Project PRIDE: A Cognitive-Behavioral Group Intervention to Reduce HIV Risk Behaviors
Among HIV-Negative Young Gay and Bisexual Men

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Abstract

Young gay and bisexual men are at increased risk for HIV infection. Research suggests that the stress associated with being a stigmatized minority is related to negative mental health outcomes, substance use, and condomless sex. However, interventions aimed at reducing HIV risk behaviors in young gay and bisexual men have failed to address these important variables. The purpose of the present paper is to assist cognitive and behavioral therapists who work with young gay and bisexual men to conduct therapy for stress management and HIV prevention. This paper provides an overview of the research on stress and coping among gay and bisexual men and its relation with condomless sex among young gay and bisexual men. The treatment described here integrates minority stress theory (e.g., Meyer, 2003) and stress and coping theory (e.g., Lazarus, 2000) in a small group counseling framework that uses psychoeducation, cognitive reframing, and role-plays to help young gay and bisexual men to manage stress, reduce substance use, and reduce condomless sex. The application of empirically-supported theory and a combination of cognitive and behavioral techniques to reduce both psychological distress and HIV risk behavior for young gay and bisexual men is illustrated using three case examples. The present treatment may help therapists working with young HIV-negative gay and bisexual men who engage in condomless sex and who wish to remain HIV-negative by decreasing their HIV risk behavior.

Keywords: young adults, gay men, stress, coping, HIV/AIDS, sexual behavior
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In North America, gay, bisexual, and other men who have sex with men (MSM) are disproportionately affected by HIV. Sixty-three percent of new HIV infections in the United States in 2010 were accounted for by gay, bisexual, and other men who have sex with men (MSM; Centers for Disease Control and Prevention, 2014). In Canada, MSM represented 46.7% of all HIV cases at the end of 2011 (Public Health Agency of Canada, 2012). Likewise, among new HIV infections in 2012 in Canada for adults over the age of 15 with a known route of HIV transmission, 50.3% were among MSM (Public Health Agency of Canada, 2013). Moreover, HIV incidence appears to be rising among young gay and bisexual men. In the United States, HIV infections among young (aged 13-24) gay and bisexual men increased by 22% from 2008 to 2010 (Centers for Disease Control and Prevention, 2014). A possible explanation for the high rates of HIV among young gay and bisexual men is that they are engaging in riskier sexual behavior than their older gay and bisexual male counterparts. For example, one study found that young gay and bisexual men had an average of three sexual partners within a six-month period (Rosario, Schrimshaw, & Hunter, 2006). Results of another study showed that approximately 40% of young gay and bisexual men have had multiple anal sex partners in the three months prior to the study (Mustanski, Garofalo, Herrick, & Doneber, 2007). Within the previous three months, 43.9% of young gay and bisexual men reported having engaged in condomless anal sex (Mustanski et al., 2007). Moreover, gay and bisexual men younger than 25 years of age engage in risky sexual behavior more frequently than older gay and bisexual men (Crepaz et al., 2000).

**Stress and Coping Theory and Research**

One possible explanation for the high rates of HIV and sexual risk-taking among gay and
bisexual men—an umbrella term we use to encompass a broad group of individuals who identify as men; are attracted to or engage in sex with men; do not identify as heterosexual; and may identify as gay, bisexual, queer, same-gender-loving, or a related term—is that increased stress related to being a sexual minority puts men at risk for engaging in behaviors linked to HIV transmission. Lazarus and Folkman (1984) defined stress as “a particular relationship between the person and the environment that is appraised by the person as taxing or exceeding his or her resources and endangering his or her well-being” (p. 19). As such, stress results when something in the environment (a stressor) is at odds with the person and overwhelms the person’s ability to successfully deal with the stressor. In the case of gay and bisexual men societal heterosexism (i.e., anti-gay/bisexual stigma, prejudice, and discrimination) is a stressor that can endanger well-being. Indeed, Lazarus and Folkman note that social stress occurs when there is a “mismatch” (p. 234) between the person and society. Among lesbian, gay, and bisexual (LGB) individuals, this social stress has been termed minority stress (Meyer, 1995, 2003), and refers to the stress of living in a societal environment that is stigmatizing of non-heterosexual sexual orientations.

Meyer (2007) identified three overarching characteristics of minority stress. First, minority stress is unique. That is, the stress of living in an environment that stigmatizes non-heterosexual sexual orientation is unique to LGB individuals and different from the normal stressors encountered by all people. In addition, the unique stress of minority stress is additive to the stress caused by normal everyday stressors. Second, minority stress is chronic. LGB people experience this stress on a daily basis, from being concerned about holding one’s partner’s hand in public to instances of harassment and violence (Herek & Garnets, 2007). Finally, minority stress is socially-based. That is, minority stress is caused by factors outside the individual, such as other people, institutions, and social-political processes.
Meyer (1995, 2003) delineated minority stress into five separate components: internalized homophobia, perceived stigma, sexual orientation concealment, prejudice events, and compensatory coping. Internalized homophobia refers to negative views of homosexuality that have been internalized by the LGB individual. Perceived stigma relates to the view that a person will be treated unfairly because of his or her sexual orientation. Sexual orientation concealment refers to attempts to “pass” as heterosexual. Prejudice events are the actions of others toward a LGB individual that are discriminatory, biased, or violent and can vary in intensity from overt physical or verbal attacks to more subtle instances of bias. Finally, these stressors require coping strategies to manage.

