions to make the story clear and begins identifying the thoughts and feelings that may have affected the client's behavior. The counselor helps the client to identify the thoughts and feelings he was having and how they are associated with his decision to engage in the UAI episode (Step 4). Finally, the counselor asks the client what he will do in the future and supports his constructive plans (Step 5).

Development of *PCC*

PCC was developed and tested at the AIDS Health Project (AHP), a major provider of HIV testing and counseling services located in San Francisco. By the mid-1980s, the AHP's program data showed that many MSM who were counseled and tested for HIV were getting tested multiple times and receiving prevention counseling each time but were continuing to engage in high-risk sexual behavior. Data on seroconversion showed that the rate of new HIV infection among the men who were testing repeatedly was almost three times that of men who had not received multiple HIV tests. The AHP recognized the need to provide a different counseling approach for repeat testers who engaged in risky behavior. With a team of researchers including AHP staff, the agency developed and tested ***PCC***, which was shown to significantly reduce high-risk sex among repeat testers.

Conceptual Framework of *PCC*

Development of the ***PCC*** intervention was based on the work of cognitive psychologist Ron Gold and colleagues (see references in **Appendix 1 or Appendix 5**). Gold studied how people make risky decisions in spite of knowing the risks. He hypothesized that the decision to engage in high-risk sex is allowed to happen when the person rationalizes the potential risk through "self-talk" that minimizes the known risk, which is referred to as *self-justifications*.

Gold proposed that during *on-line thinking*—thinking in the moment during a sexual encounter–individuals use self-justifications to rationalize giving themselves permission to engage in risky sexual behavior. In *off-line thinking*—thinking that occurs away from the immediacy of a sexual encounter—the individual's thinking is more realistic about risks and their consequences. Cognitive theories of behavior suggest that helping an individual consider his on-line self-justifications in an off-line state may help prevent future risky behavior in the on-line state.

Research Findings

Two randomized controlled studies at the AHP have established that ***PCC*** reduces episodes of UAI in the target population of MSM repeat testers. In the first study (Dilley et al., 2002), ***PCC*** was delivered by licensed mental health professionals trained in the intervention. Participants included 248 MSM. Seventy-six percent of the men were Caucasian and 24 percent were men of color (Asian, African American, Latino, and Other). Each of the men had a history of at least one previous negative HIV test result and self-reported UAI in the previous 12 months with non-primary partners of unknown or discordant HIV status. Two intervention groups received standard HIV counseling and testing plus ***PCC***, while two control groups received only standard HIV counseling and testing. Follow-up was at 6 and 12 months. The results showed that men who received the single session of ***PCC*** significantly reduced their number of episodes of UAI more at both 6 and 12 months than did men who received the standard HIV counseling and testing alone.

Recognizing that most CBOs do not have the resources to hire mental health professionals, the researchers designed a second study (Dilley et al., 2007). In this study, ***PCC*** was conducted by paraprofessional counselors who had bachelor's-level education, training in HIV prevention counseling, were certified in HIV counseling and testing, and had a minimum of one year's experience providing HIV counseling and testing. Before providing ***PCC***, the counselors went through extensive role-play training in conducting the intervention.

Participants included 305 MSM. Sixty-seven percent of the men were Caucasian and 33 percent were men of color. All men had a history of at least one previous negative HIV test result and self-reported UAI in the previous 12 months with non-primary partners of unknown or discordant HIV status. Participants were randomly assigned to standard HIV counseling and testing plus ***PCC*** or standard counseling and testing alone. Follow-up was at 6 and 12 months. The results confirmed that paraprofessional counselors using ***PCC*** could bring about the same results as the first study: men who received ***PCC*** plus standard HIV counseling and testing had a greater reduction of UAI episodes than men receiving standard HIV counseling and testing alone.

Reprints of the original publications describing the two studies are included in **Appendix 1** of this manual.

How *PCC* is Different from Other HIV Prevention Counseling

Using ***PCC*** requires not only the learning of new skills, but the "unlearning" of certain routines and assumptions that go with other types of counseling but do not fit with ***PCC***. When learning the intervention, it is useful to highlight what ***PCC*** is, and also what it is *not*. This helps clarify how ***PCC*** fits into the continuum of interventions an agency can provide. It also helps counselors adjust their own expectations of what they are expected to do and how they are to do it. The following summaries describe how ***PCC*** is different from other HIV prevention counseling interventions.

Not primarily educational. ***PCC*** is designed for men who already have a basic understanding of how HIV is transmitted, and know that UAI is risky. Clients who do not understand the basics of HIV transmission are not appropriate for ***PCC*** and should receive an educational intervention instead. While some educational information may be provided, if needed, ***PCC***'s last step emphasizes helping clients use, rather than ignore, what they already know about HIV transmission.

Not an unstructured session led by the client. Sometimes the term "client centered" is used to mean a counseling approach where the client's feelings and concerns guide the session. In contrast, ***PCC*** structures the session to address risk-related thinking. The client's feelings and concerns are important in ***PCC***, and are drawn out and addressed by the counselor, but primarily as they relate to the ***PCC*** steps.

Not directed at soothing any negative feelings the client may have. Counselors sometimes feel a sense of responsibility to make clients feel better in the short term. While ***PCC*** counselors are empathic and concerned about the client, their goal is not to soothe the client. The goal of ***PCC*** is to help the client change his future behavior by reflecting on and reconsidering the thoughts that he used to justify risky behavior. The intervention may result in the client getting in touch with his reality-based anxiety—that is, his anxiety that if he takes risks he may get HIV. This anxiety is seen as constructive because it helps motivate the client to avoid future risk behavior.

Not completed by the counselor handing the client a solution. The ***PCC*** session closes with the counselor asking the client what he will do in future high-risk situations and supporting any constructive plans he mentions.

PCC Core Elements

To achieve outcomes similar to those found in the original research, agencies implementing ***PCC*** need to retain the Core Elements of the intervention. Core Elements are critical components of an intervention's conceptualization and design that are believed to be responsible for the intervention's effectiveness. Core Elements are essential and cannot be discarded, added to, or changed, in order to maintain intervention fidelity and intent.

Based on the original research studies, the following seven Core Elements are considered responsible for the effectiveness of ***PCC***:

> **Core Element 1:** Provide one-on-one counseling focusing on a recent, memorable high-risk sexual encounter.
>
> **Core Element 2:** Provide the service with counselors trained in HIV counseling and testing and in the ***PCC*** intervention.
>
> **Core Element 3:** Use the ***PCC*** questionnaire specifically tailored to identify key self-justifications used by clients in the target population.
>
> **Core Element 4:** Using the questionnaire and discussion, identify specific self-justifications (thoughts, attitudes, beliefs) used by clients in making the decision to engage in the specific high-risk behavior.
>
> **Core Element 5:** Explore the circumstances and context for the risk episode in detail (before, during, and after event).
>
> **Core Element 6:** Clarify how the circumstances and self-justifications are linked to the decision to engage in high-risk behavior.
>
> **Core Element 7:** Guide the clients to re-examine the thinking that led to their decisions to have high-risk sex and identify ways they might think differently, and therefore have protected sex in future potentially risky situations.

PCC Key Characteristics

While *Core Elements* must be maintained, *Key Characteristics* are parts of an intervention (activities and delivery methods) that can be adapted to meet the needs of the agency or target population. ***PCC*** has the following:

Key Characteristic 1: Conduct ***PCC*** in the context of HIV testing and counseling.

When the original research was conducted at the AIDS Health Project, which was already serving the target population, ***PCC*** was implemented within an HIV testing program. Participants were screened when they first requested HIV testing, and then received ***PCC*** in the interval between giving a blood sample and receiving the result. However, ***PCC*** also seems particularly well suited to the following settings: Comprehensive Risk Counseling and Services (CRCS), mental health services, or primary medical care.

Key Characteristic 2: Counseling staff can be paraprofessionals or mental health professionals as long as they are, as specified in the *Core Elements*, trained and experienced HIV test counselors who are also trained in ***PCC***.

Key Characteristic 3: Complete the intervention in **one** 30- to 50-minute session.

The ***PCC*** intervention is designed to be conducted in a single 30- to 50-minute session. However, the intervention could be longer than 50 minutes when needed.

PCC Behavior Change Logic Model

The ***PCC*** behavior change logic model is available on the following page. The purpose of a logic model is to show the specific logic of change underlying an intervention. An intervention is a program of change. The ***PCC*** logic model can give your agency a greater understanding of the ***PCC*** intervention.

The logic model gives an overview of the population and the problem the ***PCC*** intervention is intended to address, the intervention activities, and the expected outcomes of ***PCC***.

- The **problem statement** describes the target population and the risk factors that the intervention is intended to address. It also discusses the major risk factor and contextual factors, i.e., why the intervention is needed. ***PCC*** was designed for men who have sex with men (MSM) who are HIV-negative and who have previously tested for HIV. Despite previous counseling, these men report unprotected anal intercourse since their last HIV test with a male who was not their primary partner and that partner's serostatus was positive or unknown. The risk factor addressed by the intervention is the use of self-justifications (thoughts, attitudes, and beliefs) to continue having unprotected anal intercourse.
- The **behavioral determinants** are things that influence risky behavior, such as one's attitudes, justifications, and perceptions about risk behaviors. The behavioral determinants are what the intervention intends to change.
- The **activities** to address the behavioral determinants and are the specific, measurable components of the intervention. For ***PCC***, the activities correspond to the intervention's five steps, which are delivered in the context of HIV testing.
- The **outcomes** are the expected changes in the behavioral determinants that result from the activities. For ***PCC***, the immediate outcomes are increased awareness of self-justifications in potentially risky situations, increased awareness of how thoughts, attitudes, and beliefs may promote high-risk behavior, and stating an alternative way of thinking or behaving in the future. The intermediate outcome is a decrease in the risky behavior of unprotected anal intercourse with non-primary partners and partners who are HIV-positive or whose HIV status is unknown.

Personalized Cognitive Counseling Intervention Behavior Change Logic Model

Problem Statement: ***PCC*** was designed for men who have sex with men (MSM) who are HIV-negative and have previously tested for HIV. Despite previous counseling, these men report unprotected anal intercourse since their last HIV test with a male who was not their primary partner and that partner's serostatus was positive or unknown. The major risk factor addressed by the intervention is the use of self-justifications to continue engaging in high-risk behaviors.

Behavioral Determinants	**Activities** ***To address behavioral determinants***	**Outcomes** ***Expected changes as a result of activities targeting behavioral risk determinant***	
		Immediate Outcomes	**Intermediate Outcomes**
• Personal attitudes related to risk behavior • Personal cognitive justifications for risk behavior • Personal perceptions of risk behavior	One-session, five-step counseling intervention, delivered in the context of HIV testing by counselors who are trained professionals or paraprofessionals. The client is assisted to: • Recall a recent high-risk behavior episode • Identify specific self-justifications underlying the decision to engage in high-risk behavior, starting with the use of the ***PCC*** *Questionnaire*, and then through open-ended discussion • Explore the context of the risk episode and clarify how the circumstances and self-justifications are linked to the risky behavior • Reexamine the thinking that led to the behavior • Replace self-justifications with more realistic thoughts and attitudes, and consider alternative behaviors, to lead to safer ways of handling future situations	• Increased awareness of personal self-justifications in potentially risky situations • Increased awareness of how thoughts, attitudes, and beliefs may promote high-risk behavior • Stating alternative ways of thinking and behaving in future potentially risky situations	• Decreased unprotected anal intercourse with HIV-positive partners and partners of unknown serostatus

Personalized Cognitive Counseling

GETTING STARTED

Assessing Agency Capacity

Before an agency plans implementation of ***PCC***, two activities are necessary: assessing agency capacity and developing the budget. These activities do not happen strictly in the order they appear in this manual—they may happen at the same time. These activities appear in this order in the manual because they build on one another: capacity issues lead to discussions around budget development.

Agency Capacity Issues

Capacity issues are focused on assessing agency readiness and securing the buy-in of stakeholders. For ***PCC***, capacity issues focus on agency culture and facilities, staff skills and training, and client referrals and screening.

The following Agency Readiness Checklist can assist an agency in deciding if they are able and ready to conduct ***PCC***. The results of this assessment will help your agency develop an action plan and identify the best use of resources to ensure successful implementation. The ***PCC*** Agency Readiness Checklist includes six key areas:

1. Mission and Organizational Culture
2. Facilities
3. Training and Supervision
4. Staffing
5. Client Referrals and Screening
6. Agency Commitment to Implement ***PCC***

Agencies can use this checklist to identify gaps in their readiness to implement ***PCC*** and assess whether they can address these gaps through training and technical assistance. If all of your responses are in the first two columns, your agency may well be suitable for implementation of ***PCC***. If any of your responses are in the last column, you should consider whether your agency is a good candidate to implement ***PCC*** and whether training and technical assistance can address these issues.

Following is the ***PCC Agency Readiness Checklist.***

PCC Agency Readiness Checklist

1. Mission and Organizational Culture			
***PCC* Requirement**	**Yes**	**Not now, but this can be addressed**	**No, and change is not feasible**
Nonjudgmental regarding MSM. Can we provide counseling services to men who have sex with men in a nonjudgmental, supportive way?			
Cultural competence. Do we provide services to each of the racial/ethnic or cultural groups within the target population we will reach?			
Sex positive. Are we comfortable assuring clients that they can continue to have very satisfying sexual experiences while promoting safer behavior?			

2. Facilities			
***PCC* Requirement**	**Yes**	**Not now, but this can be addressed**	**No, and change is not feasible**
Do we have private office(s) where ***PCC*** can be conducted? (Sessions are up to 50 minutes, so at least one office is needed per client per hour during the hours ***PCC*** will be provided.)			

3. Training and Supervision			
***PCC* Requirement**	**Yes**	**Not now, but this can be addressed**	**No, and change is not feasible**
Do we have regular, ongoing cultural competence training?			
Are our staff members available for 2 days to attend the ***PCC*** training?			

As staff turnover, will new staff be available to be trained?			
Through contracted or in-house staff, can we provide regular clinical supervision meetings to ***PCC*** counselors by ***PCC***-trained clinical supervisor(s)?			
Do agency policies and procedures enable staff to be mandated to receive training and clinical supervision?			

4. Staffing

***PCC* Requirement**	**Yes**	**Not now, but this can be addressed**	**No, and change is not feasible**
Do we have trained and certified HIV test counselors?			
Do we have staff with at least one year experience providing HIV test counseling?			
Do we have HIV test counselors who possess a bachelor's degree in a helping field (such as psychology or social work), or at least two years of college plus two years of pertinent experience or have work experience in these fields?			
Do these staff members have knowledge and experience with the target population(s) to be served?			
Are these staff members committed to providing culturally competent services?			
Are these staff members comfortable with and knowledgeable about men who have sex with men?			

Are these staff members comfortable discussing sex frankly using everyday language?			

5. Client Availability

PCC Requirement	Yes	Not now, but this can be addressed	No, and change is not feasible
Do we have ongoing access through "inreach," outreach, and referrals to clients who are MSM, who have already had at least one previous HIV test, and who have had high-risk sex since the last test?			

6. Agency Commitment to Implement *PCC*

PCC Requirement	Yes	Not now, but this can be addressed	No, and change is not feasible
Do we have an "intervention champion?" (defined on page 23)			
Do we have commitment from our community advisory board, and board of directors?			
Do we have commitment from our senior management staff?			
Do we have commitment from coordinator/line staff supervisors?			
Do we have commitment from line staff?			
Do we have commitment from other key partners if applicable (funders, partner agencies, etc.)?			

Buy-In and the Intervention Champion

Getting "buy-in" is crucial because it assures the support of agency administration and allows agency resources to be used for intervention implementation. Buy-in is done best with an intervention champion. The champion is often the program manager but could be a counselor or a team of people. Regardless of the number of champions, the main issue is convincing the agency that implementing ***PCC*** would make the quality of its prevention services better and that the agency is capable of implementing ***PCC***.

A champion is someone within the agency who serves as a link between the administration and staff. The champion needs to be good at answering questions and helping make any changes in organizational structure. The champion can serve as a negotiator of any necessary trade-offs or compromises. The champion becomes the intervention's spokesperson, anticipates the reservations of the staff, and answers questions about the intervention needs and resources. The champion must have excellent knowledge of the intervention including its costs, Core Elements, and Key Characteristics.

The champion can use the marketing materials available in the intervention package, information presented in this manual, and the rest of the package to address any questions or concerns about ***PCC***.

Your agency's intervention champion can use the following stakeholders checklist to get support for implementing ***PCC***. The stakeholders include people on your board of directors or executive board, in your community, agency, your staff, or your funding source who have interest in the successful implementation of your intervention.

Stakeholders Checklist

STEP 1: Find out whether or not the community will support ***PCC***.

STEP 2: Identify your stakeholders. These will include:

- Your agency's board of directors/executive board/advisory board
- Staff members from your agency who will have a role in the operation of the intervention
- Administrators who will get support
- Supervisors who will oversee the intervention
- Staff who will interact with clients at any level
- Other likely stakeholders are:
    - Local agencies from where you could recruit clients, counselors, or both
    - Agencies with support groups for MSM
    - Health care providers and mental health professionals serving MSM
    - Social service agencies reaching MSM
    - Organizations of MSM and organizations that may have members who are MSM
    - Organizations that can provide assistance or other resources
    - Agencies, merchants, printers, publishers, broadcasters, and others who can advertise the intervention
    - Agencies that can provide transportation
    - Advisory board to help adapt an intervention to a population
    - Partner agencies that can give information for resource packets
    - Agencies that your agency needs to keep good community or professional relations with
    - Local health department
    - Local medical and mental health associations
    - Your funding source(s)
    - Others

STEP 3: Get stakeholders informed, supportive, and involved by:

A. Informing stakeholders about the intervention:

- Decide in advance what specific roles you want each stakeholder to play, e.g., who will you ask to:
  - Give financial support?
  - Refer MSM to the intervention?
  - Serve as an intervention counselor?
  - Be a resource that you can refer clients to?
  - Join your community advisory board?
  - Help tailor the intervention for your target population?
  - Provide a room where the session can be held?
  - Speak supportively about ***PCC*** in conversations with their associates?
- Send letters to stakeholders to tell them:
  - About ***PCC*** and its importance,
  - Your agency will be making the intervention available,
  - What specific role(s) you think they might play in the success of the intervention, and
  - Offer a chance for them to learn more.
- Call in two weeks and assess their interest. If they are interested, schedule a time to meet (e.g., one-on-one, lunch-and-learn at your agency with a group of other stakeholders, presentation at their agency for several of their staff or association members).
- Hold the meeting and answer questions.

B. Getting their support:

- Describe several specific roles they could play.
- Emphasize the benefits of their involvement to themselves, their agency, the community, and MSM, and answer their questions.
- Invite them to commit to supporting ***PCC*** by taking on one or more roles. Keep track of commitments.

C. Getting them involved:

- Soon after meeting, send a thank-you letter that specifies the role(s) to which they committed. If they did not commit, send a letter thanking them for their time and interest and ask them to keep the letter on file in case they reconsider it later.
- For persons who committed to a role that is important to pre-implementation, put them to work as soon as possible.
- For persons who committed to involvement later in the process, send them brief progress updates and an idea of when you will be calling on their support.
- Hold periodic celebratory meetings for supporters to show your appreciation for valuable contributions, update them on the intervention's progress, and keep them engaged.

Developing a Budget for *PCC*

The second getting started activity is developing the budget. It is expected that ***PCC*** will be embedded within an organization already conducting HIV testing and prevention counseling. For these agencies, ***PCC*** will be an enhancement of services that will entail additional costs. The budget can be done either for the additional costs only, or for the entire costs of the ***PCC*** portion of the agency's budget. Since the latter is the approach most agencies are likely to take, this is the type of sample provided below.

The cost depends on a number of factors, including:

How many *PCC* sessions do you expect to deliver annually?

From this, you can determine how many counselor hours will be needed, how much space you will need, and how much supervisory time and other expenses, including how much of your agency's operating expenses and overhead should be included in the ***PCC*** budget.

Does your staff have the qualifications to deliver ***PCC***?

You may find that you have to pay staff a higher wage to meet educational and training requirements. (Staff qualifications are detailed on page 42.)

Do you have a clinical supervisor at your agency?

You will either need to contract with a qualified clinician (contact your CDC program officer for potential resources), or allocate time from a clinician already at your agency. An in-house clinical supervisor would need to be paid to attend the ***PCC*** training, and to meet weekly with each ***PCC*** counselor.

Do you have a data entry clerk or another staff person who will do the required data entry, or will counselors do their own data entry?

Assuming the CDC funds your ***PCC*** program, you will need staff who record program data on each client. Many agencies find it works best to have the counselors enter the data at the end of each shift. If you choose this option, you will want to add more time to your estimate for the counselors' time. If a data entry clerk or other person will do the entry, they should be represented in the budget.

Do you have regular cultural competence training at your agency or do you have access to trainings?

This is necessary for agencies delivering ***PCC***. If staff members are not comfortable and experienced in counseling MSM, additional training in this area will also be required.

Do you have a private space for conducting *PCC* sessions? Is there enough time available in the space you have?

PCC sessions take longer than most other HIV testing counseling, so you may need to increase your private counseling space, or there may be special scheduling required, which could have cost implications.

Will there be any new outreach to conduct at your agency's expense?

If you are not already conducting sufficient outreach or receiving clients through referral, you may want to consider starting outreach efforts. Outreach to MSM is necessary to recruit the target population into your program. This includes meeting with organizations, meeting with community stakeholders, and conducting outreach in bars, religious organizations, and social organizations that serve MSM. This special outreach may have additional costs, particularly in personnel time.

Will the number of HIV test encounters increase?

If the number of HIV tests your organization conducts will increase when you implement ***PCC***, you will want to estimate the expenses of additional HIV testing kits and lab expenses.

Following is a list of categories and methods of calculating a budget that may help you consider all the budgetary requirements of ***PCC***.

Costs of Implementing the *PCC* Intervention

The following categories are given as a starting point. Use the staffing and payment type appropriate for your agency. If the budget you are developing is for a funding application, thoroughly review the budgeting requirements of the funder, and modify the categories below as needed.

Adjust the staffing to make it appropriate for your agency and your procedures. For example, if an administrative assistant will conduct the required data entry, include this job function in your time estimate for the administrative assistant. If a counselor or another staff person will do the data entry, include additional time for the counselor or other staff person in the budget.

Some costs shown may not be included in your budget depending on your agency. For example, you may not have a Program Coordinator. The individual items in this budget outline should be adapted to your agency.

Salaried Service Staff

	# staff	% time		Salary		
Clinical Supervisor(s)	____	____	X	_____	=	_____
PCC Counselor(s)	____	____	X	_____	=	_____

Or, if clinical supervisor and ***PCC*** counselors are contractual at your agency:

Contractual Staff

	# staff	# hrs/year	Cost/hr.		Contractual cost
Clinical Supervisor(s)	____	____	X_ ____	=	_____
PCC Counselor(s)	____	____	X _____	=	_____

Other Supervisors, such as:

	# staff	% time		Salary		*PCC* salary
Program Director	____	____	X	_____	=	_____
Project Director	____	____	X	_____	=	_____
Program Coordinator	____	____	X	_____	=	_____
Other management	____	____	X	_____	=	_____

Other Salaried Managerial Staff

	# staff	% time		Salary		*PCC* salary
Admin. Assist	____	____	X	_____	=	_____

Clerical/Secretary	____	____	X	_____	=	_____
Outreach Workers	____	____	X	_____	=	_____

Training Costs

Cost of travel to training, lodging, per diem _____
Extra hours for contractual employees, such as clinical supervisor _____

Other Costs

Volunteers _____
Other contractual staff _____
Facilities (rent) _____
Travel _____
Supplies (office, HIV testing, etc.) _____
Other expenses and overhead (utilities, telephone, photocopying, insurance, administrative fees) _____

TOTAL COST _____
Total all the costs for ***PCC*** from this and the previous page.

Time for Counselors and Supervisors

For ***PCC*** counselors' time, estimate one hour per client and estimate the number of clients per week per counselor. Then, estimate supervision time (about one hour per week), training, meeting, and record-keeping time, which could average about one to two hours per week depending on the number of clients and extent of record keeping.

Once you have the hours per week, you can determine the percentage time. For example, if full-time counselors work 40 hours per week, and will meet with four ***PCC*** clients per week and spend two hours on related activities (such as supervision and record keeping), they will spend 6 of their 40 hours per week on ***PCC***, or 15 percent time. Total costs of salaried staff are then determined by multiplying the number of staff at each salary level by the percent time by the salary, and then totaling the costs for the entire staffing category.

Contractors and Consultants

If necessary, include costs related to the use of contractors and consultants. For example, you may want to contract a licensed mental health professional to conduct clinical supervision. You will need to include these costs in your budget. (If you are funded by the CDC, first ask your program officer if clinical supervision resources are available.)

Training

The CDC provides a 2-day training of counselors at no cost to implementing agencies through its Diffusion of Effective Behavioral Interventions (DEBI) project. However,

your agency is responsible travel related expenses (travel, lodging, and meals). Travel expenses and staff time (salaried or contractual) will need to be included in your budget.

Facilities

Estimate the proportion of your clients that will be ***PCC*** clients to determine the total amount of the facilities to charge to the ***PCC*** budget. For example, if 10 percent of your clients are anticipated to be ***PCC*** clients and annual office rent is $30,000, then the rental cost charged to the ***PCC*** budget would be $3,000. If additional private meeting spaces need to be rented exclusively for conducting ***PCC*** sessions, this amount would go into the budget as well. If your agency conducts HIV testing and counseling at more than one site and you plan to reach ***PCC*** clients at those facilities, calculate the cost for each facility.

Travel

Travel to recruit clients and travel to provide ***PCC*** at alternate sites should all be included in your budget when applicable, and include travel expenses to professional conferences for staff, where appropriate.

Supplies

HIV test kits and other testing supplies for ***PCC*** clients would ordinarily be a separate budget item. Other office supplies and equipment directly connected with implementing ***PCC*** may go in the supplies or equipment categories, or included in "Other Expenses and Overhead," as described below.

Other Expenses and Overhead

If ten percent of your clients are anticipated to be ***PCC*** clients, if permitted by your funding agency you may decide to apportion your other expenses, such as photocopying, utilities, telephone, maintenance, insurance, and other overhead to the ***PCC*** project. Laboratory fees and transport fees may be included in this category as well.

PCC Sample Budget

Following is one example of a ***PCC*** budget. This is for the purpose of illustration only—every agency will have a different budget, so use your experience to develop a budget that is accurate for your agency. Remember to thoroughly review the budgeting requirements of any agency you may be applying to for funding.

This budget assumes a moderate level of salaries and program costs. Obviously, salaries and other costs will vary from program to program depending on your geographical area and other variables. In your budget, use realistic costs—higher or lower than the example—based on the true costs of operating an agency in your geographical area.

Salaried Service Staff

	# staff	% time	Salary/Benefits	***PCC*** portion
PCC Counselor	2	15%	2 @$45,000 = $90,000	$13,500

Notes: In the example above, the budget is determined with the expectation that full-time counselors work 40 hours per week, and will be seeing four ***PCC*** clients per week and spending two hours on related activities such as supervision and record keeping, they are 6/40 time on ***PCC***, or 15 percent time.

Contractual Staff

	# staff	Hours per year	Cost per hour	Contractual cost
Clinical Supervisor(s)	1	135	$100	$13,500

Other Salaried Managerial Staff

	# staff	% time	Salary/Benefits	***PCC*** portion
Program Director	1	5%	$85,000	$4,250
Program Coordinator	1	15%	$60,000	$9,000

Other Nonsupervisory Staff

	# staff	% time	Salary/Benefits	***PCC*** portion
Receptionist	1	15%	$40,000	$6,000

Training Costs

PCC trainings are provided at no cost through the CDC's DEBI project; however, transportation, meals, and lodging have to be figured into the budget.

Travel for four staff @ $250 each	$1,000
Lodging, two nights, for four staff @ $100 each	$400
Per diem and misc. expenses for 4 staff @$200 each	$800

Rent and Utilities

Rent	$3,600
Utilities	$540

Note: This is calculated by apportioning 15 percent of the testing program's rent and utility expenses to ***PCC***. The total rent is $24,000 and the total utilities are $3,600.

Costs Except for Overhead

$13,500	for counselors	
$13,500	for clinical supervisor	
$6,000	for receptionist	
$4,250	for program director	
$9,000	for program coordinator	
$2,200	for lodging and travel costs related to training	
$3,600	for rent	
$ 540	for utilities	
	Subtotal:	$52,590

Overhead

Overhead	$7,888.50

Note: Includes insurance, office supplies, bookkeeping, routine travel, etc., and calculated as 15 percent of total personnel, rent, utilities, and supplies.

Total cost: $60,478.50

PRE-IMPLEMENTATION

Introduction to Pre-Implementation

Once your agency has completed **assessing agency capacity and developing the budget**, you can begin the pre-implementation phase, which prepares the implementing agency to conduct the intervention. It is during this period that your agency should develop a timeline for implementation, identify or hire the appropriate staff to implement ***PCC***, compose a community advisory board, develop a monitoring and evaluation plan, and make changes to the intervention to fit your agency's target population, if needed. Each of these topics is discussed in this section.

PCC Implementation Timeline

(Times suggested are approximate and will vary from agency to agency.)

1. Conduct agency readiness assessment (Months 1–2)

The *Agency Readiness Checklist* (included in the *Getting Started* section of this manual on pages 20-23) identifies issues that should be addressed before implementing ***PCC***.

2. Select or hire staff to be trained, (Months 3–5)

The *Staff Qualifications*, included in this section of this manual on page 42, spell out the skills and education needed to be a ***PCC*** counselor or a clinical supervisor.

3. Acquire or schedule additional office space, if required (Months 3–5)

Because the ***PCC*** intervention takes longer than many HIV test counseling protocols, agencies may need to arrange for additional private counseling space.

4. Plan additional efforts to find clients, if required *(Months 3-5)*

If the *Agency Readiness Checklist* identifies a need for additional efforts to reach more ***PCC*** clients, your agency may need to work with other agencies to get referrals or conduct outreach to recruit clients for ***PCC***. A plan on how to do this, including how you will do "inreach" (reaching into your current client pool and drawing out those eligible for ***PCC***) needs to be developed.

5. Train counselors and clinical supervisor (Month 6)

Once the arrangements have been made to offer ***PCC*** and the staff members are available, counselors and the clinical supervisor must attend a ***PCC*** Training of Counselors (TOC).

6. Orient other staff and agency partners (Months 3-6)

Before ***PCC*** is instituted, other agency staff members (receptionists, nurses, outreach staff, staff conducting monitoring and evaluation, etc.) need to know about ***PCC***. They may be providing information to clients, and/or screening and referring clients. Likewise, agency partners and stakeholders—those who refer clients, and those who provide other needed services in tandem—need to be informed about the new service.

7. Begin implementation of *PCC* (Month 7, then ongoing)

Following training, implementation should begin as soon as possible, to take advantage of the momentum provided by the training, and to reinforce the learning provided by the training.

8. Implement quality assurance (Month 7, then ongoing)

Quality assurance consists of 1) weekly supervision sessions, supplemented by Q&A and troubleshooting as needed; 2) use of the ***PCC*** *Steps Checklist* (page 93); and 3) use of the ***PCC*** *Satisfaction Questionnaire* (page 94).

9. Check-in for "course adjustment" and troubleshooting (Month 8, then ongoing)

For the first three months of implementation, or longer if needed, the agency's entire ***PCC*** team should meet semi-monthly to identify any issues that need to be addressed. Consultation with your CDC Project Officer and/or submitting a request for capacity building assistance (CBA) can be initiated when needed.

10. Implement any needed adjustments (Month 8, then ongoing)

Anticipate that some fine-tuning and problem solving will need to take place in the first few months of implementation.

11. Finalize implementation of PCC with standard level of clinical supervision (Ongoing)

About six months into implementation, it is anticipated that the initial problems will have been identified and corrected, the staff will be familiar and comfortable with delivering ***PCC***, and the referral processes will be in place. The frequency of supervision sessions can be reduced to monthly, and the use of the ***PCC*** *Steps Checklist* can be reduced to every fourth client, if desired. The ***PCC*** team check-in can become a part of regular staff meetings. Regular ongoing training in cultural competence should still continue.

12. Train new staff as needed (Ongoing)

Staff turnover will necessitate arranging training for the new staff from a ***PCC*** trainer, and more intensive supervision for the new staff will be required for their first three months of work. Contact your CDC Project Officer or health department liaison to schedule training. In the mean time, new staff should become familiar with the ***PCC*** implementation manual. Counselors **should not** conduct ***PCC*** until they are formally trained.

PCC Sample Timeline (Actual time required will vary from agency to agency)

Note: A solid bar means the activity stops at the end of the indicated period. A bar that has an arrow on the right indicates an ongoing activity.

