Getting Off:

A Behavioral Treatment Intervention For Gay and Bisexual Male Methamphetamine Users

Cathy J. Reback, Ph.D.
Steven Shoptaw, Ph.D.
Joshua Riley, M.S.
Kevin Shone

A Training Manual for Counselors

Cover art by Rob Costin.

Acknowledgments

This training manual for counselors was generously support by a grant from the California HIV/AIDS Research Programs (#MU04-FRII-704).

This training manual was updated in 2023 through the generous support of the Opioid Response Network (Substance Abuse and Mental Health Services Administration [SAMHSA], #1H79TI083343) and the contributions of Drs. Cathy J. Reback, Jeremy Kidd, and Margaret Paschen-Wolff, and Avery Desousa and Layton “Sam” Phillips, CADC-II.

Copyright
Friends Research Institute, Inc.
2009, 2019, 2023

For further information, please contact Dr. Cathy J. Reback, Senior Research Scientist, Friends Research Institute, Inc., (323) 463-1601, reback@friendsresearch.org

TABLE OF CONTENTS

Introduction ……i

Session 1: Calendars and Dots Around the Clock 1

Session 2: The Talking Wall 6

Session 3: Trigger - Thought - Craving - Use...... 10

Session 4: A Private Matter 14

Session 5: External and Internal Triggers 20

Session 6: Meet Auntie Tina 24

Session 7: Other Drugs & Alcohol: Do They Count? 27

Session 8: Redefining Your Place in the World...... 31

Session 9: Knowing How to Handle a Relapse is Not Permission to Have a Relapse. 35

Session 10: Your Social Web 39

Session 11: Creating a Safe Space 43

Session 12: Where Have We Been & Where Are We Heading? 46

Session 13: Addiction & the Brain; Stages of Recovery 50

Session 14: Drugs, Sex, and Euphoric Recall...... 54

Session 15: Talking Meth, Talking Recovery 57

Session 16: Coming Out All Over Again: Reconstructing Your Identity……60

Session 17: Preventing Relapse……64

Session 18: Relapse Analysis……68

Session 19: What About These Feelings?......72

Session 20: Setting Goals & Solving Problems 77

Session 21: Why You Use and Low-Tech Sex 81

Session 22: A Community Changed 85

Session 23: Socializing vs. Isolating 88

Session 24: Auntie Tina Moves In……91

Appendix 1: Glossary……94

Appendix 2: Tailored Cognitive Behavioral Therapy ……95

Appendix 3: Other Considerations: Minority Stress and Intersectionality……96

Appendix 4: HIV, HCV & Fentanyl……97

References ……98

Introduction

Getting Off is an evidence-based outpatient methamphetamine use treatment program that helps gay and bisexual men to stop or reduce their methamphetamine use, and to reduce and change risk behavior(s) related to HIV and other substance use (by Drs. Cathy Reback and Steven Shoptaw). The intervention consists of an 8-week, 24 session gay-specific cognitive behavioral therapy (GCBT) intervention that follows this manual. Before turning to the session-specific sections of the manual, counselors should review the following general information about working with gay and bisexual men, and other sexual minority men, around their methamphetamine use. These recommendations are based on interviews and focus groups with gay and bisexual men in treatment for methamphetamine use, as well as with substance use treatment providers working with gay and bisexual men.

The Methamphetamine Use Spectrum

Participants come to the Getting Off program with a range in methamphetamine use frequency and intensity. The DSM-5 defines a substance use disorder as meeting at least two of eleven criteria across four main categories: impaired control over substance use (e.g., experiencing cravings; consuming more of the substance than intended); social impairment (e.g., impaired ability fulfill major obligations at work or at home; reduction in recreational or social activities because of use); risky use (e.g., use in unsafe environments); and pharmacologic criteria (e.g., needing a higher dose to get the same effect [tolerance]; experiencing withdrawal symptoms). Individuals with mild use disorder meet two to three of the eleven criteria' moderate meet four to five, and those with severe use disorder meet at least six criteria. For more information, see https://www.ncbi.nlm.nih.gov/books/NBK565474/table/nycgsubuse.tab9/.

Counselors should keep in mind that not all individuals in the Getting Off program engage in problematic methamphetamine use; and, some participants will not meet criteria for a methamphetamine use disorder. Other participants may engage in occasional use that sometimes or regularly causes problems, and others may engage in chronic use and meet criteria for a severe use disorder. The Getting Off program was designed to work with all participants that seek treatment to reduce or eliminate their methamphetamine use.

Participant Needs Outside of Getting Off

A person may relapse if their emotional and structural needs are not being met; thus, discussions of health, wellness, housing, employment, social support, legal resources, and transportation are important components to address within the Getting Off group sessions. Counselors should regularly check in with participants to see if they would like to connect with case management services. Such services may be available at your own organization; otherwise, provide participants with information and support as needed to connect with local external organizations that may assist with housing, employment, legal, and transportation resources. Consider providing participants with a list of local resources, including contact information and websites.

Empower participants by providing them with tools and resources for recovery and harm reduction. Encourage participants to focus on the feelings associated with health and wellness by asking, “How does it feel when you take care of yourself?” Provide examples of how one could take care of themselves, such as getting enough sleep, eating nutritious foods, and spending time with supportive people. Ask participants to describe their everyday surroundings and interactions, and if they are emblematic of participants’ conceptions of their own recovery. For example, do participants spend time with people who are supportive of their recovery, rather than people who encourage harmful substance use?

Addressing Trauma in Treatment

Trauma is a prevalent theme among people who use substances; substance use may be a means of self-medicating to treat trauma-related conditions like post-traumatic stress disorder, anxiety, depression, and other mental health concerns. Simply addressing and changing behaviors such as harmful substance use may not be enough to support sustained recovery; rather, getting to the root cause of those behaviors, such as underlying trauma, is crucial to many participants’ healing. Participants with significant trauma may benefit from individual therapy in addition to the Getting Off program given that group counseling is not an optimal setting to address individual experiences with trauma. Offer your participants resources to connect to individual therapy as needed, whether within your own organization or externally. Consider providing participants with a list of local resources, including contact information and websites.

Conflict Between Getting Off Participants

To mitigate conflict between participants, it is recommended that the counselor redirect participants' attention away from the conflict itself, and toward the feelings underlying the conflict. This can be achieved by acknowledging participants' negative emotions (e.g., anger, frustration, hurt feelings) and asking them, "Where is this feeling coming from for you?" Once the counselor has worked with participants to identify their underlying emotions, the counselor can foster empathy between participants by reminding them that they are all in this group for the same reason, regardless of how they got here.

<u>Example of a conflict between participants</u>: Participants may have different reactions when other substance use treatment programs and support groups, such as 12-step, come up in conversation. The spiritual component of many 12-step programs can feel off-putting for those with religious trauma, while others may find spirituality and faith to be helpful in their recovery.

- In this example, encourage the participant to describe what aspects of the 12-step approach have been helpful to them and why they wanted to share that with the group. Invite other participants to share how those aspects may be helpful in or relevant to their own paths to recovery.

