Harm Reduction

NS/01
1721

Staying Negative – It's Not Automatic: A Harm Reduction Approach to Substance Use and Sex

by Richard Elovich,
Director; Substance Use Counseling and Education

For publication:
AIDS and Public Policy Journal

Summer/Fall 1996

GMHC

GAY MEN'S HEALTH CRISIS

Staying Negative – It's Not Automatic: A Harm Reduction Approach to Substance Use and Sex

Introduction

How Do We Address Substance Use As It Relates to AIDS Prevention Among Gay Men?

AIDS prevention has largely ignored the complex and variable role of alcohol and non-injection drug use in sexual risk-taking among gay men. Although substance abusers are perceived as constituting only a subgroup or minority of the gay population, in fact drinking and drug use are common in most settings where gay men socialize. Focus has been on substance abuse as a cause of HIV transmission; the more complex and variable relationship between alcohol and other non-injection drug use and sexual risk-taking still remains largely unstudied (Stall, 1994) and unaddressed by prevention. The Multicenter AIDS Cohort Study in Chicago identified cocaine use as the single most statistically significant association with seroconversion among gay men (Ostrow, 1995). The relationship between cocaine and alcohol use and unprotected anal sex remains complex and variable because the desires for unprotected anal sex are often preexisting.

This article describes the implementation of a Substance Use Counseling and Education (SUCE) program at Gay Men's Health Crisis (GMHC) . The program is among the first efforts by a community- based AIDS organization to: (1) expand harm reduction principles and methods to non-injection substance users; (2) apply the "staging" model of behavior change developed by researchers Prochaska, Norcross and DiClemente in order to match educational interventions to stages of readiness for change (Prochaska et al.,1994); and (3) develop approaches that address some of the theoretical challenges being raised in the area of HIV prevention for gay men (Odets, 1995). Among these issues and challenges are the development of prevention services specifically targeted to HIV-negative gay men, interventions that address the psychological toll of the epidemic over the passage of time, and a psychosocial educational and counseling strategy for gay men that specifically focuses on ego-strengthening, values clarification, communication skills-building and the development of alternative coping strategies. Finally, SUCE programs also utilize mentoring and peer-groups as processes to provide gay men with therapeutic experiences of relationships.

Counseling gay men, SUCE staff have observed that men bingeing on drugs such as cocaine, crystal methadrine and alcohol seem more likely for a number of reasons to have unprotected anal sex. Many of our clients report having a desire for receptive anal sex but have difficulty tolerating thinking or talking about this desire because of the internal and external associations to receptive anal sex. Cocaine acts as a disinhibitor with regard to anal sex, and also makes it easier for men to dispense with safer sex guidelines. Eager for sexual contact but physiologically unable to maintain an erection or have insertive sex, men used to playing the active role (top) in anal intercourse give up and become receptive partners (bottom). Men who have sex with men, but do not identify as gay, when they are able to dissociate through cocaine or alcohol use, let themselves engage in anal sex without a condom.

In terms of substance use and HIV prevention, the SUCE model has made two significant paradigm shifts: (1) moving from looking at substance abusers as a discrete subgroup of the gay population to looking at a continuum of substance use across a population where substance use is common and commonly associated with sex; and (2) looking at substance using behaviors along a continuum of HIV risk, from minimal to extreme.

While the program strategy described here is targeted to gay men, I hope that some of the ideas, concepts, and experience that shaped the development of the program may resonate with underserved populations at multiple risk, including adolescents and women.

How Can We Use Existing Theory to Guide Our AIDS Prevention Efforts?