**Correlates of minority stress.** Several studies have demonstrated links between minority stressors, such as discrimination and prejudice events, and mental health, including suicidal ideation, anxiety, and depression (e.g., Diaz, Ayala, Bein, Henne, and Marin, 2001; Hatzenbuehler, Nolen-Hoeksema, & Erickson, 2008; Meyer, 1995; Smith & Ingram, 2004). For example, Preston, D’Augelli, Kassab, and Starks (2007) found a relation between stigma and mental health such that experience of stigma was associated with low self-esteem and internalized homophobia. Studies of gay and bisexual youth have yielded similar results (e.g., Kelleher, 2009; Pachankis & Goldfried, 2006; Toomey, Ryan, Diaz, Card, & Russell, 2010). Experiences of discrimination have also been linked to substance use disorders in large population-based studies of gay and bisexual men (McKirnan & Peterson, 1988, 1989). Likewise, longitudinal studies have shown that discrimination was associated with frequency of drug use over a period of 18 months (Hatzenbuehler et al., 2008). Among youth, gay and bisexual high school boys who experienced discrimination were more likely to engage in substance use (Bontempo & D'Augelli, 2002).
Minority stress and risk behaviors. Several studies have found that discrimination and internalized homophobia are associated with greater likelihood to engage in behaviors that place gay and bisexual men at higher risk for HIV (e.g., Hatzenbuehler, 2008; Herek & Glunt, 1995; Kelly, Bimbi, Izenicki, & Parsons, 2009). Among young gay and bisexual men aged 18 to 22 years, those who reported engaging in condomless anal sex were less accepting of their gay identity (Waldo, McFarland, Katz, MacKellar, & Valleroy, 2000). Conversely, young gay and bisexual men aged 14 to 21 who reported more positive views of homosexuality reported fewer instances of condomless receptive anal sex and fewer sexual partners (Rosario et al., 2006). Indeed, empirically-supported theoretical models posit that minority stress leads to psychological distress and substance use, which in turn lead to increased sexual partners and sexual encounters. These sexual encounters in turn lead to condomless anal sex. In addition, substance abuse is hypothesized to be directly related to condomless anal sex, given that substance use decreases inhibition and acts as a barrier to safer sex practices (Rosario et al., 2006). The associations among minority stress, mental health problems, substance use, and HIV risk have been conceptualized as a syndemic, defined as “a set of closely intertwined and mutual enhancing health problems that significantly affect the overall health status of a population within the context of a perpetuating configuration of noxious social conditions” (Singer, 1996, p. 99). When these multiple psychosocial risk factors combine, the resulting impact on HIV risk is greater than the sum of their individual effects (Safren, Reisner, Herrick, Mimiaga, & Stall, 2010; Stall, Friedman, & Catania, 2008; Stall et al., 2003).

In addition, evidence suggests that young gay and bisexual men may engage in a variety of coping strategies to deal with minority stress, including strategies that may put them at risk of HIV. Coping strategies may include adaptive coping strategies, such as seeking social support,
cognitive reframing, and educating others, and maladaptive coping strategies, such as avoidance strategies, self-blame, condomless sex, and substance use (Hequembourg & Brallier, 2009; Kelly et al., 2009; McDavitt et al., 2008). The avoidance coping strategies of condomless anal sex and substance use in the context of sexual situations are both risk factors for HIV transmission (e.g., Lambert et al., 2011).

Lack of HIV-Prevention Interventions for Young Gay and Bisexual Men

Despite their high HIV incidence and prevalence, there is a surprising lack of empirically-supported HIV prevention interventions for young gay and bisexual men, with one exception that entails creation of a new community center for youth (Centers for Disease Control and Prevention, 2013; Kegeles, Hays, & Coates, 1996). It is therefore critical that interventions be developed and tested that are more feasibly implemented in already existing community-based and clinic settings. Herbst et al (2005), in a meta-analysis, identified four components of effective HIV-prevention interventions for MSM: interventions should be theory-based; interventions should focus on interpersonal skills; interventions should use multiple delivery methods, such as counseling, group discussions, and role-plays; and interventions should provide multiple exposures over time (i.e., more than one session, at least four hours total, and at least spanning three weeks). Both Herbst et al. (2005) and Lyles et al. (2007) noted that it is important that interventions help participants to identify situational risk factors or triggers for sexual risk-taking and to develop coping skills. As such, there is a need for new interventions that are targeted toward the unique issues faced by young gay and bisexual men and that assist gay and bisexual men in developing adaptive coping strategies. Given the evidence from these reviews, an approach that uses cognitive-behavioral techniques is an ideal fit for addressing the problems faced by young gay and bisexual men.
A Novel Intervention to Reduce HIV Risk in Young Gay and Bisexual Men

The intervention for the present manuscript is based on the theory of stress and coping (Lazarus, 2000; Lazarus & Folkman, 1984), Meyer’s (1995, 2003) theory of minority stress, and cognitive and behavioral principles related to HIV risk reduction (Coates, Richter, & Caceres, 2008; Kelly, 1995). In addition, it was informed by Sikkema and colleagues’ coping-focused group intervention for HIV-positive individuals, which was efficacious at decreasing condomless sex and substance use (Meade et al., 2010; Sikkema, Hansen, Kochman, Tate, & DiFranceisco, 2004; Sikkema et al., 2008). The present intervention focuses on cognitive appraisals regarding the meaning of sexual minority stressors and emotional and behavioral responses to sexual-orientation-related stress. A main intervention component is identifying and implementing adaptive coping strategies. The intervention is conducted in a group format to maximize the adaptive coping response of seeking social support and to reduce loneliness, which is a risk factor for condomless sex (Martin & Knox, 1997). Finally, the intervention focuses on self-efficacy and skill development for safer sex negotiation and safer sex behaviors.

The current intervention is titled Project PRIDE (Promoting Resilience In Discriminatory Environments). It attempts to promote resilience among young gay and bisexual men by assisting them in developing effective coping strategies for dealing with minority stress. This program is designed to use cognitive-behavioral principles in a format that is accessible to paraprofessionals who comprise the majority of staff working at LGB youth centers and HIV/AIDS community-based service organizations. Moreover, paraprofessionals have been shown to be able to effectively implement cognitive-behavioral therapies (e.g., Montgomery, Kunik, Wilson, Stanley, & Weiss, 2010). Overall, the goals of Project PRIDE are to produce increases in well-being and decreases in negative mental health outcomes, substance use, and condomless sex. We
will illustrate Project PRIDE using three case examples.