<u>Note on Harm Reduction:</u> The goal of the Getting Off program is generally to achieve abstinence from methamphetamine; abstinence from other substances is encouraged, but not required. Getting Off operates from a harm reduction perspective in acknowledging that complete abstinence may not be a realistic nor desirable goal for everyone; therefore, it is important to accurately assess participants' treatment goals. When implementing the Getting Off program, no one is removed from the program, or asked to leave a group session, due to continued substance use. Rather, the counselor can utilize a participant's substance use as a learning opportunity for both that participant and all group members.

Session 1: Calendars and Dots Around the Clock

Individuals who enter outpatient treatment for methamphetamine use find themselves dealing with a great deal of chaos due to the consequences of their drug use on the social, work, and/or legal spheres of their lives. The antidote for this chaos is to emphasize the role of structure in building order and predictability into participants' lives. Beginning with this session and at the start of each subsequent session, it is crucial for the counselor to underscore the importance of building structure into participants' lives. Moreover, when people enter residential or hospital treatment, structure is imposed by an agency and by the rules of the program. Compliance with structure is mandatory in these settings. In outpatient treatment, however, compliance with structure is voluntary and has to originate from the participant. Participants who inform you that they are incapable of building structure into their scheduling, or are unwilling to adhere to such structure, are poor candidates for outpatient treatment. In these cases, consider recommending that the participant seek a more intensive level of intervention such as day treatment or residential care, which best set an environment for compliance with structure. Sometimes participants can be surprised by their unwillingness to adhere to a schedule, only to find that this unwillingness is a harbinger of relapse—especially when the participant is unwilling to commit to a schedule of non-using events for a time during the week that he often used methamphetamine (for example, 5 p.m. on Fridays).

Related to the concept of structure is the importance of a participant understanding his current use of drugs and alcohol and his sexual behaviors that are related to such use; this understanding begins by the participant paying attention to his behavior. This may sound simple, but most people who use drugs who experience problems related to their use stop paying attention to how their use affects them precisely because noticing this might indicate the need to change behaviors. Thus, one of the important first steps in achieving sobriety from methamphetamine is to pay attention to current methamphetamine use, other drug and alcohol use, and related sexual behaviors. Even if a participant has been abstinent from methamphetamine for some time, keeping track of other drug and alcohol use and sexual behavior is just as important, especially in terms of understanding what might be related to that use. For many participants, methamphetamine is their main focus, but as they begin to keep track of other drug or alcohol use and/or high-risk behaviors, they realize that

drinking at a bar, going to a bathhouse, or spending time online can lead to methamphetamine use. “Calendars and dots” is helpful in early recovery for building structure and predictability into participants’ lives, for discovering the role of drugs, alcohol, and sex in participants’ lives, and for mapping possible directions for change. Dots serve to subtly and simply reinforce sobriety.

Participants who are just getting sober are vulnerable to return to use. One of the biggest distractions in early recovery is unstructured time. Participants need help determining how to best fill unstructured time, time that was previously occupied with procuring drugs, using drugs, and recovering/withdrawing from drug use. In the initial days and weeks of abstinence from methamphetamine, participants experience vast expanses of free time—time that previously was allocated to their drug use. Creating and adhering to a schedule can be a key tool for helping participants to plan alternative activities during particularly difficult times such as weekends and holidays. Similarly, scheduling can help participants avoid specific people, places, things, events, and feelings that are associated with drug use. Structuring time becomes not only a coping tool for the participant, but also a diagnostic tool for the counselor. Prior to seeking help for their methamphetamine use, many gay and bisexual men who use methamphetamine used the drug to form the nexus of their social and sexual lives. The absence of methamphetamine from their lives has a profound effect on their identity, social networks, and sexual behaviors at precisely the time when withdrawal from methamphetamine exaggerates the sharpness of each negative feeling and thought. Using structure and keeping a schedule that includes safe and sober activities can help minimize challenges related to socializing and sex. Creating a schedule and adhering to it is a useful tool for participants implementing new habits and avoiding difficult times. A very simple fact that participants can value is: When a person creates a schedule that does not include methamphetamine use and he keeps to that schedule as planned, he will achieve the goal of methamphetamine abstinence.

As participants begin to pay attention to their schedule and the ways that methamphetamine use factors into that schedule, they will likely begin to talk about the ways in which methamphetamine use negatively impacts their lives. For many participants, the impacts of methamphetamine use are things we all seek to avoid—mounting debt; personal problems with partners, significant family members, and friends; trouble holding down a

job; and health concerns such as HIV and other sexually transmitted infections (STIs). It may be hard for many participants to find non-methamphetamine-using activities to fill their schedule, especially if finances are a problem. The final exercise in this session asks participants to think about their satisfaction in several areas of life. This survey serves as a baseline for keeping track of the hard work and improvements participants will begin to see in their life without methamphetamine.

Goals of the Session

1. Introduce the importance of daily structure and routine.
2. Help participants begin to see patterns in their drug use and sexual behavior.
3. Help participants begin to identify events that might lead to their use, and begin to see the connections between their methamphetamine use and other behaviors, particularly high-risk sexual behaviors.
4. Help participants assess their current satisfaction with areas of their life and establish a baseline for monitoring progress.

Handouts & Materials

1. Session 1, pp. 1–7
2. Pens
3. Blank calendars (if providing them)
4. Dots or festive stickers (round Avery brand colored stickers work well)

Session Format, Presentation, & Timing

1. Check-in and Feedback – 30 minutes (no more than 45 min.)
    - This is a fairly long session. Be aware of this during the check-in. Remember, in addition to giving individual motivational feedback, check-in serves as a time for counselors to weave together common themes that participants touch on. The themes from the check-in can be useful for guiding the session topic.

2. Topic Presentation and Discussion – 60 minutes
    - Calendars and Dots: Briefly introduce the concept of structure, schedules, and behavior change. Emphasize that the first step in

changing behavior is to notice current behaviors. Explain that the purpose of Calendars and Dots is to help participants begin to notice the amount of time they invested in their drug and alcohol use. It is also helpful to point out the ways that sexual behaviors are frequently linked to their using. This latter point is important, as the issue of sexual behaviors is brought up early and often throughout this program. The topic of building a healthy sexual life, including building time for sex into the schedule, is important. Many men find themselves in a place in their sexual lives in which they cannot remember having sex with another man without the assistance of a substance. Encourage participants to be honest about their schedules and to pay attention to what their behaviors are (even if they are embarrassing), how often they occur, when they occur, and with whom they occur.

- Instruct participants to place a dot on the calendar for any day they do not use methamphetamine. They might also choose to write items on their calendar such as their use of other drugs and alcohol, any sexual activity, or any other events that are associated with their drug use. Remind participants that the purpose of this exercise is to look for patterns that emerge from charting their drug use and behaviors. Thus, they should keep track of whatever behaviors are most meaningful. These behaviors will, of course, vary among participants.
- Explain that drug use and high-risk sexual behavior can be difficult to change at first, and that acknowledging these behaviors can bring up uncomfortable feelings. These feelings can make it more difficult to be honest, especially if the participant is new to the program. Encourage participants not to judge their behaviors, but to just start paying attention to what they are and writing them down.
- Ask participants to complete the calendar at the top of Page 2, following the instructions on the bottom of Page 1. Ask participants to read these instructions, and walk them through filling in the calendar. Discuss any patterns, obvious potential triggering events (such as holidays and birthdays), and sexual behaviors. Encourage participants to also document alcohol and other drug use in addition to methamphetamine use.
- Day-to-Day Routine: Read over the material in the middle of Page

2 and discuss it with participants. After a brief introduction, have participants complete the questions on the bottom of Page 2 and continuing on Page 3 and discuss them. Encourage participants to talk about how their drug use took up time and how they have managed their time since entering treatment for their methamphetamine use.