A Harm Reduction Approach

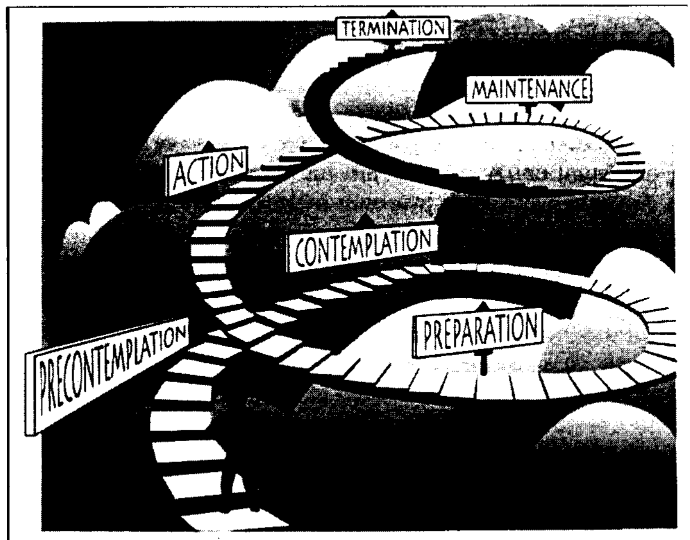
The strong association between the use of alcohol and recreational drugs on the one hand, and sexual risk-taking on the other, indicates the necessity for new and innovative prevention approaches. First, substance use counseling and education needs to be integrated into HIV prevention efforts in a way that meets each individual's self-identification, purposes, and needs. Harm reduction supports a continuum of change that supplants an all-or-nothing approach, and that acknowledges that small incremental steps are still progress and necessary to longer term change. Whether dealing with alcohol use, drug use or sex, a harm reduction approach identifies a range of risk, encourages people to start where they are able in order to protect themselves or their partners, and to set their own realistic targets and to move at their own pace.

Specifically, for sexually active gay men who use alcohol and other non-injection drugs, a harm reduction effort should attempt to: 1) reach gay men in their social networks and encourage them to think about the role that alcohol and drug use plays in their lives; 2) engage both HIV-positive and HIV-negative gay men in assessing the impact of their substance use and sexual behavior on their health and the health of others; 3) offer them the opportunity to participate in a process of behavior change that they direct themselves; and 4) develop a network of both HIV-negative and HIV-positive peer educators, particularly among gay youth and in communities of color.

Stages of Change

In an effort to understand how our clients change over time, the SUCE program has utilized and expanded on Prochaska and DiClemente's Transtheoretical staging model in a way that recognizes the difficulty of precisely mapping human decisions. To paraphrase the painter Magritte, the wriggly blue line identified as the Delaware River on the map is not the Delaware River. But we can use this map (see illustration below) to expand our thinking. The Transtheoretical staging model delineates five stages of change: precontemplative, in which individuals are not yet considering change, but ambivalence about the issue exists; contemplative, in which ambivalence is high, and the possibility of change is unfocused; determination (preparation or preaction), in which the balance is now tipped and the ambivalence is about taking action, identifying realistic alternatives and removing obstacles; action, in which the individual works through the conflict between belief and action, and change is initiated; and maintenance, in which earlier ambivalence, particularly concerning the costs of making change, is re-identified in order to maintain change.

This model emphasizes that ambivalence and relapse are part of, even essential to, the process at each stage. This model, which was initially developed around cigarette smoking, is conceived as a spiral or a wheel rather than a linear path because most people making change cycle through the stages repeatedly before building the motivation and skills for effective action and maintenance.



Printed with permission of Avon Books, 1994. New York. From Prochaska, Norcross & DiClemente, *Changing For Good.*

How Do We Translate Theory into Program? What are the Lessons Learned So Far?

The SUCE Program: Proactive Recruitment

In its first year of operation, the Substance Use Counseling and Education Department created GMHC's first prevention campaign targeted directly to HIV-negative gay men and gay men who have not been tested. Bearing the title, "Staying Negative—It's Not Automatic," the campaign included posters, public service announcements in gay publications, stickers, post cards, and pocket-size brochures for HIV-positive and HIV negative gay men that are being distributed in bars, clubs, at parties, and other places where gay men gather in New York City (see illustration below).

"When I'm feeling good is when the condoms get clumsy."

"I like sex with someone I don't know. It makes me feel most alive. but a lot of times it happens after I've been out drinking. When I'm feeling good is when the condoms get clumsy. I just tell him to not bother. I don't want to stop drinking but I spend days panicking wondering if I'm going to get infected when I'm too wasted to care."

staying negative – it's not automatic

We have free workshops that can help you stay uninfected. By talking about the sex you are having, what you like about it and what you don't, you can make partying – and sex – safer. Call today.

SUCE – 212 337-3343
Substance Use Counseling and Education
GMHC

© 1995
photo: allen frame/frank franca
This campaign is sponsored in part by

This campaign is a significant departure from earlier AIDS prevention messages for a number of reasons: (1) it specifically identifies HIV negative gay men as its target audience; (2) it pictures gay men together in conversation or companionship, rather than having sex as physically idealized, disembodied torsos; (3) it provides a range of diverse social contexts for gay men relating to each other (unlike the majority of images in gay publications, which direct the viewer to gaze desiringly at other men in the shower or dancing naked on stage); (4) its texts acknowledge the ambivalence and the complicated feelings gay men experience in their lives; (5) it encourages gay men to communicate about these issues; (6) it integrates alcohol and drug use issues into HIV prevention; and ('7) it uses a harm reduction approach, which is non-directive and open-ended.