Method

Development of Project PRIDE

We created Project PRIDE through a thorough literature review of the literature and based on feedback from focus groups and community advisory boards. We conducted focus groups in Montreal and Toronto, with focus groups conducted bilingually in Montreal (French and English) and unilingually (English) in Toronto. The focus groups consisted of young gay and bisexual men ($N = 17$ across the two cities) and service providers who work with young gay and bisexual men ($N = 14$ across the two cities). The focus groups provided input on the content, delivery, and design of Project PRIDE. Based on the extant literature and focus group feedback, we developed an initial draft of the intervention manual. We then provided this draft to community advisory boards consisting of young gay and bisexual men and other men who have sex with men but who use other labels, such as same-gender-loving, and service providers in both Montreal and Toronto. We also met with these community advisory boards throughout the delivery of the intervention to obtain feedback and ensure Project PRIDE was meeting the needs of the community. Based on community advisory board feedback, we edited the intervention manual to increase clarity and participant engagement and finalized the intervention.

Description of Project PRIDE

Each group was led by a trained peer facilitator who was similar in age to the participants and identified as gay, bisexual, queer, or same-gender-loving, and by either a licensed psychologist or a doctoral student in counseling psychology. Young gay/bisexual male peer facilitators, who have experience working with LGB individuals and working in sexual health education settings, provide participants with a facilitator who matched the participants on key
demographic variables. Indeed, research on client-therapist match reveals that, while therapist behaviors are more predictive of client outcome, having a gay or lesbian therapist is related to positive outcomes (e.g., Jones, Botsko, & Gorman, 2003).

The intervention is completed in eight sessions that last two and a half hours each, to enable feasibility of administration by short-term counseling providers or in community-based service organizations. Most empirically-supported HIV prevention programs use similar short-term treatment models, with a median of 6-8 sessions (Crepaz et al., 2006). An outline of the intervention sessions is presented in Table 1. In addition, the Appendix includes selected examples of activities and worksheets.

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Insert Table 1 about here
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The first two sessions consist of introductions, setting of ground rules, exploration of expectations and apprehensions, a broad exploration of participants’ different gay/bisexual identities, and an introduction to the minority stress theory (Meyer, 1995, 2003). Special attention is paid to creating a safe space for all participants and the establishment of a non-judgmental, sex-positive atmosphere. Sessions 3 and 4 consist of an introduction to the stress and coping model (Lazarus, 2000; Lazarus & Folkman, 1984), application of the model via a group activity to facilitate understanding, and an exploration of gay/bisexual-associated stressors in different areas of participants’ lives (e.g., friendships, romantic and/or sexual relationships, school/work, family). Participants are asked to set specific mental and sexual health goals using the SMART (specific, measurable, attainable, realistic, and time-bound) goal-setting model (Cothran & Wysocki, 2012). Session 5 consists of identifying links between sexual behavior,
minority stress, and coping, with an emphasis on triggers for condomless sex such as substance and alcohol use. In sessions 6 and 7 safer sexual practices and sexual communication skills are addressed through group activities and psychoeducation, with an emphasis on harm reduction. Examples of activities include demonstration of proper condom application using a penis model, demonstration of opening an internal condom, and watching a video regarding the importance of using water-based lubricant during sex. An example of sexual communication includes the explanation and demonstration of assertive communication, with an emphasis on assertive communication regarding one’s sexual needs and boundaries. Session 8 consists of a review of the topics covered in the group and participants’ experiences of the group, with an emphasis placed on what participants learned and what topics participants thought they still needed to focus on. The group facilitators seek feedback regarding the areas of the intervention that were effective and ineffective. Finally, participants are given a chance to say goodbye to the facilitators and other members.

It is important to note that a number of key elements are present throughout the eight sessions. First, participants are asked to identify the coping strategies they use when encountering stress in general, and with gay/bisexual-related stress in particular. Second, group co-facilitators engage in psychoeducation regarding stress and coping and encourage members to examine the adaptiveness of their current coping strategies. Third, sexual risk-taking is used as the main model to examine stress and coping, and after participants help each other to produce a variety of adaptive coping strategies they are asked to try to implement some of these coping strategies in their daily lives. Fourth, participants are encouraged to identify and engage in both emotion-focused and problem-focused coping strategies. Finally, participants are encouraged to engage in minority group coping, such as becoming involved in LGB community activities.
All sessions end with various relaxation techniques that can be administered by paraprofessional staff members and counselors who are not expert in cognitive-behavior therapy, such as brief guided imagery and breathing training exercises. Similar to behavioral therapies, the sessions end with homework assigned to promote at-home practice of the psychoeducational, cognitive, or behavioral skills presented in each session. Homework assignments are intended to be specific to the participant’s stressors and mental and sexual health goals. Moreover, to be engaging and developmentally-targeted, several homework assignments make use of technology, such as taking photos of thematic topics using smart phones. Starting in session 2, all sessions begin with a review of homework assigned in the previous session. All participants receive a list of referrals for low-cost or free mental health and sexual health care before beginning Project PRIDE and at the end of the Project PRIDE. In addition, Project PRIDE facilitators are able to make specific referrals if a youth requests or reports problems for which specific counseling is available.

**Procedures Used for Case Examples**

The intervention and recruitment procedures were conducted in both English and French in Montreal and in English in Toronto. Three groups received the intervention; two groups, one in English and one in French, were conducted in Montreal, a multicultural but predominantly bilingual French/English city, and the third was conducted in Toronto, a multicultural city in which English is the dominant language. We advertised the study through flyers placed in venues frequented by gay and bisexual men (e.g., LGB bars, cafes in LGB areas), emails sent through local LGB LISTSERVs, and through a popular, GPS-based phone application where men can meet other local men to date or for sex. Recruitment materials targeted HIV-negative or HIV-status-unsure men, aged 18-25, who self-identified as gay, bisexual, same-gender-loving, queer, or a related term. The recruitment materials included the contact information for the project
coordinator and a link to the study’s informational website. The website provided details about the study procedures, compensation, and eligibility, as well as the contact information for the study coordinator.