- Ask participants to begin completing the schedules on Pages 4–6. Often participants complete these at home or after group sessions. Invite participants to use the schedules on Pages 4–6 as a framework, encouraging them to create a schedule for themselves in whatever way works best for them, such as keeping a notebook, journal, or a planner, and to adhere to the schedule until the next group.
- Initial Assessment: Read the instructions at the top of page 7. Ask participants to complete the assessment, rating their satisfaction in different areas of their life, using the scale provided. Remind participants that they can hold on to this assessment as a living document to keep track of the progress they are making in different areas of their lives. As with all of the assessments in the manual, participants may wish to revisit it every couple of weeks.

Before Next Session:

- If they have not already received them, give participants a copy of the calendar booklet and some dots or stickers to get them started. Ask participants to commit to using calendars and dots for at least the next week and to notice what patterns emerge. In addition, ask participants to complete the daily schedules in the session materials and to try to adhere to the schedules until the next group session

Session 2: The Talking Wall

Participants begin using drugs and alcohol for a variety of reasons, often quite simply because they "fit the bill"—at least at first. The reasons for using vary from person to person, but there are some common themes. Some people use for purely recreational or social reasons. Some people use as a means of coping with stress. Some people use in order to free themselves from anxiety or inhibition about who they are and what they like to do. Some people use to enhance sex. What is also true is that no one sets out to acquire the problems that harmful substance use creates in their life. Typically, one does not use drugs to destroy a relationship or to seek out financial ruin. Usually, one starts to use drugs and alcohol for seemingly good reasons and generally, at first, drugs and alcohol work—they make you feel better.

What is also true, as anyone seeking treatment for methamphetamine use knows, is that at some point drugs stop working like they did at first. The negative aspects of using begin to outweigh the seemingly positive attributes of the drug. Examining the role of methamphetamine in participants' lives and talking openly about its effects is an important component of early recovery. In this session, participants are asked to reflect on how this process happened—how the scales tipped from good to bad and prompted them to seek help. Participants are asked to respond to a series of questions that take them through the process of looking at their methamphetamine use. Honest sharing, done in a nonjudgmental atmosphere, can be a refreshing change for people who use drugs, many of whom have been consumed by shame and secrecy. Paradoxically, being able to reflect on the once good things about methamphetamine helps facilitate a healthy mourning for the loss of the drug and the important or adaptive role it played in their lives. Similarly, talking about what was good helps participants begin to look at ways that they can meet some of the same needs methamphetamine met with different behaviors. The "Talking Wall" becomes a forum for exploring these issues.

Some participants may initially object to this exercise as it makes them feel like they are swapping "war stories" or glorifying their past methamphetamine use. Let participants who are worried about this know that it is okay to acknowledge the functional use methamphetamine had for them. Acknowledging the functional aspects of their methamphetamine use

helps participants begin to identify ways that their needs, once met in the context of methamphetamine use, can begin to be met in recovery through other activities.

The final component of this exercise follows naturally from the discussion by asking participants to begin to think about the good things that they can invite back into their lives. Participants are asked to brainstorm and write down different activities they can do instead of using methamphetamine. It can be helpful to let participants know that it is hard to plan activities that they will really do, especially after years of methamphetamine use. But still, help each person come up with a series of activities that they can reasonably expect themselves to fit into their schedules.

Goals of the Session

1. Build group cohesion by sharing common experiences.
2. Help participants see the arc of their using from experimentation, to occasional use, to regular use, to harmful use and/or methamphetamine use disorder, and to identify consequences of their use.
3. Help participants articulate the ways that methamphetamine is no longer working for them.
4. Help participants identify healthy behaviors and activities to replace their methamphetamine use.

Handouts & Materials

1. Session 2, pp. 8–12
2. Pens
3. Dots or stickers
4. Large flip chart pad or dry erase boards
5. Markers, crayons, colored pencils, etc.

Session Format, Presentation, & Timing

1. Check-in and Feedback – 30 minutes (no more than 45 min.)
    - Invite participants, if they wish, to share about what it was like to follow the schedule they set for themselves in the previous

session. How easy was it? Did it bring up any feelings for them? What helped them to adhere to their schedule? What were the challenges? Remember that participants do not have to share about the homework or whether they completed it. A good open-ended question to ask might be, "Did anything come up for you that you would like to share?" (Please note: It is okay if participants choose not to complete homework assignments.)

2. Topic Presentation and Discussion – 60 minutes

- The Talking Wall: Session questions should be written on large pieces of flip chart paper, or written on a large dry erase board, if available. Papers can be hung on a sturdy surface or placed on a table. Make sure to arrange them so that more than one participant can write on them at once. Place markers, pens, and crayons at each station.
- After the check-in and feedback, briefly introduce the concept of "The Talking Wall" and provide its history and use, as discussed in the treatment manual. Explain that the purpose of The Talking Wall questions is to help participants think about how the balance of their methamphetamine use tipped from good to bad.
- Ask participants to think about their answers to each question and if they wish to make notes on their handouts. Ask participants to then circulate among The Talking Wall question sheets and write some of their answers and thoughts about the questions. Encourage participants to be as honest as they can and to share the thoughts and feelings they are having right now. Participants do not need to identify their answers as their own. They may express themselves however they wish.
- After participants have written on each sheet, place or hang the sheets where all participants can see them and facilitate a discussion about the questions and participants' answers. What did they notice about the questions? Did anything surprise them about the questions or their answers? Based on the answers, identify common themes. Remind participants to speak from their experience and to use "I" statements.
- During this discussion it may be appropriate to talk about and normalize participants' ambivalence about stopping methamphetamine use. Counselors may consider facilitating a

brief discussion about ambivalence to help contextualize participants' shifting feelings about and commitment to seeking treatment for their methamphetamine use.

- Building the Good Back into Your Life: The discussion of the Talking Wall will likely identify some common reasons why participants used methamphetamine. The most common reasons are often “to feel better” (feeling), “to relieve boredom” (thinking), and “to have fun” (doing). Ask participants to write down some activities they can do to feel better, relieve boredom, and to have fun instead of using methamphetamine. Often these are activities that participants used to do before they started using methamphetamine. After they have written several options, have participants share their list if they wish and brainstorm other options together as a group. Write these on a dry erase board for all to see.

Before Next Session:

- As instructed on Page 12, ask participants to commit to doing at least one of the activities they listed on their handouts between now and the next session. Remind participants to continue to schedule their time and to keep track of calendars and dots.

Session 3: Trigger → Thought → Craving → Use

A trigger is any person, place, thing, feeling, situation, or behavior that becomes associated with methamphetamine use. Triggers cause cravings, which if not interrupted, can lead to drug use. Triggers are different for everyone, but there are some very common triggers that gay and bisexual men who use methamphetamine describe. Some of these include: Friday nights or the weekend, online sex sites, bars, bathhouses or sex clubs, the gym, feeling horny, payday or money, loneliness, insecurity and other feelings of anxiety, pornography, and significant holidays or anniversaries. Some triggers can be controlled or avoided, such as not going to the gym, not getting online, or not going to bar, while others are more difficult or sometimes impossible to avoid, such as the arrival of the weekend, or running into an old using buddy or sex partner. As participants identify their triggers, they are better able to avoid those that can be avoided.