The campaign grew out of SUCE's first groups for HIV-negative men. A team of staff, clients, and peer educators wrote the text and developed the materials, which are linked directly to workshops and counseling services. The tag-line, "Staying Negative -It's Not Automatic" is a response to over-simplified AIDS prevention messages (just use a condom every time), which provide a simple easy instruction intended to establish a community norm, and which for many gay men, may mean that if they are not following the norm, they are not good members of their community. Such social marketing risks promoting silence

about the very issues that SUCE is attempting to help men talk about. The specific texts and the tag-line of this campaign encourage gay men to think about HIV and talk with their friends. The campaign acknowledges that admitting confusion can be a first step toward making better choices or clarifying the issues that have inhibited the individual from following through on choices he has made. If a gay man can't talk honestly about how badly he feels about himself and how cocaine makes him feel more powerful, more sexy, and more connected with others, how is he going to find an alternative to weekend binges?

As a recruitment tool for our more intensive interventions, we have developed a three-session workshop based on the Fenway model in Boston. Targeted to the broadest range of HIV negative gay men concerned about staying uninfected, the workshop series is not limited to substance use issues. Focused on issues of immediate relevancy, the workshop provides an opportunity for information and experience sharing and reflection. For some participants, these workshops serve as a non-threatening entry point into more intensive individual and group counseling services. For others the groups may be an opportunity for information sharing and clarification of values around oral sex or testing. For some the groups provide referrals into other support services and activities designed for HIV-negative gay men, and for yet others, the groups fill an unmet need for a safe and supportive space to begin addressing feelings about life in the epidemic.

Engagement Strategies

Many individuals report experiencing our advertisements (see illustration at right) in local club magazines as a primary intervention. They have opened the magazine looking for the number for a sex phone line, or a party, for example, and encountered our ad. They call the listed number to have a conversation, to schedule an assessment, or to find out about drop-in counseling. When the person on the phone or in the face to face assessment asks them, "Why now? What is the concern or question that brought you here?" some, often the precontemplators, say, "I don't know. Something about the ad spoke to me. I related to it." This then, is a primary intervention, because the person says that before he saw the ad, he wasn't thinking about his substance use; he wasn't thinking about the connections between sex, drugs and HIV.

The counselor is challenged in an initial one-on-one assessment and in weekly individual counseling sessions to start "where the client is at." Our goal is to make the assessment client- centered enough that the client can get something from that session that enables him to come back. The client's reaction at this stage is likely to be not to think about the issue or problem that prompted him to call us. What can we do to help that person stay engaged? Our objective in the earliest stages of behavior change is to get them to return. We are working with precontemplators, contemplators, maybe some individuals who are in a determination stage, so the goal is drop-out prevention, not action.

Rather than "confronting denial," our counseling strategy employs a kind of psychological judo, engaging and leveraging an individual's ambivalence or reluctance into beginning their own relationship with an incremental change process. Prochaska et al identify proactive recruitment into behavior change programs as non-action oriented interventions designed for precontemplators and contemplators. Hence, we don't wait for people to identify a problem and walk across our threshold. With cigarette smoking, Prochaska et al described a precontemplators group as "a smokers group for smokers who don't want to stop smoking." By proactively recruiting individuals who are ambivalent about acknowledging their problems, or an action they are ready to take, we are attempting to increase our impact. There are far greater numbers of gay men who identify problems which may be attributable to substance use or who suspect they are using alcohol and drugs in ways that may put them and others at risk, than there are individuals ready to declare their interest in a specific action such as abstinence. By acknowledging that complex set of feelings, we help them open the door to their own change process.

"I was feeling good but
I wanted to feel
fabulous
so I started
doing coke. I met this
really gorgeous guy and we were
really going at it. I didn't have a condom,
and I didn't care. NOW I'M FREAKING OUT
WONDERING IF I'M STILL NEGATIVE."

Sound familiar? You're hardly alone if it does.

Alcohol and drugs can affect the way you practice safer sex. And bingeing can interfere with doing other things in life that are important to you. If sex, drugs or alcohol are causing you any problems, you can make changes

You don't need to be an alcoholic or a drug or sex addict to get the answers you need.