	Month 1	2	3	4	5	6	7	8	9	ongoing
1. Conduct agency readiness assessment										
2. Select/hire staff to be trained										
3. Acquire/schedule office space										
4. Plan additional efforts to find clients										
5. Train counselors and clinical supervisor										
6. Orient other staff and agency partners										
7. Begin implementation of ***PCC***										
8. Implement quality assurance										
9. Check-in for "course adjustment" troubleshooting										
10. Implement needed adjustments										
11. Finalize implementation of ***PCC*** with standard level of clinical supervision										
12. Train new staff										

PCC Intervention Implementation Summary

The Implementation Summary provides you with an overview of the resources, activities, and deliverables needed to successfully implement ***PCC***. It can be useful in planning your implementation and also in verifying that the intervention has been implemented completely.

Inputs *Inputs are the resources needed to operate a program to conduct the intervention activities.*	**Activities** *Activities are the actions conducted to implement an intervention.*	**Outputs** *Outputs are the deliverables or products that result when activities are conducted. Outputs provide evidence of service delivery.*
PCC-specific screening protocols and system to integrate the ***PCC*** intervention into flow of client in HIV testing program services	Screen all male clients who present for HIV testing services for selection criteria: MSM, previous HIV testing, HIV-negative, and unprotected anal intercourse since last test	At least 90% of all male clients requesting HIV testing services are screened for counseling with ***PCC***
Private space to conduct the one-on-one ***PCC*** intervention	Counsel ***PCC*** clients in a private space	100% of all clients counseled with ***PCC*** rate their counseling session as having taken place in a private space
30 to 50 minutes dedicated time for counseling each ***PCC*** client	Counsel each ***PCC*** client in a 30- to 50-minute one-on-one ***PCC*** session	90% of all clients counseled with ***PCC*** completed the counseling in not less than 30 minutes and not more than 50 minutes
PCC counselor(s) and clinical supervisor of ***PCC*** counselor(s)	Ensure competency of HIV test counselors to conduct ***PCC*** in the context of HIV testing, including ongoing review of counseling sessions by a ***PCC*** clinical supervisor	30% of ***PCC*** sessions are reviewed by the ***PCC*** clinical supervisor and 80% of the sessions reviewed receive a satisfactory rating by the client and the counseling supervisor
Time for supervision of ***PCC*** counselors	***PCC*** clinical supervisors provide 30-minute review of sessions and guidance to ***PCC*** counselors for a subset of all clients counseled using ***PCC***	***PCC*** clinical supervisors and ***PCC*** counselors conduct a weekly supervision session lasting at least 60 minutes reviewing at least 25% of each counselor's ***PCC*** sessions
Sensitivity to issues involved in working with MSM, and cultural competence with populations served	Counselors distribute post-counseling client satisfaction form; provisions made for clients to return this anonymously	60% of clients report a high level of client satisfaction with services received

Implementing *PCC* in an Existing Service Agency

Embedding

Because the ***PCC*** intervention is intended to be offered along with HIV testing, it should be embedded within a service called "counseling and testing." As recommended by CDC guidelines, these services often include additional components such as consenting processes, referral processes, partner notification services, and individual or group education programs. In addition, local laws and organizational policies will be applied to regulate the ***PCC*** intervention.

To effectively use this package, providers are encouraged to embed the ***PCC*** intervention within their service or program in a way that minimizes disruption and changes to the protocol.

New Programs

If ***PCC*** is to be implemented as part of a completely new service program, the complexity of the process is greatly increased. It is beyond the scope of the ***PCC*** Implementation Manual to describe how to set up and operate an HIV testing and counseling program from the ground up. It is recommended that you contact the CDC and/or your state and local health department for assistance.

Enhancement

Many agencies that will implement ***PCC*** will already be serving the target population and will have most of the required systems in place, including ongoing cultural competence training, regular supervision of counselors, and a referral network and/or outreach program that brings in members of ***PCC***'s target population.

Implementation of ***PCC*** will involve enhancing the agency's services through training the counselors and clinical supervisor(s) in ***PCC***, adding additional quality assurance (supervision, fidelity forms, and client feedback form), and in some cases, increasing recruitment of clients eligible for ***PCC***.

Screening

If all HIV test counselors who provide services to MSM are trained in ***PCC***, they can conduct the screening in the initial risk assessment and then seamlessly transition into providing ***PCC***. If only some of the counselors are trained in ***PCC***, those who are not trained need to learn how to screen clients, and then make a referral to a ***PCC*** counselor. This may not be practical when a ***PCC*** counselor is not immediately available. It may then be necessary for the counselor to provide a conventional HIV counseling and testing session instead of ***PCC***. The client may not want to defer his testing, and it is important not to lose the opportunity to provide the service. If the client appears to be genuinely motivated, it may be possible to postpone the testing until a ***PCC*** counselor is available; this would be a case-by-case call.

Quality Assurance

PCC comes with a quality assurance (QA) component, including a checklist to be completed by counselors and a feedback form to be completed by clients. Integrating this into the agency's existing QA plan will take some thought. For example, if you already have clients completing a satisfaction survey, you will want to consider whether you want to substitute the ***PCC*** form, or combine the information on one form for these clients.

Funding

It may be necessary to think through the funding implications of ***PCC***. If the agency is being funded on a per-session basis, additional funds for ***PCC*** will probably be necessary, since the session is usually longer and costs a little more to deliver than conventional HIV counseling and testing.

Staff Qualifications, Training, Roles, and Responsibilities

Counselors' Qualifications and Training

Based on the research projects in which ***PCC*** was tested, the necessary qualifications for being a ***PCC*** counselor are:

- Training as an HIV antibody test counselor.
- At least one year of experience providing HIV test counseling.
- Training and experience in a helping field (psychology, social work, counseling).
- Experience with and dedication to pursuing cultural competence with the populations of clients to be served.
- Comfort with and knowledgeable about men who have sex with men.
- Comfort with discussing sex frankly using everyday language.
- Completion of training to learn the ***PCC*** intervention.
- If counselors are to enter required M&E data, they will need training on this.

Counselors' Roles and Responsibilities

- Screen clients for the ***PCC*** intervention. Other staff may also screen clients.
- Conduct the ***PCC*** intervention.
- Complete ***PCC*** *Steps Checklist* (page 93).
- Provide clients with ***PCC*** *Satisfaction Questionnaire* (page 94) and inform clients on the importance of returning completed questionnaires.
- Review returned ***PCC*** *Satisfaction Questionnaires* from clients.
- Record and enter the NHM&E DS data. Other staff may also enter data.

Clinical Supervisors' Training and Qualifications

- Master's level training as a counselor, social worker, or therapist with a degree in psychology, social work, counseling, or a similar helping field.
- At least one year of experience as a clinical supervisor.
- Completion of training to learn the ***PCC*** intervention. (***PCC*** Clinical Supervisors may be available through the CDC or the CDC can provide names of qualified agencies or people with whom your agency can contract.)

Clinical Supervisors' Roles and Responsibilities

- Provide one hour a week or more of clinical supervision to counselors. Clinical supervision includes review of sessions recordings, discussion of issues raised in ***PCC***

sessions, review of the ***PCC*** *Steps Checklist*, review returned *Satisfaction Questionnaires*, aiding counselors in understanding and dealing with feelings raised by ***PCC*** sessions, and providing feedback and advice to optimize service fidelity and quality.

Program Director/Executive Director/Clinic Manager/Coordinator/etc. Training and Qualifications

Management staff may have different titles, as well as different types of education and training. There is no specific educational background required. The key qualifications are:

- Ability to manage an HIV-related counseling program.
- Knowledge and experience with the target population.
- Overall understanding of ***PCC*** including knowing the target populations, qualifications of staff needed, need for clinical supervision, and relationship to HIV testing.

Program Director/Executive Director/Clinic Manager's Roles and Responsibilities

- Provide leadership and oversight of the implementation of ***PCC***.
- Conduct the implementation steps described in this manual, and/or delegate them to others; monitor progress of activities delegated to others and take corrective action as necessary.
- Oversee the other staff and make sure they are performing their duties, i.e., that the ***PCC*** counselors are counseling clients, the clinical supervisor is meeting with counselors weekly, the bookkeeper is recording expenses.
- Ensure that ***PCC*** counselors and other staff have the resources necessary to perform their duties. These resources include training, space, time, and day-to-day guidance.
- Oversee budgeting and track expenditure of funds.
- Review process and outcome data and make corrections as necessary.
- Assist with quality assurance through review of data, direct observation, and consultation with staff.

Administrative Staff such as Receptionist, Data Entry Clerk, Bookkeeper's Qualifications and Training

- Past experience in the job or a job with similar duties.
- Data entry clerks, if any, should have training on entering any required M&E data.
- The bookkeeper should be oriented as to which expenses are to be assigned to the ***PCC*** budget.

- The receptionist should have training in cultural competency and be knowledgeable about and comfortable with the target population. If the receptionist is to aid with screening, he or she should have training in the ***PCC*** screening criteria.

Administrative Staff Roles and Responsibilities

- The data entry clerk attends data training to enter any required M&E data using any required software (unless this responsibility is assigned to the counselors).
- The receptionist welcomes clients and orients them to the testing procedures, telling them where to wait, how long they will wait, and answering related questions. In some agencies, the receptionist may conduct part of the ***PCC*** screening and direct the clients to ***PCC*** counselors or schedule ***PCC*** appointments.
- The bookkeeper tracks and accurately records the ***PCC***-related expenses.

Finding Clients: “Inreach,” Outreach, and Referrals

This section reviews how to find clients and improve your current efforts. ***PCC*** was originally developed as an enhancement of an existing HIV testing and counseling service that already served the target population. It is assumed that your agency already has MSM in the target population coming to the agency for HIV testing, and that you will be able to reach into this pool of clients and identify candidates for ***PCC***. This is called “inreach.” You also may choose to build your organizational linkages to receive more referrals of ***PCC***-eligible men from other agencies. Finally, you may also wish to conduct outreach directly to identify appropriate clients.

Publicity and organizational linkages

When you implement ***PCC***, it is a good time to review your existing marketing and publicity as well as organizational linkages. These are some of the ways that you communicate your mission and programs to the larger community, and recruit members of the ***PCC*** target population. Some important aspects of this are discussed below.

Web sites

- Web sites are increasingly important in disseminating information to the public. You will probably want to revisit your own Web site, along with any other Web sites that describe your services. In addition to the hours for HIV testing and counseling and location where the service is offered, the Web site content should emphasize confidentiality, sensitivity to the needs of MSM, all races and ethnicities are welcome, and a nonjudgmental attitude.
- You may want to state explicitly, “If you are a man who has sex with men, and you are worried about some things you have done since your last HIV test, we would be more than happy to provide another HIV test. Our test counselors do not judge or criticize.”
- Explaining ***PCC*** directly to the public or target populations is not recommended. This is because it is a counseling intervention that requires training to fully understand. However, the nonjudgmental stance and sensitivity to needs of MSM are worth emphasizing wherever possible.

Brochures and directory listings

- The same kind of language described above should be included in brochures and in print directories. Directories put out by other organizations may be out of date, so it is worth making a special effort to seek them out and update them if necessary.

Where to conduct outreach

- Bars, bathhouses, sex clubs, and areas in gay neighborhoods are all places outreach can be conducted. Sending outreach staff to religious, sports, and recreational events that are frequented by MSM is also a productive strategy. You may also want to place advertisements in both gay and general-readership publications. Some agencies find that posters and flyers are helpful. For more information on outreach to MSM, including guides, materials, and other resources, visit http://www.cdcnpin.org/scripts/hiv/outreach.asp

Linkages

- Linkages to other organizations are a key source of getting a stream of referrals. In addition to outreach programs and medical services, organizations that serve or represent MSM can be important partners. Traditionally, bars, clubs, and bathhouses have been important partners in spreading the word about HIV prevention services, including testing. Other organizations that can be good partners include gay sports clubs, political groups, and religious organizations. If your agency is not in touch with these groups, consider recruiting a community advisory board that has these connections. Their input will aid in terms of sensitivity, as well as help you build linkages in the community.

Planning How to Integrate *PCC* into the Testing/ Counseling Session

Before your agency begins to offer ***PCC***, you will need to decide how you want to integrate it within the process of intake, testing, and counseling that your agency uses. The time to make this plan is after your staff counselors have been trained and are fully conversant with the ***PCC*** intake requirements and the ***PCC*** steps.

Below are some examples to consider as you plan. You can fit ***PCC*** into your service sequence in a variety of ways depending on what works best for your agency. However, if your agency offers ***PCC***, remember that the clients need to be screened, and have time for a private session (some may last up to 50 minutes), and the session needs to be with a trained ***PCC*** counselor.

Example #1

The two agencies that tested ***PCC*** during the REP project (case study agencies) found it fairly easy to integrate ***PCC*** into their systems. In both, clients who present for HIV testing are already asked screening questions to assess risk. The customary risk questions will establish if the client has had UAI since his past HIV test, and if this UAI was with an HIV-positive person or someone whose HIV status was unknown. When this is true for a client, the only remaining question to ask for the purposes of ***PCC*** is if the UAI was with a boyfriend or regular partner (for detail and definitions, see the discussion of screening, beginning on page 59).

At the case study agencies, the same counselor who does the screening conducts the counseling, so once the client is identified as appropriate for ***PCC***, the counselor initiates the session. At these sites, the ***PCC*** session is conducted before the client is referred to the lab, where the HIV and other STD tests are conducted. So the ***PCC*** takes place immediately before the actual test is given and before the results are given.

Example #2

Another procedure is followed at the AIDS Health Project RNA testing program. At this site, clients who test negative on a regular HIV rapid test, but who have had UAI recently (according to RNA test guidelines) are offered RNA testing. In the process of determining the HIV risk, the ***PCC*** screening questions are asked. Then clients who meet ***PCC***'s entry criteria and RNA testing criteria are oriented to the RNA test procedure. The clients are told they will give a blood sample, and then return for the results on a later day. The clients are also informed that at the time they get the RNA test results, the prevention counselor will talk with them for about 30 minutes.

Then, when clients return for the RNA test results, the ***PCC*** counselor first gives them the results and then conducts the ***PCC*** session.

This procedure has been very well received by clients. Some have wondered if clients would be willing to stay for a counseling session after having received the results, but this has not been a problem.

Options

There are reasonable options that have not yet been tried. For example, if a receptionist or outreach worker conducts the screening, they could identify the clients appropriate for ***PCC*** and then introduce them to the ***PCC*** counselor. Agencies choosing to do this will want to think through how the introduction will take place so that it will be comfortable and convenient for the client.

Another option is to conduct the ***PCC*** session in the waiting period between taking an oral swab or blood sample and reporting the results. While the ***PCC*** session could delay receiving the results for some minutes, this was not identified as a problem by ***PCC*** counselors.

Write it down

Before implementing ***PCC***, it is recommended that each agency write down its plan for integrating ***PCC*** into its service sequence, and that all staff involved be brought together in person to become familiar with the plan. Then, several role-play walk-throughs should be conducted to ensure everyone knows what will happen when and what they will say to the client at each step.

Adjustments

As ***PCC*** is implemented, it is likely that some questions and exceptions will come up, so the service sequence should be revisited weekly until everything works smoothly. Adjustments to the procedure should be documented so that everyone understands them and new staff can be oriented.

Community Advisory Board

The advisory board is made up of individuals from the community your agency serves, who understand the various needs of the community, and who know the best way to effectively communicate with the target population. The advisory board is not absolutely necessary to successfully implement ***PCC***. However, because of the members' unique insights into your target population, the advisory board can be helpful in modifying ***PCC*** for your agency and facilitate making organizational linkages. Assembling an advisory board is not a long or extensive process, and the size of the board will vary. Your agency can pilot the intervention with the board, and the members' feedback can help your agency improve the quality of delivery. Some other ways that the advisory board can assist your agency are by providing ideas about marketing and recruiting. The advisory board may be a valuable resource in making ***PCC*** a culturally appropriate intervention for your community.

Adaptation of *PCC*

PCC has been proven to be a successful intervention for MSM, and has been tested with hundreds of MSM. However, no two communities are exactly alike; therefore, ***PCC*** may need to be modified to fit the needs of your community and agency. Before making any adaptations to the program, your agency is strongly encouraged to deliver the intervention as written with no changes. This will give your agency a better sense of how the session flows, how MSM respond to the program, and how the intervention works for your agency. You may find that the intervention fits your needs perfectly as written. Or, you may find that you will need to adapt ***PCC*** to fit the specific needs of your population.

Considerations to keep in mind when adapting the intervention include the needs of your population, the capabilities and resources of your agency, and the intervention's Core Elements. Adaptation should improve the delivery of the intervention and make the information more accessible for the clients. Adapting does not and should not alter, delete, or add to the Core Elements of ***PCC***. Working closely with your CDC Project Officer, local or state health department, or requesting CBA services will help your agency to make the most appropriate adaptations. Some areas where adaptation may be necessary include:

Populations

When agencies are considering adapting ***PCC*** for other populations, they should take into account the populations' sexual risk behaviors. ***PCC*** was designed and shown to be effective with MSM engaging in UAI with non-primary partners. Thus, the ***PCC*** questionnaire reflects the self-justifications MSM may have in this type of sexual encounter. If ***PCC*** were to be adapted to other populations, extensive background research would be required to identify the self-justifications used by the target population when engaging in unprotected sex. If the findings indicate different self-justifications, the questionnaire would need to be modified and tested through focus groups and other means.

Settings

PCC has been delivered by a community-based organization in their STD testing clinics and by a public health department in a space made available in a gay bathhouse. A mobile van testing facility equipped with an area that is private and soundproof, with trained HIV counselors who are culturally appropriate to the target population, could provide an appropriate setting as well.

A mental health center or prevention case management program with trained HIV counselors, who are culturally appropriate to the target population, and MSM clients requesting HIV testing could also provide an appropriate setting for ***PCC***.

Program Review Board

If CDC will be funding all or part of your agency's implementation of ***PCC***, your agency must follow the "Requirements for Contents of AIDS-Related Written Materials, Pictorials, Audiovisuals, Questionnaires, Survey Instruments, and Educational Sessions in Centers for Disease Control and Prevention (CDC) Assistance Programs" (**Appendix 6**). You also must submit the intervention session, content, and information collection forms you plan to use for approval by a local Program Review Board (PRB). The PRB's assessment will be guided by the CDC's Basic Principles found in 57 Federal Register 26742. If all of your funding for ***PCC*** is from another source, check with that funder for their PRB approvals policy.

It is recommended that you first find out what the local PRB's procedures are and work within them. The PRB may not want to review every page. Your PRB may want an abstract or executive summary of the intervention session to accompany submission of all or part of the materials. If so, copy the section "Introduction to the Personalized Cognitive Counseling (***PCC***) Intervention" from this Implementation Manual. Attaching this text to a copy of the research article (found in **Appendix 1** of the Implementation Manual) may be useful for PRB members who are interested in the scientific evidence supporting the intervention.

Emphasize the activities that are Core Elements of the intervention. Emphasize that these elements are required in order to obtain results similar to those of the original research. Be prepared to answer questions, to provide clarification, or refer PRB members to sections of the package materials for information.

Monitoring and Evaluation

To achieve the best performance and outcome for ***PCC***, agencies should plan to conduct evaluations of the intervention. There are four types of monitoring and evaluation that are relevant to your ***PCC*** program: formative, process monitoring, process evaluation, and—when possible—outcome monitoring. Formative evaluations are performed during the pre-implementation phase to assess the needs of the target population for ***PCC***. The other three types of monitoring and evaluation—process monitoring, process evaluation, and outcome monitoring—are performed in the Maintenance phase, after the program has been delivered. More information, including guidance on how to develop a monitoring and evaluation plan, on the types of monitoring and evaluation, including sample tools, can be found in the ***PCC*** *Monitoring and Evaluation Field Guide.*

Personalized Cognitive Counseling

IMPLEMENTATION

Introduction to Implementation

The purpose of this section is to instruct counselors on how to conduct ***PCC***. It begins with an overview of the ***PCC*** intervention. The summary is followed by a detailed step-by-step description of how to conduct the intervention. The step-by-step material does not give a script, because ***PCC*** needs to be personalized for each client, but it gives sample language along with transcripts from actual ***PCC*** sessions.

Overview of the Five-Step *PCC* Intervention

This brief overview is provided as an introduction to the five steps of ***PCC***. New ***PCC*** counselors can also use this overview as a reference during ***PCC*** sessions. A more detailed discussion of each step with sample dialogue follows this section.

Screening

First, a potential client is screened to determine if he is appropriate for ***PCC***. The key criteria are: MSM; has been tested for HIV before and the test was negative; and since the last test, has had UAI with a non-primary partner of unknown or positive HIV status.

Step 1. Recall a Recent Memorable Episode of UAI

After the client is determined to be eligible for ***PCC***, the counselor asks him to think of a recent memorable episode of UAI which they will focus on during the rest of counseling session. Through conversation, the counselor helps the client identify an appropriate incident.

Step 2. Administer *PCC Questionnaire*

Once an appropriate incident is identified, the counselor asks the client to complete the ***PCC*** *Questionnaire*, with the specific episode in mind.

Step 3. Draw Out the Story, and Ask About Thoughts and Feelings

The counselor helps the client tell the whole story of the recent episode of UAI—what led up to it, what he did, what happened afterward, and how he thought and felt about it along the way. That is, as the client tells the before, during and after story of his episode, the counselor also asks him to talk about what his thoughts and feelings were at the time of the UAI episode.

Step 4. Identify Self-Justifications and Discuss Them

While listening for any self-justifications for UAI, such as “This guy looks so healthy, he can’t possibly be infected.” The counselor mirrors (re-states) any justifications heard, and asks the client how and to what extent he thought about HIV transmission during the episode. The counselor asks the client what he thinks now about his thoughts and feelings–the self-justifications that were in his mind–during the UAI episode, thus assisting the client in identifying or making note of his risk decision making (self-justifications).

Step 5. Talk About What the Client Will Do in the Future

After the story has been told, and the client has reflected on his thoughts, feelings, and decisions, the counselor asks the client what he thinks he could do in a future, similar situation to be safer. How might he think or decide differently? The counselor supports the client's constructive plans.

Brief Guide to *PCC* Step-by-Step Activities and Skills

The description that follows describes in detail how to conduct ***PCC***, and gives sample dialogues illustrating how each step can be conducted. *Please note that* ***the sample dialogues are not scripts to be used with clients***.

Purpose and Skills

At the beginning of each step, the primary purpose of and skills used in each step are specified. They are given in blue (or gray, if the manual is printed in black and white) boldface type as shown below:

> **Skills: Active listening; use of open-ended questions/ neutral probes; use of prompts.**

Throughout the steps, the following counseling skills are used:

- **Active listening.** This includes mirroring—paraphrasing back what a client said to show him he has been heard, and to encourage him to tell you more. For instance, "So, you were lonely and bored, and you thought you'd visit the far end of the park to see if anyone good-looking was hanging out." It also includes summarizing what a client said. This shows the client he has been heard but it is briefer and tends to move the dialogue forward. For example, "You were lonely and decided to visit the park."
- **Use of open-ended questions.** These are questions that do not require a short specific answer such as yes or no. For example, "What were you feeling as you first talked to him?"
- **Use of prompts.** Prompts are closed questions that prompt the client to share particular information. For example, during screening, "Did you know his HIV status?"
- **Remaining nonjudgmental.** Avoid critiquing the client or expressing your disapproval or negative feelings about what he tells you.

The following additional skills are used:

- **Instructing/directing.** Clearly orienting the client or telling the client what to do. For example, "Now, before we talk more about what happened, I'd like for you to complete this questionnaire about what you were thinking when you decided to have sex without a condom."
- **Identifying self-justifications.** Self-justifications are thoughts that allow people to decide to engage in risky behavior that contradictions the knowledge and beliefs they have that support avoiding risk. The counselor listens for and mirrors (or re-states) the client's self-justification for UAI. This assists the client in identifying and making

note of their risk decision making (self-justifications). For example, if the client says, "This guy looks so healthy, he can't possibly be infected." The counselor may say, "It sounds like because you told yourself, 'He looks healthy," that made you feel OK about fucking without a condom." The counselor does not always point out the risk decision so directly. Ideally, the ***PCC*** process leads the client to identify or recognize his self-justifications on his own. The client recognizing his own self justifications often works faster and better than the counselor trying to identify them for him.

- **Gently challenging.** The counselor gently challenges the client by encouraging him to reconsider a thought or behavior. For example, "So in the moment you thought, 'I can't bring up condoms now because that would break the mood and mess things up.' What do you think about that now?"

Skills and Procedures That Are *Not* Used

There are many valid HIV prevention counseling approaches; however, combining approaches interferes with conducting ***PCC***. Not only do they tend to pull the session off track, but they can use up time. Some important things to avoid include educating (beyond briefly correcting misinformation), and role-playing how to handle situations. It is also important to avoid counseling the client on how he generally thinks, feels, or behaves beyond the memorable episode being discussed. For example, the counselor should not ask the client: "Do you generally feel depressed?"***PCC*** is not general mental health counseling. The focus in ***PCC*** needs to be on the client's thoughts and feelings during the memorable UAI episode being discussed to help identify self-justifications or risk decisions made. In recalling and stating his thoughts, the client is likely to recall the risk decisions made or self-justifications he had during the episode.

Procedure

After the purpose and skills, the procedure for implementing each step is described in detail.

Sample language

Although there is no script for ***PCC***—the intervention is personalized for each client—examples of language that can be used in each step are provided as a starting point for counselors. Examples are in boldface in a text box:

> **What questions do you have before we start?**

The "why" behind the procedure

Understanding the ideas that underlie ***PCC*** helps the counselor master the intervention and tailor it to suit the needs of each client. Important conceptual material is indented and surrounded by a shaded area:

By allowing the client to recall thoughts and feelings before, during, and after the event, the counselor can help him understand his own internal process and decision making that allowed him to place himself at risk for HIV.

Notes to the counselor

Brief advisory notes are indicated by this pencil and notepaper icon.

Key terms defined

On-line thinking is "heat of the moment thinking" or thinking during a heightened state of arousal—in a sexual situation—and where there are immediate rewards for risky behavior. On-line thinking may be more automatic and impulsive than off-line thinking.

Off-line thinking is "cold light of day thinking" which takes place in a situation where there are no immediate rewards. In an off-line state, a person may think or evaluate risk information very differently than in an on-line state. That is, he may weigh costs and benefits with greater attention and make more use of the information he already knows about how HIV is acquired to make safer decisions.

Self-justifications are thoughts, attitudes, and beliefs that "allow" people to make a decision to engage in risky sex that contradicts other knowledge and beliefs they have that support avoiding risk. Self-justifications tend to occur during on-line—"in the heat of the moment"—thinking; therefore, they tend to be "automatic" rather than deeply considered. The ***PCC*** session makes the link between the client's risk-justifying thoughts (self-justifications) and his decision to have UAI. In the ***PCC*** session, the client learned something about his decision-making process and re-experienced the anxiety associated with the risk of infection. As a result, he is able to remember and apply lessons about his risk decision-making or self-justifications when new sexual situations present themselves in the future.

Screening and Transitioning to *PCC*

Purpose

Determines if the client is eligible for *PCC* and begin the session.

Skills

Open-ended questions; use of prompts; remaining nonjudgmental; instructing/directing.

How to determine if the client is eligible for *PCC*

In many agencies, much of the ***PCC*** eligibility screening can take place in the context of the initial questions that all testing clients are asked.

You should begin the eligibility screening by asking what brought the client in for testing and obtaining some basic risk information about him. If you learn that the client is an MSM and has had UAI with a non-primary partner since his last HIV test, consider moving ahead to the ***PCC*** intervention. Check first to confirm that the client understands that UAI puts him at risk for HIV.

The eligibility criteria for ***PCC*** are spelled out and the terms are defined below. Then, the next section shows the process in graphic form.

Eligibility criteria for *PCC*

A client is eligible for ***PCC*** if he is a man who:

- Has sex with other men
- Has tested for HIV at least once before and was found to be HIV-negative
- Has had one or more episodes of unprotected anal sex since the last test
- Had UAI with a non-primary partner (definition of “primary” follows below)
- Did not know the HIV serostatus of his sex partner or knew the partner was HIV-positive
- Understood that this behavior put him at risk for HIV

Key terms are defined below.

Serostatus

PCC is designed to be used with a client whose sexual episode is with a partner whose serostatus is either unknown or known to be positive. If the client assumed or guessed the partner was negative, for the purposes of ***PCC*** his serostatus is considered unknown. If the client believed the partner was negative based on an explicit discussion with the

partner, the status of the partner is considered known. As a result, an instance of UAI with this partner would not be appropriate for the ***PCC*** intervention.

Perception of risk

PCC is for men who already have a basic understanding of how HIV transmitted. While a moderate degree of denial does not mean a client cannot participate in ***PCC***, men who truly do not feel at risk or do not know that HIV is transmitted by UAI are not suitable for ***PCC***. An intervention that provides information about HIV transmission would be more appropriate in these cases.

Primary partners

If the only partner with whom the client has had UAI is his primary partner, then ***PCC*** is not suitable. For ***PCC*** purposes, a primary partner is defined as a partner who the client defined as "a boyfriend of greater than three months, a husband, or domestic partner."

Screening questions

Screening questions should be specific and phrased in a way that is comfortable for the client. Typically MSM use slang terms for sexual activities, but the counselor should select language based on experience, judgment, and the language used by the particular client.

In ***PCC*** screening, do not put several screening criteria into one question. The screener would never ask, "Since that last test, have you had unprotected anal sex with a non-primary partner whose serostatus was unknown or was HIV-positive?" Instead, screening is conducted through a process involving a series of questions and careful listening. Always use language appropriate for the individual client.

Typical questions

Have you had an HIV test before?

So, what made you decide to come in for an HIV test now?

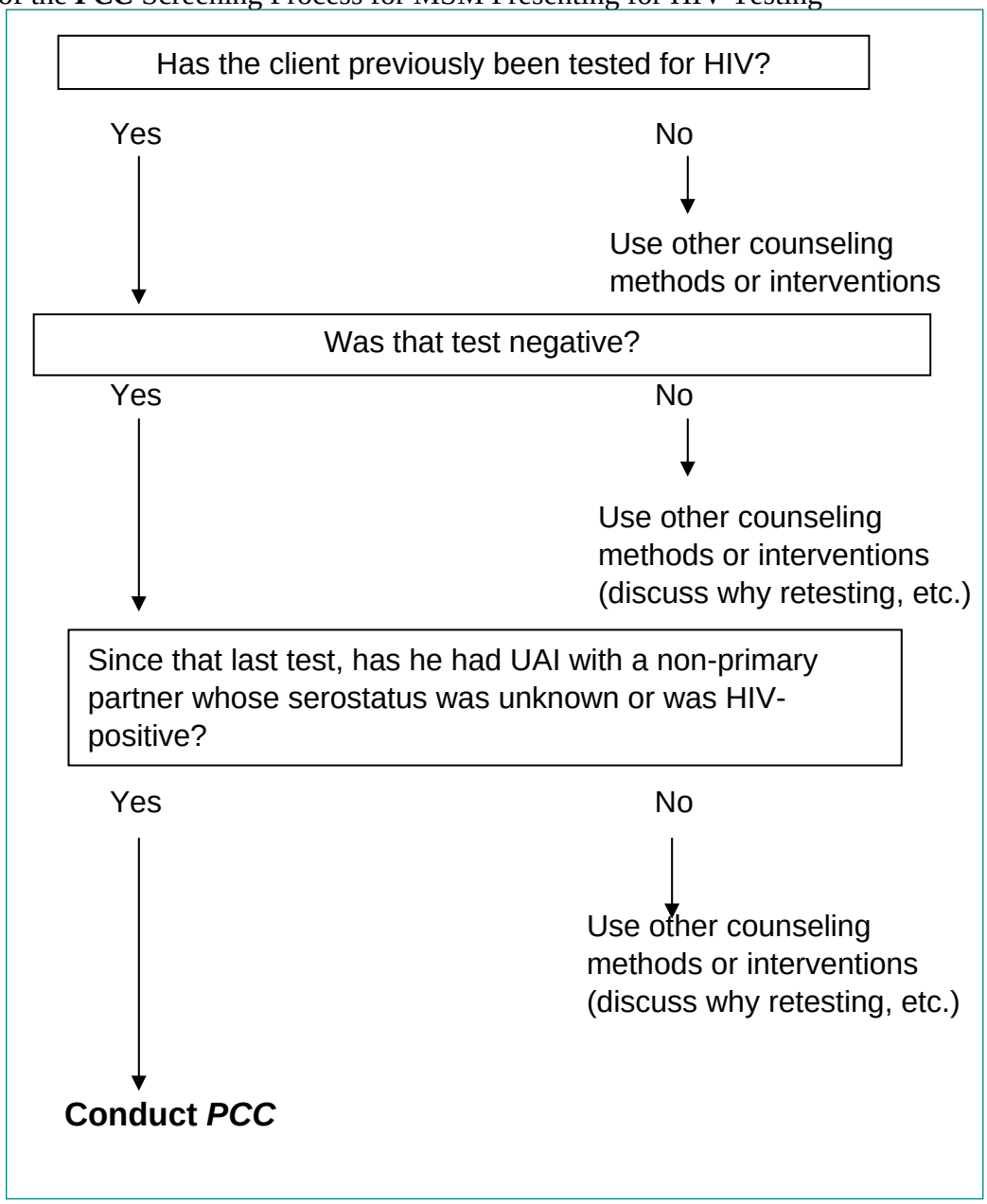
[If not covered in answer to above question:] Since your last test, have you fucked without a condom?