Interested participants contacted the study coordinator, who assessed eligibility. Eligibility criteria included: identifying as a man (both cis and trans individuals—e.g., transgender or transsexual—who identified as men were eligible); identifying as gay, bisexual, same-gender-loving, queer, or another non-heterosexual identity; self-reported HIV-negative or unsure; having at least one instance of condomless anal sex (insertive or receptive) in the past three months; ability to read and write in either English or French; and available to attend the intervention sessions. Participants completed a battery of questionnaires prior to the start of the intervention, immediately following the intervention, and three months after the conclusion of the intervention. In addition, at post-treatment and again at three-month follow-up, an interviewer who was not a facilitator conducted semi-structured interviews with all participants. These interviews queried participants about what they learned (if anything) from Project PRIDE and what they liked and did not like about the intervention. Participants were compensated $30 for each questionnaire, $30 for each interview, and $10 for each intervention session they attended.

The details for each case presented below are based upon detailed progress notes written by one of the co-facilitators after each session. The second co-facilitator then corroborated the draft progress notes each week before they were finalized and agreed upon by both co-facilitators. To add clinical detail to each case presented below, the co-facilitators discussed the progress notes and added details from memory.

**Measures**
The UCLA Loneliness Scale. Loneliness was assessed with the UCLA Loneliness scale (Russell, 1996), a 20-item scale that measures experiences of loneliness, such as feeling not close to others and lacking companionship. Participants respond to items on a four-point scale, with anchors of 1 = never, 2 = rarely, 3 = sometimes, and 4 = always. Higher scores indicate more loneliness, with a possible range of scores from 20 to 80. While a cutoff score has not been identified, mean scores in university students range from 36.69 to 39.07 (Adams, Sanders, & Auth, 2004). The measure has demonstrated good reliability and validity (e.g., alphas ranged from .89 to .94; Russell, 1996).

The Rosenberg Self-Esteem Scale. Self-esteem was measured by the Rosenberg Self-Esteem Scale (Rosenberg, 1965), a widely-used 10-item scale that measures feelings of self worth. Participants respond to items on a four-point scale from 0 = strongly disagree to 3 = strongly agree. Higher scores indicate greater self-esteem, with a possible range of scores from 0 to 30. The mean score of a large sample of men and women in the United States was 22.62 (Sinclair et al., 2010). The scale has good reliability and validity (e.g., alphas ranged from .72 to .88; Gray-Little, Williams, & Hancock, 1997).

Substance use. Substance use was assessed by eight questions that asked the frequency with which participants used various substances over the past month (Sikkema, Kochman, DiFrancesco, Kelly, & Hoffman, 2003). Participants responded to each question on a 6-point scale from 0 to 5, with anchors of 0 = no use, 1 = once or twice, 2 = about once a week, 3 = several times a week, 4 = about every day, and 5 = more than once a day. Participants were queried about alcohol, marijuana and hashish, cocaine and crack, tranquilizers, oral narcotics, amphetamines, sedatives/barbiturates, and injection drugs.

Sexual behaviors. Participants were asked to indicate, over the past three months, (a) the
number of HIV-positive male and female sexual partners they have had, (b) the number of HIV-negative or HIV-status-unsure male and female partners they have had, (c) the number of times they have had sex (anal or vaginal), and (d) the number of times they used a condom (Sikkema et al., 2000).

Case Examples

Three case examples are presented to illustrate Project PRIDE. All three participants identified as gay or bisexual men, and identified as cis. Case 1, Robert, illustrates how Project PRIDE helped decrease a participant’s loneliness following the dissolution of a long-term romantic relationship and helped to reduce condomless anal sex. Case 2, Kyle, illustrates how Project PRIDE helped a participant to more successfully negotiate sexual and platonic relationships and to reduce condomless anal sex. Case 3, Matthew, illustrates how Project PRIDE helped a participant gain more social support, develop coping skills, and also reduce condomless anal sex.

Case 1: Robert

Robert was a 20-year-old White French-speaking gay man who was born and raised in downtown Montreal, where he lived during his participation in Project PRIDE. He was a full-time student in a post-secondary institution.

Baseline. Robert reported four male HIV-negative or HIV-status unknown partners and 25 instances of condomless anal sex in the past three months. He reported drinking alcohol several times a week and no drug use over the past month. His UCLA Loneliness Scale score was 37 and his Rosenberg Self-Esteem Scale score was 21. See Figures 1 and 2 for all participants’ frequency of condomless anal sex and alcohol use over the three time points.

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Synopsis of treatment. Robert presented for Project PRIDE in order to help ease his loneliness following the dissolution of a long-term romantic relationship. He attended six of the eight sessions and often completed the homework between sessions. He was moderately vocal during the sessions he attended; he shared his own knowledge, thoughts, and experiences and left ample room for others to do the same. Robert reported feeling sad or lonely on most days due to his recently-ended romantic relationship. He reported being out to most people in his life and not experiencing many daily instances of homophobia. During the intervention, he would often share knowledgeable answers when other participants asked factual questions, such as when another participant asked about PrEP and PEP (pre-exposure prophylaxis and post-exposure prophylaxis) and Robert offered information on the topic. During session 3, Robert quickly grasped the stress and coping model and was able to think of several alternative adaptive coping strategies when working through the group stress and coping activity. For example, he reported a stressor of sometimes feeling uncomfortable with his body, for which he noted he could cope by reminding himself that his body was great the way it was (emotion-focused coping) or by going to the gym twice a week in order to build muscle strength (problem-focused coping). He later reported the stress and coping model to be useful in his everyday life. In session 4, he identified SMART goals regarding sexual assertiveness and communication. Specifically, he wanted to focus on communicating his needs to sexual partners and being assertive in asking new partners about their HIV serostatus. In session 7, during which assertive communication before and during sexual encounters was explained and practiced, Robert volunteered to participate in a role-play in order to demonstrate assertive communication. The role-play was between the two co-
facilitators, who were acting out a scene in which one man is pressuring another man to engage in condomless anal sex. The co-facilitators asked participants to offer the pressured character some suggestions regarding how he could reply, and Robert made several pertinent suggestions, such as “I am not at all passing judgment on you; using condoms is something I do with all the guys I sleep with because it’s important to me.”