Gay Men's Health Crisis offers HIV-negative gay men or gay men who haven't been tested a IO-week program that includes free, confidential counseling and evening group meetings.

Call now for more information and a confidential assessment
GMHC Substance Use Counseling & Education at **212/337-3343**

GMHC
GAY MEN'S HEALTH CRISIS

©1995

Most of the programs that are applications of Prochaska's staging model have a single action or goal: stopping smoking, stopping drinking, taking a mammogram, always using condoms. From the beginning, such programs engage the individual in single-minded pursuit of that action or goal. Certainly, an important and desired outcome in our program is to reduce HIV transmission. With the population we see in GMHC's SUCE program the key behavior we are focusing on is unprotected anal intercourse and substance use, particularly cocaine use. However, many of the individuals we see are very isolated, or have dissociative relationships to their sexual behaviors, and often lack the ability to communicate about themselves, about sex, and about what sex means to them. To engage them in a relationship to the goal of reducing HIV transmission, we must allow them to tell us what their immediate needs are, and we must help them get some of

those needs met. The issues clients identify-including broad and complex issues such as isolation, hopelessness, and lack of self-efficacy-are directly related to the goal of reducing HN transmission.

"Paul," a twenty-two year old gay man who has recently tested negative, had responded to one of our ads in a club magazine. He reported having vague concerns about his cocaine use but he did not want to stop. He was anxious about his sexual behavior, but reluctant to talk about it as a problem. He would not return to the testing program where he felt he had been preached to. He also reported smoking pot every day with his friends for "relaxation." He said: "I came out to my family and now they won't talk to me, so I'm just sleeping there but hanging out with my friends. I really want to be in a relationship. That's what I want, but right now I'm having sex almost every day with different people."

After a tense two weeks waiting for his HIV results again, Paul described his new safer sex plan. As his counselor, I asked him, "So you would let a guy you don't know fuck you but only with a condom?" 'Yeah, if he's fine-looking." "And what if you knew he was HIV-positive?" I asked. "I wouldn't go down on somebody who was infected, or let him fuck me, even with a condom." I say, 'You have told me of instances where you let guys you don't know fuck you with a condom, and you don't know if that married guy you let fuck you without a condom is really negative." And he says, "But that's why thinking about this freaks me out. I don't even want to think about it."

The contradiction is between what Paul thinks is the reality of risk and what he is actually doing, and his inability to think about this conflict. While it would be nice to imagine that we could lock ourselves in a counseling room until we all understand the rules of safer sex, the reality is that our sex lives are not necessarily the expression of a rational process. Most gay men still have not found any place to talk about the meanings, likes, dislikes, confusions and conflicts associated with their sexuality. Many still go outside of their ordinary lives to find the sex they want, disconnecting sex from their lives, just as they once had to go outside of their families and communities to come out as gay.

In our groups, when issues come up that don't relate directly to HN or substance use, they cannot be ignored: without many of the socially valued and acknowledged markers that heterosexual adults have, gay men often experience shame about not knowing what they want to do with their lives and about being confused and about not having the answer in front of others. A group member said: "I'm thirty years old. Everyone I know who I grew up with has a life. I don't, and I don't know why, and now add HN to the list. All the answers I come up with are bad. I run from it." Individuals often report feeling "stuck," depressed, self-destructive or even suicidal, because they have had difficult experiences about which they have had no opportunity to talk. They may come to feel that there is something wrong with the feelings or that there is something wrong with them for feeling the feelings.

Each of us looks to significant people in our lives to witness or have a stake in our important events or struggles. Many gay men the SUCE program sees in their early twenties to early forties are living away from their families or communities of origin, feeling like they have to "do everything on their own." Others report being unable to communicate satisfactorily important parts of their lives, events and feelings related to their homosexuality, to their family and community networks. What seems common among our clients is a perceived lack of support from anyone who cares about what happens to them as they are dealing with important developmental tasks, such as a first sexual experience, an early relationship, an accomplishment or setback in career, anxiety related to HN infection or complicated feelings aroused by AIDS related losses. They report feeling that they are "on their own" and have to "figure it out by themselves," which often effects their ability to tolerate working through the feelings and thoughts associated with these events. We have clients who come to us announcing that they have no feelings.

For these reasons, we pay attention to eliciting and addressing members' ambivalence about participating in the group itself, identifying their fears and anxieties, as well as their expectations and hopes about joining the group. Many of the gay men we see report valuing intimate relationships as something that is very important to them, but out of reach and impossible. Often, given an opportunity to learn from each other, they discover patterns in which they both idealize potential partners and devalue other gay men in their lives. Group participants report finding transformative the opportunity to share with each other their individual experiences of dating, relationships, and conflicted feelings about sex. They also report the benefits of sharing feelings of shame and anger about having their life experience devalued, unacknowledged, and seemingly uncared for by significant others.