[If yes:] Was that with a boyfriend or a primary partner?

[If no:] Did you know if he was HIV-positive?

[If not mentioned:] Did you think this might have put you at some risk for getting HIV?

Flow of the ***PCC*** Screening Process for MSM Presenting for HIV Testing



Screening flows into *PCC*

Screening is a separate activity for the counselor, but it leads very naturally to identifying a particular UAI episode. To the client, this experience should seem like a seamless conversation. When possible, this smooth flow is desirable.

Begin the *PCC* session and tell when HIV antibody testing will take place, according to your agency's protocol

Once screening has confirmed that the individual is eligible and in the target population, briefly orient the client to what is going to happen next and its benefits. It is not pertinent to give the name "***PCC***" or explain the research. Simply explain that you would like to talk with the client about a recent, memorable episode of unprotected anal sex with the goal of helping him reduce his risk of becoming infected with HIV while allowing him to have the most satisfying sex life possible. See below for sample language when transitioning from the screening process to conducting ***PCC***.

Sample language to transition from screening to *PCC*

This is not a script to be used word-for-word; each counselor will learn to transition to ***PCC*** in her or his own way.

I would like to talk to you about a recent, memorable episode of unprotected anal sex–one that you remember pretty well. The process we will go through is to help you reduce your risk of becoming infected with HIV while allowing you to have the most satisfying sex life possible. May I talk with you about that?

[As part of transitioning to the *PCC* session, continue to ask questions to help identify and specify the UAI episode.]

What if the client is reluctant to participate?

Some clients may be reluctant to participate. No one should be compelled or coerced. Usually some encouragement is all that is needed. If the client seems reluctant to continue with the session, discuss this with him and provide information as needed. For example, the client may be hesitant to disclose personal information. You can respond that the information he discloses will be kept confidential and not written down. Or, the client may be expecting the standard HIV testing session that he is familiar with and not sure if he wants something different. You can respond that the new intervention has proven to be helpful and that guys have said it is more interesting than repeating the standard testing session.

If the counselor is reluctant to conduct ***PCC***, the client may well pick this up and become reluctant to participate. This is usually a problem only when the counselor is just starting out. The answer is for the counselor to have more practice, along with discussion of the issue in clinical supervision.

Sample of encouraging a reluctant client

Client: I don't want to talk. I just want to get an HIV test and go.

Counselor: Well, I can understand that, but at this clinic we talk when we give a test. It takes less than an hour, and whatever you say is confidential. People find it helpful. Why not give it a try?

It is not the counselor's responsibility to persuade every single client to participate. A small percentage of clients will decline. If, after being encouraged to participate, the client still does not want ***PCC***, this decision should be respected. The next time the client comes back for testing, he should be offered ***PCC*** again.

PCC Steps in Detail

Step 1. Help the Client Choose a Recent Memorable Episode of UAI to Discuss in Detail During the *PCC* Session

Purpose

To prioritize, select or identify an episode of UAI the client can remember well and that otherwise is appropriate for consideration in the *PCC* session. The episode selected is to be the focal point for the rest of the *PCC* session. This step personalizes the risk. By having a specific episode in mind, it makes it possible for the client to recall and gain knowledge of the thoughts he uses to justify risky behavior.

Skills

Active listening; use of open-ended questions; use of neutral probes.

Procedure

To start the ***PCC*** session, revisit what was shared by the client during screening (he had a recent UAI episode).

Ask for more information about the UAI with a non-primary partner whose HIV status was unknown or known to be positive that occurred since the client's last HIV test.

Criteria for an episode: You and the client should identify a memorable episode of UAI that the client is concerned about and can remember in detail.

Here are some examples of both open-ended and closed questions you can ask:

Thinking about the times you have had unprotected anal intercourse with a guy who is not your primary partner, and whose HIV status was unknown or positive, select one that you can remember well and that you have some worry about. Give me a short description about what happened or a name for it (when you had sex with the Craigslist guy) so that we can focus on it from now on.

Or

Is there a time you had unprotected anal sex that you remember well and you are concerned about? [If yes, follow up with "Can you tell more about that time?"]

If there has been just one UAI episode since the last test, then that is the episode you will use as the recent memorable one. If there are multiple episodes, you can ask if there is one the client has particular concern about and remembers well.

Here is an example of helping the client identify a specific episode. This was taken from a transcript of a ***PCC*** session. The conversation moves from the general to the specific.

Counselor: Tell me what actually brings you in here for testing today.

Client: Well, I've had a couple of sexual partners who I was not safe with and then I found out later that they were positive. So I, it's, I'm overdue for my test anyway. It should be every six months to a year. And I'm a little overdue, but then when I found that out, that I was at more risk, I just thought that I had to come in.

Counselor: OK. Wow. How was that, how, how did you hear about them testing positive?

Client: They decided to tell me three days later.

Counselor: After the fact?

Client: After.

Counselor: OK. I, I—

Client: I was like, "OK. Yeah."

Counselor: I wonder like, maybe they had gotten, actually gotten tested after the fact and found out then, but—

Client: No, they had found out about two, three months before. So they were very new themselves so—

[**Here the client is saying "they," but it appears that this refers to a specific person. It appears that the counselor understands this and starts focusing in on a specific event.]**

Counselor: OK. Tell me a little bit about that. How long ago was it?

Client: That was in November.

[Here it becomes clear the client and counselor are talking about a specific episode.]

Counselor: OK. So not that long ago, a couple months or so.

Client: Yeah.

Counselor: And when you say unsafe, what—

Client: Without a condom.

Counselor: OK.

Client: I was the top.

Counselor: For anal sex?

Client: Yes.

Counselor: OK. OK.

Client: I know that statistically I'm supposed to be less at risk if you're the top, but I'm still scared shitless so—

Counselor: Wow. Yeah, as I can imagine.

Client: Yeah. So—

Counselor: Yeah. Yeah. And you're right, statistically it's less risky, but obviously people do still get infected that way.

Client: Right.

[Here, the client shows he understands that this UAI was risky.]

Counselor: OK. So actually, that's kind of what I think today's session's going to be a bit about, is talking something about that. So what we kind of have people do is tell a story about one particular time that you didn't use protection. And when, it's not necessarily with someone that, like a memorable situation, but a situation that you remember really clearly. Not, not, and not someone like a boyfriend or partner but someone you might have had just an encounter with. So kind of thinking about how you met this person and what was kind of going on for you that day, like during work, if you were having a good day, a bad day. How you hooked up, how you kind of decided—

Client: So the whole story?

Counselor: Yeah. How you decided to not use protection, you know, thoughts and feelings while you were having sex and anything you were thinking after that. OK? So actually, before we go into that—

Client: OK. I was about to say, "It's a little long."

Counselor: Yeah. And that's OK. I have a questionnaire that kind of helps you focus on this one particular time, you know, any time that you choose.

Client: OK.

Counselor: And then this questionnaire should take about five minutes to do, so it's pretty short. It just kind of gets you in the frame of mind and kind of thinking about that one particular time.

Client: OK.

Counselor: So I'll let you fill that out.

Client: OK. [Pause to fill out questionnaire] All right.

Counselor: All done? OK. Let's put that on the side there. So it's basically just a story, kind of in as much detail as you can remember, how the day started and what was going on for you, how you met, how you made your decisions and any thoughts or feelings after that.

Step 2. Have the Client Complete the *PCC* Questionnaire

Purpose

Helps the client start to get in touch with what he was thinking (his self-justifications) that helped him justify behavior he knew was risky. The questionnaire subtly clues the client into the nature or focus of the *PCC* session by showing him some common self-justifications of gay men for risk behavior.

Skills

Instructing/directing; open-ended questions.

Resources

Questionnaire in Appendix 3.

Procedure

Once the client has identified a particularly memorable episode of UAI, ask the client to complete the ***PCC*** *Questionnaire* with the episode he identified in Step 1 in mind.

The ***PCC*** *Questionnaire*, found in Appendix 3, is necessary to conduct the intervention. The language in the questionnaire comes from MSM and is not clinical, professional language. The goal of the questionnaire is to be acceptable and understandable to the audience, putting the men at ease and preparing them to talk explicitly about their sexual behaviors. The ***PCC*** *Questionnaire* is to be used only with this particular at-risk population, not with the general public or other at-risk populations.

Explain to the client that the questionnaire is not kept by the agency and will be destroyed, or the client may take it with him at the end of the session. Tell the client not to write his name on the questionnaire.

If the client has literacy, language, or vision difficulties, you may administer the questionnaire orally. Normally, clients complete the questionnaire on their own. It should take approximately five to eight minutes to complete the questionnaire.

While the client is completing the questionnaire, the counselor should stay within earshot in case the client has a question or needs some help. At the counselor's discretion, he or she can check in with the client partway through:

Do you have any questions?

or

How's it going?

While the client is completing the questionnaire, the counselor can complete the other paperwork that goes along with HIV testing.

Sample language

Here is some sample language (but not a script) to explain the questionnaire:

Here is a questionnaire that asks what you were thinking when [selected UAI episode, such as, "when you had sex with the Craigslist guy."] This is just for you—we don't keep the questionnaire. It lists thoughts that other men had in their minds around the time they decided to have unprotected sex. Please mark any that were in your mind when you had unprotected sex.

or

Now I'm going to give you a questionnaire to complete about that particular time. This questionnaire lists thoughts that other men have reported were in their minds just before they decided to have unprotected sex. If any of these thoughts were in your mind during your selected event [use the client's name for the episode] when you had unprotected sex, mark the questionnaire accordingly. We'll talk more about [the selected event] and your thoughts and feelings after you finished the questionnaire.

Be sure not to begin Step 3 until you know that the client has completed the entire questionnaire.

How the *PCC* Questionnaire works

The questionnaire is a tool to help the client become aware of his thoughts and feelings (self-justifications) at the time of the UAI and to start recalling details of his own story, which he will tell in Step 3. Once he completes the questionnaire, the counselor and the client usually do not need to refer to it again. However, if the client has difficulty recalling his thoughts and feelings during the UAI episode in Step 3, the questionnaire can be used to help the client remember what he said and to ask him about some of the answers.

Step 3. Draw Out the Story of the Memorable Episode, Including Specific Thoughts and Feelings

Purpose

Brings out the details of the client's memorable episode to help the client recall, state, or identify the thinking or self-justifications underlying his risk behavior. Neutral probes of who, what, when, where, how, thoughts, and feelings are used to help the client "tell the story" and state his justifications (thoughts, beliefs, attitudes) used to decide to engage in risky behavior.

Skills

Open-ended questions; active listening; use of probes.

Resources

List of probes in Appendix 4.

Procedure

After the client completes the questionnaire, help him describe in detail the episode he identified in Step 1 and that he was thinking about while completing the questionnaire (Step 2).

The following is some sample language for introducing this step:

> **The purpose of the next part of the session is to go over that time you had unprotected anal sex. I want you to tell me about what you were experiencing at that time. For instance, where you were, how you were feeling, what type of mood you were in, what was going on that day before, during, and after sex. I'd also like you to talk about the thoughts that were going through your mind, the kinds of things that you may have been telling yourself that allowed you to go ahead and have unprotected anal sex.**
>
> **OK, so what I'd like you to do is tell me the story, starting at the beginning. How did you meet?**

Encourage the client to recall his thoughts and feelings during the episode by primarily using open-ended questions (who, what, where, when, how, thoughts, feelings, tell me more, etc.) such as:

Can you tell me how you were feeling that day?

Where and how did you meet?

What did he look like?

What were your thoughts at that time?

What happened next?

What did you think and feel about that?

Allow the client to tell his story without suggesting your own ideas about his motives and thoughts. Don't try to "lead" the client, with your questions, toward thoughts and conclusions of your own. Use probing questions sparingly. A list of sample probing questions ("probes") is included in Appendix 4.

Give the client time to tell his story. Some clients will spontaneously tell you a relatively complete story, sketching out the episode with a beginning, a middle, and an end covering the thoughts and feelings they had throughout the episode. Sometimes, the client will provide a short version with broad statements, such as:

- "Well, I went to a bar and met this guy. We had a couple of drinks and then ended up at his house where we had a couple more drinks and then had sex."

The counselor should listen actively, display interest and concern, and then as necessary lead the client to discuss each aspect of the episode in more detail (i.e., thoughts and feelings the client had during the event coinciding with specific activities (who, what, when). You want the client to provide details especially in terms of what he thought (self-justifications) or decided. You want him to give the details of the action, plot, motives, scene, actors, and so on to help him recall his thoughts and feelings.

For example:

OK, great. Now I'd like to ask you to go back and tell me more about what you were thinking and feeling. Why don't we start with what was going on for you before you even went to the bar. What was going on in your life earlier that day or that week? How did you decide to go out that particular night?

During this discussion, ask the client to detail his thoughts and experience throughout the entire episode. Some questions you might ask are:

So you met him at a bar. Can you tell me exactly how that happened? You arrived and then what?

Who spoke first?

What was it about him that attracted you?

How were you feeling?

What were you thinking?

Where did you have sex?

What exactly did you do to him? What did he do to you?

What did you think? What did you feel?

Again, the idea is to understand as much as possible of what was going on in the client's mind (his thinking, especially his self-justifications for taking the risk) before, during, and after the episode.

Before

The counselor should gently probe for the client's thinking about HIV infection before the sexual encounter, such as:

Was there a conversation about HIV? If not, why not?

Was there a discussion of condoms? If not, what got in the way of this discussion?

During

The counselor should continue to explore the client's thinking just before and while having UAI. Focus in on the client's thoughts and feelings at the decision point where intercourse without a condom began. Ask explicit questions, such as:

So you were making out and giving each other blow jobs. At some point you moved to having anal sex [use the terminology of the client]—how did that happen?

How were you feeling at that point?

What were you thinking at that point?

After

Finally, the counselor should explore the client's thinking and feelings after the sexual encounter, for example:

So how were you feeling after you had sex?

What were you thinking after you had sex?

For clients who are having a difficult time providing details on their thoughts and feelings before, during, or after the UAI episode, the counselor can refer him back to the ***PCC*** *Questionnaire* he completed in Step 2 to recall his thoughts and feelings.

At this point, the client may begin to express anxiety and unhappiness over what he had done in the "heat of the moment." His rational mind begins to evaluate his behavior and the risks taken. The counselor should remain nonjudgmental and help the client reflect on the episode, and explore how his thoughts and feelings were connected to his behavior.

Sometimes counselors become uncomfortable with the client feeling anxious and unhappy about having had UAI, and want to step in at this point to try to make the client feel better. While well-meant, this is not helpful. It is reasonable and appropriate for a client to feel unhappy about having done something risky. Using ***PCC***, the counselor will guide the client to use this emotional energy constructively to change his behavior in the future. **So the counselor's job at this point is not to make the feelings go away, it is to help the client get in touch with his feelings.**

Your screening has determined that the client has been tested before and presumably received some basic HIV information and education. It is likely that HIV risk was in his mind during the UAI encounter. This suggests a conflict, meaning the client knows what he is doing is high risk for HIV infection, yet he decides to take the chance anyway. ***PCC*** is based on working with this conflict.

> By allowing the client to recall thoughts and feelings before and during the event, the counselor can help him understand his own internal process in placing himself at risk for HIV. By focusing on the client's thoughts and feelings after the event, the counselor can help the client revisit the anxiety and worry that often comes with taking a risk. The counselor has the opportunity to talk with the client about ways to prevent placing himself at risk for acquiring HIV and to make safer choices with less anxiety in the future.

Below is an excerpt from a transcript of a ***PCC*** session in which the client tells his story and the counselor asks about his thoughts and feelings.

Counselor: OK. So now what I'd like you to do is sort of walk me through that experience. How did you meet your partner? Where did you go? What did you do?

Client: Weekend night. Probably was smoking weed all day, but did speed at night. Went out to the bars. Bars closed. Went to a sex club and purposely looked, you know, to have sex without a condom, purposely. You know, that, that was my goal.

[Here the client is talking about what he did before the episode of UAI.]

Counselor: OK.

Client: And I found it. And it's ridiculous, you know, looking back, looking back at it now, all the stupid stuff I did this summer. You know? You just, you just honestly don't know what you're thinking at the time. I mean you, you have a general rationale that what you're doing is absolutely ridiculous. But it doesn't take, you know, the drug takes precedence over it and, and the feelings associated with it. And until you can pull your head out of the clouds and realize what's really going on. Just you sit in a spiral and, you know, it's, I don't know. It's, it's a mess.

[Above, the client is talking about his state of mind before the episode of UAI.]

Counselor: OK. And when you got into the sex club, did you beeline for somebody or was it kind of a, did you do a walk around to see what was going on?

Client: No, just, yeah. Yeah, I mean you're pretty high, you're messed up so you just check everything out.

Counselor: Yeah. OK. And when you were doing that walk around, were you, were you looking for somebody? Was that sort of—

Client: Oh sure.

Counselor: —what was going on? OK. And then you found somebody obviously.

[Now the conversation moves to the actual episode.]

Client: Uh-huh.

Counselor: So what attracted you to that person?

Client: Body style.

Counselor: Body style. OK.

Client: Maybe ethnicity. You know, he was Latino, nice body. There you go.

Counselor: OK. Yeah. And did you approach him? Did he approach you?

Client: It was mutual.

Counselor: Mutual? OK. And was there a conversation that was had or was it basically straight on to making out?

Client: No, not much conversation.

Counselor: Yeah? OK. And when, when you guys came together and started making out, what was, like, did it start with kissing? Did it go right to oral sex or did it go like right to anal or—

Client: It started with kissing and then we just moved on rather rapidly, you know?

Counselor: OK. So when you say you moved on rather rapidly, where did you go from kissing?

Client: God. Went upstairs, disrobed what we had left, oral. He fucked me. I fucked him. Maybe an hour and a half, two hours. And there you go.

Counselor: OK. And when you say you went upstairs, did that mean you went to your own room or—

Client: Oh, no. It was just a different part of the club.

Counselor: Oh, OK. OK. And so, OK, you went upstairs and then oral happened. Was that also a both—

Client: Um-hmm.

Counselor: You performed oral and he performed oral and—

Client: Yes.

Counselor: OK. And then anal sex-wise, did he top you first or did you top him first?

Client: He topped me first.

Counselor: OK. And then you switched.

Client: Um-hmm.

Counselor: Did he end up ejaculating?

Client: Afterwards.

Counselor: Afterwards?

Client: Well, not—

Counselor: Not during the anal sex?

Client: We both, no, we both, we both masturbated after that and ejaculated.

Counselor: OK. OK.

Client: But, you know, it doesn't mean anything.

Counselor: Yeah. And did you use a condom for him or was it both, all, the whole event was unprotected?

Client: Exactly.

Counselor: OK. And, and you said that you didn't really talk beforehand so there was no discussion as to protection—

Client: Zero. No.

Counselor: —or HIV or STDs or anything along those lines?

Client: Nothing.

Counselor: OK. Cool. So you topped him, he topped you, and then you both jacked off at the end. Was there any talk at the end or was that basically parted ways.

Client: That was pretty much it. Yeah.

Counselor: Yeah. OK. And then where did you go from there?

[Now the conversation moves to after the episode.]

Client: I went home.

Counselor: Just went home?

Client: Well, I walked around for a while. But I didn't have any other contact or anything. I just hung out for a while. I love the city at night. I probably walked around until 5, 5:30 in the morning.

Counselor: OK.

Client: It was only a little bit after that. Maybe another hour, hour and a half.

Counselor: Yeah. OK. And then went to bed or—

Client: Oh, probably not. Probably just watched TV for another couple of hours.

Counselor: OK. And when you left the club and your started doing your walking around and, you know, eventually made it back to home, was there any thoughts about what had gone on that night for you?

Client: Negative?

Counselor: Hmm?

Client: Negative thoughts?

Counselor: Any thoughts, doesn't have to be negative.

Client: God, you know, I'm so embarrassed to even say it, but I'm here right now, probably just the most asinine thoughts possible that, you know, it was, oh God … talking about this, it was hot sex and that's what I was thinking about, you know? Was I thinking about the ramifications? No, I was probably still high and I probably was for the next day or two after that. So thinking about reality in that case, no, I wouldn't be. But about the sexual gratification that I got, probably. And—

Counselor: Yeah. So it was, it was good sex for you?

Client: [Laughter] Yeah. It was. Excuse me. I'm sorry.

Counselor: Oh, no. It's, this is, this is—

Client: Might as well be if you're going to be stupid. [Laughter]

Step 4. Identify the Self-Justifications That Contribute to Risky Sex and Talk About Them

Purpose

Recognizing self-justifications helps the client to take control of the self-justifications and reduces their power to undercut the client's understanding of his willingness to protect himself. The counselor assists the client in identifying or making note of his risk decision making (self-justifications).

Skills

Open-ended questions; identifying self-justifications; gently challenging.

Procedure

In this step, the counselor moves from drawing out the story to helping the client identify the thoughts and feelings—to note his self-justifications for risk—that lead to or underlie the decision to have UAI with a partner of unknown or positive HIV status. This information will likely overlap with Step 3 as the client is recalling details about the UAI episode because he may have recollected and stated his self-justifications in his telling of the story of the episode. The extent to which he noticed or attached some importance to this may or may not have happened in Step 3. Step 4 refers more to making some notice or drawing attention to self-justifications in terms of "identifying" them. Step 3 refers more to simply stating or recollecting them in the context of telling the story of the episode.

Before we discuss Step 4 further, we need to review a few important concepts used in ***PCC***.

Self-justifications

Self-justifications are thoughts, attitudes, and beliefs that "allow" people to make a decision to engage in risky sex that contradicts other knowledge and beliefs they have that support avoiding risk. They are "automatic" (as opposed to highly considered) and tend to occur during on-line thinking—"in the heat of the moment." The ***PCC*** session makes the link between the client's risk-justifying thoughts (self-justifications) and his decision to have UAI. Because, in the PCC session, the client learned something about his decision-making process and re-experienced the anxiety associated with the risk of infection, he is able to remember these lessons when new sexual situations present themselves in the future.

All of us use self-justifications at times. For instance, we might want to lose weight, but tell ourselves, "One more piece of cake won't make that much of a difference." In a few weeks, when stepping on the scale, we see that the extra eating that would not "make that much of a difference" has indeed made a difference.

Acknowledging that this form of thinking is common and something we all do in other situations (such as eating or drinking too much; not wearing a seat belt) helps clients acknowledge that they may use self-justifications. With this understanding, counselors can facilitate a discussion of how certain thoughts are associated with having UAI with someone whose serostatus is unknown or positive.

On-line and off-line thinking

During the heat of the moment, while emotions are high and social pressures are strong; it can be easy to use self-justifications. The term "on-line" thinking refers to thinking in the heat-of-the-moment situations. Later, in a well-lighted office and talking to a counselor, waiting for the results of an HIV test, the great majority of MSM who engaged in UAI can see through their own self-justifications. We use the term "off-line" to describe the thinking that happens when the client is thinking more rationally, away from the immediate temptation in the situation. The *PCC* intervention draws the client's attention to this difference, and helps him to be better prepared to bring clear off-line thinking into making decisions about risk when he is "on-line." *PCC* actually has the client apply off-line thinking to his on-line thinking and self-justifications for risk as a way of helping him to think and behave more safely in future risk situations.

Mirroring

If the client has trouble "recognizing" or identifying a self-justification he stated, the counselor can mirror back what had been said in the session. In this context, mirroring back simply means repeating specific justifications the client expressed. Then, the counselor can ask the client how he feels about that now that he is not thinking in the heat of the moment. For example, the counselor might mirror the client's self-justification, and then ask the client about it as follows: "I just heard you say, 'This guy looks so healthy, he can't possibly be infected.' Thinking about that decision you made now, how factual or real do you think that is or what do you think about that now?"

Other ways to phrase it are:

What thoughts were in your mind at the time you decided to have UAI [use the client's language]?
[If the client responded, "If I asked him to put on a condom, he would think I was a cock tease and leave."

[Mirror the thoughts that appear to be self-justifications

So you were thinking, 'If I ask him to use a condom, it will stop the flow and we won't have sex.']

Important note: The counselor is never to use the term "self-justification" with the client. In the ***PCC*** session, the counselor should not tell the client his thinking is a self-justification; instead, gently challenge him to see the relationship between the thinking (self-justifications for the decision made) and having UAI. The main way is to mirror the self-justification he stated and let him know it was a decision he made. Below are some sample questions to draw out self-justifications.

Sample questions

What did you tell yourself that let you decide to have sex without a condom?

Did you have any thoughts that having unsafe sex this time was OK? What were they?

Did you notice any other connections between how you were thinking and the risk you took?

If the client seems unable to articulate any of his self-justifications, you can also refer back to the ***PCC*** *Questionnaire*, where the client checked off what he was thinking during the memorable UAI episode.

Before you move ahead to "gently challenging" the client's self-justifications, make sure you have a clear understanding of what the client's self-justifications were prior to sex that influenced his behavior.

Gently challenging

A "gentle challenge" is a diplomatic questioning of a client's self-justification, or an informative statement, usually followed by a question.

If the client said something like, "If I asked him to use a condom, he would think I have HIV and leave me", the counselor's response might be: "If you had asked him to use a condom, how likely is it that it would have ruined the sex that night?"

As you're thinking now about the possible decisions you could have made, I wonder if you thought about how it might be for you to potentially lose a sexual partner versus potentially becoming infected with HIV?

If the client's self-justification is "I can't get infected if I'm on top", the counselor could say, "Of course you're right—being a top is safer than being a bottom—but it's still risky. We've had people here who are tops find out they're HIV-positive. Have you ever felt some concern that you could get HIV while being a top?"

These gentle challenges can seem judgmental if made in a critical tone of voice. The counselor's voice, facial expression, and other body language need to show respect for the client as a thinking adult.

The following is an example from a ***PCC*** transcript. The client is talking about how he feels after reflecting on his UAI episode, about his on-line thinking at the time, and his off-line thinking during the ***PCC*** session. Now, the client is feeling ashamed (emphasis added below).

Counselor: OK. And how do you feel about it now?

Client: Oh my God. You know, for the first thing, I moved, I moved here about 13 years ago. And I was, I was always a pretty good kid. And all of my friends, well not all of my friends, but so many people I know have become infected that I should be smarter and I was smarter. And how do I feel about it now? Just that I'm, I'm an absolute idiot because, you know, I, I got to be, well, I was 34 the last time I was tested. And, you know, to be living here for that long a time, you know, it's, I don't want to say it's lucky because it's not really lucky. But it's an accomplishment. And, you know, I, I, before the summer came and I, I started, I did speed this summer, I knew the ramifications. I had done it, you know, 10 years ago for a while. I, I knew what it did to me. But when you're depressed a lot of times, you just don't care. You're depressed. And, you know at the time, at the time, I knew exactly what I was getting into. But I was depressed and I didn't care. And now that, you know, it's hindsight, *I'm looking back at it, I can believe I did it because I did it, but I feel shame. I feel shame talking to you right here*

about it. I think that's why I'm sweating so much. Yeah. I feel shame. And, I, I don't know how else to, to really explain it.

Building awareness

PCC helps clients build awareness of their internal processes and the link between these processes and their behavior. This is accomplished by identifying and discussing thoughts and feelings linked to the decision to have UAI.

Often the client will present his episode of UAI as something that "just happened" and distances himself from the act. The counselor's goal is to assist the client to become aware of the decision he made—even if he passively allowed it to happen—and assist him to see that he can choose to have more control over future situations. No change can occur without awareness that there is a need to change.

Self-challenging

Once the client has become aware of the link between his thoughts and his decision to engage in UAI, the counselor encourages the client to begin to challenge his own thoughts. For example, the client may recall a situation involving a partner he just met at a bar. The client may say, "He was so nice that I just couldn't imagine him putting me at risk of HIV infection by fucking me without a condom while knowing he had HIV." This is "on-line thinking." The counselor should encourage the client to self-challenge himself if this difference between his on-line thinking/self-justification and his off-line thinking occurs in the future. The client should ask himself: What was the rationale for reaching this conclusion? Do I really know this person? Is it possible that this person is unaware that he is infected?

Validating assumptions

A client may say he had UAI with a partner because "if I brought up the issue of condoms, my partner would reject me." While this assumption may be true, there is really no way to know without the client actually experiencing it. That is, the client needs to try bringing up the issue of condoms and seeing what really happens before discounting it as an option. The counselor should assist the client in understanding the importance of validating his assumptions.

Building awareness, *improving the clients ability to challenge his own thoughts, and validating assumptions* and *taking care of oneself* are ways of putting to use the ideas that 1) the client's thoughts, feelings, and attitudes are related to his behaviors, and 2) becoming aware of this connection will enable the client to challenge his own thinking in a future situation. This is accomplished by paying attention to self-justifications that lead to risk decision and plan to apply them the next time he is in an on-line state.

There is more information about these skills in the ***PCC*** Training of Counselors, and more can be provided through technical assistance and by consulting your supervisor.

Step 5. Talk About What the Client Will Do In the Future

Purpose

Mental rehearsal increases the likelihood that the client will put what he learned to use the next time he is in a potentially risky situation.

Skills

Instructing/directing; open-ended questions; prompting.

Procedure

In contrast to some other HIV prevention interventions, ***PCC*** does not end with developing a formal risk reduction plan. After the client has told his story, reflected on his thoughts and feelings, and talked about his self-justifications, the counselor asks the client what he thinks will happen in the future. The client should be encouraged to validate his assumptions and the counselor should support his constructive plans. In the re-telling and re-living of the high risk episode, the ***PCC*** session makes the link between the client's risk-justifying thoughts and his decision to have UAI. Because, in the ***PCC*** session, the client learned something about his decision-making process and re-experienced the anxiety associated with the risk of infection, he is able to remember these lessons when new sexual situations present themselves in the future. Armed by the ***PCC*** session with the knowledge of how his thinking is linked with his behavior, he is better able to make different, less risky sexual decisions in the future.

In Step 5, the counselor asks the client to reflect on the experience of telling the story and given the experience of the counseling session, how he might handle future sexual situations and then concludes the session. It is not critical that the client say the words, "Next time I'm going to use a condom or not have so much to drink." Often the client will in fact say such things, but in many of the sessions in our research studies, this kind of statement was not heard. Nevertheless, clients reduced their future high risk behavior.

While other interventions focus on developing a formal risk reduction plan, the key part of ***PCC*** is the middle two-thirds of the session in which the client goes through the experience of telling his story of a specific risky incident and re-experiences many of his feelings, thoughts and decisions associated with taking that risk. This makes a cognitive/emotional connection that has a lasting effect. ***PCC*** works by helping the client develop an understanding of the link between his thinking and his decision to engage in high risk behavior and his subsequent fear or anxiety about the possibility of infection. ***PCC*** does not really work by facilitating planning or eliciting promises to change. The client already knows how to protect himself. Once the client has reflected on how the way he thinks might lead him to have UAI and re-experienced some of the emotions involved, the session is essentially complete.

Here are some sample probes to help the client talk about what will happen in the future:

If you're in a similar situation again, how do you think you'll handle it?

Considering what we've been talking about, what thoughts do you have about what you'll do in the future?

When you're at the bar and in the mood to hook up with someone, what are the kinds of things you want to say to yourself?

Instead of "It won't matter if I don't use a condom this one time" [or whatever self-justification he used], what kinds of things could you say to yourself instead?

Here is an example of the counselor asking what the client thinks will happen in the future (Step 5).

Counselor: OK. And there's also a really sort of interesting part for me at least was that you had in the middle of the sex, when he first started topping you, that moment of, "Oh, well I don't have a condom. I don't know if I want to be doing this," and stuff along those lines. But then I think you had said that you just, you were like it's already happening, I might as, and it feels really good and I might as well just go with it. Do you feel like if you had a situation like this again in the future, you know, really hot Latin guy and, you know, all of these factors sort of coming into play again, do you feel like it would play out the same way for you?

Client: Probably not.

Counselor: No? How would it play out for you do you think?

Client: Well, I think I would be prepared. I would bring a condom with me if that was going to happen.

Here is another excerpt from a ***PCC*** transcript in which the counselor asks about the future:

Counselor: And so looking sort of toward the future for you, what do you, do you feel like if a situation like that came up again where for whatever reason crystal came into the picture again and stuff along those lines, do you think it would play out the same for you?

Client: My body can't even tolerate it. My body just hates it so much—

Counselor: Yeah.