This session introduces the Trigger → Thought → Craving → Use model. Understanding this model can help participants learn to interrupt the cycle and de-escalate their cravings. For many people who use methamphetamine, the craving process feels automatic and unavoidable. A particular trigger, its resulting craving, and the decision to use become so closely associated that using feels inevitable the instant the trigger hits. This cognitive behavioral model helps participants to slow this process down and to see its component parts (thoughts, feelings, and behaviors). By examining this process, participants develop a deeper understanding of and more control over their triggers and cravings. This exercise invites participants to identify some of their triggers and to choose thought-stopping techniques that work for them to help keep triggers from developing into craving.

Although this session suggests and describes several different thought-stopping techniques, counselors should encourage participants to brainstorm a more comprehensive list, reminding them that different thought-stopping techniques work for different people. Participants should be empowered to find the techniques that work best for them. It can be useful to leave the Trigger → Thought → Craving → Use model written at the top of the board for every session. Counselors refer to it often.

Goals of the Session

1. Introduce the concept of triggers.
2. Help participants understand the Trigger → Thought → Craving → Use model.
3. Help participants begin to identify their triggers.
4. Help participants identify effective thought-stopping techniques they can use.

Handouts & Materials

1. Session 3, pp. 13–16
2. Pens
3. Dots or stickers

Session Format, Presentation, & Timing

1. Check-in and Feedback – 30 minutes (no more than 45 min.)
   - Invite participants to share about their homework assignment, if they wish: What was it like to do some of the positive activities they identified from the previous session?

2. Topic Presentation and Discussion – 60 minutes
   - Invite participants to discuss their understanding of the difference between triggers and cravings. Have participants share any steps they may have already taken to avoid triggers. These could include things like getting rid of paraphernalia, avoiding certain people or places, spending less time online, or not going online. Ask participants to share how this has been for them. In addition to discussing cravings and triggers related to methamphetamine use, ask participants to think about triggers and craving related to high-risk sexual behaviors. Remind participants that cravings are temporary and that they pass.
   - Read the beginning of the Session 3 handout to initiate the discussion of the Trigger → Thought → Craving → Use model, emphasizing that interrupting triggers and cravings requires changing thinking patterns and behavior. The session also introduces the idea that when we dwell on a trigger, it is more

likely to turn into a powerful craving—the more we think about it, the stronger it gets and the more likely we are to choose to use.

- The image of a boulder rolling down a progressively steeper hill provides a helpful visual representation of this concept. If participants let their thinking overwhelm them, then the time it takes to go from trigger to possible use can be very fast—accelerating like the boulder rolling down the hill. Putting obstacles in the way of this process helps slow it down and stop it.
- Explain that at each stage in the process, participants have the ability to interrupt and reverse the progression from trigger to thought and from thought to craving. Once a craving starts and begins to grow, it can be very hard to stop it from becoming a "use." First, participants can minimize triggers by avoiding those that can be avoided. Obviously, some triggers will still occur. Thought-stopping is the next defense in this process. Blotting out the thoughts or cravings can stop the progression toward use. It is important to stress to participants that when they let a trigger progress to a craving, they are making a choice to be passive in their recovery. Leaving recovery to chance is not a good choice. If thought-stopping techniques do not prove effective, and a craving comes, remember: Cravings are temporary. Participants can be taught that using a distraction or another technique can be helpful in letting the craving pass.
- Facilitate a discussion, inviting participants to share their understanding of the model. Ask participants if they have had any experiences where they have engaged in a thought-stopping technique but did not realize it.
- Go over the thought-stopping techniques listed on Page 15. Participants will likely discuss why a particular technique would or would not work for them. Remind participants that new behaviors often feel artificial or forced at first and so they should not make up their minds about what will or will not work for them at this time. Ask participants to be open to try something new and see if it is effective.
- Ask participants to brainstorm a list of other thought-stopping techniques. Remind participants that the purpose of the brainstorm is to get as many ideas written on the board as possible and that afterward participants may consider how effective a particular

technique may be for them.

Before Next Session:

- Ask participants to pay attention to any thought-stopping

Session 4: A Private Matter

The use of methamphetamine can contribute to the transmission of HIV and other STIs by facilitating high-risk sexual behaviors when under the influence. Most gay and bisexual men who use methamphetamine report that the drug strongly enhances their sexual experiences. Although not every person who uses the drug describes methamphetamine-enabled sexual risk behaviors, the association between methamphetamine and sex among gay and bisexual men is well documented. Gay and bisexual men who use methamphetamine tend to have more casual (non-primary) sex partners, engage in more multi-partner sexual activities, seek and engage in more sex in public places or commercial sex venues, report less consistent condom use, report using the Internet to find sex partners, and report more instances of unprotected insertive and receptive anal sex than do gay and bisexual men who do not use methamphetamine.

Many people who use methamphetamine report that methamphetamine use and sex get paired so often that it is difficult for them to imagine being able to have sex—or even wanting sex—without methamphetamine (or methamphetamine without sex). The repeated pairing of methamphetamine with sex causes each behavior or sensation to become a trigger for the other, mutually reinforcing the fusion of methamphetamine use and sex. This complicates recovery, for while it may be relatively easier to imagine a life without methamphetamine, it is almost impossible, and indeed not preferable, to imagine life without sex. However, in recovery, people who use methamphetamine must not only begin the difficult work of rebuilding their life free of methamphetamine, but must also work to rebuild their sexual life, and this often requires significant changes to their sexual behavior.

As part of a comprehensive program of recovery from methamphetamine, it is helpful for participants to have the opportunity to explore issues related to their sexual behavior, sexual expression, sexual boundaries, and relationships. For many, having the opportunity to imagine what sex and relationships may be like once they are not using methamphetamine may be a novel exercise. This is the first of several sessions that deals directly with this topic.

Experience has revealed an interesting paradox: While one might assume that gay and bisexual men brought together in a safe, supportive, non-sexual environment would easily talk about sex, this is not necessarily the case. Many men who use drugs feel shame and guilt about their sexual experiences. Some participants may have become HIV-infected or contracted other STIs as a result of their methamphetamine use; others may have started using methamphetamine as a coping strategy to deal with the stigma, shame, and denial about their HIV infection and thus may have suppressed feelings about their HIV infection, often using sex as a way to "numb out." In recovery, these feelings begin to surface and can be uncomfortable and triggering. Some experience shame about the kinds of sex they had, or the potentially harmful consequences, or the way they were treated or treated others. In addition, gay and bisexual men live in a society that stigmatizes their same-sex feelings and behaviors. Many internalize this homophobia, and the conflict and shame they feel can lead to methamphetamine use and high-risk sexual behaviors. In this session, participants are invited to privately examine some of their previous sexual behaviors and experiences and begin to think about the role sex and relationships play in their lives.

Sexuality and sexual behavior can be sensitive topics. It is critical that counselors suspend their judgment and respond with support to participants. However, counselors do not have to agree with the choices participants make or acquiesce if they believe the behavior described is potentially risky; education and confrontation offered during this session must be gentle, inquisitive, respectful, and informative, rather than judgmental or directive. Counselors should become familiar with the terms used and behaviors described in the session (such as "felching" and "bukkake"), and, if necessary, be comfortable interpreting such behaviors to other group members.