**Outcomes of the intervention.** At post-treatment, Robert reported six male HIV-negative or HIV-status unknown partners, an increase of two from baseline. He reported no instances of condomless anal sex. At three-month follow-up, Robert again reported six male HIV-negative or HIV-status unknown partners and no instances of condomless anal sex. At post-treatment, his reported drinking frequency decreased to about once a week in the past month and he reported no drug use. At three-month follow-up, Robert again reported drinking about once a week in the past month and no drug use. At post-treatment, his loneliness score decreased (37 at baseline; 26 at post) and his self-esteem score increased (21 at baseline; 25 at post). At follow-up, loneliness again decreased to 24 and self-esteem increased to 31. At both post-treatment and three-month follow-up, Robert reported assertive communication having been a useful skill to have acquired and reported engaging in assertive communication regarding his sexual needs and boundaries outside of the intervention since acquiring this skill. Specifically, he reported becoming more comfortable asking about serostatus early in the relationship or date, and much more comfortable addressing safer sex and his preference for using condoms with all partners.

**Case 2: Kyle**

**Baseline.** Kyle was a 22 year old, predominantly English speaking, White gay man who lived in downtown Montreal, but who reported being originally from an English-speaking suburb of Montreal. Kyle worked part-time and was in college part-time. Kyle reported 10 male HIV-
negative or HIV-status unknown partners and 10 instances of condomless anal sex in the past three months. He reported drinking alcohol several times a week and marijuana use once or twice in the past month. His UCLA Loneliness Scale score was 45 and his Rosenberg Self-Esteem Scale score was 19.

**Synopsis of treatment.** Kyle presented for Project PRIDE in order to meet more gay men as friends after losing a significant source of intimacy, as Kyle and his ex-boyfriend of two years broke up a little more than three months ago. Kyle reported that although he was a social person, he frequently felt lonely and that it was harder to engage in intimate emotional conversations with his friends, most of whom were heterosexual. Kyle participated frequently in session, and was talkative but sensitive to share talking time with others. He attended all eight sessions and stayed on task during the group and individual in-session exercises. In sessions 1 and 2, he reported that he had come out three years ago, and although he was comfortable being gay, he often noticed tolerating homophobic comments from peers when playing online multiplayer video games, which made him feel irritated and have a desire to conceal his sexual orientation when online. He also reported feeling excluded in family events because they typically revolved around heterosexual marriages and children, which made him feel like he was not following his family’s implicit rules. However, Kyle often was hesitant to be assertive for fear of being criticized. In session 3, when the stress and coping model was introduced, Kyle was enthusiastic about learning to better use problem-focused coping, as he added that he sometimes procrastinates rather than solving stressful situations. In session 4, Kyle developed SMART goals for substance use, sexual health, and stress management. These goals included reducing the frequency with which he engaged in sex while inebriated because it led to him engaging in condomless anal sex. Related, his sexual health goal was to avoid condomless anal sex. For
stress management, his goal was to complete a paper that was due in class in two weeks. In session 5, he reported not working on the class paper since session 4, which was earlier in the same week, but instead reported he accomplished a task that was more stressful, which was to tell a female friend that he was hurt last week when she had been rude to him at a party. The group members reinforced Kyle for his success at handling what he reported was a difficult social situation.

In session 5, Kyle added that one of his emotion-focused strategies when feeling socially isolated or lonely as a single gay man was meeting a sexual partner for a one-night stand, which was often while inebriated. He reported this strategy did not seem helpful in reducing stress, and sometimes made him feel guilty. The facilitators asked Kyle and the group for other strategies that could be more successful in reducing Kyle’s stress when meeting a new sex partner. The group members identified several strategies, such as completing a stress management exercise that was covered in Project PRIDE, spending time with a friend, going out to a coffee shop, or having sex without getting inebriated so he felt more in control during a sexual encounter. Kyle reported that he realized that he wanted to find more supportive friends or to pursue a romantic relationship again instead of seeking companionship through sex. In session 6, Kyle reported already being quite familiar with the safer sex information presented. In sessions 7, Kyle mentioned that although he knew about HIV and sexually transmitted infections, he realized he was putting himself at risk by having condomless anal sex with multiple partners. Upon further discussion with group members about why he was having condomless anal sex, he reported that it was pleasurable but the reason why he did not often use condoms was that he did not want to be rejected by a sexual partner. He and a co-facilitator completed a role-play in which the co-facilitator played the role of a man who was friendly but gently trying to persuade Kyle to have
sex without a condom. Despite it being a role-play, Kyle initially avoided having an “awkward conversation,” but eventually said “I know you don’t want to use a condom, but I do if we are going to have sex.”

**Outcomes of the intervention.** At post-treatment, Kyle reported 20 male HIV-negative or HIV-status unknown partners in the past three months; he had condomless sex with all 20. It should be noted that the past three months also included one month before Kyle began Project PRIDE, so some of these partners may have been before the start of treatment. At three-month follow-up, Kyle reported having no sexual partners and therefore no instances of condomless anal sex. At post-treatment, his reported drinking frequency remained unchanged and his marijuana use increased from once or twice in the past month to about once a week. However, at three-month follow-up, his marijuana use returned to once or twice a month; his drinking remained unchanged. At post-treatment, his loneliness score was fairly stable (45 at baseline; 46 at post), as was his self-esteem score (19 as baseline; 20 at post). However, at follow-up, his loneliness increased (53) and his self-esteem decreased (17). When asked in the follow-up interview about his thoughts about Project PRIDE, he reported that he did not like feeling guilty after having sex or worrying about having a sexually transmitted infection, and realized he wanted to have sex in a longer-term relationship and to have closer friends if he wanted to feel better about himself as a gay man and to feel less lonely. He added that the social interaction at Project PRIDE was helpful and that he had made new friends through the group. When asked about what he still wanted to accomplish, he added that he was still sad about the loss of his relationship and still sometimes avoided stressful situations, but he believed that the “group had given me the resources to deal with it” and that he was still pursuing a serious relationship and making stronger friendships.
Case 3: Matthew

Matthew was a 21-year-old Black English-speaking bisexual man. He was born in Northern Ontario and had moved to Toronto after graduating high school at the age of 17. He was a full-time student in a post-secondary institution as well as working part-time in the restaurant industry.