Client: —that, you know, I refused it so many times, you know, not so many times, but enough times that I'm, I used to never be able to say no, you know, you're, I don't want to say a kid, but you know, I used to be younger. I'd be like, "Yeah, OK." You know? What do you care? You know? You're getting high. But, you know, there's things my body, I'm getting old and my body, I can't, my body can't tolerate it. My skin just gets wrecked. And with all of the, with all of the, the, with all of the positive feelings that go along, especially with speed, it's such a negative come down. It's so self-loathing afterwards and so, and so negative that at least for a while, I mean I don't even think I have to, to worry about speed coming back into the picture. What I worry about is two or three years from now when I remember, you know, how much fun it was or forget about how much my body hates it. But, but I don't, I don't even worry about it coming back into the picture right now. I mean it, it literally just, it tore my body apart. Because it was nasty, nasty stuff.

Counselor: Yeah.

Client: But based on, you know, prior history, I can see, I can see myself, yeah, in two or three years possibly having different thoughts. But in the short term, right now, no.

Counselor: OK.

Client: It doesn't really, doesn't really worry me if it came into the situation because it's, the negative effects are too fresh in my memory now to even, want to even think about it.

Counselor: OK. And so even without the crystal, if you find yourself in a position where you're having that desire to go out and go to like a sex club and get your groove on as it were—

Client: As it were.

Counselor: [Laughter]

Client: [Laughter] Bless you.

Counselor: Do you feel like you would want to do it unprotected again or do you feel like because the crystal's been not there anymore that that sort of has changed for you?

Client: It changes for you. It does. God. The only time, see the thing is I have no problems finding partners or, or people. I don't need to go to the sex club but when I'm on drugs, it's the only thing I can think about. I mean the only time I go to sex clubs is when I'm on, when I'm on speed.

Counselor: OK.

Client: So I go out to bars and I hang out with my friends and, you know, you pick up people here and there. But like being in that same sort of environment again, right now I don't see that happening.

Closing summary

To close the session, the counselor summarizes what the client has done in the ***PCC*** session and supports any constructive plans for the future.

Sample closing

> **Well, thanks for coming in and sharing your experience with me. I hope you've found it useful to talk about how you were feeling and what you were thinking when you made the decision to have unprotected anal intercourse [use the client's terminology]. It sounds to me like you've really looked at how your thoughts and feelings influenced your sexual decisions, and found some ways to think differently to protect yourself—and enjoy a satisfying and less-worrying sex life.**

The following is an example of an actual closing summary from the transcript of a ***PCC*** session from the original research. This transcript demonstrates how to support the client's continued efforts to minimize risk:

Counselor: You know, in general, it sounds like your risk assessment process is really good. You're putting a lot of thought into it. And as long as you're thinking about it clearly, and talking about it with your partners … you know, that's the most important part. You can't guarantee yourself safety for the rest of your life. But you can do whatever you need to, to minimize your risk. And it sounds like you're doing a really good job of that, so … I support you in that, and urge you to continue.

Maintenance

Introduction to Maintenance

After you start implementing ***PCC***, maintaining it requires ongoing efforts including training, supervision, and quality assurance. These are described in the following pages. Tools for monitoring fidelity and client satisfaction—both important parts of quality assurance—are also provided.

Maintenance

Once ***PCC*** has been successfully implemented, your agency will need to support and maintain the intervention to keep it going and make it standard practice. Some ongoing efforts to consider in order to maintain ***PCC*** include:

Staff recruitment

Trained staff may leave the agency or change positions. You should have a plan in place to recruit appropriate staff as staff turnover. This will help maintain ***PCC*** implementation.

Training plan

In addition, a plan for ongoing training of existing ***PCC*** staff and training of new replacement staff will be necessary to ensure continuation of ***PCC*** in the agency.

Clinical supervision

It will also be necessary to maintain ***PCC*** clinical supervision of ***PCC*** counseling staff in order to maintain the intervention'. As detailed earlier in *Staff Qualifications, Roles, and Responsibilities* (page 42), this means allocating time for supervision, as well as training the supervisor. This also includes recruiting and training new supervisors as clinical supervision staff leave or change positions.

Quality assurance

Utilizing the QA tools and procedures in this manual (starting on the next page) will also help to maintain ***PCC***.

Funding

Ongoing funding development efforts may need to be incorporated into organizational plans in order to support and maintain ***PCC*** counseling staff, clinical supervision, and other time and space requirements.

Adopt *PCC*

Adopting ***PCC*** as part of the culture of the organization and establishing it as one of the program services that the agency provides will ensure that ***PCC*** is maintained. If ***PCC*** is required as part of the counseling protocol for appropriate clients, then the organization will allocate time, space, staff, and training and budget to carry out this program component.

Quality Assurance Procedures

Clinical Supervision

As noted earlier (pages 42-43), clinical supervision can include discussion of issues raised in ***PCC*** sessions, reviewing session recordings, reviewing the ***PCC*** *Steps Checklist*, reviewing returned *Satisfaction Questionnaires*, aiding counselors to understand and deal with feelings raised by ***PCC*** sessions, and providing feedback and advice to optimize service fidelity and quality.

Clinical supervisors can monitor counselors' ***PCC*** sessions in regular individual or group supervision meetings, by telephone, or live video-cam sessions. The sessions can also be reviewed in case conferences. One option for monitoring sessions is audio recording. Clients must give consent for sessions to be recorded and be informed that the recordings will only be used for supervision and then erased. Clinical supervision can also use the ***PCC*** *Steps Checklist* and the ***PCC*** *Satisfaction Questionnaire* (below) as tools to monitor sessions.

Tools to Monitor Adherence and Client Satisfaction

The ***PCC*** *Steps Checklist* and the ***PCC*** *Satisfaction Questionnaire* are provided as tools that can be used in clinical supervision and case conferencing to monitor adherence to the Core Elements and client satisfaction with the ***PCC*** intervention.

PCC Steps Checklist

The ***PCC*** *Steps Checklist* (page 93) is to be completed by the counselor after a ***PCC*** session. It specifies each step of the ***PCC*** process and provides check boxes to indicate which steps were completed. There is space provided for counselor's comments under each step. Noting these comments provides helpful information during the counseling process, such as specific issues or difficulties in completing the step that are relevant to understanding what happened with the client. There is also an area at the bottom of the checklist for any additional counselor notes (i.e., referrals made, testing issues, problems handling the client, counselor's management issues, etc.). It is not necessary to write the client's name anywhere on the checklist.

It is recommended that the *Checklist* be used as a training tool for the counselor's first ten ***PCC*** sessions. As a QA tool, the *Checklist* should be used after every fourth session, or more often at the discretion of the implementing agency.

PCC Satisfaction Questionnaire

The ***PCC*** *Satisfaction Questionnaire* (page 94) is a tool to determine client's satisfaction with the counseling session. Clients are asked to rate their experience in the session on:

- Quality of service provided by the counselor
- Counselor's competency during the session
- Satisfaction with the help received

- Dealing with identified problems
- Learning something new
- Causing any mental stress
- Effect on future engagement in UAI

Each client that completes a ***PCC*** session should complete the ***PCC*** *Satisfaction Questionnaire*. The questionnaire is completed anonymously. The client can complete the questionnaire and place it through a slot in a box in the lobby, or the questionnaire can be handed out with a stamped return envelope so the client can complete the questionnaire away from the program site and mail it back to the agency.

PCC Steps Checklist

Counselor Name: _____ Date of Session: _____

Client eligibility for ***PCC***:

___ MSM
___ previously tested for HIV
___ result showed seronegative on that test
___ knows unprotected anal intercourse is risky
___ engaged in unprotected anal intercourse since last test
___ with a male who was a non-primary partner
___ whose HIV status was unknown or positive

***PCC* STEP**	**Step completed?**	
	YES	**NO**
1. Choose memorable recent episode of UAI **Comments**:		
2. Complete ***PCC*** *Questionnaire* **Comments**:		
3. Draw out the story of the UAI; ask about thoughts and feelings before, during, and after **Comments**:		
4. Identify self-justifications and discuss them **Comments**:		
5. Talk about what the client will do in the future **Comments**:		

Additional comments:

_____

_____

_____

PCC Satisfaction Questionnaire

We would like to know about your recent counseling session with us. We want to know if it was helpful for you, and how we might improve our service. Please circle your answers–only one number for each question. Do NOT write your name on the form.

1. How would you rate the quality of the service you have received from your counselor?

1	2	3	4
Excellent	Good	Fair	Poor

2. How competent was your counselor?

1	2	3	4
Highly competent	Competent	Somewhat competent	Not at all competent

3. How interested was your counselor in helping you?

1	2	3	4
Very interested	Interested	Uninterested	Very uninterested

4. How satisfied are you with the help you have received from your counselor?

1	2	3	4
Very satisfied	Satisfied	Somewhat dissatisfied	Very dissatisfied

5. Would you recommend our program to a friend with similar concerns?

1	2	3	4
Yes, definitely	Yes, probably	Probably not	Definitely not

6. How much did your participation in the counseling session result in your changing some risk-related thoughts, beliefs, or attitudes?

1	2	3	4
A great deal of change	A lot of change	Some change	No change

7. Did your participation in the counseling session result in your having a plan for thinking and behaving more safely in future situations?

1	2	3
Yes	Sort of	No

8. Did your participation in your counseling session cause you any particular mental stress?

1	2	3	4
No stress	Some stress	Moderate stress	Considerable stress

9. Will your participation in the counseling affect your likelihood of engaging in unprotected anal sex in the future?

1	2	3	4
Made it almost impossible that I will engage in unprotected anal sex in the future	Made it a lot less likely	Made it a bit less likely	Made no difference

10. How old are you? Please check one:

__18 or less __19 to 30 __31 to 40 __41 to 50 __51 to 60 __ Over 60

11a. What is your ethnicity (select one)**?** __Hispanic or Latino __Not Hispanic or Latino

11b. What is your racial background (select one or more)**?**

__American Indian or Alaskan Native __Asian __Black or African American

__Native Hawaiian or other Pacific Islander __White

Comments or suggestions_____

_____

_____

_____

Thank you very much for your ratings and comments!

Please place your survey in the box in the lobby or return it in the supplied stamped envelope.

APPENDICES

Appendix 1: Original Research Articles

JAIDS Journal of Acquired Immune Deficiency Syndromes
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Changing Sexual Behavior Among Gay Male Repeat Testers for HIV

A Randomized, Controlled Trial of a Single-Session Intervention

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Context: High-risk sexual behavior is increasingly prevalent among men who have sex with men (MSM) and among men with a history of repeat testing for HIV.

Objectives: The study assessed whether one counseling intervention session focusing on self-justifications (thoughts, attitudes, or beliefs that allow the participant to engage in high-risk sexual behaviors) at most recent unprotected anal intercourse (UAI) is effective in reducing future high-risk behaviors among HIV-negative men.

Design, Setting, and Participants: A randomized, controlled, counseling intervention trial was conducted at an anonymous testing site in San Francisco, California, between May 1997 and January 2000. Participants were 248 MSM with a history of at least one previous negative HIV test result and self-reported UAI (receptive or insertive) in the previous 12 months with partners of unknown or discordant HIV status. Two intervention groups received standard HIV test counseling plus a cognitive-behavioral intervention, and two control groups received only standard HIV test counseling. Follow-up evaluation was at 6 and 12 months.

Main Outcome Measure: Number of episodes of UAI with nonprimary partners (of unknown or discordant HIV status) in the 90 days preceding the interview was measured via self-report during face-to-face interview.

Results: A novel counseling intervention focusing on self-justifications significantly decreased the proportion of participants reporting UAI with nonprimary partners of unknown or discordant HIV status at 6 and 12 months (from 66% to 21% at 6 months and to 26% at 12 months, $p = .002$; $p < .001$) as compared with a control group when added to standard client-centered HIV counseling and testing.

Conclusions: A specific, single-session counseling intervention focusing on a reevaluation of a person's self-justifications operant during a recent occasion of high-risk behavior may prove useful in decreasing individual risk behavior and thus limiting community-level HIV transmission.

Key Words: Homosexual men—Prevention of sexual transmission—Psychiatry/neuropsychological/psychosocial—Sexual behavior.

Despite marked decrease in risk for HIV among men who have sex with men (MSM) during the 1980s (1–3), recent evidence is mounting that unsafe sexual behavior is increasing among MSM in the United States, Australia, and Europe (4–8). In an era of effective antiretroviral therapies, concern about HIV infection appears to be decreasing (9–14). These developments speak to an urgent need for new approaches to HIV prevention.

Entering the third decade of the AIDS epidemic, standard HIV counseling and testing may not serve the pre-

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vention needs of MSM who have already tested several times (15–21). In London, for example, MSM who had been tested three or more times reported more unprotected sex than MSM testing fewer times (18). Similar data from San Francisco's anonymous counseling and testing centers confirm that many repeat testers continue to engage in high-risk activity, and MSM with a history of three or more previous tests had an incidence of HIV nearly three times that of MSM with a history of one or two previous tests (19). Experience in San Francisco also suggests that repeat testers frequently refuse referrals to additional prevention services and, by virtue of their continued risk behavior, do not appear to respond well to the prevention messages provided through the standard client-centered counseling associated with HIV testing (19). Clearly, a new intervention is needed that can be applied at the time MSM seek repeat testing.

Based on the work of Gold et al. (22–27), we developed a novel intervention: a one-time counseling session for MSM seeking repeat HIV testing after a period of high-risk sexual behavior. Gold et al. hypothesized that the decision to engage in high-risk sex is "allowed" to happen when the person "rationalizes" the potential risk through "self-talk" that minimizes the known risk. He and his colleagues subsequently identified several "self-justifications" (thoughts, beliefs, and attitudes toward risk taking) that were associated with a person's decision to engage in high-risk sex and that occur during a state of "on-line" thinking, moments when the person had limited capacity to assess risk because of the frenzy of sexual excitement. They also suggested that by assessing risk in an "off-line" or unaroused state, the person might appraise the risk differently. Identifying, modifying, or extinguishing a person's self-justifications in the off-line state may help prevent future unsafe behavior in the on-line state. This approach is similar to that of cognitive therapists who describe "self-statements" or "internal dialogue" as being causally related to unwanted behavior and amenable to intervention (28,29).

Gold et al. (27) tested their approach in a controlled trial. MSM who had recent unprotected anal intercourse (UAI) were asked to keep diaries of their sexual behaviors. After 4 weeks, men were randomized to one of three study arms: 1) a self-justification intervention plus diary; 2) observing safe-sex posters used in AIDS education programs plus diary; and 3) a control group completing only the diary. The self-justification intervention asked men to recall their thoughts at the time they decided to have UAI and to identify the self-justifications used from a list provided. Then they were asked to reflect on how reasonable each self-justification seemed in retrospect. After a 16-week intervention period, the self-justification intervention group was less likely to have had multiple episodes of UAI than the other two study arms as measured by data recorded in the diary.

We adapted this approach to fit the setting of a large HIV counseling and testing program in San Francisco by designing a face-to-face intervention for MSM repeat testers of negative or unknown status, as an addition to standard HIV counseling. A team of trained mental health professionals created a personalized counseling session that focused on identifying and reexamining self-justifications among MSM who reported recent risky UAI and who reported previously undergoing standard HIV counseling and testing. To rigorously evaluate the intervention, we conducted a longitudinal, randomized, controlled trial. Results from baseline, 6-month, and 12-month follow-up evaluations are reported here.

METHODS

Sample Selection and Study Design

The study was conducted between May 1997 and March 2000 among MSM voluntarily attending an anonymous HIV-testing clinic in San Francisco, California. Eligible participants were self-described high-risk MSM aged 18 to 49 years, with a history of at least one previous HIV-negative antibody test 6 months ago or more. "High risk" was defined as any UAI (receptive or insertive) in the past 12 months with a man of unknown or discordant HIV status. Those who reported any intravenous drug use during the previous 12 months were excluded because the measures validated by Gold et al. and used in the current study focus entirely on sexual behavior, and no similar measures exist that address thoughts associated with needle risk behavior. A sample size of 456 subjects was selected based on achieving 80% power to detect a 25% decrease in UAI at a significance level of $p = .0125$, and all participants gave written, informed consent. The study protocol was approved and monitored by the Institutional Review Board of the University of California-San Francisco.

Potential participants were screened for eligibility when they telephoned to schedule an appointment for an anonymous HIV antibody test. Of 3721 calls from self-identified MSM during the study period, 573 (15%) were from MSM initially determined to be eligible for the study. The remaining 3148 were ineligible because they failed to meet one or more of the study criteria. Of the 573 eligible men, 248 (43%) consented to participate; 7 were later excluded when they received a positive HIV test result at baseline. Those eligible who refused participation did not differ from those who agreed to participate in terms of race, age, or HIV serostatus. On arrival at the clinic for standard HIV counseling and testing, the study interviewer obtained the client's written informed consent, randomly assigned the client to one of four study arms, and administered the baseline questionnaire. All study participants received standard HIV counseling and testing, regardless of study arm assigned. Participants were randomly assigned to one of four groups: group A1 received standard HIV counseling only (control group); group A2 received standard counseling plus a sexual diary; group B1 received standard counseling plus a one-time intervention counseling targeting self-justifications; and group B2 received standard counseling, intervention counseling, and the sexual diary. The content of the intervention counseling is described below. The primary out-

come measure was individual change in UAI with nonprimary partners of unknown or discordant HIV status in the 90 days preceding the interview as measured via self-report in a face-to-face interview. All groups were reassessed at 6- and 12-month follow-up evaluations.

Diary Keeping

Participants assigned to groups A2 and B2 were asked to keep a 90-day sexual diary identifying the kinds of sex engaged in, condom use, their relationship to the sex partner, and the sex partner's HIV serostatus. The diary condition was added because Gold et al. used a diary to collect the outcome measure in their original study and because the diary itself may have served as an intervention and potentiated the effect of the self-justification–based counseling intervention. To assess the impact of the diary on standard and intervention counseling, the intervention and control conditions were further subdivided into diary and nondiary conditions. The diary was not used to collect primary study outcome measures (as in Gold et al. (27)) because it was not used in groups A1 and B1; rather, self-reported UAI (as collected via face-to-face interview) was used, thus enabling intergroup comparisons across all conditions.

Randomization

Before initiating data collection, opaque envelopes were prepared, each with one group assignment inside. To ensure equal distribution of counseling sessions across the study timeline, packets of four envelopes were assembled to contain one envelope from each of the four assignments, then each packet of four was shuffled. The first participant drew an envelope with his assignment from the first packet of four, and the next three successive participants drew from the same packet until it was exhausted. The last of four men simply received the remaining envelope. It was not possible to systematically blind interviewers from group assignment information because the self-justification counseling was only administered to the two intervention groups (B1 and B2) at baseline.

Measures

Demographic characteristics, measures of socioeconomic status, testing history, and measures of HIV risk were collected at baseline and are summarized in Table 1. HIV risk-related behavior was measured again at 6- and 12-month follow-up evaluation. For each recent sex partner, subjects were asked frequency of anal sex, condom use with that partner, partner's HIV testing history, partner's HIV serostatus, and relationship status (primary vs. nonprimary). From these measures, subjects were assessed for any UAI in the preceding 90 days with a man who was not his primary partner (i.e., the partner with whom they had sex the most) and of unknown or discordant HIV status. This measure was selected as the primary outcome because it most closely corresponded to the focus of the intervention (i.e., prevention of events where the subject knowingly places himself at high risk for HIV) and avoided the likely confounding affects that the relationship dynamics of regular partners may have introduced into the participants' cognitions.

A self-justifications questionnaire was constructed based on an instrument used by Gold et al. (originally used among MSM in Sydney, Australia, and administered to subjects in groups B1 and B2 at the end of the assessment interview). The original instrument presented a list of possible self-justifications for having anal intercourse without a condom. For each self-justification, the participant rated how strongly the thought had occurred to him the most recent time he had UAI with a male partner of unknown or discordant HIV status. The rating was based on a Likert-like scale where 1 = "had thought strongly," 2 = "had thought moderately," 3 = "had thought slightly," and 4 = "didn't have thought." The response "can't remember at all" was also offered for each self-justification. We modified the self-justifications to reflect American English and incorporated terms in common usage by the local gay community. New questions were added to address current issues. For example, the availability of new antiretroviral treatments was offered as an additional self-justification, e.g., "I'm not too concerned about being infected with HIV because the new treatments (protease inhibitors, the "cocktail") make HIV a manageable disease." After pilot testing the adapted instrument with 40 MSM seeking anonymous counseling and testing, items were added, and further revisions were made to item wording. The final questionnaire included 102 potential self-justifications for UAI.

Interventions

All participants received standard counseling associated with HIV testing according to the usual practices of the testing center and in accord with US federal guidelines (30). This encounter included an inventory of reasons for testing, current HIV status, testing history, current risk factors, proposed areas for behavior modification, and means to stay safe until returning the following week for results. Persons in group A1 received no further intervention. Persons in group A2 were additionally asked to keep the sexual diary for 90 days. Persons in groups B1 and B2 completed the self-justifications questionnaire and were scheduled for their intervention counseling session, approximately 5 to 9 days hence. Persons in group B2 were additionally instructed to keep the 90-day sexual diary.

Intervention Counseling

Persons randomized to groups B1 and B2 were scheduled for the intervention counseling session during the 1- to 2-week period between their risk assessment and blood draw ("pretest counseling") and their results-disclosure session ("posttest counseling"). Counselors conducting the intervention were licensed mental health professionals who had been trained in the intervention and had regular supervision of one of the investigators. Audiotapes of the pilot sessions were transcribed and reviewed for adherence to protocol by two investigators. During the main study, counseling sessions were taped for supervision and quality assurance. Fifty-four counseling sessions were transcribed and reviewed; consistency, completeness, and adherence to clinical standards were determined to be acceptable in pilot and main study oversight.

The intervention counseling was one face-to-face session lasting approximately 1 hour. In advance of the session, the counselor received a summary of the subject's responses to the self-justifications questionnaire. The intervention counseling session was organized into four parts: Introduction, Recent Story, Critical Examination, and Closure. During the Introduction, participants were told what to expect during the session, including that the goal was to help the client continue to have the most satisfying sexual life possible while helping him decrease or eliminate unsafe behaviors. During the Recent Story component of the session, the client was instructed to talk about his most recent episode of UAI with a man of unknown or discordant HIV status. He was encouraged to tell the story with as much detail as possible, relating the full context of the encounter, beginning with the day of the episode, and then walking through each step of the encounter. He was also instructed to relate the objective events and the exact thoughts, feelings, attitudes, or ideas that were present in his mind at

TABLE 1. *Demographic characteristics and HIV risk-related factors at enrollment*

Variable	Did not receive counseling intervention (A1, A2) *N* (%) or median	Received counseling intervention (B1, B2) *N* (%) or median	p value[a]
Age in years	32.6	32.7	0.912
Race/ethnicity			0.503
White	90 (72.6)	94 (75.8)	
Asian/Pacific Islander	7 (5.6)	8 (6.5)	
African American	4 (3.2)	4 (3.2)	
Latino	13 (10.5)	14 (11.3)	
Other	10 (8.0)	4 (3.2)	
Annual income			0.769
<$15,000	13 (10.6)	17 (13.8)	
$15,000–$29,999	32 (26.0)	36 (29.3)	
$30,000–$44,999	46 (37.4)	34 (27.6)	
$45,000–$59,999	18 (14.6)	15 (12.2)	
$60,000–$74,999	6 (4.9)	8 (6.5)	
$75,000–$89,999	3 (2.4)	6 (4.9)	
>=$90,000	5 (4.1)	7 (5.7)	
Education			0.748
No degree	1 (0.8)	0 (0.0)	
High school/GED	26 (21.1)	31 (25.0)	
Associate	18 (14.6)	17 (13.7)	
Bachelors	54 (43.9)	52 (41.9)	
Masters	22 (17.9)	22 (17.7)	
Doctoral	2 (1.6)	2 (1.6)	
HIV-positive at baseline	3 (2.4)	4 (3.2)	1.000
Times tested previously, *n*	6	6	0.684
Lifetime anal sex partners, *n*	25	25	0.958
Anal sex partners, last 12 mo, *n*	5	5	0.409
Unprotected anal sex acts, last 90 days, *n*			
All partners	2	2	0.646
Primary partner	0	0	0.469
Other partners	1	1	0.075
Primary partner HIV-positive	20 (16.1)	13 (10.5)	0.191
Other partner HIV-positive	34 (27.4)	42 (33.4)	0.271
History of gonorrhea			
Ever	31 (25.0)	36 (29.5)	0.427
Last 12 mo	6 (4.8)	13 (10.8)	0.095
History of any STD			
Ever	56 (45.2)	59 (47.6)	0.702
Last 12 mo	14 (11.3)	24 (19.4)	0.078

[a] χ^2 test for differences in proportions; Wilcoxon rank sum test for continuous variables and ordered categories. Totals for categories do not always add up to 124 as a result of missing data.

each step, paying closest attention to the moments leading up to the high-risk activity. In preparation for the Critical Examination, the counselor made note of any self-justifications identified during the story that were not on the client's summary of endorsed items from the self-justification questionnaire. As part of the review, the client and counselor critically examined the self-justifications in the off-line state. Together, the counselor and participant reassessed these ideas and discussed the differences between the participant's on-line and off-line perceptions of risk. Agreements were often made about how the participant might manage such situations differently in the future. During the Closure phase of the intervention, the counselor asked the participant to talk about his feelings and his satisfaction with the session.

Main Study Outcome

The primary study outcome was any UAI in the 90 days preceding the interview with any nonprimary partner of unknown or discordant HIV status, as collected by self-report during the face-to-face interview.

Incentives

Participants were paid $15 for completing the baseline interview, $20 for the 6-month visit, and $25 for the 12-month visit. In addition, those participants randomized to the counseling intervention were given a supplementary $20 for the counseling session, and those randomized to one of the diary conditions received $13 for returning the diary and $.50 for each of the 90 days that contained a diary entry.

Data Analysis

The impact of the interventions was compared across study arms using a generalized linear model with a binomial distribution family and identity link in Stata software. The primary outcome was binary, defined as engaging in any UAI with a nonprimary partner of unknown or discordant HIV status in the preceding 90 days. Primary effects of the intervention arms (A2, B1, B2) are modeled as the additional decrease in probability of engaging in UAI over the effect of standard counseling (A1) at 6- and 12-month follow-up evaluation.

A second set of analyses assessed the decrease in the number of episodes of UAI. Because of the nonnormal distribution, episodes of UAI were compared using nonparametric statistical tests. Decreases in episodes of UAI were first assessed for persons in each study arm from baseline to 6 months and baseline to 12 months using the Wilcoxon sign rank test for matched pairs. To compare decreases in UAI among the four study arms, subjects were scored according to how many more (+) or fewer (−) episodes of UAI they reported at baseline compared with at follow-up evaluation. The Kruskal-Wallis test was used to assess whether scores differed significantly between the four study arms. Post hoc pair-wise analyses were conducted comparing scores of persons in the standard counseling arm (A1) with each of the three intervention arms (A2, B1, and B2) using the Wilcoxon rank sum test.

RESULTS

Sample at Each Stage

Two hundred forty-eight subjects were enrolled and randomized into one of the four study arms. The majority of the sample was white, had an annual income more than $30,000, and held a college degree. Median age was 33 years. Participants reported a median of six previous HIV tests, a median of 5 anal sex partners in the past 12 months, and a median of 2 anal sex partners in the past 90 days. Table 1 displays baseline demographic and HIV risk-related behavior of participants, comparing those randomized to intervention counseling (B1 and B2, $n = 124$) with those not receiving the intervention counseling (A1 and A2, $n = 124$). There were no significant intergroup differences in demographic characteristics or HIV risk-related behavior histories at baseline. However, history of any STD in the past 12 months at baseline was borderline significant by intervention type ($p < .08$), with the self-justification counseling arms having had a higher absolute number of participants with history of STD than the standard counseling arms (24 vs. 14, respectively).

Compliance to assigned protocol activities was high in all study arms. All 248 participants completed standard client-centered counseling associated with HIV testing. All but 4 of the 124 participants randomized to receive intervention counseling (B1 and B2) completed the session. Of persons randomized to the diary groups, 77% completed all 90 daily diary pages in group A2 (standard counseling), whereas 61% completed all pages in group B2 (intervention counseling). Figure 1 illustrates retention rates by study arm. Overall retention at 6 and 12 months was 87% and 83%, respectively. Of note, 6-month follow-up retention was lower for group B2 (intervention counseling plus diary, 77%) compared with other groups ($p = .045$). By 12 months, this difference was no longer significant ($p = .094$).

Self-Justifications

Participant ratings of the inventory of 102 potential self-justifications at the time of most recent UAI with a nonprimary partner were tabulated, and the 10 most common responses are presented in Table 2 (31). Figure 2 illustrates the proportion of subjects reporting any UAI with nonprimary partners of unknown or discordant HIV status in the preceding 90 days, as reported at baseline, 6 months, and 12 months by study arm. Although statistical analyses were conducted on the personal level behavior change, the figure provides an aggregate view of behavior change for the four study arms. Of note, somewhat fewer participants randomized to control group A1 (standard counseling, no diary) reported UAI (45%)

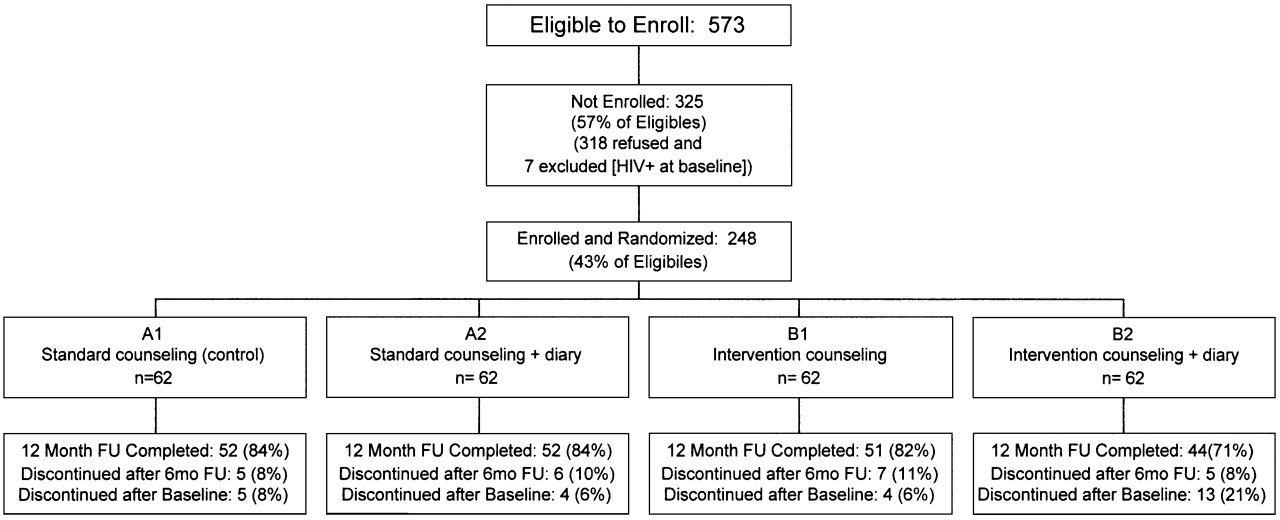

FIG. 1. Flow of subject participation.

TABLE 2. *Most frequently endorsed self-justification (N = 124)*[a]

Rank	At the time I decided to fuck without a condom, I thought to myself something like. . .	% agreeing at least slightly
1	I want to have unprotected sex because it feels good.	75.8
2	Most of the time I am careful, but I can't be perfect—it's only human to slip up occasionally.	58.5
3	It'll be safe to fuck without a condom, so long as we don't cum in the ass. So, we'll just fuck without cumming.	58.1
4	We take chances every day—after all, it's even taking a chance to cross a road. Taking a risk is a part of life.	57.3
5	I didn't want to fuck without a condom but I was so horny I couldn't think properly.	57.3
6	If I'm on top—the one doing the fucking—my chances of getting infected are low. He's the one at risk, so that's his problem, not mine.	53.2
7	Condoms destroy the magic of sex. How can we suddenly interrupt everything just to put on a condom?	46.0
8	I want to feel what it was like when you could do what you liked sexually, as it was before AIDS.	43.1
9	If this guy was really infected, he's be a lot more careful about taking a risk than he's being now. The fact that he is willing to fuck without a condom means he can't be infected.	42.7
10	This guy looks so healthy, he can't possibly be infected.	42.7

[a] Only Groups B1 and B2 completed this questionnaire.

within the preceding 90 days at baseline compared with participants randomized to the other groups (61%, 66%, 61% for A2, B1, B2, respectively; $p = .098$).

Change in UAI Behavior at Follow-Up Evaluation

At 6-month postintervention evaluation, the proportion of subjects reporting UAI decreased in all four groups. Among subjects in the standard counseling control group (A1), UAI decreased from 45% at baseline to 31% at 6 months—an absolute decrease of 14% and a relative decrease of 31% ($p = .086$). Among men in the self-justifications counseling arm (B1), the change in percentage reporting UAI decreased from 66% at baseline to 21% after 6 months. The absolute decrease in UAI of 45% (relative decrease of 69%) in the self-justifications counseling group (B1) exceeded that of the standard counseling group (A1) by 31% ($p = .002$). Similarly, the 36% absolute decrease (59% relative decrease) in UAI among subjects in the combined diary plus self-justifications group (B2) exceeded the decrease in the control group (A1) by 22% ($p = .041$). However, the additional 7% decrease in UAI among men in the diary group (A2) over the control group (A1) was not significant ($p = .472$).