Goals of the Session

1. Introduce and describe the connection between methamphetamine use, sexual risk behaviors, and HIV infection.
2. Create a comfortable environment in which conversations about sex are welcome and supported.
3. Help participants begin to understand how their sexual behaviors and methamphetamine use go together.

4. Help participants begin to identify differences between sex on methamphetamine and "sober" sex.
5. Help participants think about the role sex has played in their lives in the past and to imagine the role sex might play in the future.

Handouts & Materials

1. Session 4, pp. 17–19
2. Pens
3. Dots or stickers

Session Format, Presentation, & Timing

1. Check-in and Feedback – 30 minutes (no more than 45 min.)
    - Invite participants to share about their homework assignment if they wish. The following question is a good place to start: Did you find yourself using any of the thought-stopping techniques identified in the previous session? Did you become aware of techniques you might have already been using but were not aware of it? Were there any challenges?

2. Topic Presentation and Discussion – 60 minutes
    - Introduce the topic. Briefly describe the connection between methamphetamine use and sex. Read or summarize the first section of the session topic out loud.
    - Remind participants that sex can be a difficult subject to discuss, even in a safe environment, and that they do not need to tell all. Assure participants that the topic will come up again and that they should share only what they're comfortable sharing.
    - Sexual Behaviors Questionnaire: Explain the sexual behaviors questionnaire to participants, indicating that one of the goals of the exercise is to help them begin to see patterns in their sexual behavior when high and when sober. Explain that they should put a check beside any behavior they have engaged in or anything they have done in the past month while high on methamphetamine, while high on any other drugs or alcohol, or while sober. Remind participants to include poppers and erectile dysfunction/sexual enhancement drugs. Assure participants that

they are answering for themselves and that they do not need to share their answers out loud.

- Invite participants to take a look at their answers. Did they have sex while sober? Did they have the kind of sex they wanted? What is different about their sober and non-sober sex? Invite them to share with the group, but only if they feel comfortable. Use the standard open-ended question, “Did anything come up for you that you want to share?”
- Guided Imagery: Introduce and explain the next part of the topic—a guided imagery exercise. Explain that the goal is to think about some of the differences between the sex they have had while high and their sober sexual experiences. The ultimate goal of these visualizations is to think about and imagine the best or ideal role sex can play in their lives. The purpose of the exercise is not to have participants judge themselves or feel guilty about past behaviors, but to look at what has worked and what has not worked for them in meeting their sexual and emotional needs. Keep in mind that there may be some in the group who have never had sex while they were sober.
- Read the instructions at the top of Page 18. Invite participants to write down and share past sexual experiences in which they have felt disconnected from their partners and from themselves—and situations when they have felt connected to their partner and to themselves. What were the differences in terms of thoughts, feelings, and behaviors? What were the cues that helped them know whether they were connected or disconnected? As some in the group may not be as comfortable sharing for themselves, counselors can frame this as “feelings or cues you have experienced or feelings or cues you know other people have experienced.” It can be helpful to write these on the board, as it gives an external focus to the group and can help de-escalate participants' nervousness when talking about sex.
- Talking About Sex: The final section of the session usually flows naturally from the guided imagery and gives participants an opportunity to practice talking about sex. Read or summarize the section at the top of Page 19. Explain that the overall goal of this part of the exercise is to imagine their ideal partner or sexual situation. What would it be like? When imagining this, participants

should think beyond physical attributes and particular sexual behaviors. They might use some of the cues listed on the board to describe what this ideal would be like for them. Some participants have never had sober sex. For these persons, it can be important to slow things down and to begin to recognize that gay sex, when not under the influence, can be frightening if one has never had that experience. For those who choose to avoid being adventuresome in thinking about or in planning for sex while sober, be sure to advocate masturbation as a way to experience pleasure on a regular basis. Also, for those who feel they are not ready for sober sex, be sure to ask whether the Internet or other sexual experiences that are available online might be a trigger to use methamphetamine. Masturbation can be perfect, but if it is part of a high-risk scenario involving the Internet and methamphetamine, then self-pleasure has to happen the low-tech way—with no computers and no drugs.

- Some participants struggle in this exercise to talk about a made-up person's experience. Counselors can re-frame this by describing that it is an opportunity to talk about their own experience or what they have heard from others' experiences.
- Counselors need to stay aware of the feelings and dynamics in the group. Talking about sex can be very triggering, either to sexual excitement or to craving for methamphetamine. Counselors should make sure there is time to defuse such feelings at the end of the session. Depending on the "temperature" of the group, counselors might want to take a quick spin around the room, round-robin style, and ask participants to name one or two feelings that may have come up for them during the exercise. What are they feeling right now? Is anyone feeling triggered to use methamphetamine or any other drug? Is anyone feeling triggered to "party and play," that is to say, to find sex and methamphetamine? It may be helpful to ask group members what their plans are immediately following group. Is anyone attending a 12-step or other form of self-help meeting? Do participants have someone they can call if they are feeling triggered or have cravings?
- Transitioning to discussing casual topics as the group ends can be a very effective cooling-down technique.

Before Next Session:

- Introduce the optional homework on Page 19

Session 5: External and Internal Triggers

Triggers are people, places, things, events, or feelings that cause cravings to use. Categorizing triggers as either “external” or “internal” offers a useful model for helping participants begin to understand and label their triggers. Often, both internal and external triggers become mutually reinforcing and can lead to methamphetamine use and high-risk sexual behavior. It is important that participants identify both internal and external triggers and examine which triggers relate to methamphetamine use and which relate to sexual behaviors—as well as how they are connected. Understanding this relationship is critical for avoiding triggers in the future. Often, because of the way they become associated with one another, triggers happen in a certain predictable sequence. For example, a participant may need to get on the computer to check his online banking. However, the Internet triggers him to check his online cruising account; having received an e-mail from a former sex- and using-buddy, the participant becomes aroused, and as thoughts of sex build, the craving for methamphetamine builds as well. This sequence may trigger the participant to begin looking at online cruising profiles, which fuels the rumination about sex and methamphetamine and propels him through the Trigger → Thought → Craving → Use cycle. In examining such patterns, a participant might need help in identifying the sequence and its predictability as well as help in identifying the internal and external triggers.

In the example above, the external triggers are the computer and everything else associated with the physical environment, such as the lighting on the desk where the computer sits, the chair, or other tangible items in the room. Other external triggers might be the time of day or even the layout and look of the websites. The internal triggers may be harder to identify; they will often be the physical sensations of excitement, the anticipation and arousal that occur when cravings begin. It is very important that participants identify in very clear language the sensations they feel. For example, “anticipation” is a good place to start, but participants need to identify what actually happens in their bodies when they start to feel anticipation: for example, increased blood pressure, rapid heart rate, flushing in the face, sweating, or butterflies in the stomach. It is also not uncommon for participants to describe feelings of dissociation, or “checking out.” As their craving builds, it can be as if they go into “automatic pilot.”