"Robert," in his mid-twenties, shared in the group that his first sexual experience was with a man who did not disclose that he was HN-positive until after they had had sex. Robert went through the experience of testing and waiting for his results by himself. Years had since passed but his distrust remained, and every time he had sex, he relived his experience with his first partner. Such feelings are similarly illustrated by another group member in his mid-thirties, "Mark" , who came to the group concerned that the sex and drugs he currently used were not as satisfying as they had been when he was twenty-five. He moved to New York from another city where he had grown up and where, over several years, he had been the primary support partner for a school friend who died of AIDS. Mark repeatedly referred to this experience with some confusion, as if it were a suitcase that he didn't know where to put down or where to place the contents were he to begin unpacking it. Mostly he replayed the narrative and focussed on his sense of incredulity and anger at his father's inability to empathize or talk with him about the experience he was going through.

In repeating his narrative, it sometimes seemed as if Mark felt he had to convince the group to feel his loss so that he could feel it and thus experience it as real. Finally, in one session, Robert talked about his early sexual experi-

ence, and Mark responded by talking about the isolation he felt caring for his friend with AIDS. Other group members shared a range of personal experiences, and they identified the common theme of the group as "witnessing for each other," much as a child who asks a parent to witness his dive off a high board. "When someone sees me do it- that's what makes it real." And weeks later, at the end of a ten week cycle, when members were recalling significant group sessions, Robert recalled Mark's sharing about taking care of his friend. In relating this to the group, Robert added one detail; he said the name of Mark's friend, "Jimmy." Mark was caught by surprise and he was visibly moved that Robert remembered his friend's name. For the participants, this kind of group process can be transforming.

The Role of HIV Positive Services in Primary Prevention

For most of the HIV-positive gay men in our counseling program, disclosure of their HIV-infection is problematic and painful. It is not like giving out your address or phone number. Many of the HIV-positive we see are asymptomatic and not yet engaged in HIV-related health and support services. They are struggling with what has changed in their lives since they learned of their infection and what hasn't.

Disclosure is complicated by many issues. In areas of high seroprevalence like New York City, gay men are often having sex with men whose serostatus they do not know. Communication and particularly communication about sex is often a challenge for gay men. Many gay men seek anonymous sex which relies on not communicating with a partner in ways that become too involved or communicative. Disclosure of a life threatening illness to a new friend or partner introduces many complicated issues and is likely to change the relationship. Participants in our HIV-positive counseling services have identified a number of questions they face. How is he going to get a condom on his partner when they are supposed to stay strangers or when acting as if his partner might be positive would disrupt his fantasy of that partner being "perfect "? Or when he is afraid if he says anything about HIV status his partner will vanish, the same way he magically appeared?

Many of our participants are struggling with fears associated with their health concerns, including those related to substance use and bingeing; with anticipated alienation from social networks; and with the implied threat to coping mechanisms brought on by contemplated changes in substance use behaviors. Another common issue among participants is how burdensome it feels to have to take care of their presumed negative sexual partners: "you can't go down on me," or "you can't let me do that." With his family and his friends, he's the sick one, but he has to guard their feelings and be responsible for their comfort in relation to his illness, his care, and his mortality. As in the HIV-negative groups, counselors and group members help HIV-positive individuals clarify issues, explore feelings and ambivalence, identify alternatives that had not occurred to them or that they didn't believe possible, or even allowed them to recognize that regular attendance in the group was evidence of change and growth.

Individual Counseling

We run individual and group counseling services to attempt to address some of these questions that cannot not be addressed in a single or three session workshops. In one-on-one sessions, counselors can assist individuals in identifying their issues or problems, and in clarifying what they want to do about them. Individuals report that they are usually not ready for or interested in taking any immediate action regarding their substance use, and are often fearful of a "hidden agenda" that might attempt to impose abstinence on them. Counselors and clinicians trained in traditional substance abuse treatment tend immediately emphasize the negative consequences of the behavior and confront the client's denial. In this program, the counselor exercises patience and encourages the client to identify and talk about the benefits and utility of his substance use or sexual behavior as well as the costs or concerns that brought him to the program. In doing so, the counselor models the tolerance of ambivalent or complicated feelings in order to learn something about the feelings rather than automatically acting on them in either direction.