By 12 months, UAI was only 1% (2% relative decrease) below the baseline proportion (44% vs. 45%, $p = .856$) among subjects in the standard counseling group (A1). The additional decrease in UAI among the three intervention groups was significant: 26% (43% relative decrease from baseline) for the diary group (A2; $p = .013$), 40% (61% relative decrease from baseline) for the self-justifications counseling group (B1; $p < .001$), and 28% (46% relative decrease from baseline) for the combined intervention group (B2; $p = .031$). Of note, B1 and B2 showed slight, but not significant, *increases* in UAI from 6-month to 12-month evaluations, i.e., 12 months later UAI remained *lower* than baseline.

Table 3 shows the mean decrease in episodes of UAI for participants in each study arm from baseline to 6 months and from baseline to 12 months. The mean de-

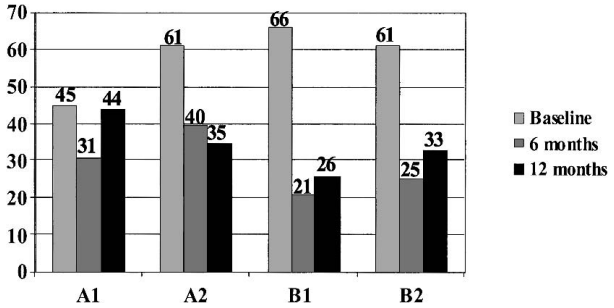

FIG. 2. Proportion of subjects reporting unprotected anal intercourse with nonprimary partners of unknown or discordant HIV status in the preceding 90 days by study arm at baseline, 6 months, and 12 months. A1, standard counseling (control); A2, standard counseling + diary; B1, intervention counseling; B2, intervention counseling + diary.

TABLE 3. *Change in episodes of unprotected anal intercourse (UAI) with nonprimary partners of unknown or discordant HIV status in the preceding 90 days within and among the four study arms*

Group	Mean[a] change in episodes of UAI, baseline to 6 months	Mean[a] change in episodes of UAI, baseline to 12 months
A1: Control	−0.50	−0.15
A2: Dairy	−0.50[b]	−1.50[c]
B1: Intervention counseling	−3.20[c]	−2.90[c]
B2: Intervention counseling and dairy	−2.50[b]	−2.90[b]
Kruskal-Wallis test, p value	0.048	0.007

[a] Means are presented to illustrate differences; however, statistical analyses were nonparametric due to the nonnormal distribution.
[b] $p < .05$, Wilcoxon signed rank test for matched pairs.
[c] $p < .001$, Wilcoxon signed rank test for matched pairs.
UAI, unprotected anal intercourse.

crease in UAI for participants in the control group (A1) was .5 episodes from baseline to 6 months and only .15 episodes from baseline to 12 months. These decreases were not statistically significant. In contrast, participants in all other groups significantly decreased their episodes of UAI from baseline to 6 months and from baseline to 12 months. The decrease was greatest among participants in group B1, with 3.2 fewer episodes of UAI on average at 6 months. At 12 months, groups B1 and B2 reported 2.9 fewer episodes.

The Kruskal-Wallis test indicated that decreases in episodes of UAI were significantly different across intervention arms at 6 months ($p = .048$) and 12 months ($p = .007$). Post-hoc pair-wise tests found that only group B1 (intervention counseling, no diary) differed significantly from control group A1 (standard counseling, no diary; $p = .008$) at 6 months. At 12 months, groups A2 (standard counseling, diary), B1 (intervention counseling, no diary), and B2 (intervention counseling, diary) all differed significantly from the control group A1 (standard counseling, no diary; $p = .006$, .001, and .047, respectively).

We also tested whether the interventions operated differently for men who reported UAI versus no UAI at baseline. We examined whether the interventions were more successful in decreasing high-risk behavior or in maintaining safe-sex behavior. In separate generalized linear models that stratified on baseline risk, baseline UAI was a significant predictor of follow-up UAI, i.e., the probability that UAI at follow-up evaluation was higher for subjects reporting UAI at baseline. Nonetheless, the self-justifications counseling intervention still significantly decreased UAI over that of the control group at 6 and 12 months ($p = .002$ and .008, respectively), even after controlling for baseline UAI. Moreover, assessment of the interaction between baseline risk and the self-justification counseling intervention indicates that the effect is similar for men who reported or did not report baseline UAI. In other words, the data support a decrease in UAI and maintenance of safer sex by the self-justification counseling intervention. Of note, the diary intervention had no significant effect on follow-up UAI after controlling for baseline UAI ($p = .637$ and .109 at 6 and 12 months, respectively).

DISCUSSION

Three prevention strategies significantly decreased risky UAI among MSM, when added to standard client-centered HIV counseling and testing: a 90-day sexual diary, a novel counseling session focusing on self-justifications for UAI, or both. Further, the prevention effects of these three interventions persisted to 12 months. In contrast, standard counseling alone appeared to have, at best, only a small, short-term primary prevention effect in this population of MSM who have tested several times previously.

The self-justification counseling strategy has strong, practical appeal. First, it can be implemented as one session between pretest and posttest counseling. Second, the magnitude of the prevention effect, roughly decreasing UAI with partners of unknown or discordant HIV status by three episodes per 90-day period, may produce substantial decreases in personal risk for HIV acquisition and thus limiting the community-level longevity of the epidemic. For example, one model among MSM found that the addition of only one unsafe partner per year would be sufficient to reverse the decreasing epidemic of the 1980s (32). Although the sexual diary also had a significant prevention effect, presumably by focusing attention on daily behavior for a 90-day period, the mean decrease in episodes of UAI at 12 months was half that of the self-justification counseling intervention. Moreover, the time required to complete the 90-day diary is greater, and compliance with the diary in our study was lower compared with the self-justification counseling session. Finally, we believe the ability to offer our target population, MSM who have received standard counseling several times before, a new and alternative prevention program with evidence of effectiveness has great merit.

Our data support the original assertion of Gold et al. that focusing on a person's on-line thinking that preceded his decision to engage in high-risk sex can decrease future risk. Beyond the trial conducted by Gold et al, we found a decrease in any UAI, not just multiple episodes of UAI. A difference between our intervention and that of Gold et al. was the addition of a face-to-face encounter with a counselor trained to elicit and process the person's self-justifications. Our modification, which ensures that the discussion is personally relevant by using the person's own thoughts and experiences, may be a vital component of the self-justification intervention (25). The change, however, resulted in two separately scheduled visits. Although we think of the self-justification counseling intervention as a one-session event, the questionnaire was actually completed at baseline and reviewed with the counselor 1 week or more later. Therefore, it is possible that the two events separated in time are necessary to the success of the intervention. Finally, unlike Gold et al., we conducted our intervention within the context of standard client-centered counseling provided only to MSM seeking repeat HIV antibody testing.

We cannot say specifically what it was about the intervention that resulted in the prevention effect; it may be that the self-justification counseling helped participants to learn something new about themselves and their behavior. As a result, they may have preferentially retained information from this experience that proved useful when faced with future sexual situations. Further, the cognitive schema provided by the intervention presented the participant's self-justifications explicitly or implicitly as having been causally related to the "decision" to put himself at risk, which may have provided an explanation for behavior that transgressed the participant's own safe sex rules. This possibility seems especially relevant to those men who anecdotally reported that they had been unsure exactly why they had allowed the high-risk activity to occur, given their knowledge of the potential risks. By offering a plausible explanation, the intervention may have helped the participant feel that his behavior is more understandable and, thus, more controllable in the future.

Although we have no specific data to support it, it may be that an affective component to the self-justification counseling intervention contributed to its effectiveness. To the extent that the episode discussed by the participant was in some measure "traumatic," the detailed retelling of the encounter in the company of an empathic counselor may have resulted in the reliving of some painful or, at least, awkward moments as the participant recalled the event and the possibility that he may have become infected with HIV. Reexperiencing that negative emotional state coupled with a renewed sense of having "escaped" from a potentially dangerous situation, and the new learning offered by the cognitive schema described previously, may have worked together to make the intervention memorable and, therefore, available in future situations. The combination of affect plus a new cognitive perspective has been shown in other therapeutic efforts to improve medical and psychologic health (33).

Limitations

The impact of the interventions must be interpreted cautiously in light of the lower proportion of subjects reporting UAI at baseline in the standard counseling group (A1). Because baseline information was recorded before any intervention activities, we find no plausible reason other than chance to account for the baseline difference ($p = .092$). The original work of Gold et al. (27) benefited from equal UAI incidence at baseline across study groups; in the absence of this limitation, that analysis still demonstrated a significant effect in the intervention group. These findings contribute to the likelihood that the differences seen at follow-up evaluation in the current study resulted from the intervention.

However, the lower level of risk behavior in the control group may result in greater difficulty in achieving further decreases in UAI for men in the standard counseling arm, although the overall effectiveness of standard counseling and testing in decreasing future unsafe sex behavior for HIV-negative persons has been questioned in several previous studies. For example, in an ambitious meta-analysis of 27 different studies addressing the issue, Weinhardt et al. (34) concluded that HIV counseling and testing appear to be effective in decreasing disease transmission from HIV-positive people to those who are not infected, but it does not appear to be effective in decreasing the high-risk behavior of HIV-negative persons. Also, if subjects in the intervention groups reported unusually high levels of risk at baseline, then it may not be surprising to observe lower levels on subsequent measures, i.e., "regression to the mean." In support of real intervention effects, the proportion of men reporting UAI in the control group returned to baseline level by 12-month follow-up evaluation but remained significantly lower in the intervention groups. In the absence of a real intervention effect, we would expect all groups to return to a common baseline value. Moreover, the absolute level of UAI in the intervention groups, not just the relative change in UAI, was below that of the control group at 6- and 12-month evaluations.

We included the diary as a condition in two groups to assess its ability to either potentiate or attenuate the effects of the self-justifications counseling intervention. Although the self-justification counseling group (B1) showed significant absolute decreases in UAI at each follow-up session, it would appear from the less steep absolute decreases among the combined diary plus self-justifications group (B2) that adding the diary to the self-justifications counseling intervention may have attenuated the effect of the former. It has been theorized that the self-justifications counseling intervention requires implementation in the absence of other interventions that may distract the participant (35). We find this plausible because the diary could have been interpreted as a competing intervention. In the original study (27), the diary was the source for the key outcome measure (UAI); the current study was a first step toward elimination of the diary via comparison to a nondiary group. This area would benefit from continued focus in future research, especially in terms of collection of key outcome variables via means other than same-day recall via diary keeping.

Whenever key outcome variables are collected via self-report during a face-to-face interview, social desirability of these outcomes must be considered as a potential source of bias. In our study, all participants were aware of the presence of an intervention and a control group and may have seen themselves as having received the intervention, thus leading them to adjust their self-report of UAI. However, to the degree this bias was present, it was homogenous across study arms as each arm contained an activity that could have been construed by the participant to be an intervention. Presumably, if this was a source of bias, it would not have had differential effects by study group; thus, it is unlikely that social desirability bias would have contributed significantly to the intergroup differences we found. Additionally, in the original study by Gold et al. (27), two separate intervention groups were followed, and only the self-justifications group reported change in UAI relative to a nonintervention control group.

An additional potential limitation is the added cost of this intervention. In this study, additional staff time and participant time were required, which may prove difficult in the real, day-to-day world of counseling and testing. We believe further research is indicated to assess whether this intervention can be added to standard counseling and testing.

We conclude that this novel, single-session, self-justifications counseling intervention decreased high-risk sexual behavior beyond that achieved by standard HIV counseling and testing alone. Moreover, the effect of the self-justification counseling was sustained at 1 year, whereas that of standard counseling was transient at best. The use of a sexual diary may have had some effect on risk behavior beyond that associated with standard counseling, but this effect neither surpassed nor enhanced the effect of the self-justifications counseling itself. These findings and the previous research of Gold et al. provide strong arguments for further research into the use of self-justifications counseling within routine HIV testing programs.

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Brief Cognitive Counseling With HIV Testing To Reduce Sexual Risk Among Men Who Have Sex With Men

Results From a Randomized Controlled Trial Using Paraprofessional Counselors

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Objectives: To test the efficacy and acceptability of a single-session personalized cognitive counseling (PCC) intervention delivered by paraprofessionals during HIV voluntary counseling and testing.

Methods: HIV-negative men who have sex with men (MSM; n = 336) were randomly allocated to PCC or usual counseling (UC) between October 2002 and September 2004. The primary outcome was the number of episodes of unprotected anal intercourse (UAI) with any nonprimary partner of nonconcordant HIV serostatus in the preceding 90 days, measured at baseline, 6 months, and 12 months. Impact was assessed as "intent to treat" by random-intercept Poisson regression analysis. Acceptability was assessed by a standardized client satisfaction survey.

Results: Men receiving PCC and UC reported comparable levels of HIV nonconcordant UAI at baseline (mean episodes: 4.2 vs. 4.8, respectively; $P = 0.151$). UAI decreased by more than 60% to 1.9 episodes at 6 months in the PCC arm ($P < 0.001$ vs. baseline) but was unchanged at 4.3 episodes for the UC arm ($P = 0.069$ vs. baseline). At 6 months, men receiving PCC reported significantly less risk than those receiving UC ($P = 0.029$ for difference to PCC). Risk reduction in the PCC arm was sustained from 6 to 12 months at 1.9 ($P = 0.181$), whereas risk significantly decreased in the UC arm to 2.2 during this interval ($P < 0.001$ vs. 6 months; $P = 0.756$ vs. PCC at 12 months). Significantly more PCC participants were "very satisfied" with the counseling experience (78.2%) versus UC participants (59.2%) ($P = 0.002$).

Conclusions: Both interventions were effective in reducing high-risk sexual behavior among MSM repeat testers. PCC participants demonstrated significant behavioral change more swiftly and reported a more satisfying counseling experience than UC participants.

Key Words: cognitive behavioral therapy, CONSORT, HIV prevention counseling, men who have sex with men, paraprofessional, personalized cognitive counseling, voluntary counseling and testing

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The ability of counseling associated with voluntary HIV testing to effect behavior change has been the subject of numerous studies. A review article from 1991 suggested that a positive overall reduction in high-risk sexual or drug use behavior was found after counseling and testing but concluded that because of a range of methodologic difficulties, the question could not be fully answered.[1] An ambitious meta-analysis in 1999 of 27 different studies concluded that "HIV counseling and testing appears to provide an effective means of secondary prevention for HIV positive individuals, [though it] is not an effective primary prevention strategy for uninfected participants."[2] The authors focused on reductions of high-risk sexual behavior (reduced frequency of unprotected intercourse and increased condom use) as the measure of success and suggested the need to develop and examine further the effectiveness of specific counseling approaches. It should also be noted that 23 of the 27 studies reviewed by Weinhardt et al[2] were published before 1993, the year that Centers for Disease Control and Prevention (CDC) published guidelines for client-centered counseling; thus, further studies of the effectiveness of the client-centered model are warranted.[3]

In 1997, we developed a new approach to counseling associated with testing to address the needs of high-risk men who have sex with men (MSM) who had tested multiple times for HIV yet persistently reported unprotected anal intercourse (UAI) with nonprimary partners. The new intervention, based on cognitive theory and earlier work by Gold and colleagues,[4–6] targeted the "self-justifications" (thoughts, attitudes, or beliefs) that persons employ when deciding to engage in high-risk behavior. This "personalized cognitive counseling" (PCC) intervention was conducted by trained mental health professionals in a single counseling session during the week between

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standard pre- and posttest HIV test counseling sessions.[7] The goal was to identify the specific thoughts, attitudes, or beliefs used by the client "in the heat of the moment" when he decided to engage in UAI, re-evaluate those ideas in the "cold light of day" in the company of an empathic counselor, and discuss alternative ways to think about and approach future sexual situations. Our clinical trial found that the PCC intervention was effective: at the 6- and 12-month follow-up visits, participants who received PCC reported significantly fewer episodes of UAI with nonprimary non–HIV-seroconcordant partners than controls who received CDC-defined client-centered counseling or usual care (UC).[7] Controls also demonstrated a small decline in high-risk behavior at 6 months, but this effect dissipated by 12 months.

Although these results were encouraging, the projected cost of employing mental health professionals to provide the PCC intervention was thought to be unsustainable in the "real world." As such, we conducted and report here on a randomized controlled trial designed to assess the effectiveness of the PCC intervention when conducted by trained paraprofessional antibody test counselors during the pretest counseling session compared with UC (HIV risk reduction counseling as described by the CDC[8]).

METHODS

Overall Study Design

We conducted a randomized controlled trial between October 2002 and September 2005 at publicly funded HIV counseling and testing venues in San Francisco. The primary study aims were to determine (1) whether paraprofessional counselors could learn and conduct the PCC intervention according to protocol, (2) whether this cognitively focused intervention would remain effective in reducing future episodes of UAI when provided by paraprofessionals and be more effective than UC, and (3) whether client satisfaction would be at least as high in the experimental condition versus the control condition. Study participation consisted of 3 visits. At visit 1, baseline risk behavioral assessment, counseling intervention, an HIV test, and multiple tests for sexually transmitted infections were conducted; visit 2 occurred 6 months later and consisted of the assessment with an optional HIV test. Visit 3 occurred 12 months after baseline and included the assessment and exit HIV and sexually transmitted disease (STD) tests. To assess the participants' experience of the intervention, a standardized client satisfaction questionnaire with a client's study code was mailed to the client 1 week after visit 1 with a self-addressed stamped envelope for return.

Subjects

Study participants were MSM who presented for anonymous HIV counseling and testing between October 2002 and September 2004. Each was screened for eligibility when he telephoned to schedule an appointment or presented at a drop-in clinic, and eligible testers were scheduled to receive study enrollment and data collection at the same visit as their HIV test. Eligible participants were men 18 years of age or older with a history of 1 or more previous HIV-negative antibody tests at least 6 months before enrollment and at least 1 episode of UAI (receptive or insertive) in the prior 12 months with a nonconcordant (unknown or known positive HIV serostatus) and nonprimary (neither a husband, domestic partner, nor boyfriend for more than 3 months) male partner. Persons who reported nonprescription intravenous drug use during the prior 12 months were excluded. The study interviewer obtained the participant's written informed consent when he presented for testing, administered the baseline interview, and retrieved the random assignment to one of 2 study arms. Participants were paid $5 for completing the client satisfaction questionnaire, $40 for completing the baseline interview, $45 for completing the 6-month interview, and $50 for completing the 12-month interview.

Measures

Participants completed the baseline study interviews at the HIV testing site just before their pretest counseling session, with follow-up study interviews at 6 months and 12 months after baseline. All 3 interviews included assessments of HIV testing history, history of sexual behavior, history of STDs, and drug/alcohol history (Addiction Severity Index)[9,10] using audio computer-assisted self-interview (ACASI) technology.[11] Unless otherwise specified, the time frame for retrospective behavioral questions was the preceding 90 days.

For the 2 most recent sex partners, participants reported the number of anal sex episodes, number of condom-protected anal sex episodes, partner's HIV testing history, partner's HIV serostatus, method of establishing the partner's HIV serostatus (direct [eg, "he told me"] vs. indirect [eg, "he looked healthy, so he must be negative"]), and relationship type ("committed relationship" vs. various other nonprimary relationship types). From these measures, we calculated the number of episodes of UAI in the prior 90 days with nonprimary HIV-nonseroconcordant (discordant or of unknown HIV serostatus) male partners. This calculated measure was selected as the primary outcome because it most closely corresponded to the focus of the intervention (ie, preventing events in which the subject knowingly places himself at elevated risk for HIV acquisition). The primary outcome for the efficacy hypothesis was defined a priori as a change in the number of episodes of UAI with nonprimary nonconcordant male partners in the prior 90 days as measured via self-report in the ACASI interview. Episodes of UAI with partners from a "committed relationship" were excluded, because we found in our previous study that the intervention was ineffective in addressing these behaviors.[7]

To compare the acceptability and utility of the 2 interventions from the clients' perspective, we used the client satisfaction survey, a standardized instrument with excellent psychometric properties.[12] This self-administered questionnaire asks the participant to rate his satisfaction with the session and his attitude about the utility of the session.

Randomization

Randomization was conducted using a "blocked randomization" scheme. Four opaque envelopes were prepared: 2 with the UC assignment inside and 2 with the PCC assignment inside. The envelopes were shuffled and placed in a green box. Group assignment was retrieved by study staff at

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the site while the participant was completing the ACASI interview by selecting the first envelope in the box, and the group assignment was recorded in the chart. The used envelope was retired into a red "discard" box. Once all 4 envelopes had been retired, they were shuffled and placed back into the green box. Blinding was used for participants (ie, they were not informed of their group assignment at any time) and data analysts. On-site study staff (recruiters and counselors) were masked until group assignment was made and were not masked after that time (required for scheduling), but they were not involved in data collection or outcome assessment.

Interventions

All participants received standard counseling associated with HIV testing according to the usual practices of the testing center and in accord with CDC guidelines.[13] The CDC recommends use of "client-centered counseling," which involves active listening, respect for the client's concerns, and an assessment of the participant's "general" sexual activities and willingness to change based on the stages of change theory to help clients identify the behaviors and circumstances that put them at increased risk for HIV transmission.[14] HIV knowledge, risk behavior, and substance use are assessed, and a realistic and incremental plan for reducing risk is negotiated. Persons in the UC group received no further intervention. The UC intervention lasted approximately 30 minutes.

All study participants received their HIV test results and posttest counseling in the same manner, regardless of study arm (ie, by standard clinic protocol). They were scheduled to return 7 days after the pretest counseling session, when they were assigned by order of arrival at the clinic to the next available posttest counselor. Posttest sessions at our clinics last 15 to 20 minutes for HIV-negative results and 1 hour for HIV-positive results (on average). For HIV-negative test results (persons with HIV-positive test results were not included in the present analysis), the posttest counseling protocol includes an assessment of readiness to receive the test result, disclosure of the test result, assessment of risk during the 1-week waiting period, and negotiation of an achievable risk reduction goal for the client.

Persons in the PCC group, in addition to the standard counseling, received the experimental intervention for an average of 50 total minutes of counselor contact. On joining the participant, the counselor asked the participant to complete a revised "self-justifications" questionnaire (SJQ-R).[15] To do so, the participant was instructed to recall a recent episode of UAI with a male partner of unknown or known HIV-positive serostatus. After bringing a specific episode to mind, the participant completed the SJQ-R, noting whether and to what extent any of the items from the questionnaire were present in his mind just before or during the sexual encounter. The revised instrument, derived from our experience in our earlier study,[15] presented a list of 33 possible self-justifications for having anal intercourse without a condom. For each self-justification, the participant rated how strongly the thought had occurred to him using a Likert scale, where 1 indicates "I had this thought strongly (in the forefront of my mind)," 2 indicates "I had this thought to a moderate degree," 3 indicates "I had this thought slightly (in the back of my mind)," and 4 indicates "I didn't have this thought at all." The response "can't remember at all" was also offered for each self-justification. Examples of self-justifications include "I want to have unprotected sex because it feels good"; "he looks healthy, so he must be HIV-negative"; and "a condom will mean (I) can't get an erection, and the sex will be spoiled."

After completing the SJQ-R, the counselor asked the participant to narrate as fully as possible the events that led up to his episode of high-risk sexual activity using the following guidelines:

- Before start of the episode: describe events, activities, mood states, and other descriptors that characterized his state of mind before the high-risk episode.
- At the start of the episode: describe where the participant met his partner, his wishes about specific sexual activity, and how strong his sexual attraction was for this particular partner, for example.
- At the start of sexual activity: describe details about his mood, desires, and how sexually aroused he was and what influence alcohol or drugs may have had in the moment. Communication between the partners about HIV or specific sexual activities was assessed.
- During sexual activity: describe communication, specifically about condom use, body language, the use of drugs/alcohol, and to estimate the level of risk involved in the episode.

On completing the narrative, the counselor and participant discussed any identified self-justification(s). The participant was asked to reflect on his view of the self-justifications he employed during the episode and how these thoughts may have played a role in the participant's decision to engage in UAI. The counselor helped the participant to confront these ideas and work toward a plan to address these in the future.

The paraprofessional counselors who conducted the PCC intervention were bachelor's level–trained and California-certified HIV test counselors with a minimum of 1 year of HIV test counseling experience. Before the start of the study, they received 4 hours of didactic training on the principles of cognitive behavioral interventions and instruction on implementing the PCC, completed 4 supervised role plays of PCC sessions, and reviewed audiotapes of those role plays with the investigators to refine their technique. During the study, they received regular supervision by one of the investigators, and audiotapes of the sessions were reviewed for adherence to protocol.

Data Management and Statistical Methods

A sample size of 300 subjects was selected a priori to detect a 25% decrease in the number of episodes of UAI based on a data completion rate of 80%, power of 80%, and $\alpha = 0.05$.

Data were collected using Questionnaire Development System 2.0 (NOVA Research Systems, Bethesda, MD)[11] and were analyzed using STATA 8.0 (StataCorp, College Station, TX).[16] All electronic data were password protected and stored on a secure server. The impact of the counseling interventions was assessed as "intent to treat" by comparing the episodes of UAI with a nonprimary HIV-nonseroconcordant partner

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between men randomized to PCC and those randomized to UC using random-intercept Poisson regression. Random-intercept Poisson regression models assess the effect of group assignment (PCC vs. UC) while accounting for the dependence of repeated measures on individuals over time. This analytic approach assesses the individual's change in risk behavior rather than the difference in average risk between the 2 arms at follow-up. In other words, the effect of the intervention is measured by how much a person reduces his risk rather than by how much the control group reduced overall risk on average.

We compared the difference in the outcome between PCC and UC at baseline, 6 months, and 12 months. We also compared the change from baseline to 6 months and from 6 to 12 months within each study arm. To adjust for incomplete data, we used the "offset" option for the generalized linear latent and mixed model (gllamm) command in STATA, which specifies that a variable to be added to the linear predictor without estimating a corresponding regression coefficient. A likelihood ratio test was used to assess the fit of the model. Comparisons of baseline characteristics between PCC and UC participants were done using the χ^2 test for proportions or the t test for means.

Human Subjects Protections

All participants gave written informed consent before enrollment. The study protocol was approved and monitored by the Institutional Review Board of the University of California at San Francisco and by a Data and Safety Monitoring Board consisting of 4 volunteers (an ethicist, an epidemiologist, a person living with HIV, and a physician specializing in HIV). The trial was registered on the Web site (ClinicalTrials.gov [NCT00218699]) after data collection began but within the first week of the availability of the trial registration system and before data analysis was begun.

RESULTS

Of the 7087 telephone calls during the study period, 587 (8%) were from persons initially determined to be eligible for the study (Fig. 1; diagram of flow of participants through each stage). The remaining 6500 persons were ineligible because they failed to meet 1 or more of the study criteria (most [92%] because they did not self-report UAI in the prior 12 months). Of the 587 eligible men, 336 (57.2%) consented to participate. Of the 336 enrollees, 31 were later excluded (10 who reported UAI at screening but denied UAI at interview, 19 who reported HIV-negative serostatus at screening but tested HIV-positive at baseline, 1 who was deemed unable to give informed consent, and 1 who participated in the entire protocol twice [his second course was excluded]), yielding a final sample of 305 men (147 were randomized to PCC and 158 to UC). Those who were eligible but declined study participation did not differ significantly from those who agreed to participate in terms of race, age, or reported HIV serostatus.

There were no significant differences between groups on any demographic characteristics (Table 1) at baseline. Overall, mean age was 35.5 years, 35.7% of the cohort were men of color (including 7.5% African American and 11.8% Latino), and the modal annual household income was between $30,000 and $59,999. Although 21.7% had no more than a high school degree, 76.0% had at least 1 advanced degree. Risk for HIV acquisition was high: the mean number of male anal sex partners in the previous 90 days was 4.6 (range: 0–70), and 22.6% of the sample had been diagnosed with an STD in the previous 12 months (Table 2 shows the history of STDs). Risk for acquiring HIV (Table 3) was acknowledged by 79.3%, who agreed or strongly agreed with the statement "given my behavior, I could get infected with HIV," and desire to change this risk was also evident, because 54.1% reported considerable or extreme desire to change their risk. These men were highly experienced testers; the mean number of prior HIV tests was 9.6 (range 1–40).

Complete follow-up achieved for UC participants (91.8%) was higher than for PCC participants (83.1%) (P = 0.033). There were no differences in age (P = 0.86), income (P = 0.93), and education (P = 0.55) between intervention and control subjects lost to follow-up. We also compared mean episodes of UAI at baseline for those who were ultimately lost to follow-up by 12 months with those who were retained. For controls, there was no difference in mean episodes of UAI (4.46 for those lost to follow-up vs. 4.82 for those retained; P = 0.87). For intervention, there was no significant difference, but it was borderline higher for those lost to follow-up (7.29 for those lost to follow-up vs. 3.61 for those retained; P = 0.068).

PCC and UC participants reported comparable levels of high-risk sex at baseline (mean number of episodes: 4.2 vs. 4.8, respectively; P = 0.151; Fig. 2). At 6 months, the mean number of episodes of high-risk sex decreased to 1.9 ($P < 0.001$) for the PCC intervention participants, a level significantly lower than for the UC controls (mean number of episodes = 4.3 at 6 months; P = 0.029 for difference to intervention; P = 0.069 for change in controls over baseline). The reduction in mean number of episodes of high-risk sex among the PCC intervention participants was sustained at 1.9 from 6 to 12 months (P = 0.181), whereas the mean number of episodes significantly decreased to 2.2 among the UC control participants ($P < 0.001$) during the same interval, a level not significantly different from the 12-month PCC intervention level (P = 0.756).

Regarding risk behavior variables (Table 3), the randomization produced comparable groups with the notable exceptions of amphetamine and cocaine use at baseline. The differences persisted at 6 and 12 months of follow-up. To assess the potential impact of these imbalances on the effectiveness of the intervention, we repeated the primary analysis removing men reporting use of these drugs at baseline. In doing so, the prevention effect of the intervention was slightly but not substantially lower (by 9% with respect to amphetamine use and 4% with respect to cocaine use).

Client Satisfaction Questionnaire Results

The standardized client satisfaction questionnaire[12] was mailed to all 305 participants and was returned by 230 (75.4%). Results are presented in Table 4. The return rate did not differ by study group (74.8% for PCC participants and 75.9% for UC participants; P = 0.821). PCC participants were significantly more likely than UC participants to rate the

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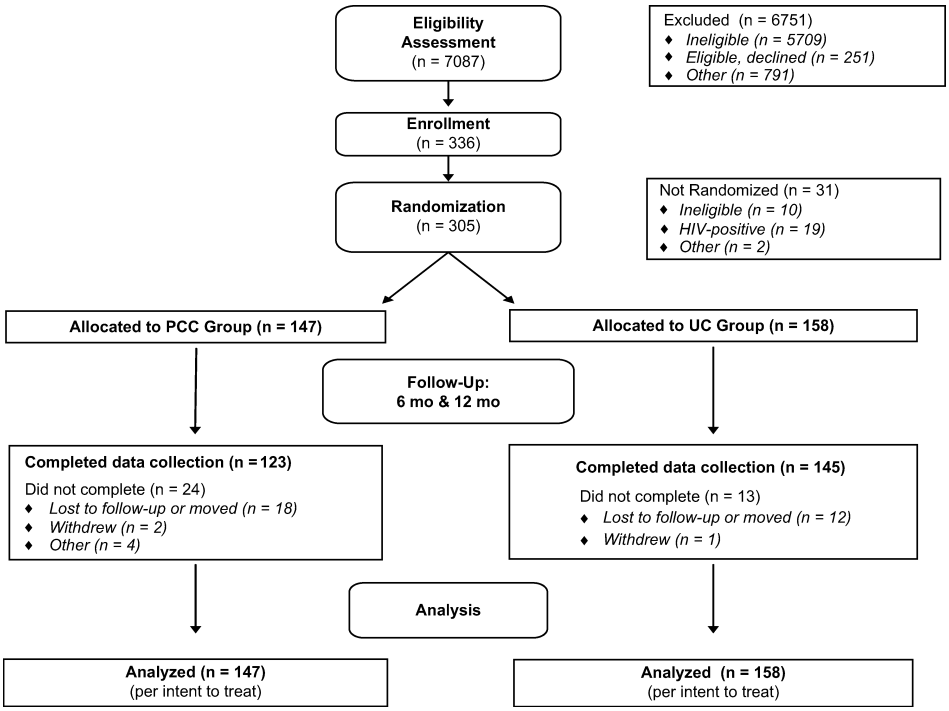

FIGURE 1. Trial participant recruitment, randomization, and retention.

quality of service they received as "excellent" (69.1% vs. 54.2%, respectively; $P = 0.022$), to rate their perception of their counselor's competence as "high" (58.2% vs. 39.2%; $P = 0.005$), or to rate their overall satisfaction as "very satisfied" (78.2% vs. 59.2%; $P = 0.003$). More than one quarter (25.8%) of the UC group reported that the problems that led them to take an HIV test (presumably risk for HIV infection, suspected exposure to HIV, or other sexual risk issues) remained "unchanged" after receiving the UC counseling, whereas only 9.1% of the PCC group did so ($P = 0.001$). From the clients' perspective, the PCC counseling seemed to be more useful and effective in addressing the participants' presenting concerns. Included in the standardized client satisfaction questionnaire is an assessment of stress experienced by the participant as a result of the counseling session. None of the participants in either group reported "considerable stress" (0 of 110 PCC participants and 0 of 120 UC participants), and reports of any stress at all (some or moderate) were comparable for the 2 groups (41 [37.3%] of 110 PCC participants and 47 [39.2%] of 120 UC participants; $P = 0.136$).