Baseline. Matthew reported two male HIV-negative or HIV-status unknown partners and 17 instances of condomless anal sex in the past three months. He reported drinking alcohol several times a week and no drug use in the past month. His UCLA Loneliness Scale score was 34 and his Rosenberg Self-Esteem Scale score was 13.

Synopsis of treatment. Matthew presented for Project PRIDE in order to meet other gay and bisexual men and gain social support, as most of his friends were heterosexual. He was initially reserved and spoke less often than the other participants in the group intervention. When he did speak, he was thoughtful and considerate of others. He attended all eight sessions and often stayed on task during the group and individual in-session exercises. In session 3, the group formed into dyads in order to work through the stress and coping model using vignettes, then reported back to the larger group. When Matthew and his teammate reported back to the larger group, Matthew spontaneously explored an anticipated prejudice/vigilance-related stressful event that he had experienced earlier that day. Specifically, Matthew had disclosed his sexual orientation in a passing comment to a small group of people at his workplace. Although Matthew reported his coworkers not explicitly demonstrating any biphobia, he reported thinking some of them had given him “funny looks.” He reported wanting to continue disclosing his sexual orientation to people at his workplace, but feeling uncomfortable and “stressed out” regarding his co-workers’ potential reactions.
With the help of the group (e.g., group members provided responses in addition to Matthew’s responses), Matthew successfully applied the stress and coping model to the aforementioned experience and not only identified the stressor (possible prejudice from co-workers and feeling vigilant) and his appraisal of the stressor (“I can’t do anything about other people’s prejudice”), but also several different emotion-focused coping strategies such as engaging in cognitive reframing via noting that he did not know what his coworkers were thinking and reframing the potential “funny looks” to possible looks of interest or intrigue. Matthew reported this exercise was useful for him and reported applying the stress and coping model to stressful events in order to identify adaptive coping strategies both at post-treatment and three-month follow-up.

In session 4, Matthew established a SMART goal regarding stress management; he reported avoiding thinking about stress and drinking alcohol in order to distract himself from stress as his emotion-focused coping strategies. He also sometimes used sex to avoid dealing with stress. He added that he did not believe these strategies were effective for him and he wished to change those coping strategies for more adaptive ones. Thus, his SMART goal was to more actively deal with stress and to reduce his reliance on alcohol and sex as stress management coping strategies. He and a co-facilitator explored different possible alternative coping strategies and Matthew decided to enroll in a creative course (such as performing arts), which would allow him to express himself and relieve stress. At follow up, Matthew reported still being enrolled in that course and it having a positive effect on his level of perceived stress. Lastly, after session 4, Matthew disclosed to the co-facilitators that he had genital herpes and was being treated by a general practitioner. He asked specific questions regarding how herpes is transmitted, as he wanted to avoid transmitting it to sexual partners. The co-facilitators answered his questions and
referred him to a local clinic that specializes in sexually-transmitted infections (STIs) and gay and bisexual men’s sexual health. In session 6, Matthew disclosed his diagnosis to the group and shared some of the information he had learned at the sexual health clinic with the group, such as when the virus is and is not transmittable. He also shared his resolution to disclose his STI diagnosis to future sexual partners and use condoms during future sexual encounters.

**Outcomes of the intervention.** At post-treatment, Matthew reported three male HIV-negative or HIV-status unknown partners. He reported five instances of condomless anal sex, a decrease of 12 from baseline. At three-month follow-up, Matthew reported four male HIV-negative or HIV-status unknown partners and zero instances of condomless anal sex. At post-treatment, his reported drinking frequency remained several times a week in the past month. At three-month follow-up, his alcohol use decreased to about once a week in the past month. He reported no drug use at post-treatment or follow-up. At post-treatment, Matthew’s loneliness score decreased (34 at baseline; 30 at post) and his self-esteem score increased (13 at baseline; 16 at post). At follow-up, loneliness was 32 and self-esteem was 14. At both post-treatment and three-month follow-up, Matthew reported the friendship building aspect of Project PRIDE was useful and helped decrease his loneliness. For example, he reported many of the participants becoming friends on a social networking site and several of them, including himself, reaching out to each other when facing a problem or feeling overwhelmed, sad, or lonely. Lastly, he reported the discussion of herpes being beneficial; specifically, he reported now feeling like he acquired tools regarding this particular STI (e.g., increased knowledge and ability to speak to partners about STIs) and was able to answer questions and give advice regarding herpes when talking with other gay and bisexual men.

**Discussion**
The case studies provide preliminary evidence for the mental and sexual health benefits of Project PRIDE. Based on minority stress theory (Meyer, 1995, 2003), stress and coping theory (Lazarus, 2000; Lazarus & Folkman, 1984), and cognitive and behavioral principles for HIV prevention (Coates et al., 2008; Kelly, 1995), Project PRIDE is a novel primary-HIV-prevention intervention for young gay and bisexual men. It is delivered in an engaging group format that integrates cognitive and behavioral techniques to help participants develop adaptive coping strategies and increase their safer sex skills. Although the social support aspects of the group may be helpful to decrease loneliness, in order to achieve sexual health and substance use goals, the skills building exercises may be the most useful. The findings from the case studies suggest that Project PRIDE may reduce condomless anal sex, alcohol use, and loneliness, and may increase self-esteem.