Identifying and describing internal and external triggers in precise, easy-to-understand language is important for two reasons. First, participants who have a clear understanding of their triggers are better able to identify triggers when they arise and are better able to use thought-stopping and other cognitive behavioral techniques to de-escalate these triggers. Second, participants who are able to describe their triggers in detail are less overwhelmed by them, are better able to avoid those that can be avoided, and are better able to change those that can be changed. In the example above, the participant might decide to cancel his Internet at home, rearrange his desk area or furniture, get a new desk chair, and change the lighting. He may start practicing meditation or reading a book about mindfulness in order to better stay in the present when the feelings of dissociation come. These changes may sound trivial, but they are all effective steps to take when trying to break the association between external and internal triggers.

Any change is good, and participants need to be reinforced consistently for the big and small changes they make. They may not be ready to change their cell phone number, but they may be ready to turn the volume down so they do not hear the incoming call, leading the caller to leave a message, and thereby allowing the participant to control who he talks to and when. Anything that gives a participant time to intervene on his own behalf and use the tools he has been given to help avert methamphetamine use and high-risk sex is a step toward disarming triggers.

Goals of the Session

1. Introduce the concept of internal and external triggers.
2. Help participants begin to identify internal and external triggers related to their sexual behavior and methamphetamine use.
3. Help participants strategize about how to avoid their internal and internal triggers.
4. Help participants think about the role sex has played in their lives in the past and to imagine sex in the future.

Handouts & Materials

1. Session 5, pp. 20–24 note: This session should be copied single-sided as participants must refer to other pages in the session as they work.

2. Pens
3. Dots or stickers

Session Format, Presentation, & Timing

1. Check-in and Feedback – 30 minutes (no more than 45 min.)
   - Invite participants to share anything that may have come up for them about sex or relationships since the last session.

2. Topic Presentation and Discussion – 60 minutes
   - Introduce the topic. Briefly describe triggers and read the paragraph that opens the session topic on Page 20. Brainstorm a list of external triggers with group members, writing the triggers on the board. Tailor this section to particular triggers that are relevant to locations in the local community, that is to say, specific bars or clubs, commercial sex venues, pride festivals, or other related events. Also, introduce the idea that participants may want to hang on to this exercise as a living document and invite them to refer back to it and see what changes over time.
   - External Trigger Chart: Explain the next part of the exercise that begins on the top of Page 21. Using the external triggers listed on the previous page and those brainstormed on the board, complete the chart, indicating which triggers are associated with methamphetamine use and high-risk sex and their degree of association. As participants work on this section, they may need help working on the “never use” column. Make sure that participants understand that the “never use” column should list persons, places, things, and activities that are truly safe for them. In other words, just because a participant has never used in a particular place or situation or with a particular person does not necessarily make that place, situation, or person safe. Sometimes participants need help making this distinction.
   - Internal Trigger Questionnaire: Next, ask participants to consider their internal triggers. Read the top of Page 22 and ask participants to put a check beside any of the internal triggers (feelings) listed that have led them to use methamphetamine or engage in high-risk sex within the previous 30 days. If there are participants in the group who have not used within this period of

time, then ask them to think more generally about triggers they recognize from their most recent use and high-risk sexual experiences. Also, take some time to brainstorm other internal triggers and write them on the board.

- Follow the remaining instruction on Page 23, Part B, listing internal and external triggers into columns and connecting external triggers and internal triggers that are associated. This portion of the exercise can be done as a group on the board or it can also be done in pairs.
- Finally, ask participants to think about the question listed in Part C of the exercise and jot down any notes or thoughts. Then have the group talk about this. In some cases, this discussion naturally occurs earlier.

Before Next Session:

- Although there is no homework assignment for this session, counselors may ask participants to continue thinking about external and internal triggers for methamphetamine use and high-risk sexual behaviors. Counselors can remind participants to be aware of any triggers and/or patterns they notice about triggers between now and the next group. Participants may wish to record their triggers in their calendars, which can help them become aware and discern patterns regarding when and how their triggers occur.

Session 6: Meet Auntie Tina

A difficult but important task for participants in early recovery is examining where their drug use has taken them and how this path has led them to enter treatment. When participants examine the consequences of their methamphetamine use, its helps them to remember why it is that they have decided to enter treatment—this realization can fade quickly and be replaced with “euphoric recall” (see Session 14 for more on euphoric recall). It is important that participants see clearly what has brought them to this point and acknowledge the range of feelings attached to their methamphetamine use and to entering treatment. The purpose of this session is to begin this task. Participants may struggle with feelings of guilt and shame about their using. Remind them that it is not helpful to judge their past behaviors and/or feelings. Rather, it is useful to acknowledge that something about their methamphetamine use was not working and that they made a decision that it was important to make a change. Participants who have been in treatment previously might think of the letter they are asked to write in this session as a “good-bye to drugs” letter (a common tool used in many treatment programs). It is important to note that this exercise is not such a letter, but an opportunity for participants to lay out the pros and cons of their methamphetamine use and to describe what led them to seek treatment at this point.

This session introduces the character of “Auntie Tina” (or, “anti-Tina”). Participants have a wide range of reactions to this character, and in some cases, they have a hard time understanding her role. Counselors should be ready to explain this character’s purpose and role in the program. It is helpful to see how participants interpret and react to Auntie Tina before explaining her to the group. Her role will differ for each participant, and it is useful not to explain too much so that participants may interpret her role for themselves. In general, Auntie Tina can be framed as a fictional character, “a favorite aunt” who gives the participant unconditional support and with whom he can share just about anything. Additionally, Auntie Tina is created to embody or represent characteristics that the participant may be looking for in people in their support system. Participants may fixate too much on trying to understand Auntie Tina's role or who she is. If so, it is helpful to simply remind them that regardless of their understanding of her, doing the exercise will give them helpful information, even if they are not yet quite sure what role Auntie Tina will play in their recovery.

Goals of the Session

1. Introduce the character of Auntie Tina.
2. Help participants begin to identify Auntie Tina as a helpful ally in their recovery.
3. Help participants examine their use history and how it led them to seek treatment.
4. Help participants begin to articulate their use history.

Handouts & Materials

1. Session 6, pp. 25–26
2. Pens
3. Dots or stickers

Session Format, Presentation, & Timing

1. Check-in and Feedback – 30 minutes (no more than 45 min.)
   - Invite participants to share anything that may have come up for them about external or internal triggers since the last session.

2. Topic Presentation and Discussion – 60 minutes
   - Introduce the topic. Briefly explain the character of Auntie Tina and read the paragraph that opens the session topic on Page 25. Help participants describe who Auntie Tina is for them, suggesting, as needed, that she represents the ideal support and encouragement they would like to receive from people in their own support network.
   - Explain that participants will write a letter to Auntie Tina describing their methamphetamine use, the people they first used methamphetamine with, some positives aspects of their methamphetamine use, some negative aspects of their methamphetamine use, and how they came to seek treatment.
   - Assure participants that they will not be asked to read their letter to the group and that they do not have to share information about it if they do not wish to.
   - Read the example letter aloud and then ask participants to write

their own letter.