DISCUSSION

This study demonstrated that our PCC approach could be taught to and successfully executed by experienced paraprofessional HIV antibody test counselors. Further, when compared in a randomized controlled trial with usual client-centered risk reduction counseling, the approach had a stronger and more immediate effect at reducing the incidence of UAI among high-risk repeat testing MSM. Additionally, the effect was persistent: the sharp decrease in risk behavior among the PCC group from baseline to 6 months was sustained at 12 months after the intervention, a finding consistent with the long-term effects of the same intervention when conducted by licensed mental health professionals.[7] Moreover, the approach seems highly acceptable to this key behavioral risk population.

The finding of decreased risk among control subjects from 6 to 12 months is puzzling. We considered 5 possible explanations. First, we were aware that a new counseling approach entailing review of a narrative of a recent risk episode (a key component of the PCC intervention) began to be applied by some counselors providing UC at the study sites based on the success of the well-known Project RESPECT.[17] We were aware that some clients received nonscheduled HIV tests during the interval between visit 1 and visit 3, and we hypothesized that this new counseling approach, if received by control subjects at these nonscheduled HIV tests, may have caused "cross-contamination" in our study. To test this hypothesis, we identified all control subjects who reported receiving any HIV counseling and testing between their baseline and 12-month visits (n = 45) and conservatively reclassified any such controls as having received the PCC intervention. We then reanalyzed the main outcome. The reduction in risk among the control group from 6 to 12 months did not substantially change, suggesting that this type of cross-contamination was not responsible for the effect.

Second, we wondered if the number of times that a participant tested for HIV between study visits may have affected the outcome. We hypothesized that repeatedly interviewing participants on the details of their sexual behavior may have resulted in their reporting fewer episodes of risky sex over time because of social desirability response bias or a real effect. To test this hypothesis, we assigned a score for each participant representing the total number of counseling and

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TABLE 1. Demographic Characteristics of Trial Participants by Group Assignment

Characteristic	UC, n (%)	PCC, n (%)	P*
Total	158	147	—
Age, years			
19–30	45 (28.5)	45 (30.6)	0.419
31–40	70 (44.3)	69 (46.9)	
41–60	42 (26.6)	31 (21.1)	
≥61	1 (0.6)	2 (1.4)	
Race/ethnicity			
American Indian/Alaskan Native	1 (0.6)	3 (2.0)	0.587
Asian	11 (7.0)	11 (7.5)	
Black/African-American	11 (7.0)	12 (8.2)	
White	98 (62.0)	98 (66.7)	
Latino	20 (12.7)	16 (10.9)	
Native Hawaiian/Pacific Islander	3 (1.9)	1 (0.7)	
More than 1 race or ethnicity	9 (5.7)	3 (2.0)	
Other	5 (3.2)	3 (2.0)	
Education			
No degree	4 (2.5)	3 (2.0)	0.954
High school/GED	33 (20.9)	33 (22.4)	
Associate's or bachelor's degree	86 (54.4)	81 (55.1)	
Master's or doctoral degree	35 (22.2)	29 (19.7)	
Household annual income, US$			
<15,000	29 (18.4)	20 (13.6)	0.549
15,000–44,999	47 (29.7)	53 (36.1)	
45,000–74,999	46 (29.1)	40 (27.2)	
75,000 or more	34 (21.5)	33 (22.4)	
Not reported	1 (0.6)		0 (0.0)

*χ^2 test for differences in proportions.
GED indicates general equivalency diploma.

TABLE 2. Self-Reported History of STDs by Group Assignment

Characteristic	UC, n (%)	PCC, n (%)	P*
Total	158	147	—
Any sexually transmitted infection			
Ever	114 (72.2)	92 (62.6)	0.075
Past year	37 (23.4)	32 (21.8)	0.731
Gonorrhea			
Ever	21 (13.3)	14 (9.5)	0.302
Past year	22 (13.9)	17 (11.6)	0.538
Syphilis			
Ever	0 (0.0)	1 (0.7)	0.299
Past year	7 (4.4)	4 (2.7)	0.424
Chlamydia			
Ever	14 (8.9)	9 (6.1)	0.365
Past year	16 (10.1)	13 (8.8)	0.703
Genital herpes simplex virus			
Ever	4 (2.5)	6 (4.1)	0.448
Past year	4 (2.5)	9 (6.1)	0.875
Genital human papillomavirus			
Ever	5 (3.2)	11 (7.5)	0.091
Past year	9 (5.7)	12 (8.2)	0.395
Hepatitis A, B, or C			
Ever	0 (0.0)	0 (0.0)	—
Past year	2 (1.3)	1 (0.7)	0.605
Other			
Ever	3 (1.9)	1 (0.7)	0.350
Past year	8 (5.1)	5 (3.4)	0.473

*χ^2 test for differences in proportions.

testing sessions received during study participation (range: 1–4) and tested for a dose-response type of effect on risk behavior. Results failed to support this hypothesis: in fact, we found that as the number of counseling and testing sessions increased, risk did as well.

Third, we considered whether outliers could account for the apparent intervention effect or the drop in risk among controls from 6 to 12 months. Repeating the primary analysis while removing men with extremely high levels of risk (ie, >20 episodes of potentially discordant UAI) did not alter the magnitude or significance of the principal findings.

Fourth, we wondered whether the differential loss to follow-up for intervention versus control might have affected the drop in risk among controls from 6 to 12 months or affected the principal outcome. Assessing the impact of loss to follow-up on interpretation of the outcome, we compared mean episodes of UAI at baseline for those ultimately lost to follow-up by 12 months with mean episodes of UAI of those who were retained. For controls, there was no difference in mean episodes of UAI (4.46 for those lost to follow-up vs. 4.82 for those retained; $P = 0.87$). For the intervention group, there was no significant difference, but mean episodes of UAI at baseline was borderline higher for those lost to follow-up (7.29 for those lost to follow-up vs. 3.61 for those retained; $P = 0.068$). This does raise the issue that some of the decrease in episodes of UAI in the intervention arm may be attributable to loss of the highest risk subjects. This does not necessarily undermine the evidence of an intervention effect, however, for 2 reasons: (1) it could be that those who are at highest risk are also those who respond best to the intervention, and the data could thus underestimate the effect, and (2) the analysis adjusts for the individual person's level of risk, so it is the person's change in risk (not just the group differences) that also matters.

A fifth possibility is that the finding may be explained by "regression to the mean." In other words, our study may have recruited men in a period of higher than usual risk behavior. To the extent that when men entered the study, they were a engaging in more risk than usual (eg, the reasons for seeking testing), it might be expected that they would return to a lower risk baseline in the long term. Evidence that this is the case may be in the finding that men in the intervention arm reduced their risk in the period immediately after the session, whereas those in the control arm did so in a longer time frame. Evidence against this is that we did not see this effect in our previous trial.[7]

It is important to note that the primary outcome variable in the present study (number of episodes of UAI in the past 90 days with a nonprimary partner) is more specific than that in the first study (any UAI in the past 90 days with a nonprimary partner) and is limited to up to 2 nonprimary

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TABLE 3. Behavioral Characteristics of Trial Participants by Group Assignment

Characteristic	UC, n (%)	PCC, n (%)	*P*
Total	158	147	—
Total no. prior HIV tests			
1	7 (4.4)	8 (5.4)	0.910
2–5	52 (32.9)	49 (33.3)	
6 or more	99 (62.7)	90 (61.2)	
No. male anal sex partners (previous 3 mo)			
0	10 (6.3)	11 (7.5)	0.905
1–5	106 (67.1)	97 (66.0)	
6–24	37 (23.4)	36 (24.5)	
≥25	5 (3.2)	3 (2.0)	
Desire to change risk for HIV			
Extreme	41 (25.9)	32 (21.8)	0.735
Considerable	45 (28.5)	47 (32.0)	
Moderate	39 (24.7)	30 (20.4)	
Slight	4 (2.5)	3 (2.0)	
None	29 (18.4)	35 (23.8)	
"Given my behavior, I could get infected with HIV"			
Strongly agree	49 (31.0)	43 (29.3)	0.951
Somewhat agree	78 (49.4)	72 (49.0)	
Somewhat disagree	27 (17.1)	27 (18.4)	
Strongly disagree	4 (2.5)	5 (3.4)	
Current substance use (in the past 30 d)			
Mean no. days used alcohol	10.0	9.4	0.981
Mean no. days used marijuana	4.8	3.7	0.781
Any Viagra use	36 (22.8)	29 (19.7)	0.515
Any amphetamine use	35 (22.2)	17 (11.6)	0.014*
Any cocaine use	32 (20.3)	15 (10.2)	0.015*
Any ecstasy use	30 (19.0)	20 (13.6)	0.205
Any GHB use	16 (10.1)	13 (8.8)	0.703
Any ketamine use	11 (7.0)	4 (2.7)	0.087
Any heroin use	0 (0.0)	0 (0.0)	—
Lifetime substance use			
Ever used antidepressants	59 (37.3)	46 (31.3)	0.267
Ever used cigarettes	114 (72.2)	92 (62.6)	0.075
Ever injected nonprescription drugs	5 (3.2)	5 (3.4)	0.908
Ever used nonprescription steroids	10 (6.3)	8 (5.4)	0.743

*$P < 0.05$, χ^2 test for differences in proportions, t-test for differences in means. GHB indicates gamma hydroxybutyrate.

partners during the recall period. This was done as a result of the evidence collected during the first study: the median number of sex partners in the prior 90 days for those study participants was 2.[7] For the current study, we wanted to collect in-depth data regarding sex partners and encounters (eg, insertive vs. receptive position, serostatus and race/ethnicity, use of alcohol or other drugs during sex) and decided to limit the number of partners reported on to minimize the burden on the participants and potential recall bias. Ultimately, limiting the recall and reporting to the past 2 partners should result in a valid representation of the past 90 days, because few participants reported more than 2 nonprimary partners in that period. On balance, we believe the specificity we gained with this limitation was preferable.

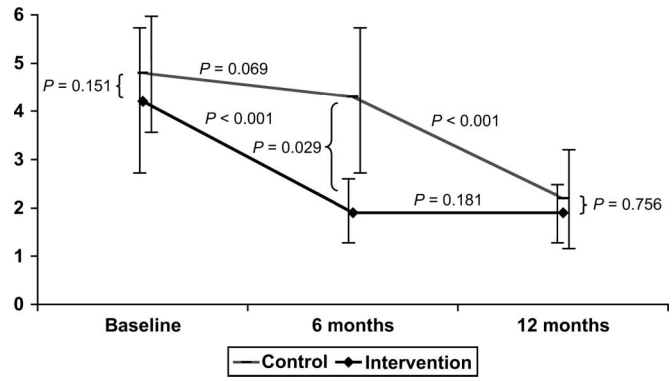

FIGURE 2. Mean episodes of UAI with a nonprimary partner of unknown HIV serostatus or known discordant serostatus in the preceding 90 days, intervention versus control counseling, in MSM in San Francisco, 2002 to 2004.

Several limitations of the study narrow the generalizability of our findings. First, to date, this approach has only been tested by our group. Ideally, other research teams at other sites would demonstrate the effectiveness of the intervention. Second, the participants in the PCC group received more counselor contact time (50 vs. 30 minutes), and we have no way of telling if this time difference in attention may have played a role in the eventual outcome. Third, persons who reported nonprescription injection drug use during the prior 12 months were excluded based on the assumption that the

TABLE 4. Client Satisfaction Survey Results by Group Assignment

Characteristic	UC, n (%)	PCC, n (%)	*P*
Total	120	110	—
Quality of service received rated "excellent"	65 (54.2)	76 (69.1)	0.022*
Counselor competence rated "high"	47 (39.2)	64 (58.2)	0.005*
Overall satisfaction with service rated "very satisfied"	71 (59.2)	86 (78.2)	0.003*
Problems that led participant to test rated "Unchanged" after the intervention	31 (25.8)	10 (9.1)	0.001*
Receiving the intervention decreased the likelihood of engaging in UAI in the future considerably or "made it impossible"	52 (43.3)	61 (55.5)	0.086
Degree of mental stress experienced as a result of receiving the intervention			
None	73 (60.8)	68 (61.8)	0.136
Some	40 (33.3)	34 (30.9)	
Moderate	7 (5.8)	7 (6.4)	
Extreme	0 (0.0)	0 (0.0)	

*$P < 0.05$, χ^2 test for differences in proportions.

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physical imperatives associated with drug use may lead to cognitive dynamics that might not be susceptible to the intervention. Fourth, the study was limited to MSM only; it is possible that the self-justifications that contribute to sexual risk taking among non-MSM populations would also be amenable to this approach, but we elected to limit our study population to that which represents most new HIV cases in San Francisco.

The imbalance between study arms with respect to use of amphetamines and cocaine in the previous 30 days could introduce bias but only if the intervention works differently among drug users versus nonusers (because our analysis is based on the individual's change in behavior rather than on the group differences). The sensitivity analysis we conducted suggests that this was not the case. Finally, some other unknown bias may have been present in our sample that could have influenced the outcome; still, our use of randomization may have balanced such biases across study arms, such that the likelihood of compromise of our primary results should be minimal.

Despite these limitations and the puzzling results of the control group results from 6 to 12 months, we believe that when compared with standard client-centered counseling, this new approach (PCC) has shown itself to be superior when working with repeat testing MSM who continue to report high-risk sexual activity. The rapid and steep decline in unprotected anal sex from baseline to 6 months and the persistent reduced numbers of such episodes at 12 months argue strongly that the intervention was having some real effect. Further, the client satisfaction data suggest that the participants actually preferred this approach and that significantly more of those who received the new intervention thought it had been helpful in addressing the problems that led to their testing episode.

What is it about this novel single-session intervention that produced future behavior change? One possibility is that for these men who had repeatedly tested for HIV (mean number of previous tests was 9.6), an important aspect was that the intervention itself was different and, with its emphasis on a recent specific high-risk exposure, perhaps was experienced as more "personally relevant" than standard counseling associated with testing.[18] It may also be that this approach, which focuses on the specific thoughts, attitudes, and beliefs employed by these men at the time they decided to have unsafe sex, offered them an opportunity to discover something about their own decision-making process that was previously unknown to them. Finally, by recounting an experience in great detail and "reliving" this experience in the company of an empathic counselor, the participant may have had an affective experience that was memorable, and thus more readily retrievable, when faced with future potential high-risk exposures. The memory of the counseling experience may have provided him an opportunity to recall the discomfort associated with a high-risk experience and eventually to exercise greater control over his decision making.

This study and several recent studies conducted in STD clinic populations have demonstrated the usefulness of counseling in achieving sexual risk reduction,[19–23] despite initial review papers that showed equivocal support for counseling associated with testing.[1,2] This newer information is particularly important, given the recent decision by the CDC that counseling no longer be a required component of HIV testing,[24] and is data that should be considered in future discussions about the merits of this approach. Repeat testers remain at particularly high risk for seroconversion, and our intervention has now been shown in 2 different studies to reduce their risk behavior favorably.[25] Considering the limited resources available for prevention efforts with this high-risk population, a cost-effectiveness analysis comparing this effective intervention with other interventions is the next logical extension in this area.

By its nature, counseling is a fluid interaction, and it is easy for counseling protocols to "slip." To be done well, counseling requires thought and intention on the part of the counselor. Supervision is necessary to help counselors remain on task and on target. Taken together, these studies suggest that if applied thoughtfully and under a supervised protocol, even short-term counseling delivered by paraprofessionals can achieve meaningful behavior change in high-risk repeat testing populations, and our new counseling approach seems to offer an effective and viable alternative to standard counseling associated with testing.

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Appendix 2: Glossary and Guide to Abbreviations

Behavior Change Logic Model
A logic model is a graphical depiction of the processes and underlying assumptions upon which a program or intervention activity is expected to lead to specific outcomes.

Core Elements
Core Elements are required components that represent the theory and internal logic of the intervention and most likely produce the intervention's main effects.

Key Characteristics
Key Characteristics are crucial activities and delivery method components of the intervention that can be changed without undermining fidelity to the original intervention.

MSM
Men who have sex with men. This includes people who identify themselves as "gay," men who identify themselves as "bisexual," and men who have some male sex partners but do not identify themselves as gay or bisexual in terms of sexual orientation.

Off-Line Thinking
"Off-line" thinking happens away from the immediate temptation and pressure of a potentially sexual situation. It is "cold light of day" thinking.

On-Line Thinking
"On-line" thinking is thinking in the heat of the moment in a potentially sexual situation, where there are immediate rewards for risky behavior.

Primary Partner
In the ***PCC*** research, a "primary partner" was defined as a boyfriend of greater than three months, a husband, or a domestic partner.

Self-Justifications
Self-justifications are thoughts that allow people to make a decision to engage in risky behavior, in contradiction to other knowledge and beliefs they have that support avoiding risk. The individual uses self-justifications to allow desired, but known, risky behavior to occur.

Serodiscordant
Refers to partners with differing serostatus. An HIV-positive person is a serodiscordant partner with an HIV-negative person.

Serostatus
Status of being HIV-negative or positive in terms of blood antibodies. People without HIV do not have HIV antibodies in their blood, so their serostatus is HIV-negative. People with HIV antibodies in their blood have an HIV-positive serostatus.

UAI
Unprotected anal intercourse.

Appendix 3: *PCC Questionnaire*

Note: Because the terms "Personalized Cognitive Counseling" and "***PCC***" are not used in conversations with the client, the version of the ***PCC*** *Questionnaire* given to the client is simply titled "Questionnaire."

QUESTIONNAIRE

I. Below we have listed some statements. For each one, please indicate how true each statement is for you:

	Very True	Moderately True	Slightly True	Not True at All	I Can't Remember at All
1) My (or his) cock was rubbing up against his (or my) ass, and it just slipped in by accident. Neither of us really meant to fuck without a condom.	[ ]	[ ]	[ ]	[ ]	[ ]
2) I didn't want to fuck without a condom but I was so horny I couldn't think properly.	[ ]	[ ]	[ ]	[ ]	[ ]
3) I didn't want to fuck without a condom but I couldn't find the words to tell him.	[ ]	[ ]	[ ]	[ ]	[ ]
4) I didn't want to fuck without a condom but I couldn't find the right moment to tell him.	[ ]	[ ]	[ ]	[ ]	[ ]
5) I didn't want to fuck without a condom but I was too embarrassed to tell him.	[ ]	[ ]	[ ]	[ ]	[ ]

II. Next is a particularly difficult section. So please try to think very carefully before you answer. We would like to find out what sorts of things you were thinking or saying to yourself (even in the back of your mind) that allowed you to fuck without a condom. How did you justify to yourself fucking without a condom? Below, we have listed a number of ways that you might have done this. For each one please indicate whether you had that thought, or not, at the time you decided to fuck without a condom. Some of the justifications may seem silly, but they've been included because they may apply to other people.

AT THE TIME I DECIDED TO FUCK WITHOUT A CONDOM:	I had this thought strongly (in the forefront of my mind)	I had this thought to a moderate degree	I had this thought slightly (in the back of my mind)	I didn't have this thought at all	I can't remember at all whether I had this thought or not
6) I thought to myself something like: "This guy and me have been faithful to each other for a long time now, and neither of us has symptoms of HIV. So it will probably be OK."	[ ]	[ ]	[ ]	[ ]	[ ]
7) I thought to myself something like: "We take chances every day—after all, it's even taking a chance to cross a road. Taking a risk is part of life."	[ ]	[ ]	[ ]	[ ]	[ ]
8) I thought to myself something like: "I'm feeling low and I need something to make me feel good and this will do it for me."	[ ]	[ ]	[ ]	[ ]	[ ]
9) I thought to myself something like: "It'll be safe to fuck without a condom, so long as we don't cum in the ass. So we'll just fuck without cumming."	[ ]	[ ]	[ ]	[ ]	[ ]
10) I thought to myself something like: "Other guys fuck without a condom much more often than I do. I'm at less risk than most guys."	[ ]	[ ]	[ ]	[ ]	[ ]

AT THE TIME I DECIDED TO FUCK WITHOUT A CONDOM:	I had this thought strongly (in the forefront of my mind)	I had this thought to a moderate degree	I had this thought slightly (in the back of my mind)	I didn't have this thought at all	I can't remember at all whether I had this thought or not
11) I thought to myself something like: "I'm fed up with having to think and worry about HIV all the time. It's so depressing. At the moment, I just can't handle thinking about it at all. I refuse to think about HIV right now."	[ ]	[ ]	[ ]	[ ]	[ ]
12) I thought to myself something like: "I had an HIV test a while ago, and it was negative. After all the things I'd done, it was still negative; I was OK. So it can't be all that easy to get infected."	[ ]	[ ]	[ ]	[ ]	[ ]
13) I thought to myself something like: "This guy looks so healthy, he can't possibly be infected."	[ ]	[ ]	[ ]	[ ]	[ ]
14) I thought to myself something like: "I'm not very sexually attractive, and it's really great that I've managed to get this guy. I just can't afford to be very choosy about what I do. I don't get many opportunities."	[ ]	[ ]	[ ]	[ ]	[ ]
15) I thought to myself something like: "I'll be all right. I've always been a lucky guy and my luck will hold."	[ ]	[ ]	[ ]	[ ]	[ ]

AT THE TIME I DECIDED TO FUCK WITHOUT A CONDOM:	I had this thought strongly (in the forefront of my mind)	I had this thought to a moderate degree	I had this thought slightly (in the back of my mind)	I didn't have this thought at all	I can't remember at all whether I had this thought or not
16) I thought to myself something like: "I love this guy. A condom would spoil all the romance. I can't have a condom separating me from the man I love. I can't have a condom coming between us."	[ ]	[ ]	[ ]	[ ]	[ ]
17) I thought to myself something like: "I'll have one last fling and do only safe sex from then on. I'll be good starting tomorrow—I won't fuck without a condom after this last time."	[ ]	[ ]	[ ]	[ ]	[ ]
18) I thought to myself something like: "I want to feel what it was like when you could do what you liked sexually, as it was before HIV."	[ ]	[ ]	[ ]	[ ]	[ ]
19) I thought to myself something like: "This guy doesn't seem to be on the scene much (he told me he doesn't get around much/I've never seen him before/he told me he hates the scene, etc.), so he's probably not infected."	[ ]	[ ]	[ ]	[ ]	[ ]
20) I thought to myself something like: "If I'm on top—if I fuck him—my chances of getting infected are low. He's the one at risk, so that's his problem, not mine."	[ ]	[ ]	[ ]	[ ]	[ ]

AT THE TIME I DECIDED TO FUCK WITHOUT A CONDOM:	I had this thought strongly (in the forefront of my mind)	I had this thought to a moderate degree	I had this thought slightly (in the back of my mind)	I didn't have this thought at all	I can't remember at all whether I had this thought or not
21) I thought to myself something like: "I just have to have good sex and I can't have good sex without fucking and I can't enjoy fucking if I use a condom—condoms take all the feeling away."	[ ]	[ ]	[ ]	[ ]	[ ]
22) I thought to myself something like: "Condoms destroy the magic of sex. How can we suddenly interrupt everything just to put on a condom?"	[ ]	[ ]	[ ]	[ ]	[ ]
23) I thought to myself something like: "Most of the time I'm careful, but I can't be perfect—it's only human to slip up occasionally."	[ ]	[ ]	[ ]	[ ]	[ ]
24) I thought to myself something like: "The two of us have fucked without a condom before, not so long ago, so there is no point in stopping now."	[ ]	[ ]	[ ]	[ ]	[ ]
25) I thought to myself something like: "We've both had the HIV test, and the tests were both negative, so neither of us is infected."	[ ]	[ ]	[ ]	[ ]	[ ]
26) I thought to myself something like: "Part of being in love with a guy is trusting him and showing him that you trust him. I want him to know that I trust him."	[ ]	[ ]	[ ]	[ ]	[ ]

AT THE TIME I DECIDED TO FUCK WITHOUT A CONDOM:	I had this thought strongly (in the forefront of my mind)	I had this thought to a moderate degree	I had this thought slightly (in the back of my mind)	I didn't have this thought at all	I can't remember at all whether I had this thought or not
27) I thought to myself something like: "If I put on (or he puts on) a condom, I (or he) won't be able to get an erection, and the sex will be spoiled."	[ ]	[ ]	[ ]	[ ]	[ ]
28) I thought to myself something like: "This guy is clearly concerned about HIV, so I'm sure he's been careful. So he can't possibly be infected."	[ ]	[ ]	[ ]	[ ]	[ ]
29) I thought to myself something like: "I want to have unprotected sex because it feels good."	[ ]	[ ]	[ ]	[ ]	[ ]
30) I thought to myself something like: "Some people seem to be immune to the virus. I've done lots of risky things in the past and have never gotten infected so I must be one of those people who's immune."	[ ]	[ ]	[ ]	[ ]	[ ]
31) I thought to myself something like: "Sex is more exciting when it's dangerous, when it's breaking the rules. I want to feel that thrill when I fuck without a condom."	[ ]	[ ]	[ ]	[ ]	[ ]

32) Were there any other reasons for fucking without a condom that you can remember giving yourself (even just at the back of your mind)? If so, please describe them.

_____

_____

_____

Appendix 4: Supplemental Material: *PCC Interviewing Tips*

Probing questions ("probes") are used to help the client tell his story and identify the thoughts and feelings he was having before, during, and after the UAI encounter. This appendix provides additional information about possible probing questions. The probes are to be used as needed. Some clients will tell their story easily and the counselor's main focus will be to stay out of the way. Others will need more guidance and encouragement.

Do's and Don'ts

How you use probes is even more important than the probes you use. The table below gives some do's and don'ts to help you make your probing questions work for you.

Do	**Don't**
Use open-ended probing questions	Ask a series of closed questions
Tie your next question to what the client just said	Read off the probes like a checklist
Let the client be in charge of his own narrative	Let your probes structure the narrative
Use the client's own words, echo or briefly summarize the content and feelings the client is expressing to show you understand	Spoon-feed words describing the client's experience, making you rather than him responsible for telling his story
Use silence to cue the client to think about and expand on what he just said	Interrupt while the client is thinking

Partner probes

In this context, "partner" refers to the sexual partner in the episode of UAI.

- "Tell me about your partner."
- "How did you meet?"
- "What made him attractive?"
- "At what point did you realize that your interaction with this man might become sexual? How did you know? How were you feeling about it?"
- [*Only if interaction was with a boyfriend*]: "How did being in a relationship influence the types of sex you had and how you felt about it?"

Mood probes

- "How were you feeling emotionally the day before you had sex with [name]?"
- "What kind of mood were you in that day or week?"
- "How were you feeling about yourself in general?"

Time probes

- "What time of day was it when you guys had sex?"
- "What had you just been doing at the time you met?"
- "Were you expecting to hook up with someone that night/day? Why?"
- "What were your thoughts about whether or not you would have sex that night/day?"

Place probes

(Type of venue, chat room, time of day, environment, social situation, work setting, etc.)

- "Where did you meet your partner?"
- "Where did you have sex?"
- "What was the place like?"
- "How were you feeling about the place?"

Substance use probes

- "Were either you or your partner drunk or high?"
- "How much had you been drinking/using?"
- "How was the alcohol/drug making your body feel?"
- "Was it affecting how you were thinking? How?"

Sex probes

- "How did having sex get started?"
- "At that time, what was going through your mind?"
- "What did you guys do sexually?"
- "At what point did you decide to have anal sex?"
- "What was going through your mind while you were having sex?"
- "How were you feeling while you were having sex?"
- "What were you feeling afterward?"

- “Was the sex satisfying? How so/why not?”

Communication probes

- “What kinds of body language did the two of you exchange about whether you would use a condom?”
- “What did you say about whether you would use a condom?”
- “Did you make any assumptions about your partner being HIV-negative or positive? Based on what?”
- “Did these assumptions affect what you did?”

Perceived HIV risk

- “Would you consider what you guys did to be safe or unsafe with respect to HIV?” “What part made it safe or unsafe?”

Probes for thoughts before sex

Goal: Make sure you have a clear understanding of any difference between the on-line thinking/self-justification and the off-line thinking the person had prior to sex that could have influenced his behavior. This is important because it lays the groundwork for the next step.

- “What kinds of thoughts were you having earlier that day?”
- “Do you have a sense of what was triggering those thoughts?”
- “How does that kind of thinking make you feel? What does that mean to you?”
- “What were you thinking when you first got there? What were you saying to yourself?”
- “At what point did that thought change? What made it change?”
- “What were you thinking when you first started talking?”
- “How long were you thinking that? Do you usually think those kinds of things when you are in situations like that?”

Probes for feelings before sex

Goal: Make sure you have a clear understanding of the client’s feelings prior to sex that could have influenced his behavior. His strategies to manage his feelings may be important in leading to risky behavior.

- “How were you feeling earlier that day?”
- “Do you have a sense of what was triggering those feelings?”
- “What does that mean to you that you were feeling that way?”

- “What were you feeling when you first got there? What was that like for you?”
- “At what point did your mood shift? What made it change?”
- “How were you feeling when you first started talking?”
- “How long did that feeling last? Do you always feel that way when you are in situations like that?”
- “What do you usually do when you feel that way?”

Probes for thoughts during sex

Goal: Get a sense of his specific thoughts at various moments during the sexual encounter. Give the client plenty of time to recreate it in his mind so he can give you specifics.

- “While you were having sex, do you remember what you were thinking?”
- “How did that thinking make you feel?”
- “At what point (of sexual encounter) did your thought change?”
- “Do you think those thoughts had anything to do with what you did sexually? How or why?” “If not, can you imagine how your thoughts might interfere with being able to have safer sex?”

Probes for feelings during sex

Goal: Get a sense of his specific emotions at various moments during the sexual encounter. As with probes for thoughts, give the client plenty of time to recreate it in his mind so he can give specifics.

- “While you were having sex, do you remember what you were feeling emotionally?”
- “At what point (of sexual encounter) did your feelings change?”
- “Do you think your feelings had anything to do with what you did sexually? How or why?” “If not, can you imagine how your feelings might interfere with being able to have safer sex?”

Suggested probes for thoughts after sex

Goal: This will be helpful information to know when the counselor is identifying a difference between the on-line thinking/self-justification and the off-line thinking. These questions will reflect the negative consequences of the client’s behavior, which he will want to avoid re-experiencing.

- “What about afterward? What were you thinking then? What were you saying to yourself about that encounter?”
- “How did you feel about yourself at that point?”

- “So when you have thoughts about _____ before or during sex and after unprotected anal sex you end up feeling _____? Is that right? Do you see that as a problem?”

Suggested probes for feelings after sex

Goal: This will be helpful information to know when the counselor is identifying a problem. These questions will reflect the negative consequences of the client’s behavior, which he will want to avoid re-experiencing.

- “What about afterward? What were you feeling then? How did you feel about yourself?”
- “How long did you feel that way? What did you do?”
- “So when you feel _____ before or during sex and after unprotected anal sex you end up feeling _____? Is that right? Do you see that as a problem?”

Appendix 5: References

Gold, R. S., Skinner, M. J., Grant, P. H., et al. (1991). Situational factors and thought processes associated with unprotected intercourse in gay men. *Psychology Health, 5*, 259–78.

Gold, R.S., Skinner, M.J., Ross, M.W. (1994). Unprotected anal intercourse in HIV-infected and non-HIV-infected gay men. *Journal of Sex Research, 31*, 59–77.

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Gold, R.S., Skinner, M.J. (1997). Unprotected anal intercourse in gay men: The resolution to withdraw before ejaculating. *Psychological Reports, 81*, 496–8.

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Appendix 6: CDC Required Materials

- CDC Statement on the ABC's of Smart Behavior
- CDC Fact Sheet for Public Health Personnel: Male Latex Condoms and Sexually Transmitted Diseases
- Program Review Panel Guidelines for Content of AIDS-related written materials, pictorials, audiovisuals, questionnaires, survey instruments, and educational sessions in Centers for Disease Control and Prevention (CDC) Assistance Programs (Interim Revisions June 1992).
- Program Review Panel Instructions for Form 0.113
- Form 0.113
- CDC Statement on Nonoxynol-9 Spermicide Contraception Use, May 10, 2002
- CDC Statement on Study Results of Product Containing Nonoxynol-9

The ABCs of Smart Behavior

To avoid or reduce the risk for HIV

- **A** stands for abstinence.
- **B** stands for being faithful to a single sexual partner.
- **C** stands for using condoms consistently and correctly.