Implementation of Sexual Health Goals

Regarding sexual health, all participants created goals related to their sexuality. Kyle had a specific goal of reducing condomless anal sex. Matthew’s goal was to engage in other coping strategies besides sex to deal with stress and Robert’s goal was to be more assertive and communicative in sexual situations. Condomless anal sex was reduced in all participants at three-month follow-up. Two participants, Robert and Matthew, reported no condomless anal sex at follow-up and reduced their instances of condomless anal sex at post-treatment. While Robert and Matthew did not identify specific goals around condomless anal sex, these salubrious outcomes are in line with their sexual health goals. These data suggest that counselors and therapists administering Project PRIDE (a) can let youth identify their own sexual health goals and (b) do not need to direct youth to focus on condoms or avoiding condomless anal sex in order for the youth to end up achieving these outcomes. This approach is comparable to
techniques used in motivational interviewing (e.g., Miller & Rollnick, 2012), in which the specific goal is chosen by the client.

Kyle increased from ten to twenty instances of condomless anal sex from baseline to post-treatment and reported zero at follow-up due to sexual inactivity. Thus, Kyle eventually was successful at meeting his stated goal of reducing condomless anal sex at follow-up. However, given that he had no sexual partners at follow-up, it is unclear whether he would have been successful in reducing condomless anal sex were he to have engaged in sex.

Behavior therapists administering this counseling program should therefore be aware that condomless anal sex might decrease partially due to decreased sexual activity, as opposed to a client achieving a stated goal of reducing risk for HIV. In the case where a youth seeks to reduce condomless anal sex but instead avoids all sexual activity, it may be useful to explore with the youth about whether the youth has not met desirable sexual partners, or if the youth is avoiding sexual activity due to fear of failing at his behavioral goals. If a youth reports that he fears failing, two skill-building strategies may be helpful. First, the therapist may assist the youth to identify problem-focused cognitive strategies that help the youth to identify how stress is affecting his sexual health, such as in sessions 4-6. Second, practicing behavioral skills, such as those in sessions 6 and 7, may also be useful to increase self-efficacy to achieve one’s goals.

**Implementation of Substance Use Goals**

Regarding substance use, both Kyle and Matthew created goals related to decreasing substance use. Kyle’s goal was to avoid engaging in sex while inebriated and Matthew’s goal was to reduce his reliance on alcohol as a means of coping with stress. Robert did not have any substance use goals. For all participants, alcohol use was either diminished or remained stable over time. At three-month follow-up, two of three participants had decreased their alcohol use
from baseline. Kyle’s alcohol use was unchanged at any time point, which may reflect Kyle’s perception that his alcohol use itself was not problematic *per se*, but he did not wish to use alcohol to cope with stress of meeting men. Although Robert did not create a substance use goal, he reduced his use of alcohol at post-treatment and was able to maintain that change through follow-up. Matthew’s reductions in alcohol use were not evidenced until follow-up. It is not surprising that the effects for alcohol use were less than those for condomless anal sex. Project PRIDE included specific behavioral strategies for safer sex but did not include specific alcohol treatment techniques, although alcohol use was discussed throughout the intervention. Given the high proportion of alcohol use among young adults in general (e.g., 40% of college students reported heavy drinking in the past two weeks; Johnston, O’Malley, Bachman, & Schulenberg, 2007), and among sexual minority youth in particular (e.g., sexual minority adolescents engage in substance use at almost three times the rate of their heterosexual peers; Marshal et al., 2008), HIV prevention programs for young MSM may benefit from the inclusion of more focused substance use treatment techniques.

Finally, Project PRIDE appears to have promise for increasing self-esteem and decreasing loneliness. At post-treatment, all three participants reported increases in self-esteem. However, at follow-up, Kyle and Matthew reported decreases in self-esteem from post-treatment. It is possible that the effects on self-esteem may subside with time. Thus, the addition of “booster” sessions—additional periodic follow-up sessions to reinforce progress and sustain change—could be beneficial for participants. Regarding loneliness, Project PRIDE was developed as a group intervention to provide participants with social support, an important coping strategy for those dealing with minority stress (Meyer, 2007). Most participants reported reductions in loneliness at post-treatment; however, Kyle reported a small increase in loneliness.
from baseline. For Kyle, this may have reflected that his loneliness was not due to avoidance of social interactions, but was partially related to a desire to have a boyfriend. If this were an unstructured program, Kyle may have benefited from cognitive restructuring to assist him in managing his mood while single. Indeed, for clients needing more extensive cognitive restructuring, referral to individual therapy would be appropriate.

Limitations of Case Examples and Future Directions

Although Project PRIDE appears to be a promising cognitive- and behaviorally-based intervention for reducing HIV risk in young gay and bisexual men, there are limitations to the generalizability of these cases. First, because Project PRIDE is conceptualized as a program that can be administered not only by mental health clinicians, but also at community-based organizations serving young MSM (e.g., LGB youth centers, HIV/AIDS service organizations), no diagnostic interviews were conducted to evaluate if there were diagnostic changes over time. Project PRIDE does include discussions of substance use, but this component would likely not be sufficient for young men with moderate to severe substance use disorders. The cognitive techniques and role-plays may also not be sufficient to help young men with more severe social anxiety or depression. Other HIV prevention interventions are available for those with more severe diagnoses (e.g., Calsyn et al., 2013; Hart, Tulloch, & O’Cleirigh, 2014). All cases presented were young men who identified as HIV-negative gay or bisexual men, so it is not known to what extent findings would generalize to young men living with HIV. Moreover, Project PRIDE was created as a primary HIV-prevention intervention. It is likely that it would require changes to be appropriate as a secondary HIV-prevention intervention. Finally, as noted in the method section, the procedures for recording details for the case studies come from a combination of progress notes and some recall by memory. Similar to other case studies, the
details could have been subject to recall biases.