- When most people have finished writing, ask participants if they would like to share something that came up for them while writing their letter.
- As the discussion progresses, ask participants to think about what Auntie Tina might say to them in response to their letter. Participants are often able to do this but tend to judge themselves as they give themselves feedback. Remind participants that the goal is not to judge themselves, but to confront behaviors that were not working for them. Sometimes it can be helpful to ask participants how they would respond to a friend who was telling them the things written in their letter. That is, participants are often able to respond more compassionately and honestly to an imagined friend who is going through the same things they are, than they are able to compassionately respond to themselves. Participants are often very self-critical.
- Sometimes members of group are quick to want to ameliorate, minimize, or excuse the feelings of other participants. It may be important to remind participants not to judge their own feelings or the feelings of other group members. The counselor's job is to listen and understand.
- When participants begin telling the story of their use, strong feelings or memories can be triggered. Counselors should normalize this for participants and support them in anticipating and developing plans for coping with these possible triggers.

Before Next Session:

Although there is no homework for this session, counselors may suggest that participants write notes or a journal entry, or check in with someone about anything that might come up for them after this session. Participants should also be encouraged to keep the letter as a living document, refer back to it from time to time, and add to it as they gain more clarity.

Session 7: Other Drugs and Alcohol: Do They Count?

The Getting Off intervention focuses on methamphetamine treatment. The intervention takes a harm-reduction, or high-tolerance, approach to the use of other drugs and alcohol, meeting participants where they are in terms of their use. The intervention asserts that abstinence from all substances is the best way to remain methamphetamine-free but understands that participants may not be ready for total abstinence and must discover this for themselves. Agencies that require total abstinence in order for participants to remain compliant or stay in the program, may wish to consider whether this intervention is the right fit. Thus, an important goal of the intervention is for participants to look critically at their use of other drugs and alcohol, see clearly the role these substances play in their life, and examine the connections among their methamphetamine use, their use of other drugs and alcohol, and their high-risk sexual behavior.

For many people who use methamphetamine, there is a strong connection between methamphetamine use and the use of other substances. For some, one substance triggers the use of methamphetamine; for example, as a participant drinks alcohol with friends at a bar, his inhibitions are lowered and he may then choose to go to a sex club or bathhouse or go home to cruise online for methamphetamine and sex. Similarly, participants may use other drugs or alcohol to cushion the crash from coming down from methamphetamine. People who use methamphetamine frequently report also using marijuana, as that drug helps them feel calmer and helps them to eat and drink. Often, benzodiazepines such as Xanax, Klonopin, or Valium, or prescription sleep aids are used for this purpose as well. Some people who use methamphetamine report drinking alcohol to cushion the crash from methamphetamine use, but use of alcohol for that purpose is much less frequent than use of marijuana.

Many people with methamphetamine use disorder in treatment report that their methamphetamine use was very closely linked to the use of other drugs, and that all of these drugs were often combined with having sex. Some people who use methamphetamine also report use of GHB, ketamine, erectile dysfunction medications such as Viagra®, Levitra®, or Cialis® (to ensure sustained erections that facilitate prolonged sexual functioning), and poppers or amyl nitrite (used to relax muscles in the anus,

which facilitates receptive anal sex and eases discomfort). For men who frequently combine other substance use with their methamphetamine use, the use of one or more of these substances may unexpectedly become a trigger for using methamphetamine. For example, a man who frequently used poppers with methamphetamine during sex may be surprised to discover that, even after a period of abstinence from methamphetamine, he becomes triggered to use methamphetamine when he uses poppers while having sex.

For some people who use methamphetamine, there can be a connection between mental health and the use of other drugs and alcohol; some may use recreational drugs as a means to lower anxiety, to numb feelings, or to lessen depression. The program asks participants to take a look at the ways drugs and alcohol function in their life to facilitate sex, to relieve psychological pain, to party, and to escape. It is helpful for the participants to assess what is working and not working about their substance use, with the idea that they may consider changing what's not working for them.

Counselors need to be familiar with the questions in the topic. Often the discussion naturally combines or re-orders the questions, and counselors can gently lead the discussion to other questions if they see the group beginning to shift in that direction. It is important to cover all the questions but not necessarily in the exact order given.

Goals of the Session

1. Help participants examine their use of other drugs and alcohol and the role these substances play in their life.
2. Help participants identify connections between their use of other drugs and alcohol and their methamphetamine use.
3. Help participants identify feelings associated with their use of other drugs and alcohol and begin to think about the function of these substances in their life: for example, to facilitate sex, give energy, lose weight, provide strong physical experiences, alleviate depression, reduce anxiety.
4. Help participants think about abstinence and what abstinence might mean for them.
5. Help participants think about what addiction means to them.

Handouts & Materials

1. Session 7, pp. 27–30
2. Pens
3. Dots or stickers

Session Format, Presentation, & Timing

1. Check-in and Feedback – 30 minutes (no more than 45 min.)
   - Invite participants to share anything that may have come up for them about their letter to Auntie Tina since the last session.

2. Topic Presentation and Discussion – 60 minutes
   - Introduce the topic. Read the introduction and then proceed to the questions.
   - Explain that participants may write or take notes during the discussion.
   - Read the first question on Page 27 to open the discussion.
   - Keep in mind that participants will have a variety of different perspectives on abstinence and their other substance use. Similarly, some participants may be connected to the 12-step community, while some participants may be 12-step averse or may not have had any experience with 12-step support. All perspectives are welcome, but participants may need to be reminded to speak from their own experience. Furthermore, some participants may have a hard time separating the very idea of abstinence from the 12-step definition of recovery. Remind participants that there are many paths and that some tools work for some people but no tool will work for everyone.
   - Progress through the questions, inviting discussion and drawing connections among group members' answers. A good summarizing, open-ended question that ties the questions together is: "What activities and feelings go with other drugs and alcohol?"
   - Proceed to the exercise on Page 29. Read the introduction, explaining that the purpose of the exercise is for participants to look closely at their use of other drugs and alcohol and to look at

where they are today in terms of that use. Remind participants to keep this graph as a living document to see how their answers or feelings change over time.

- After completing the table, proceed to the questions at the top of Page 30, and open up the discussion about how participants' use patterns have changed since entering treatment.
- Finally, discuss the remaining questions regarding addiction and abstinence. Keep in mind that there will be a wide variety of opinion and experience among group members and that participants may need to be reminded to speak from their experience and to accept the perspective of others, even if it differs from their own.

Before Next Session:

Although there is no homework for this session, counselors can encourage participants to begin paying attention to their use of other drugs and alcohol and to be aware of triggers for methamphetamine use related to their use of other drugs and alcohol. Participants may wish to record their use of other drugs and alcohol, and any related triggers, in their calendar.

Session 8: Redefining Your Place in the World

As with many other populations, alcohol and drug use has always been a part of lesbian, gay, bisexual and transgender (LGBT) culture. This is due, in part, to the fact that opportunities for socializing comfortably with other LGBT individuals often occur at venues where alcohol and other drugs are present, such as bars, clubs, and other social events. Historically, gay bars were the only commercial venue available for gay men and lesbians to congregate and socialize. Additionally, alcohol and other drugs can be an effective tool for coping with stigma, shame, and homophobia, and for numbing uncomfortable feelings. Self- and sexual-identity development occur differently for gay and heterosexual individuals; many gay people describe growing up feeling different, feeling ashamed, or feeling guilty or confused about their sexual identity. Many gay or bisexual men use alcohol and other drugs as a tool to cover discomfort in social and sexual situations; having felt uncomfortable or ashamed or confused most of their lives, alcohol and drugs help ease anxiety. Over time, using drugs and alcohol can cause problems, one of which is that some gay men report never having had sex with another man without using drugs or alcohol. They have never had the opportunity to practice being sober in social and/or sexual situations, which reinforces their belief that the only way to be comfortable, have fun, or be attractive to others, is through the use of substances.