Centers for Disease Control and Prevention
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Male Latex Condoms and Sexually Transmitted Diseases

On This Page

- Sexually Transmitted Diseases, including HIV Infection (#STD)
- HIV / AIDS (#HIV)
- Gonorrhea, Chlamydia, and Trichomoniasis (#GCT)
- Genital Ulcer Diseases and HPV (#HPV)

Condoms and STDs: Fact Sheet for Public Health Personnel

Consistent and correct use of male latex condoms can reduce (though not eliminate) the risk of STD transmission. To achieve the maximum protective effect, condoms must be used both consistently and correctly (brief.html#Consistent). Inconsistent use can lead to STD acquisition because transmission can occur with a single act of intercourse with an infected partner. Similarly, if condoms are not used correctly, the protective effect may be diminished even when they are used consistently. The most reliable ways to avoid transmission of sexually transmitted diseases (STDs), including human immunodeficiency virus (HIV), are to abstain from sexual activity or to be in a long-term mutually monogamous relationship with an uninfected partner. However, many infected persons may be unaware of their infections because STDs are often asymptomatic or unrecognized.

This fact sheet presents evidence concerning the male latex condom and the prevention of STDs, including HIV, based on information about how different STDs are transmitted, the physical properties of condoms, the anatomic coverage or protection that condoms provide, and epidemiologic studies assessing condom use and STD risk. This fact sheet updates previous CDC fact sheets on male condom effectiveness for STD prevention by incorporating additional evidence-based findings from published epidemiologic studies.

Sexually Transmitted Diseases, Including HIV Infection

- *Latex condoms, when used consistently and correctly, are highly effective in preventing the sexual transmission of HIV, the virus that causes AIDS. In addition, consistent and correct use of latex condoms reduces the risk of other sexually transmitted diseases (STDs), including diseases transmitted by genital secretions, and to a lesser degree, genital ulcer diseases. Condom use may reduce the risk for genital human papillomavirus (HPV) infection and HPV-associated diseases, e.g., genital warts and cervical cancer.*

There are two primary ways that STDs are transmitted. Some diseases, such as HIV infection, gonorrhea, chlamydia, and trichomoniasis, are transmitted when infected urethral or vaginal secretions contact mucosal surfaces (such as the male urethra, the vagina, or cervix). In contrast, genital ulcer diseases (such as genital herpes, syphilis, and chancroid) and human papillomavirus (HPV) infection are primarily transmitted through contact with infected skin or mucosal surfaces.

Laboratory studies have demonstrated that latex condoms provide an essentially impermeable barrier to particles the size of STD pathogens.

Theoretical and empirical basis for protection. Condoms can be expected to provide different levels of protection for various STDs, depending on differences in how the diseases are transmitted. Condoms block transmission and acquisition of STDs by preventing contact between the condom wearer's penis and a sex partner's skin, mucosa, and genital secretions. A greater level of protection is provided for the diseases transmitted by genital secretions. A lesser degree of protection is provided for genital ulcer diseases or HPV because these infections also may be transmitted by exposure to areas (e.g., infected skin or mucosal surfaces) that are not covered or protected by the condom.

Epidemiologic studies seek to measure the protective effect of condoms by comparing risk of STD transmission among condom users with nonusers who are engaging in sexual intercourse. Accurately estimating the effectiveness of condoms for prevention of STDs, however, is methodologically challenging. Well-designed studies address key factors such as the extent to which condom use has been consistent and correct and whether infection identified is incident (i.e., new) or prevalent (i.e. pre-existing). Of particular importance, the study design should assure that the population being evaluated has documented exposure to the STD of interest during the period that condom use is being assessed. Although consistent and correct use of condoms is inherently difficult to measure, because such studies would involve observations of private behaviors, several published studies have demonstrated that failure to measure these factors properly tends to result in underestimation of condom effectiveness.

Epidemiologic studies provide useful information regarding the magnitude of STD risk reduction associated with condom use. Extensive literature review confirms that the best epidemiologic studies of condom effectiveness address HIV infection. Numerous studies of discordant couples (where

only one partner is infected) have shown consistent use of latex condoms to be highly effective for preventing sexually acquired HIV infection. Similarly, studies have shown that condom use reduces the risk of other STDs. However, the overall strength of the evidence regarding the effectiveness of condoms in reducing the risk of other STDs is not at the level of that for HIV, primarily because fewer methodologically sound and well-designed studies have been completed that address other STDs. Critical reviews of all studies, with both positive and negative findings (referenced here) point to the limitations in study design in some studies which result in underestimation of condom effectiveness; therefore, the true protective effect is likely to be greater than the effect observed.

Overall, the preponderance of available epidemiologic studies have found that when used consistently and correctly, condoms are highly effective in preventing the sexual transmission of HIV infection and reduce the risk of other STDs.

The following includes specific information for HIV infection, diseases transmitted by genital secretions, genital ulcer diseases, and HPV infection, including information on laboratory studies, the theoretical basis for protection and epidemiologic studies.

HIV, the virus that causes AIDS

- *Latex condoms, when used consistently and correctly, are highly effective in preventing the sexual transmission of HIV, the virus that causes AID*

HIV infection is, by far, the most deadly STD, and considerably more scientific evidence exists regarding condom effectiveness for prevention of HIV infection than for other STDs. The body of research on the effectiveness of latex condoms in preventing sexual transmission of HIV is both comprehensive and conclusive. The ability of latex condoms to prevent transmission of HIV has been scientifically established in “real-life” studies of sexually active couples as well as in laboratory studies.

Laboratory studies have demonstrated that latex condoms provide an essentially impermeable barrier to particles the size of HIV.

Theoretical basis for protection. Latex condoms cover the penis and provide an effective barrier to exposure to secretions such as urethral and vaginal secretions, blocking the pathway of sexual transmission of HIV infection.

Epidemiologic studies that are conducted in real-life settings, where one partner is infected with HIV and the other partner is not, demonstrate that the consistent use of latex condoms provides a high degree of protection.

Other Diseases transmitted by genital secretions, including Gonorrhea, Chlamydia, and Trichomoniasis

- *Latex condoms, when used consistently and correctly, reduce the risk of transmission of STDs such as gonorrhea, chlamydia, and trichomoniasis.*

STDs such as gonorrhea, chlamydia, and trichomoniasis are sexually transmitted by genital secretions, such as urethral or vaginal secretions.

Laboratory studies have demonstrated that latex condoms provide an essentially impermeable barrier to particles the size of STD pathogens.

Theoretical basis for protection. The physical properties of latex condoms protect against diseases such as gonorrhea, chlamydia, and trichomoniasis by providing a barrier to the genital secretions that transmit STD-causing organisms.

Epidemiologic studies that compare infection rates among condom users and nonusers provide evidence that latex condoms can protect against the transmission of STDs such as chlamydia, gonorrhea and trichomoniasis.

Genital ulcer diseases and HPV infections

- *Genital ulcer diseases and HPV infections can occur in both male and female genital areas that are covered or protected by a latex condom, as well as in areas that are not covered. Consistent and correct use of latex condoms reduces the risk of genital herpes, syphilis, and chancroid only when the infected area or site of potential exposure is protected. Condom use may reduce the risk for HPV infection and HPV-associated diseases (e.g., genital warts and cervical cancer).*

Genital ulcer diseases include genital herpes, syphilis, and chancroid. These diseases are transmitted primarily through “skin-to-skin” contact from sores/ulcers or infected skin that looks normal. HPV infections are transmitted through contact with infected genital skin or mucosal surfaces/secretions. Genital ulcer diseases and HPV infection can occur in male or female genital areas that are covered (protected by the condom) as well as those areas that are not.

Laboratory studies have demonstrated that latex condoms provide an essentially impermeable barrier to particles the size of STD pathogens.

Theoretical basis for protection. Protection against genital ulcer diseases and HPV depends on the site of the sore/ulcer or infection. Latex condoms can only protect against transmission when the ulcers or infections are in genital areas that are covered or protected by the condom. Thus, consistent and correct use of latex condoms would be expected to protect against transmission of genital ulcer diseases and HPV in some, but not all, instances.

Epidemiologic studies that compare infection rates among condom users and nonusers provide evidence that latex condoms provide limited protection against syphilis and herpes simplex virus-2 transmission. No conclusive studies have specifically addressed the transmission of chancroid and condom use, although several studies have documented a reduced risk of genital ulcers associated with increased condom use in settings where chancroid is a leading cause of genital ulcers.

Condom use may reduce the risk for HPV-associated diseases (e.g., genital warts and cervical cancer) and may mitigate the other adverse consequences of infection with HPV; condom use has been associated with higher rates of regression of cervical intraepithelial neoplasia (CIN) and clearance of HPV infection in women, and with regression of HPV-associated penile lesions in men. A limited number of prospective studies have demonstrated a protective effect of condoms on the acquisition of genital HPV.

While condom use has been associated with a lower risk of cervical cancer, the use of condoms should not be a substitute for routine screening with Pap smears to detect and prevent cervical cancer, nor should it be a substitute for HPV vaccination among those eligible for the vaccine.

Related Materials

- Selected References (references.html)

- Page last reviewed: December 16, 2008
- Page last updated: February 6, 2009
- Content source: Centers for Disease Control and Prevention (http://www.cdc.gov/)

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CONTENT OF AIDS-RELATED WRITTEN MATERIALS, PICTORIALS, AUDIOVISUALS, QUESTIONNAIRES, SURVEY INSTRUMENTS, AND EDUCATIONAL SESSIONS IN CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC) ASSISTANCE PROGRAMS (Interim Revisions June 1992)

Basic Principles

Controlling the spread of HIV infection and AIDS requires the promotion of individual behaviors that eliminate or reduce the risk of acquiring and spreading the virus. Messages must be provided to the public that emphasize the ways by which individuals can fully protect themselves from acquiring the virus. These methods include abstinence from the illegal use of IV drugs and from sexual intercourse except in a mutually monogamous relationship with an uninfected partner. For those individuals who do not or cannot cease risky behavior, methods of reducing their risk of acquiring or spreading the virus must also be communicated. Such messages can be controversial. These principles are intended to provide guidance for the development and use of educational materials, and to require the establishment of Program Review Panels to consider the appropriateness of messages designed to communicate with various groups.

a. Written materials (e.g., pamphlets, brochures, fliers), audio visual materials (e.g., motion pictures and video tapes), and pictorials (e.g., posters and similar educational materialsusing photographs, slides, drawings, or paintings) should use terms, descriptors, or displays necessary for the intended audience to understand dangerous behaviors and explain less risky practices concerning HIV transmission.

Written materials, audiovisual materials, and pictorials should be reviewed by Program Review Panels consistent with the provisions of Section 2500 (b), (c), and (d) of the Public Health Service Act, 42 U.S.C. Section 300ee(b), (c), and (d), as follows:

"SEC. 2500. USE OF FUNDS.

(b) CONTENTS OF PROGRAMS. - All programs of education and information receiving funds under this title shall include information about the harmful effects of promiscuous sexual activity and intravenous substance abuse, and the benefits of abstaining from such

activities.

(c) LIMITATION. - None of the funds appropriated to carry out this title may be used to provide education or information designed to promote or encourage, directly, homosexual or heterosexual sexual activity or intravenous substance abuse.

(d) CONSTRUCTION. - Subsection (c) may not be construed to restrict the ability of an education program that includes the information required in subsection (b) to provide accurate information about various means to reduce an individual's risk of exposure to, or to transmission of, the etiologic agent for acquired immune deficiency syndrome, provided that any informational materials used are not obscene."

c. Educational sessions should not include activities in which attendees participate in sexually suggestive physical contact or actual sexual practices.

d. Messages provided to young people in schools and in other settings should be guided by the principles contained in "Guidelines for Effective School Health Education to Prevent the Spread of AIDS" (MMWR 1988;37 [suppl. no. S-2]).

Program Review Panel

b. Each recipient will be required to establish or identify a Program Review Panel to review and approve all written materials, pictorials, audiovisuals, questionnaires or survey instruments, and proposed educational group session activities to be used under the project plan. This requirement applies regardless of whether the applicant plans to conduct the total program activities or plans to have part of them conducted through other organization(s) and whether program activities involve creating unique materials or using/distributing modified or intact materials already developed by others. Whenever feasible, CDC funded community-based organizations are encouraged to use a Program Review Panel established by a health department or another CDC-funded organization rather than establish their own panel. The Surgeon General's Report on Acquired Immune Deficiency Syndrome (October 1986) and CDC-developed materials do not need to be reviewed by the panel unless such review is deemed appropriate by the recipient. Members of a Program Review Panel should:

(1) Understand how HIV is and is not transmitted; and

(2) Understand the epidemiology and extent of the HIV/AIDS problem in the local population and the specific audiences for

which materials are intended.

The Program Review Panel will be guided by the CDC Basic Principles (in the previous section) in conducting such reviews. The panel is authorized to review materials only and is not empowered either to evaluate the proposal as a whole or to replace any other internal review panel or procedure of the recipient organization or local governmental jurisdiction.

Applicants for CDC assistance will be required to include in their applications the following:

(1) Identification of a panel of no less than five persons which represent a reasonable cross-section of the general population. Since Program Review Panels review materials for many intended audiences, no single intended audience shall predominate the composition of the Program Review panel, except as provided in subsection (d) below. In addition:

> (a) Panels which review materials intended for a specific audience should draw upon the expertise of individuals who can represent cultural sensitivities and language of the intended audience either through representation on the panels or as consultants to the panels.
>
> (b) The composition of Program Review Panels, except for panels reviewing materials for school-based populations, must include an employee of a State or local health department with appropriate expertise in the area under consideration who is designated by the health department to represent the department on the panel. If such an employee is not available, an individual with appropriate expertise, designated by the health department to represent the agency in this matter, must serve as a member of the panel.
>
> (c) Panels which review materials for use with school-based populations should include representatives of groups such as teachers, school administrators, parents, and students.
>
> (d) Panels reviewing materials intended for racial and ethnic minority populations must comply with the terms of (a), (b), and (c), above. However, membership of the Program Review Panel may be drawn predominately from such racial and ethnic populations.

(2) A letter or memorandum from the proposed project director, countersigned by a responsible business official, which includes:

> (a) Concurrence with this guidance and assurance that its

provisions will be observed;

(b) The identity of proposed members of the Program Review Panel, including their names, occupations, and any organizational affiliations that were considered in their selection for the panel.

CDC-funded organizations that undertake program plans in other than school-based populations which are national, regional (multi state), or statewide in scope, or that plan to distribute materials as described above to other organizations on a national, regional, or statewide basis, must establish a single Program Review Panel to fulfill this requirement. Such national/regional/State panels must include as a member an employee of a State or local health department, or an appropriate designated representative of such department, consistent with the provisions of Section 2.c.(1). Materials reviewed by such a single (national, regional, or state) Program Review Panel do not need to be reviewed locally unless such review is deemed appropriate by the local organization planning to use or distribute the materials. Such national/regional/State organization must adopt a national/regional/statewide standard when applying Basic Principles 1.a. and 1.b.

When a cooperative agreement/grant is awarded, the recipient will:

(1) Convene the Program Review Panel and present for its assessment copies of written materials, pictorials, and audiovisuals proposed to be used;

(2) Provide for assessment by the Program Review Panel text, scripts, or detailed descriptions for written materials, pictorials, or audiovisuals which are under development;

(3) Prior to expenditure of funds related to the ultimate program use of these materials, assure that its project files contain a statement(s) signed by the Program Review Panel specifying the vote for approval or disapproval for each proposed item submitted to the panel; and

(4) Provide to CDC in regular progress reports signed statement(s) of the chairperson of the Program Review Panel specifying the vote for approval or disapproval for each proposed item that is subject to this guidance.

Filling out CDC Form 0.113 for Written Educational Materials on HIV/AIDS

In conjunction with the Centers for Disease Control and Prevention's (CDC's) efforts to increase awareness and use of evidence-based effective HIV prevention interventions, we are distributing copies of CDC form 0.113 (see attached). The following provides rationale and instructions on how to complete form 0.113.

Form 0.113 asks you to list the names and other identifying information for the individuals who make up your Program Review Panel. A Program Review Panel is a group of at least five people, representing a cross section of the population in a given area, who review written materials intended for HIV/AIDS educational programs. The Program Review Panel represents local standards and judgment as to what materials are appropriate for selected local audiences.

Should you need to form a Program Review Panel, see CDC's "Content of AIDS-Related Written Materials, Pictorials, Audiovisuals, Questionnaires, Survey Instruments, and Educational Sessions in Centers for Disease Control and Prevention (CDC) Assistance Programs (Interim Revisions June 1992)." Following are a few key points from that document:

- Written educational materials on HIV prevention should use language or displays necessary for the intended audience to understand dangerous behaviors and explain less risky practices regarding HIV transmission.
- Such materials should be reviewed by a Program Review Panel.
- Whenever possible, CDC-funded community-based organizations (CBOs) are encouraged to use a Program Review Panel formed by a health department or other CDC-funded organizations rather than establish a new one.

To complete the enclosed form 0.113:

1. List the name, occupation, and affiliation (organization, business, government agency, etc.) of each member of the Program Review Panel you are using. There must be at least five members of this panel. If there are more, list them on the back of the form.
2. List the name of your organization, your grant number (if known), and ensure the form is signed by both your project director and an authorized business official. Have each person date the form after signing it.
3. If you are not developing any new HIV/AIDS related materials and therefore do not need to use a Program Review Panel, complete the second page, "Statement of Compliance with Content of HIV/AIDS-Related Written Materials, Pictorials, Audiovisuals, Questioners, Survey Instruments, and Educational Sessions." This states that your organization is using materials previously approved by the local Program Review Panel.

Please note that form 0.113 is currently undergoing revision. The revised version will soon be available. A key change in the new form is that is requires, rather than recommends, that CBOs use the Program Review Panel established by the local or state health department rather than forming a new one. Please contact us if you have questions or need technical support.

Once you have completed form 0.113, please return it to your Project Officer or maintain it in your files if you are not directly funded by CDC.

CENTERS FOR DISEASE CONTROL AND PREVENTION

ASSURANCE OF COMPLIANCE

with the

"REQUIREMENTS FOR CONTENTS OF AIDS-RELATED WRITTEN MATERIALS, PICTORIALS, AUDIOVISUALS, QUESTIONNAIRES, SURVEY INSTRUMENTS, AND EDUCATIONAL SESSIONS IN CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC) ASSISTANCE PROGRAMS"

By signing and submitting this form, we agree to comply with the specifications set forth in the "Requirements for Contents of AIDS-Related Written Materials, Pictorials, Audiovisuals, Questionnaires, Survey Instruments, and Educational Sessions in Centers for Disease Control and Prevention (CDC) Assistance Programs," as revised June 15, 1992, 57 Federal Register 26742.

We agree that all written materials, audiovisual materials, pictorials, questionnaires, survey instruments, proposed group educational sessions, educational curricula and like materials will be submitted to a Program Review Panel. The Panel shall be composed of no less than five (5) persons representing a reasonable cross-section of the general population; but which is not drawn predominantly from the intended audience. (See additional requirements in attached contents guidelines, especially paragraph 2.c. (1)(b), regarding composition of Panel.)

The Program Review Panel, guided by the CDC Basic Principles (set forth in 57 Federal Register 26742), will review and approve all applicable materials prior to their distribution and use in any activities funded in any part with CDC assistance funds.

Following are the names, occupations, and organizational affiliations of the proposed panel members: (If panel has more members than can be shown here, please indicate additional members on the reverse side.)

NAME	OCCUPATION	AFFILIATION
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
		(Health Department Representative)

_____ _____

Applicant/Grantee Name Grant Number (If Known)

_____ _____

Signature: Project Director Signature: Authorized Business Official

_____ _____

Date Date

CDC 0.1113(Revised 3/93)

MMWR Weekly
May 10, 2002 / 51(18);389-392

Nonoxynol-9 Spermicide Contraception Use --- United States, 1999

Most women in the United States with human immunodeficiency virus (HIV) become infected through sexual transmission, and a woman's choice of contraception can affect h risk for HIV transmission during sexual contact with an infected partner. Most contraceptives do not protect against transmission of HIV and other sexually transmitted diseases (STDs) (*1*), and the use of some contraceptives containing nonoxynol-9 (N-9) might increase the risk for HIV sexual transmission. Three randomized, controlled trials the use of N-9 contraceptives by commercial sex workers (CSWs) in Africa failed to demonstrate any protection against HIV infection (*2*--*4*); one trial showed an increased ri (*3*). N-9 contraceptives also failed to protect against infection with *Neisseria gonorrhoea* and *Chlamydia trachomatis* in two randomized trials (*5*,*6*), one among African CSWs an one among U.S. women recruited from an STD clinic. Because most women in the Afric studies had frequent sexual activity, had high-level exposure to N-9, and probably were exposed to a population of men with a high prevalence of HIV/STDs, the implications of these studies for U.S. women are uncertain. To determine the extent of N-9 contraceptive use among U.S. women, CDC assessed data provided by U.S. family planning clinics for 1999. This report summarizes the results of that assessment, which indicate that some U. women are using N-9 contraceptives. Sexually active women should consider their individual HIV/STD infection risk when choosing a method of contraception. Providers family planning services should inform women at risk for HIV/STDs that N-9 contraceptives do not protect against these infections.

CDC collected information on types of N-9 contraceptives purchased and family plannin program (FPP) guidelines for N-9 contraceptive use. The national FPP, authorized by Tit X of the Public Health Service Act, serves approximately 4.5 million predominantly low income women each year. Program data for 1999 were obtained from all 10 U.S. Department of Health and Human Services (HHS) regions on the number of female clier and the number of female clients who reported use of N-9 contraceptives or condoms as their primary method of contraception. CDC obtained limited purchase data for 1999 for specific N-9 contraceptives and program guidelines from eight state/territorial FPPs with six HHS regions. State health departments, family planning grantees, and family plannin

councils were contacted to request assistance in collecting data on purchasing patterns of the 91 Title X grantees; of the 12 FPPs that responded, eight provided sufficient data for analysis.

In 1999, a total of 7%--18% of women attending Title X clinics reported using condoms their primary method of contraception. Data on the percentage of condoms lubricated wi N-9 were not available. A total of 1%--5% of all women attending Title X clinics reporte using N-9 contraceptives (other than condoms) as their primary method of contraception (Table 1). Among the eight FPPs that provided purchase data, most (87%) condoms were N-9--lubricated (Table 2). All eight FPPs purchased N-9 contraceptives (i.e., vaginal filn and suppositories, jellies, creams, and foams) to be used either alone or in combination w diaphragms or other contraceptive products. Four of the eight clinics had protocols or program guidance stating that N-9--containing foam should be dispensed routinely with condoms; two additional programs reported that despite the absence of a clinic protocol, practice was common. Data for the other two programs were not available.

Reported by: *The Alan Guttmacher Institute, New York, New York. Office of Population Affairs, U.S. Dept of Health and Human Services, Bethesda, Maryland. A Duerr, MD, C Beck-Sague, MD, Div Reproductive Health, National Center Chronic Disease and Publi Health Promotion; Div of HIV and AIDS Prevention, National Center HIV/AIDS, STDs, and TB Prevention; B Carlton-Tohill, EIS Officer, CDC.*

Editorial Note:

The findings in this report indicate that in 1999, before the release of recent publications N-9 and HIV/STDs (*4,6,7*), Title X family planning clinics in the U.S. purchased and distributed N-9 contraceptives. Among at least eight family planning clinics, most of the condoms purchased were N-9--lubricated; this is consistent with trends in condom purchases among the general public (*8*). The 2002 STD treatment guidelines state that condoms lubricated with spermicides are no more effective than other lubricated condom in protecting against the transmission of HIV infection and other STDs (*7*). CDC recommends that previously purchased condoms lubricated with N-9 spermicide continu to be distributed provided the condoms have not passed their expiration date. The amoun of N-9 on a spermicide-lubricated condom is small relative to the doses tested in the stud in Africa and the use of N-9--lubricated condoms is preferable to using no condom at all. the future, purchase of condoms lubricated with N-9 is not recommended because of thei increased cost, shorter shelf life, association with urinary tract infections in young wome and lack of apparent benefit compared with other lubricated condoms (*7*).

Spermicidal gel is used in conjunction with diaphragms (*1*); only diaphragms combined with the use of spermicide are approved as contraceptives. The respective contributions c the physical barrier (diaphragm) and chemical barrier (spermicide) are unknown, but the combined use prevents approximately 460,000 pregnancies in the United States each yea (*1*).

The findings in this report are subject to at least two limitations. First, data on specific products and patterns of contraceptive use were limited; CDC used a nonrepresentative sample of regions and states that voluntarily provided data, and specific use patterns of tl contraceptives could not be extrapolated from these data. Second, data correlating use of 9 contraceptives with individual HIV risk were not available.

Prevention of both unintended pregnancy and HIV/STD infection among U.S. women is needed. In 1994, a total of 49% of all pregnancies were unintended (*9*). Furthermore, 26% of women experience an unintended pregnancy during the first year of typical use of spermicide products (*1*). In 1999, a total of 10,780 AIDS cases, 537,003 chlamydia cases and 179,534 gonorrhea cases were reported among U.S. women. Contraceptive options should provide both effective fertility control and protection from HIV/STDs; however, t optimal choice is probably not the same for every woman.

N-9 alone is not an effective means to prevent infection with HIV or cervical gonorrhea a chlamydia (*2*,*7*). Sexually active women and their health-care providers should consider risk for infection with HIV and other STDs and risk for unintended pregnancy when considering contraceptive options. Providers of family planning services should inform women at risk for HIV/STDs that N-9 contraceptives do not protect against these infections. In addition, women seeking a family planning method should be informed tha latex condoms, when used consistently and correctly, are effective in preventing transmission of HIV and can reduce the risk for other STDs.

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3. Kreiss J, Ngugi E, Holmes K, et al. Efficacy of nonoxynol-9 contraceptive sponge u in preventing hetereosexual acquisition of HIV in Nairobi prostitutes. JAMA 1992;268:477--82.
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9. Henshaw SK. Unintended pregnancy in the United States. Fam Plann Perspect 1998;30:24--9,46.

Table 1

TABLE 1. Number of women using male condoms or nonoxynol-9 (N-9) products as their primary method of contraception, by T X Family Planning Region — United States, 1999

Region*	No. of women served	Male condoms		N-9 products†	
		No.	(%)	No.	(%)
I	179,705	27,726	(15)	1,251	(1)
II	404,325	73,069	(18)	21,515	(5)
III	487,502	73,088	(15)	4,807	(1)
IV	1,011,126	93,011	(9)	29,630	(3)
V	522,312	61,756	(12)	2,489	(1)
VI	478,533	40,520	(8)	11,212	(2)
VII	238,971	15,949	(7)	1,386	(1)
VIII	133,735	15,131	(11)	4,885	(4)
IX	672,362	109,678	(17)	14,547	(2)
X	186,469	17,320	(9)	1,275	(2)
Total	**4,315,040**	**527,248**	**(12)**	**92,997**	**(2)**

* Region I=Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont; Region II=New Jersey, New York, Puerto Rico, Virgin Isla Region III=Delaware, District of Columbia, Maryland, Pennsylvania, Virginia, West Virginia; Region IV=Alabama, Florida, Georgia, Kentucky, Mississ North Carolina, South Carolina, Tennessee; Region V=Illinois, Indiana, Michigan, Minnesota, Ohio, Wisconsin; Region VI=Arkansas, Louisiana, I Mexico, Oklahoma, Texas; Region VII=Iowa, Kansas, Missouri, Nebraska; Region VIII=Colorado, Montana, North Dakota, South Dakota, Utah, Wyom Region IX=Arizona, California, Hawaii, Nevada, American Samoa, Guam, Mariana Islands, Marshall Islands, Micronesia, Palau; Region X=Alaska, Id Oregon, Washington.

† Primary method of contraception reported by these women was one of the following: spermicidal foam, cream, jelly (with and without diaphragm), film suppositories.

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Table 2

TABLE 2. Number of nonoxynol-9 (N-9) contraceptives purchased by Title X Family Planning Programs in selected states/territories, 1

State/territory	No. of clients served	Physical barrier method		N-9 chemical barrier methods				
		Condoms with N-9	Condoms without N-9	Gel	Vaginal Film	Vaginal Insert	Jelly	Foam
Puerto Rico	15,103	148,072	5,000	12,900	0	NA*	12,841	2,400
New York†	283,200	1,936,084	NA	0	73,788	NA	3,112	23,830
West Virginia	60,899	1,300,000	9,360	0	0	NA	1,200	9,900
Florida	193,784	3,920,000	560,000	0	468,720	NA	5,760	25,920
Tennessee	111,223	2,865,160§	717,088	0	94,500	12,528	756	2,758
Michigan	166,893	631,000	254,000	0	0	NA	1,000	1,200
Oklahoma	58,392	708,480	0	0	394,560	NA	1,200	0
Oregon	57,099	151,900	276,000	345	25,764	2,074	272	3,007

* Not available.
† 41 of 61 grantees responded.
§ Purchasing by family planning and sexually transmitted disease programs are combined and cannot be separated.

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Notice to Readers: CDC Statement on Study Results of Product Containing Nonoxynol-9

During the XIII International AIDS Conference held in Durban, South Africa, July 9--14, 2000, researchers from the Joint United Nations Program on AIDS (UNAIDS) presented results of a study of a product, COL-1492,* which contains nonoxynol-9 (N-9) (*1*). N-9 products are licensed for use in the United States as spermicides and are effective in preventing pregnancy, particularly when used with a diaphragm. The study examined the use of COL-1492 as a potential candidate microbicide, or topical compound to prevent the transmission of human immunodeficiency virus (HIV) and sexually transmitted diseases (STDs). The study found that N-9 did not protect against HIV infection and may have caused more transmission. The women who used N-9 gel became infected with HIV at approximately a 50% higher rate than women who used the placebo gel.

CDC has released a "Dear Colleague" letter that summarizes the findings and implications of the UNAIDS study. The letter is available on the World-Wide Web, http://www.cdc.gov/hiv; a hard copy is available from the National Prevention Information Network, telephone (800) 458-5231. Future consultations will be held to re-evaluate guidelines for HIV, STDs, and pregnancy prevention in populations at high risk for HIV infection. A detailed scientific report will be released on the Web when additional findings are available.

Reference

1. van Damme L. Advances in topical microbicides. Presented at the XIII International AIDS Conference, July 9--14, 2000, Durban, South Africa.

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Personalized Cognitive Counseling

TRAINING OF COUNSELORS

PARTICIPANT WORKBOOK

University of California, San Francisco
AIDS Health Project
in collaboration with
Allen/Loeb Associates

The program of research that developed and tested the ***PCC*** protocol was supported by the National Institute on Mental Health. Development of this manual was supported by the U.S. Centers for Disease Control and Prevention.

PCC Participant Workbook

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PCC Training Of Counselors Agenda: Day 1

8:30–9:00 **Module I: Introductions, Ground Rules, and Overview**

9:00–10:00 **Module II: Introduction to *PCC***

10:00–10:15 **BREAK**

10:15-10:30 **Module III: *PCC* Core Elements, Key Characteristics, and Behavior Change Logic Model**

10:30–12:30 **Module IV: Screening Clients, Step 1—Identifying UAI, Step 2—*PCC* Questionnaire**

12:30–1:30 **LUNCH**

1:30–2:15 **Module V: *PCC* Questionnaire, Self-Justifications, On-Line and Off-Line Thinking**

2:15–3:15 **Module VI: Step 3—Drawing Out the Story and Step 4—Identifying Self-Justifications**

3:15–3:30 **BREAK**

3:30–4:15 **Module VI: Step 3—Drawing Out the Story and Step 4—Identifying Self-Justifications (continued)**

4:15–4:30 **Module VII: Wrap-Up of Day 1**

Personalized Cognitive Counseling

PCC Training Of Counselors Agenda: Day 2

9:00–9:15 **Module VIII: Welcome Day 2**

9:15–9:45 **Module IX: How PCC Works; PCC in relation to other interventions**

9:45–10:45 **Module X: Step 3—Drawing Out the Story and Step 4—Identifying Self-Justifications, second practice**

10:45–11:00 **BREAK**

11:00–12:00 **Module X: Step 3—Drawing Out the Story and Step 4—Identifying Self-Justifications, second practice (continued)**

12:00–1:00 **LUNCH**

1:00–3:00 **Module XI: Step 4—Identifying Self-Justifications (continued) and Step 5—Moving from Identifying Self-Justifications to Talking About the Future**

3:00–3:15 **BREAK**

3:15–4:00 Module XII: Implementation of *PCC*

4:00–4:30 Module XIII: Wrap-Up and Closing

PCC Training Goal and Primary Learning Objectives

Training Goal

The goal of this training is to prepare experienced Human Immunodeficiency Virus (HIV) test counselors to implement ***Personalized Cognitive Counseling (PCC)*** successfully with clients who are seronegative men who have sex with men (MSM) who are repeat HIV testers, and who have had a recent unprotected anal intercourse (UAI) episode with a partner who was HIV-positive or whose serostatus was unknown.