Individual counseling is seen by the program as a support to the group process where self-directed change and growth really happen. To promote the integration of individual counseling with other services, all counselors also provide group facilitation and acupuncture.

Acupuncture

We offer ear-point acupuncture on a drop-in basis for stress, anxiety reduction, detoxification and relapse prevention. Drop-in acupuncture's atmosphere of structured "hanging out" and the non-verbal nature of the treatment can serve as a lower-threshold point of entry for individuals who may have difficulty participating in groups. By receiving treatments, individuals actively using drugs can experience and identify an internal sense of relaxation not induced by substances, or characterized by the "highs and lows" associated with substance use. Clients identify the clinic as a non-threatening and non-judgmental environment where they can develop-at their own pace-a relationship with the counselor and bonds with other participants, some of whom may already be participating in groups.

Group Counseling

Group work is central to this program. It functions in a number of ways. Firstly, the group offers an opportunity to experience oneself in the presence of others, thus acknowledging and working through feelings of isolation, fear and shame with which so many of the participants are familiar. Secondly, the group provides a mirroring process where individuals can observe or experience similarities or contrasts in thoughts, feelings, beliefs, and actions. In doing so, the group provides an opportunity to witness and models the peer transformational process. Each member is a "peer educator"; each member's attempts and struggles become teaching tools. In the course of group interactions, members become aware of their ability to have positive effects on peers, which they report improves their self-esteem. Thirdly,

the group experience provides clear parameters or limits for interaction and growth. Over time, the group becomes the social "container" for the individual process of change. Fourthly, the group provides immediate and ongoing opportunities for the development of alternative social networks that reinforce the process of change.

The groups average 8-12 men each. After a few sessions, most clients find something meaningful in the group, which encourages bonding between members and attachment to the group. As the ninth or tenth week approaches, participants become concerned about losing what has become an important relationship and a significant event in their week. We run the groups in three phases of ten-week cycles terminating at 30 weeks. Some of the participants have gone on to work with us as peer educators and counselors.

Over the 30 weeks, we utilize a developmental model to understand how the individual experiences the group and to construct the opportunity in which the experience may occur. Attachment to the group and group cohesion supports individuals to experience themselves as separate in the group but still connected. Taking incremental steps and moving at their own pace, clients are identifying and clarifying changes they want to make. We measure progress relative to each person. In fact, the groups demonstrate empathy and a high level of tolerance for individual decision-making with regard to change. Over time, members report "carrying the group inside themselves"; for example, they report thinking about something that was said in the group, their feelings about the group, or trying to integrate their experience of the group into their lives. At the same time, the psychoeducational counseling and the interpersonal process of the group adds to the richness of this experience. These men are learning to think about their life experience with other gay men. They are developing language for that kind of discussion.

Our program is premised on the idea that, among other reasons, people use drugs and alcohol to change their feelings and mental states. In individual and group counseling, the counselors utilize the Antecedent-Behavior-Consequence paradigm (Ellis, 1975) to help clients to identify what they were feeling and thinking when they got high. Clients then explore how getting high changed those feelings or thoughts, or whether or not getting high enabled them to obtain what they were looking for. Over time, client's insights help them determine what kind of change, if any, they want to make. This work can help the individual to begin discussing whether there might be more effective ways to get his needs met.

Regular participation in this counseling can reduce the "magical thinking" or dissociative behavior associated with drug use or certain kinds of sex. As clients consciously experience themselves and others talking about and tolerating the antecedent feelings and thoughts, even for a single session, they are developing alternatives to automatically acting-out of or enacting feelings, impulses and/or urges. In the SUCE program,. clients learn how to participate in individual and group counseling sessions, even while they are still using substances or engaging in high risk behaviors. The experience of being encouraged and respected, and of learning to identify, tolerate and constructively express complicated thoughts and feelings, helps individuals move through the early stages of precontemplation and contemplation, described by Prochaska et al.

From SUCE's experience, we believe that showing up and participating in a structured peer group of this kind over time helps build self-efficacy, "a person's belief in his or her ability to carry out and succeed with a specific task" (Miller & Rollnick, 1991). Belief in one's ability to effect change is a well-documented and critical component to achieving motivation for change (Bandura, 1982) and a key factor in one's ability to maintain change (DiClemente et al., 1985).