If Project PRIDE is demonstrated to be efficacious in reducing HIV risk for young gay and bisexual men through a future randomized controlled trial, it will represent an important HIV-prevention tool for therapists, public health agencies, AIDS service organizations, and LGB community agencies. These stakeholders serve a critical role in meeting the sexual health needs of young gay and bisexual men and helping to stop the HIV epidemic.
References


Lambert, G., Cox, J., Hottes, T. S., Tremblay, C., Frigault, L. R., Alary, M., ... Remis, R. S. (2011). Correlates of unprotected anal sex at last sexual episode: Analysis from a surveillance study of men who have sex with men in Montreal. *AIDS and...*


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<th>Session</th>
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| 1       | **Group forming and norming, exploration of gay/bisexual/queer/same-gender-loving (GBQSG) identity**  
  - Identify individual expectations and develop communal agreements related to program  
  - Explore individual and group understanding of what it means to be GBQSGL  
  - Gain an introductory understanding of, and experience with, stress reduction relaxation and guided imagery activities  
  - Begin group rapport building among members |
| 2       | **Introduction of the minority stress model**  
  - Introduce minority stress theory and accompanying processes  
  - Explore impact of minority stress within participants’ lives  
  - Identify personal stressors, responses to them, and subsequent outcomes |
| 3       | **Introduction of the stress and coping model**  
  - Introduce stress and coping model  
  - Identify personal stressors and automatic coping strategies  
  - Begin to discern between adaptive and maladaptive coping strategies in the participants’ own experience, including their responses to stressors and subsequent outcomes |
| 4       | **Tie minority stress and stress and coping models together, identify adaptive coping strategies**  
  - Identify personal stressors and automatic coping strategies  
  - Begin to discern between the adaptive or maladaptive coping strategies they use, as well as the subsequent outcomes of those strategies  
  - Develop SMART short and long-term coping goals, with a focus on coping with minority stress and increasing well-being (including sexual health) |
| 5       | **The intersection of minority stress and sexual and substance use behavior**  
  - Identify how maladaptive coping strategies play out in sex and substance use |
• Identify personal motivations for, and contexts that promote, particular sexual and substance use choices

6 The intersection of minority stress and sexual behavior: Developing safer sex skills

• Identify risk levels for HIV and other STIs for various sexual acts
• Learn how to correctly put on a condom, use dental dams and internal condoms, and the importance of lubricant during anal sex
• Identify barriers to safer sex

7 Putting safer sex skills into practice, continuation of safer sex topics (communication, motivation)

• Continue safer sex psychoeducation, follow up with any unanswered questions from last session
• Identify personal sexual boundaries and sexual activity preferences
• Discuss sexual communication skills, specifically assertive communication
• Practice setting sexual boundaries using assertive communication

8 Maintenance/troubleshooting and termination

• Identify personal stressors and relevant methods of adaptive coping
• Identify examples of knowledge integration and application of these adaptive coping strategies outside of intervention session
• Review participants’ successes and strengths as GBQSL men
• Enjoy informal time together via a group potluck, say goodbye
Figure 1. Condomless anal sex in the past three months.
Figure 2. Alcohol use in the past month. Note that 0 = no use, 1 = once or twice, 2 = about once a week, 3 = several times a week, and 4 = about every day.
Appendix

Example Handout/Activities from Project PRIDE

Example Handout from Session 1

*Instructions:* Ask participants to color in each segment of the relationship wheel depending on the degree to which that section and area of their lives (e.g., health, family) is impacted positively and/or negatively by their being gay/bisexual/queer/same-gender-loving. One color should represent a positive impact and another color should represent a negative impact. For example, the health section may be colored blue to represent a positive impact; the school section may be colored red to represent a negative impact; the family section may be colored 2/3 red and 1/3 blue to represent both negative and positive impacts.

Example Activity from Session 5

*Instructions:* Hand out vignettes and read each out aloud to the participants, then use the following questions to facilitate discussion.

**Example of Maladaptive Substance Use**
Jordan goes to a local college/CEGEP and lives in an apartment building where there are lots of people his age. Although he has friends from high school, he doesn’t see them as often as he used to because they are either working a lot or moved out of town. He’d like to meet more friends who go to his college/CEGEP, but he feels like it is really hard to meet new friends. He was walking down the street, and heard a bunch of people talking about a party last night that was “so gay.” Jordan is feeling upset because things don’t seem to be that much better for him as a gay man than it was in high school. Lucky for him, he at least has some vodka and juice. Jordan decides that if he is drunk, he won’t have to think about how things are still difficult for him as a gay guy. He has four to five drinks, and feels a bit better, but he also feels dizzy and a little sick to his stomach.

Ask participants: From what we know of Jordan, is this working or not working for him?

Facilitate discussion: Draw the link between stressor, emotions felt, reaction/behavior and outcome on the flipchart, while asking participants to name the different parts of the chain.

Example of Maladaptive Sex

Victor just got out of a relationship of five months with a guy he really liked, but his ex-boyfriend broke up with him. Victor would really like to be in a relationship again, but he feels like most guys seem to just want to have sex with him and that’s it. He has been feeling pretty lonely lately. It is a Saturday night around 2 am, and he gets on a gay phone app to look for another guy to talk to. He meets a guy who seems really nice and is super hot. Victor goes over to the other guy’s place and has sex with him. Although Victor doesn’t usually do anal on the first date, he really liked to bottom with his ex-boyfriend and so bottoms with this other guy. He is pretty sure the other guy is HIV-negative, but he didn’t ask and didn’t ask the other guy to use a condom so they didn’t. The sex was okay but felt kind of empty and forced. Victor goes home after the sex, and realizes that he still feels lonely and now feels like maybe it wasn’t such a good idea to have sex with this guy, especially without knowing the other guy’s HIV status.

Ask participants: From what we know of Victor, is this working or not working for him?

Facilitate discussion: Draw the link between stressor, emotions felt, reaction/behavior and outcome on the flipchart, while asking participants to name the different parts of the chain.