Training Objectives

By the end of the ***PCC*** training, participants will be able to:

1. Screen clients and determine if they are appropriate for ***PCC***, as demonstrated by role play practice.
2. Assist a client in identifying an appropriate episode of unprotected anal intercourse (UAI) to talk about in the ***PCC*** session, as demonstrated by role play practice.
3. Direct clients to complete the ***PCC*** Questionnaire using the appropriate UAI episode identified, as demonstrated by role play practice.
4. Help the client draw out the story of the memorable UAI episode, as demonstrated by role play practice.
5. Identify the client's self-justifications used during the UAI episode and ask the client to talk about them, as demonstrated by the role play practice.
6. Ask the ***PCC*** client to talk about what he will do in the future about reducing risk in a similar situation, as demonstrated by role play practice.

Welcome to the PCC Training!

Slide 1

Introducing Yourself

- **Your Name**
- **Agency/Organization where you work**
- **Job title and description**

Slide 2

Learning Objectives

The goal of this training is to prepare experienced HIV test counselors to implement *Personalized Cognitive Counseling* (PCC) successfully with clients who are men who have sex with men (MSM) who are repeat HIV testers and who have had a recent unprotected anal intercourse (UAI) episode.

Slide 3

By the end of the 2-day PCC training, you will be able to:

1. **Screen clients and determine if they are appropriate for PCC, as demonstrated by role play practice.**
2. **Assist a client in identifying an appropriate episode of unprotected anal intercourse (UAI) to talk about in the PCC session, as demonstrated by role play practice.**
3. **Direct clients to complete the PCC questionnaire using the appropriate UAI episode identified, as demonstrated by role play practice.**

Slide 4

By the end of the 2-day PCC training, you will be able to:

4. Help the client draw out the story of the memorable UAI episode, as demonstrated by role play practice.
5. Identify the client's self-justifications used during the UAI episode and ask the client to talk about them, as demonstrated by role play practice.
6. Ask the PCC client to talk about what he will do in the future about reducing risk in a similar situation, as demonstrated by role play practice.

Slide 5

Story of PCC: Who and Why?

- Developed at AIDS Health Project (AHP) in San Francisco by Dr. James Dilley
- AHP first years of program data showed that MSM were being tested for HIV repeatedly
- Repeat testers were seroconverting at a rate 3 times that of men who were not repeat testers

Slide 6

Story of PCC: Supporting Model

- Inspired by work of Ron Gold, a cognitive psychologist from Australia.
- Key concepts
  - On-line thinking—heat of the moment
  - Off-line thinking—cold light of day
  - Self-Justifications—thoughts used to engage in known risky behavior

Slide 7

Story of PCC: What is it?

- 30 to 50 minute single counseling session
- Helps client identify thoughts and feelings he had when he made decision to engage in risky behavior, and talk about what to do differently in future similar situations
- MSM who:
  - ✓ Previously tested negative for HIV
  - ✓ Had UAI with HIV+ person or person of unknown HIV status
  - ✓ UAI with non primary partner

Slide 8

Story of PCC: Results of the Study

- **MSM who received PCC significantly reduced their episodes of UAI compared to MSM who received standard HIV prevention counseling alone.**
- **MSM who received PCC reported more satisfaction with the services they received.**

Slide 9

Definition of Self-Justifications

Thoughts that allow people to make a decision to engage in risky sex, in contradiction to other knowledge and beliefs they have that support avoiding risk.

Self-justifications occur during on-line thinking—in the heat of the moment.

Slide 10

Examples of self-justifications

The *PCC Questionnaire* is made up of numerous common self-justifications, including:

- "My (or his) cock was rubbing up against his (or my) ass, and it just slipped in by accident."
- "I didn't want to fuck without a condom but I was so horny I couldn't think properly."
- "I didn't want to fuck without a condom but I was too embarrassed to tell him.

Slide 11

On-Line and Off-Line Thinking defined–

On-line thinking: heat of the moment thinking, which takes place in a situation where there are immediate rewards for unwise behavior.

Off-line thinking: cold light of day thinking, which takes place in a situation where there are no immediate rewards and more realistic thinking is easier.

Slide 12

On-Line and Off-Line Thinking Examples

On-line thinking:

"My (or his) cock was rubbing up against his (or my) ass, and it just slipped in by accident."

Off-line thinking:

"I kind of knew that was going to happen. It's risky! I could have asked him to put on a condom before, or to stop and put on a condom before continuing."

Slide 13

Step 1

Help the client choose a memorable recent episode of UAI to discuss in detail during the PCC session.

- Determines the rest of the process.
- "Memorable" means that client can recall his thoughts and feelings.
- Best if client has some anxiety about the episode

Slide 14

Step 2

Have the client complete the *PCC Questionnaire* about the memorable UAI

- Stay in the room with the client to answer questions.
- You can do paper or computer work while the client is completing the questionnaire.
- You can read aloud to those with vision or reading difficulties.

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Step 3

Draw out the story of the memorable episode. Ask the client what his thoughts and feelings were before, during, and after the episode.

- Story needs to be detailed.
- It's OK if client experiences some anxiety.

Slide 16

Step 4

Help the client identify his self-justifications for the UAI and talk about these. When necessary, provide correct HIV risk information.

- Step 3 should lead into this activity.
- Responding to the *Questionnaire* will remind him of some self-justifications.

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Step 5

Ask the client what he thinks he will do in the future about UAI. Support his positive plans.

Slide 18

Sample Questions About the Future

- **If you're in a similar situation again, what do you think you will do differently?**
- **Considering what we've been talking about, what are your thoughts about what you'll do in the future?**
- **Let's say you go to that club again, what do you think you might do differently?**

Slide 19

Inclusion Criteria

To be in the target population, the individual presenting for HIV testing must be:

✓An MSM

✓ who has previously been tested, and was HIV negative on that test, and

✓ who—since that last test—has had unprotected anal intercourse with a non-primary partner whose HIV status was unknown or was known to be HIV positive.

Slide 20

Opening Question

"What made you come in for testing today?"

Slide 21

Basic Screening Questions

"Have you been tested before? What were your test results?"

If negative, the next questions address this basic question:

"Have you had unprotected anal sex with a man, other than your boyfriend or primary partner, whose HIV status you didn't know or who was HIV positive?"

Slide 22

Example: Final Question Divided into 2

"Have you had unprotected anal sex with a man other than a boyfriend/primary partner?"

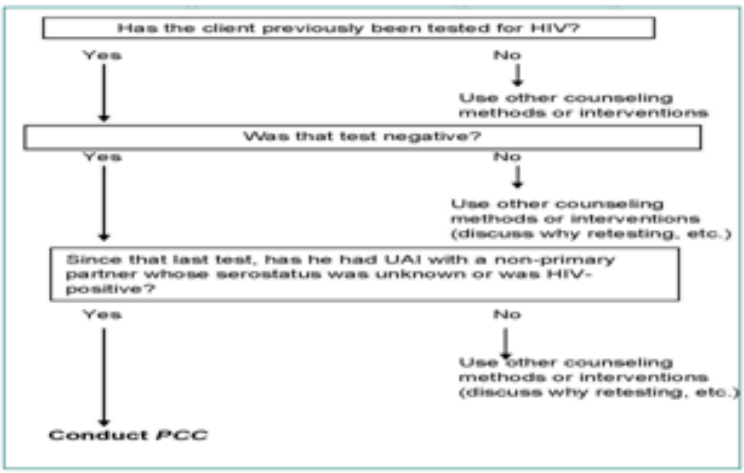
If yes, ask:

"Did you know if he was HIV positive?"

If did not know, or partner was HIV positive, client is eligible for PCC.

Slide 23

PCC Screening Process



Slide 24

PCC QUESTIONNAIRE

I. Below we have listed some statements. For each one, please indicate how true each statement is for you:

	Very True	Moderately True	Slightly True	Not True at All	I Can't Remember at All
1) My (or his) cock was rubbing up against his (or my) ass, and it just slipped in by accident. Neither of us really meant to fuck without a condom.	[ ]	[ ]	[ ]	[ ]	[ ]
2) I didn't want to fuck without a condom but I was so horny I couldn't think properly.	[ ]	[ ]	[ ]	[ ]	[ ]
3) I didn't want to fuck without a condom but I couldn't find the words to tell him.	[ ]	[ ]	[ ]	[ ]	[ ]
4) I didn't want to fuck without a condom but I couldn't find the right moment to tell him.	[ ]	[ ]	[ ]	[ ]	[ ]
5) I didn't want to fuck without a condom but I was too embarrassed to tell him.	[ ]	[ ]	[ ]	[ ]	[ ]

II. Next is a particularly difficult section. So please try to think very carefully before you answer. We would like to find out what sorts of things you were thinking or saying to yourself (even in the back of your mind) that allowed you to fuck without a condom. How did you justify to yourself fucking without a condom? Below, we have listed a number of ways that you might have done this. For each one please indicate whether you had that thought, or not, at the time you decided to fuck without a condom. Some of the justifications may seem silly, but they've been included because they may apply to other people.

AT THE TIME I DECIDED TO FUCK WITHOUT A CONDOM:	I had this thought strongly (in the forefront of my mind)	I had this thought to a moderate degree	I had this thought slightly (in the back of my mind)	I didn't have this thought at all	I can't remember at all whether I had this thought or not
6) I thought to myself something like: "This guy and me have been faithful to each other for a long time now, and neither of us has symptoms of HIV. So it will probably be OK."	[ ]	[ ]	[ ]	[ ]	[ ]
7) I thought to myself something like: "We take chances every day—after all, it's even taking a chance to cross a road. Taking a risk is part of life."	[ ]	[ ]	[ ]	[ ]	[ ]
8) I thought to myself something like: "I'm feeling low and I need something to make me feel good and this will do it for me."	[ ]	[ ]	[ ]	[ ]	[ ]
9) I thought to myself something like: "It'll be safe to fuck without a condom, so long as we don't cum in the ass. So we'll just fuck without cumming."	[ ]	[ ]	[ ]	[ ]	[ ]
10) I thought to myself something like: "Other guys fuck without a condom much more often than I do. I'm at less risk than most guys."	[ ]	[ ]	[ ]	[ ]	[ ]

AT THE TIME I DECIDED TO FUCK WITHOUT A CONDOM:	I had this thought strongly (in the forefront of my mind)	I had this thought to a moderate degree	I had this thought slightly (in the back of my mind)	I didn't have this thought at all	I can't remember at all whether I had this thought or not
11) I thought to myself something like: "I'm fed up with having to think and worry about HIV all the time. It's so depressing. At the moment, I just can't handle thinking about it at all. I refuse to think about HIV right now."	[ ]	[ ]	[ ]	[ ]	[ ]
12) I thought to myself something like: "I had an HIV test a while ago, and it was negative. After all the things I've done, it was still negative; I was OK. So it can't be all that easy to get infected."	[ ]	[ ]	[ ]	[ ]	[ ]
13) I thought to myself something like: "This guy looks so healthy, he can't possibly be infected."	[ ]	[ ]	[ ]	[ ]	[ ]
14) I thought to myself something like: "I'm not very sexually attractive, and it's really great that I've managed to get this guy. I just can't afford to be very choosy about what I do. I don't get many opportunities."	[ ]	[ ]	[ ]	[ ]	[ ]
15) I thought to myself something like: "I'll be all right. I've always been a lucky guy and my luck will hold."	[ ]	[ ]	[ ]	[ ]	[ ]

AT THE TIME I DECIDED TO FUCK WITHOUT A CONDOM:	I had this thought strongly (in the forefront of my mind)	I had this thought to a moderate degree	I had this thought slightly (in the back of my mind)	I didn't have this thought at all	I can't remember at all whether I had this thought or not
16) I thought to myself something like: "I love this guy. A condom would spoil all the romance. I can't have a condom separating me from the man I love. I can't have a condom coming between us."	[ ]	[ ]	[ ]	[ ]	[ ]
17) I thought to myself something like: "I'll have one last fling and do only safe sex from then on. I'll be good starting tomorrow—I won't fuck without a condom after this last time."	[ ]	[ ]	[ ]	[ ]	[ ]
18) I thought to myself something like: "I want to feel what it was like when you could do what you liked sexually, as it was before HIV."	[ ]	[ ]	[ ]	[ ]	[ ]
19) I thought to myself something like: "This guy doesn't seem to be on the scene much (he told me he doesn't get around much/I've never seen him before/he told me he hates the scene, etc.), so he's probably not infected."	[ ]	[ ]	[ ]	[ ]	[ ]
20) I thought to myself something like: "If I'm on top—if I fuck him—my chances of getting infected are low. He's the one at risk, so that's his problem, not mine."	[ ]	[ ]	[ ]	[ ]	[ ]

AT THE TIME I DECIDED TO FUCK WITHOUT A CONDOM:	I had this thought strongly (in the forefront of my mind)	I had this thought to a moderate degree	I had this thought slightly (in the back of my mind)	I didn't have this thought at all	I can't remember at all whether I had this thought or not
21) I thought to myself something like: "I just have to have good sex and I can't have good sex without fucking and I can't enjoy fucking if I use a condom—condoms take all the feeling away."	[ ]	[ ]	[ ]	[ ]	[ ]
22) I thought to myself something like: "Condoms destroy the magic of sex. How can we suddenly interrupt everything just to put on a condom?"	[ ]	[ ]	[ ]	[ ]	[ ]
23) I thought to myself something like: "Most of the time I'm careful, but I can't be perfect—it's only human to slip up occasionally."	[ ]	[ ]	[ ]	[ ]	[ ]
24) I thought to myself something like: "The two of us have fucked without a condom before, not so long ago, so there is no point in stopping now."	[ ]	[ ]	[ ]	[ ]	[ ]
25) I thought to myself something like: "We've both had the HIV test, and the tests were both negative, so neither of us is infected."	[ ]	[ ]	[ ]	[ ]	[ ]
26) I thought to myself something like: "Part of being in love with a guy is trusting him and showing him that you trust him. I want him to know that I trust him."	[ ]	[ ]	[ ]	[ ]	[ ]

AT THE TIME I DECIDED TO FUCK WITHOUT A CONDOM:	I had this thought strongly (in the forefront of my mind)	I had this thought to a moderate degree	I had this thought slightly (in the back of my mind)	I didn't have this thought at all	I can't remember at all whether I had this thought or not
27) I thought to myself something like: "If I put on (or he puts on) a condom, I (or he) won't be able to get an erection, and the sex will be spoiled."	[ ]	[ ]	[ ]	[ ]	[ ]
28) I thought to myself something like: "This guy is clearly concerned about HIV, so I'm sure he's been careful. So he can't possibly be infected."	[ ]	[ ]	[ ]	[ ]	[ ]
29) I thought to myself something like: "I want to have unprotected sex because it feels good."	[ ]	[ ]	[ ]	[ ]	[ ]
30) I thought to myself something like: "Some people seem to be immune to the virus. I've done lots of risky things in the past and have never gotten infected so I must be one of those people who's immune."	[ ]	[ ]	[ ]	[ ]	[ ]
31) I thought to myself something like: "Sex is more exciting when it's dangerous, when it's breaking the rules. I want to feel that thrill when I fuck without a condom."	[ ]	[ ]	[ ]	[ ]	[ ]

32) Were there any other reasons for fucking without a condom that you can remember giving yourself (even just at the back of your mind)? If so, please describe them.

_____

_____

PCC Observation Form

Counselor & "client": _____ Observer: _____

Screening: What screening questions did the counselor ask?

Step 1: What did the counselor say to help the client choose the UAI episode?

Step 2: What did the counselor say to the client about completing the questionnaire?

Counseling skills: What open-ended probing question did the counselor ask?

What did the counselor mirror?

Step 3: What did the counselor say to draw out the story of the UAI?

What did the client say that was on-line thinking?

Step 4: What self-justifications did the counselor help the client identify?

What did the client say that was off-line thinking?

Step 5: How did the counselor ask the client about what he will do in the future?

What did the client say he would do in the future about UAI?

Role-Play Client and Counselor Assignments

Review the six role-play client descriptions and select one (or have it assigned). Each group member should be a different role-play client; no duplicates. Then select group members to be counselors for the role-play clients. Each person in the group will take the role of both a client and a counselor.

Write the name of the person who is role-playing Client #1 in the space next to that role in the space below. Identify who will role-play the counselor for that client and write the counselor's name in that space. Continue through the number of clients so that each group member has been assigned a client number, and each group member has also been assigned as a counselor for a client.

Save this list so that group members can easily remember who played which role in the role-play practice, as you will continue the role-play practice in these roles.

Client 1 Name _____ Counselor Name _____

Client 2 Name _____ Counselor Name _____

Client 3 Name _____ Counselor Name _____

Client 4 Name _____ Counselor Name _____

Client 5 Name _____ Counselor Name _____

Client 6 Name _____ Counselor Name _____

Role-Play Guide—Client 1

You are a man who keeps his male-to-male sexual activities a secret—you are very concerned that your wife, family, and friends would reject you if they knew you sometimes have sex with men.

Why you came in. You came in for testing because you have had several instances over the past year of UAI, both as insertive and receptive partner.

Memorable episode. You were driving at night on the freeway, and you went to a rest area where you know that men cruise for sex. That night, you had been feeling depressed and horny. You planned, in the back of your mind, to go by the rest area. You had thought of buying condoms to take with you that day but you were afraid if you had them around your wife might find them. You hoped that you would have the "willpower" to just drive past. You hung around in the rest area parking lot to pick up somebody. You felt anxious, but very excited. After a while, you found a reasonably attractive person. After making eye contact, you spoke to him briefly. You felt very little connection to your partner, and were mainly thinking about getting it over with, so you could go home, where your absence might be noticed. You then went into the nearby woods and without conversation, had anal sex. You were the receptive partner. Afterward, you felt guilty, and eager to get home.

Your self-justifications are:

- "I didn't want to fuck without a condom but I was so horny I couldn't think properly."
- "I didn't want to fuck without a condom but I couldn't find the words to tell him."
- "Other guys fuck without a condom much more often than I do. I'm at less risk than most guys."

Off-line thinking:

- I know that UAI puts me at risk, and I', guilty and afraid about putting mywife at risk if I get HIV.
- I wish I could stop having sex with men, but I probably won't.
- I know actually could bring condoms with me to cruising places.

Role-Play Guide—Client 2

You are a gay-identified man over 35 years old. You long for a relationship.

Why you came in. You came in for testing because you had UAI with a man whom you hoped you'd have a relationship with. He then became unavailable, leaving you anxious about his HIV status.

Memorable episode. You met a man through an online dating site. He had lot of similar interests. He owned his own house and had a professional job, which made you feel like he would be a real catch. You did not have sex till the third date, when you went to his house after dinner. You felt nervous during the evening, not sure if he liked you. After dinner, you sat on the couch with him and began making out. You drank three glasses of wine. You were excited but intimidated. He invited you to his bedroom. As you took off your clothes, he said he was HIV-negative. He said he wasn't good at "performing" with a condom on. Without pausing, you said, "OK." As things went forward, you told yourself, "He's negative … not the kind of person to be HIV-positive. … I can't interrupt the flow…" and you continued with him, being the receptive partner in UAI. Afterward, you felt happy and relaxed. After you went home, you began having anxiety about having had unsafe sex.

In the next weeks, he stopped returning calls and e-mails. You remain angry and hurt, as well as afraid about having gotten HIV.

Your self-justifications are:

"He told me he's not on the scene much; he seems healthy; he's not the kind of person who'd have HIV."

"I'm not very sexually attractive, and it's really great that I've managed to get this guy. I just can't afford to be very choosy about what I do."

"If I put on (or he puts on) a condom, I (or he) won't be able to get an erection, and the sex will be spoiled."

Off-line thinking:

"I want to protect myself from HIV."

"As much as I want a relationship, it's not worth risking HIV on the chance that having unprotected sex will advance the relationship."

"You can't be sure someone is negative even if they say so; they could be lying or mistaken."

Role-Play Guide—Client 3

You are a 21-year-old college undergraduate. You "came out" about a year and a half ago. You have a strong desire to be liked and fit in. You think it's unlikely that anyone your age would have HIV unless they were "slutty." At the same time, you are informed about safe sex and HIV risk.

Why you came in. Reading Internet news reports about HIV among young people has made you anxious about the UAI you've had, and that's why you've come in for testing.

Memorable episode. You went to a party on a Saturday night. You were kind of bored, and a little down that you didn't have a date. Toward the end of the party, you ended up spending a lot of time talking with a guy named Roger. He was a popular, handsome guy you'd seen at other parties. You did not know him well, you thought he was attractive, but he'd never shown interest in you before. As the party ended, he invited you to his place. You felt pleased and excited. Once you got there, he began passionately initiating sex right away. You were flattered, but a little intimidated. The easiest thing was just to submit. After some oral sex, he nonverbally indicated he wanted to have anal sex, and you cooperated. Afterwards, it became clear that Roger didn't want to pursue anything with you, and you felt hurt and let down.

Self-justifications:

"This guy doesn't seem to be on the scene much (he told me he doesn't get around much/I've never seen him before/he told me he hates the scene, etc.), so he's probably not infected."

"I didn't want to fuck without a condom but I couldn't find the right moment to tell him."

"I'm feeling low and I need something to make me feel good and this will do it for me."

Off-line thinking:

"Anybody can have HIV, even if they are young and don't seem promiscuous."

"It's best to use condoms for anal sex until you really know and trust the person and are sure they are HIV-negative."

Role-Play Guide—Client 4

You are a man who has sex every weekend, going to gay bars, sex clubs, and bathhouses. Finding guys for sex is a pastime for you, and a way of cheering yourself up when you're bored and depressed.

Why you came in. There have been a number of times in the last year when you didn't use condoms, and worry about this has brought you in for a test.

Memorable episode. On a Saturday night you had gone to one of your regular hangouts, and pursued a couple of different guys, but nothing came of it. You felt lousy, rejected. You went to the bathhouse and there weren't many people there. The few more attractive guys who were there didn't seem interested—they wouldn't make eye contact with you. It was getting late, and you were trying not to think about Monday morning, having to go to work. You were beginning to feel very tired, from the late hour and from drinking alcohol, but you didn't want to feel defeated, rejected, which is what going home without having a sexual episode would have felt like.

A guy older than you had been paying attention to you, and you finally decided you'd settle for him. You felt like you would just get it over with and go home. You went into his cubicle, and while there were condoms there, he didn't put one on. After oral sex, one thing seemed to lead to another. At the point he penetrated you without a condom, you thought of saying something, but in your resigned mood, you didn't say anything.

Self-Justifications:

"My (or his) cock was rubbing up against his (or my) ass, and it just slipped in by accident. Neither of us really meant to fuck without a condom."

"I'm feeling low. I need something to make me feel good and this will do it."

"Most of the time I'm careful, but I can't be perfect—it's only human to slip up occasionally."

Off-line thinking:

"If I keep taking chances, I'm more likely to get HIV. Maybe it's happened. I have sex a lot; I should protect myself."

"I could have asked him to put on a condom."

"I thought it would make me feel better to just go ahead and have sex, but it didn't—I felt worse afterward, and part of that was being worried about getting HIV."

Role-Play Guide—Client 5

You prefer to have sex with men, but most of your friends aren't identified as gay. You don't say you aren't gay, you say, "I don't like labels." Your family and many of your friends do not know that you have sex with men.

Why you came in. You are worried about several episodes of UAI.

Memorable episode. This episode is memorable to you because it's one that you've worried about. On a Saturday afternoon you were at a cruise spot in a park. It was a dull weekend for you—nothing in particular planned, and the evening to follow would be spent watching TV. You were bored, a bit depressed, lonely. You made eye contact with a good-looking guy. He seemed really masculine, a turn-on to you. You felt flattered that he paid attention to you. He had a sweet smile. You wanted to be close to him. You went into a secluded area in the bushes. You began touching, hugging. You felt surprised and pleased. After some oral sex, he got behind you and was holding you. It felt good. He seemed to be doing something, reaching into his pocket. You realized he was putting on some lubricant. You felt his penis rubbing against you. The thought came to you that you didn't want to stop the flow—"It's going so well, don't ruin it now." Then, he inserted his penis, and you didn't say anything. After finishing intercourse, you felt guilty and anxious. You felt you couldn't wait to get home and shower. You tell yourself, "It's in the past, no use crying over spilt milk." But you sometimes get a jolt of fear when you wonder if your partner might have been HIV-positive.

Self-Justifications:

"His cock was rubbing up against my ass, and it just slipped in by accident. Neither of us really meant to fuck without a condom."

"I thought, this guy doesn't seem to be on the scene much—he looks straight—so he's probably not infected."

"I'm feeling low and I need something to make me feel good and this will do it for me."

"I didn't want to fuck without a condom but I couldn't find the right moment to tell him. I didn't want to stop the flow."

Off-line thinking:

"I could have asked him to put on a condom."

"You can't tell if someone is on the gay scene a lot by looking at them, or if they have HIV by looking at them."

Role-Play Guide—Client 6

You are mostly careful about HIV risk. But, every few months, you have an evening when you drink alcohol and use methamphetamine and engage in having UAI with multiple partners.

Why you came in. Knowing you have HIV risk, you regularly get tested.

Memorable episode. On a Sunday night, following a week you had been feeling bored, hemmed in, and depressed. You took some methamphetamine, opened a beer, and logged in to an Internet site for connecting with other MSM. You began conversing with other men who were online at the same time, and found a small group that was about to have a sex party. You went there, driving carefully, feeling excited and frightened at the same time. When you arrived, you took some more methamphetamine. You felt like you were surrendering to your impulses as you engaged in whatever the other men suggested, including being the insertive and the receptive partner in UAI. After several hours, the party broke up. You went home, feeling pressured and desperate. You had been drinking about a drink an hour at the party. You drove back home very cautiously. In the morning, you felt remorseful, thinking of the risks you took.

On-line thinking:

"I was too high on meth to think straight or to control my impulses."

"I'm feeling low and I need something to make me feel good and this will do it for me."

"I'll have one last fling and do only safe sex from then on. I'll be good starting tomorrow—I won't fuck without a condom after this last time."

Off-line thinking:

"Even though I was high, I really could have asked to use condoms. If I was so high that I didn't know what I was doing, I would be too high to drive to a party and have sex."

"The extra excitement I get from not using condoms is not worth the risk to my health and the unhappiness I feel afterward."

"I've had enough experience to see that probably I am not going to stop these binges any time soon, so I need to take better care when I have them.

Steps covered in this role-play:

STEP	ACTIVITY SUMMARY
Screen	Confirm has had negative test, then UAI
1	Help client choose memorable UAI episode
2	Have the client complete the PCC questionnaire
3	Draw out the story, incl. thoughts and feelings
4	Identify self-justifica-tions, gently challenge.
5	Ask what the client will do in the future

PCC Role-Play Aid #1

Possible Questions and Statements for use in Role-Play Practice of Screening, Step 1, and Step 2

Opening

- **"Why did you come in for testing today?"**

[If it seems there's more to be said:]

- **"Can you tell me some more about that?"**

Screening

- **"Have you had unprotected anal sex with a man other than a boyfriend/primary partner?"** [If the answer is yes, then ask:]
- **"Did you know if he was HIV-positive?"**

(If he did not know, or the partner was HIV-positive, the client is eligible for ***PCC***.)

Identifying a UAI Episode for the Questionnaire

- **"Are there any particular times you've had unprotected sex that you're thinking about?"**

OR

- **"Is there a time you had unprotected anal sex that you remember well?"**
- **"When was that?"**

[You need to end up with a particular instance of UAI.]

Introducing the Questionnaire

"I'm going to give you a questionnaire that asks what you were thinking when [identify UAI episode, such as, **"when you had sex with the Craigslist guy."] This is just for you—we don't keep the questionnaire. It lists thoughts that other men had in their minds around the time they decided to have unprotected sex. Please mark any that were in your mind during that event."**

PCC Role-Play Aid #2

Possible Questions and Statements for use in Role-Play Practice of Step 3 and Step 4

Steps covered in this role-play:

STEP	ACTIVITY SUMMARY
Screen	Confirm has had negative test, then UAI
1	Help client choose memorable UAI episode
2	Have the client complete the PCC questionnaire
3	Draw out the story, incl. thoughts and feelings
4	Identify self-justifications, gently challenge.
5	Ask what the client will do in the future

Draw Out the Story

- **"Can you tell me how you were feeling that day?"**
- **"How did you meet?"**
- **"What did he look like?"**
- **"What was in your mind then?"**
- **"What happened next?"**
- **"What were you thinking just before sex?"**

[Focus in on the thought and feelings at the decision point where intercourse without a condom began. Ask explicit questions.]

- **"What were you thinking during sex?" "…feeling during sex?"**
- **"What were you thinking after sex?" "…feeling after sex?"**

[Don't hurry through the story. Allow silences. Get a complete picture.]

Identify Self-Justifications

- **"What thoughts were in your mind at the time you decided to have UAI?"** [Use language appropriate for the client.]

[Mirror the thoughts that appear to be self-justifications, such as:]

- **"So you were thinking, 'If I ask him to use a condom, it will stop the flow and we won't have sex.' "**

PCC Role-play Aid #3

Possible Questions and Statements for use in Role-Play Practice of Step 4 and Step 5

Steps covered in this role-play:

STEP	ACTIVITY SUMMARY
Screen	Confirm has had negative test, then UAI
1	Help client choose memorable UAI episode
2	Have the client complete the PCC questionnaire
3	Draw out the story, incl. thoughts and feelings
4	Identify self-justifica-tions, gently challenge.
5	Ask what the client will do in the future

Continue Focusing on Self-Justifications and Gently Challenge

[One good way to start the role-play is to summarize a self-justification that emerged in the previous role-play, such as:]

- **"So you were thinking, 'If I ask him to use a condom, it will stop the flow and we won't have sex.' "**

[The client may recognize the errors in his self-justifications without prompting. If needed, gently challenge the self-justifications, such as:]

- **"As you look back on it, how likely is it that if you had asked him to use a condom, it would have ruined the sex that night?"**

[Continue focus on self-justifications until you and the client are clear on one or more. Only then—]

Ask About the Future; Support Positive Plans

- **"If you're in a similar situation again, how do you think you'll handle it?"**
- **"What do you think you might do differently?"**
- **"Considering what we've been talking about, what are your thoughts about what you may do in the future?"**

[Support any positive plan the client mentions.]

- **"That sounds like an idea that will really work for you."**

PCC Implementation To Do List

1. **People** to be informed (such as Executive Director, Clinical Director)

Name _____

Concerning _____

Name _____

Concerning _____

Name _____

Concerning _____

2. **Procedures** to be reconsidered (such as who does initial screening and when)

Procedure _____

Considerations _____

_____

Procedure _____

Considerations _____

_____

Procedure _____

Considerations _____

_____

3. **Resources** to be accessed (such as additional space if sessions take longer)

Resource _____

Resource _____

Resource _____

4. **Other notes** and comments

PCC Supervision

Benefits Regular supervision helps counselors be comfortable and effective as they implement ***PCC***. Supervision includes listening to recordings of sessions, when possible, discussing strengths and weaknesses, and monitoring fidelity.

One-on-one Supervision can take place in regular meetings (typically, once a week) between the counselor and the supervisor. In the first weeks of implementing ***PCC***, it can be helpful to have special meeting after every few ***PCC*** sessions.

Group Group supervision is another great alternative. Counselors meet together (usually with their clinical supervisor), share experiences, problem-solve, and support each other in implementing with fidelity.

The range Often there's a tendency to spend most of the time discussing the most problematic situations and clients. It's helpful to discuss providing ***PCC*** to the whole range of clients, including those who welcomed ***PCC*** and were easy to work with. The ***PCC*** *Implementation Manual* and the workbook from the ***PCC*** training have some helpful materials.

Support In the supervision feedback, it's important to pay attention to the strengths and successes of the counselor. Areas that can be improved should also be addressed, without unduly dwelling on what did not work.

Resources The ***PCC*** Steps Checklist (in the *Implementation Manual*) can be used as a discussion tool once completed. The checklist can also be filled out by the group or the supervisor and counselor together while a recording is played.

The Guidelines for Giving and Receiving Feedback (in the workbook) summarize how helpful feedback can be given.

PCC Training of Counselors Rating Form

_____ _____
Your name Location and dates of training

Please answer the following questions by circling a number. Your comments and suggestions are welcome at the bottom of this page. Feel free to continue on the back.

I. How useful was the *PCC* training you received for the following purposes?

1. Helping you become familiar with ***PCC***'s goals and objectives

0	1	2	3	4	5
Not at all useful					Extremely useful

2. Helping you become familiar with ***PCC***'s Core Elements

0	1	2	3	4	5
Not at all useful					Extremely useful

3. Helping you determine who is eligible for ***PCC***

0	1	2	3	4	5
Not at all useful					Extremely useful

4. Helping you build the skills and knowledge to provide ***PCC***

0	1	2	3	4	5
Not at all useful					Extremely useful

5. Usefulness overall

0	1	2	3	4	5
Not at all useful					Extremely useful

Comments and Suggestions: _____

_____

_____

_____

_____