Through a curriculum we have developed for the groups, we introduce tools and skills for group members to model. After each session is over, members go back into their communities with these tools. Men who have experienced interventions in which they have modeled talking about their conflicting feelings and thoughts in front of other gay men may be less likely to continue patterns of dissociative behaviors. Over time, participants discover that they can verbalize thoughts and feelings that they previously only acted upon in self-destructive behaviors. They also bring compartmentalized or "partialized" aspects of themselves together and experience them in front of the group. They experientially discover "witnessing" or "mirroring" for one another. Accountability and reliability to a relationship or the group are values which group members establish over time. For most clients, the groups are their first engagement of a true peer group in which they are able to experience themselves as relatively whole, interpersonally effective, and accepted by others.

Peer Education

Through continued participation in groups and individual counseling, program participants are provided with repeated education, reinforcement and support to reduce the incidence of unprotected anal sex, to moderate substance use, to reduce or to eliminate cocaine use and bingeing behaviors, or to sometimes move into recovery. Sharing what they have learned builds participants' experience of self-efficacy and connections to others. These new experiences allow them to remain, engaged, perceive their own growth, and transcend isolation. Even without behavior change, regular participation in the program provides an option to the alternatives of isolation or social networks exclusively characterized by drug use and sex. It is also an immediate and real experience of community, which encourages the men to care about each other, to think of themselves as part of a community, and to become peer counselors and educators. It is our goal that the next time one of the men's friends says, "I got wasted last night, had sex with a couple of different guys and didn't bother with a condom," he may ask why -in a real and inquiring way-instead of looking away and changing the subject.

Where Do We Go From Here?

By primarily framing an individual's substance use as synonymous with addiction, most education messages have targeted only people who identify as alcoholics or addicts. It is counterproductive to try to fit someone who has questions or limited concerns about his alcohol or drug use into a traditional linear framework of chemical dependency or disease progression. Interventions that imply pathology or require taking on of labels—substance abuser, addict, alcoholic, sexually compulsive or sex addict-are not useful in reaching the majority of gay men who may not identify with these labels and who may need to make only incremental changes or who are unable or unwilling to quickly change. Furthermore, traditional recovery and abstinence-based thinking in the substance abuse field which uses a "confrontation of denial approach" invariably demands that the client accept the program's conceptualization of substance abuse. In addition, most HIV prevention interventions focus solely on discouraging alcohol and drug use rather than on educating gay men on the relationship of substance use and safer sex so that they can understand the need for developing their own strategies for harm- or risk-reduction, which express their values and intents.

Finally, even gay men who identify as addicts or alcoholics often do not have access to appropriate drug treatment services. Barriers to getting help include lack of services which: address alcohol and drug use in the context of gay sexual behavior and HIV risk; are available to the uninsured or underinsured; and are gay-sensitive and gay-affirmative.

New interventions and messages need to be focused and sharpened not just for people who are infected or not infected, but for different racial, cultural, and age groups. We have to keep asking what works and why? What doesn't and why? Who is being reached? Who is not? The costs are too high not to ask. And then to answer if we can.

Evaluation of this kind of program will have to first identify the range of issues these individuals identify for themselves and the evolution or sequencing of behavior change that takes place through participation in individual and group counseling services. Secondly, we must examine the relationships between the client's goals and the program's desired outcomes. Thirdly, we need to determine what components of the program help individuals to identify, clarify, and stay connected to their pursuit of these goals. We know from experience that higher levels of participation over longer periods of time often mean more sustained change. That certainly has to be measured, but we must also identify and verify what elements of the program build or encourage sustained behavior change.

Sources

Bandura, A. (1982). Self-efficacy mechanism in human agency. American Psychologist, 37:122–47.

DiClemente, C.C., Prochaska, J.O., & Gilbertini, M. (1985). Self-efficacy and the stages of self-change in smoking. Cognitive Therapy and Research, 9:181–200.

"Edith Springer on Harm Reduction." A video of excerpt of a training on harm reduction, including insights by Springer on how she has used harm reduction in her training of street youth peer educators in New York City (25 minutes). Gay Men's Health Crisis, NY NY 1995.

Ellis, A., & Harper, R.A. (1975). A New Guide to Rational Living. Hollywood, CA: Wilshire Books.

Elovich, R., & Cowing, M. (1995). Recovery-readiness: Strategies that bring treatment to addicts where they are. In Harm Reduction and Steps Toward Change: A Training Sourcebook. New York: Gay Men's Health Crisis.

Elovich, R., & Oliveira, A. (1995a). Steps Toward Change. In Lapnotes: Lesbian AIDS Project at GMHC, 3:8–9.

Elovich, R., & Oliveira, A. (1995b). Steps Toward Change: Working with ambivalence and building motivation for change. In Harm Reduction and Steps Toward Change: A Training Sourcebook. New York: Gay Men's Health Crisis.

Isbell, M. T. & Goldenberg, J. (1995) Swimming Against The Second Wave. HIV Prevention Among Gay Men: A White Paper, Gay Men's Health Crisis, New York. 4–12.

Miller, W.R., & Rollnick, S. (1991). Motivational Interviewing: Preparing People to Change Addictive Behavior. New York: Guilford Press.

Odets, W. (1994) AIDS Education and Harm Reduction for Gay Men: Psychological Approaches for the 21st Century. AIDS & Public Policy Journal 9:1–15.

Odets, W. (1995) In the Shadow of the Epidemic: Being HIV-Negative in the Age of AIDS. Duke University Press, Durham, North Carolina.

Ostrow, D.G. et al. (1995) A Case-Control Study of H.I.V. Type 1 Seroconversion and Risk-Related Behaviors in the Chicago MACS/CCS Cohort, 1984-1992. American Journal of Epidemiology, 142:875–83.

"Points To Change." Ear point acupuncture-its philosophy and practice--are the subject of a video documentary. Practitioners and patients discuss acupuncture's applicability in a variety of community settings, including drug treatment, needle exchange, and AIDS services (25 minutes). Gay Men's Health Crisis, NY NY 1995.

Prochaska, J.O, Norcross, J.C., & DiClemente, C.C., (1994). Changing for Good: A Revolutionary Six Stage Program for Overcoming Bad Habits and Moving Your Life Positively Forward, Avon Books, New York.

Prochaska, J.O, Norcross, J.C., & DiClemente, C.C., (1982). Transtheoretical therapy: Toward a more integrative model of change. Psychotherapy: Theory, Research, and Practice, 19:276–88.

Prochaska, J.O, Norcross, J.C., & DiClemente, C.C., (1992). In Search of How People Change: Applications to Addictive Behaviors. American Psychologist, 47 (9):1101–13.

Stall, R. (1994) Intertwining Epidemic?: A Short History of Research on the Relationship Between Substance Use and the AIDS Epidemic Among Gay Men. Summit on HIV Prevention for Gay Men, Bisexuals and Lesbians At Risk. Dallas, Texas. July 15-17.

Stall, R. (1988). The Prevention of HIV Infection Associated with Alcohol and Drug Use During Sexual Activity. In L. Siegel (Ed.) AIDS and Substance Abuse (pp. 73-88). New York: Harringron Park Press.

"Talk About It." A video of six gay men who are HIV negative (or who haven't tested) talk candidly about isolation, oral sex and other issues related to staying unifected (19 minutes). Gay Men's Health Crisis, NYNY 1995.

'Walt Odets on Primary Prevention for Gay Men." A video interview with the nationally recognized psychologist and author of *In the Shadow of the Epidemic: Being HIV-Negative in the Age of AIDS.* (27 minutes). Gay Men's Health Crisis, NY, NY 1995.

Washton, A. (1996). Psychologist, author, founder of Washton Institute. Presentation on Treatment Approaches to Cocaine Use, March, 1996, Gay Men's Health Crisis, New York.

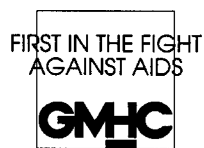
Richard Elovich is Director of Substance Use Counseling and Education (SUCE) at Gay Men's Health Crisis, Inc. Inquiries can be made to: SUCE, GMHC, 129 West 20th Street, 2nd Floor, New York, NY 10011.

The author wishes to acknowledge the following for their help in the preparation of this article: Lorne Feldman, Dave Nimmons, Al Novick, Ana Oliveira, Juan Olmedo, David Ostrow, Ron Stall, Daniel Wolf, James Cancienne, Tracy Schaffzin, Bob Bergeron, and Adam Zachary Fredericks.

Gay Men's Health Crisis is the world's oldest and largest not-for-profit AIDS organization, providing services to people with AIDS and their loved ones, educating the public and advocating for fair and effective AIDS policies.

For more information or for a free copy of our Catalog of AIDS Educational Resources, please call the Hotline.

HOTLINE: 212/807-6655
TTY: 212/645-7470 (for the deaf)



Designed by Adam Zachary Fredericks

© 1996 Gay Men's Health Crisis, Inc.