Because some gay and bisexual men have never had sex with using drugs or alcohol, many may be fearful of having sex with another man because of the strong pull to use methamphetamine. This fear may cause some men to delay a return to sexual activity. Counselors should not pressure participants to have sex if they do not feel ready. Similarly, counselors should also caution participants that returning to sex, whenever it happens, may be triggering or uncomfortable; however, avoiding sex altogether can be very risky. A craving for sex can easily turn into a craving for methamphetamine. Being able to cope with changing feelings about sex, and experimenting with new, sober sexual behaviors with the support of the group can be very helpful for participants. Some will say they are not willing to consider being sexual. For these individuals, recommend that they masturbate and fantasize about having sex with another man while not under the influence. The main point here is that sex is a universal experience, and it is helpful if participants become sexual while in the

treatment process, where they can access support from counselors and group members.

Gay and bisexual men who use methamphetamine often develop a self-identity and a sense of belonging that is closely tied to their methamphetamine use. Participants begin to identify with a methamphetamine subculture. Within gay communities, this subculture is inevitably tied to sexual behaviors and also to HIV infection. People with methamphetamine use disorder who are living with HIV often describe that their methamphetamine use helped them forget about their status, which, in turn, helped ease anxiety around disclosure and sex. Methamphetamine subculture activities may also include fetish and multi-partner sexual activities, sex in sex clubs or public sex environments, and pushing or extending sexual limits. Some participants feel shame about these behaviors and some might choose not to disclose these activities. While discussions regarding sexual behaviors are the choice of the participant, it is also important to note that keeping sexual behaviors a secret further fetishizes them and strengthens participants' identification with the methamphetamine subculture. When participants enter treatment, many choose to redefine their sexual expressions and self-identity and find a new identity that is separate from the methamphetamine subculture.

This session invites participants to think about their identity development as gay or bisexual men and to think about the role that drugs and alcohol, especially methamphetamine, played as they developed their identities. This session also asks participants to consider some big questions about who they are, how they came to be that way, how their identity was changed as a result of their methamphetamine use, and who they want their ideal self to be without methamphetamine in their lives.

Goals of the Session

1. Help participants talk about what it means for them to identity as gay or bisexual men.
2. Help participants understand and describe the role sex plays in their lives.
3. Help participants think about how their HIV status informs their identity.
4. Help participants to examine the role methamphetamine has played

in their life and how it has affected who they are as gay/bisexual men and what they do as gay/bisexual men.

Handouts & Materials

1. Session 8, pp. 31–33
2. Pens
3. Dots or stickers

Session Format, Presentation, & Timing

1. Check-in and Feedback – 30 minutes (no more than 45 min.)
    - Invite participants to share anything that may have come up for them about their use of other drugs and alcohol since the last session.

2. Topic Presentation and Discussion – 60 minutes
    - Introduce the topic. Read the introduction and then proceed to the questions.
    - Read the first question to open the discussion: “What does it mean for you to be a gay or bisexual man?” Participants generally vary in their ability to jump in and answer this question. Often they need some prompting. Counselors could also ask other open-ended questions to start the discussion, such as, “When did you realize you were gay or bisexual?” or “How did you know you were gay or bisexual?”
    - Another effective way to begin this discussion is to make a list on the board of judgments people make when they think of gay and bisexual people. Participants should list both positive and negative judgments, but counselors should not prompt for this. Typically, participants tend to list more negative judgments than positive judgments. After a period of brainstorming, ask participants to share which judgments they identify with. Participants often notice that there are more negative judgments than positive judgments. Discuss this. One question counselors might ask is, “Considering these negative judgments, what are the implications for developing a healthy sexual and self-identity?”

- Often the discussion progresses through the questions naturally.
- Participants may need to be encouraged and reinforced about being honest in their answers, especially around topics such as sexual behavior and HIV. Remind participants that the goal is to be as honest as possible so they can examine what has worked and not worked, with the idea that they will feel empowered to change what has not worked for them in the past.
- The question about positive things that methamphetamine may have provided is sometimes difficult for participants. There is a tendency to minimize or deny the positive aspects of methamphetamine use or to feel guilty about acknowledging them. When participants are able to talk about the positive aspects of their methamphetamine use, it is often in the form of euphoric recall about the use itself. Encourage participants to think beyond this and to consider how methamphetamine use became a part of their identity in positive ways (for example, by giving them a sense of community, easing their loneliness, enhancing their sexuality). It might be helpful to have a list of the functional aspects of methamphetamine use, such as the following: relieves boredom, lifts depression, boosts energy, helps focus attention, facilitates sexual experiences (especially those at the extremes), etc.
- Facilitate the discussion of the sex questions that begin on Page 32. It can be helpful to brainstorm and write answers on the board, especially regarding the questions about what is good and bad about sex with and without methamphetamine.
- Often the last question is answered throughout the discussion and brainstorming.
- Be sure to take the temperature of the group at the end and check in with group members about any feelings or triggers.

Before Next Session:

Although there is no homework for this session, counselors may encourage participants to continue thinking about the questions from this session and write notes or a journal entry or check in with someone about anything that might come up for them after this session.

Session 9: Knowing How to Handle a Relapse is NOT Permission to Have a Relapse

Relapse prevention is a significant component of any substance use treatment program. Relapse prevention strategies and messages are present throughout the Getting Off intervention, but this is the first session that deals directly with this topic. Relapse doesn't usually happen from any one single event. More commonly, relapse is a sequence or cascade of identifiable and often predictable events that end in a return to drug use after a person has some period of abstinence. It is important for each individual to learn to recognize the signs of an impending relapse. The precipitants of relapse are different for each person, but there are common patterns and pitfalls. When the triggers start, a person can feel very out of control and often think that relapse is inevitable. It is easy for people to forget that they have tools to stop and prevent the actual relapse from happening. Relapse is not inevitable. Talking about the triggers gives participants the opportunity to consider the tools they may already have to prevent relapse, and helps them to develop new tools they can use to prevent a relapse.

People in treatment are often hesitant to talk about relapse, afraid that if they talk about it, it will happen. Participants need to be reminded that talking about relapse is not permission to have one and that it can be safe and empowering; furthermore, not talking about triggers makes potential relapse more dangerous. Thus, knowing how to handle a relapse is critical for recovery. How participants handle relapse, their willingness to see it as a "slip" or mistake and come back to treatment, and their ability to process it with the group, makes a significant difference in whether they can be retained in treatment and continue to meet their treatment goals. Talking about potential relapse not only disarms fear and anxiety about relapse but also gives participants specific tools for avoiding relapse and for seeking help from their support network in recognizing signs of a potential relapse and preventing it.

Relapse for gay and bisexual men who used methamphetamine is complicated by the connection between methamphetamine use and sex. For many men with methamphetamine use disorder, having sex without being under the influence of methamphetamine is unimaginable and, therefore, even getting horny or becoming aroused can be a trigger for

using methamphetamine. Similarly, a participant may be able to avoid methamphetamine on their own, but if they continue to be sexually active, especially with old using buddies, in high-risk sex environments, or by seeking partners online, they are likely to encounter a sexual situation in which methamphetamine is present and thus using becomes a temptation. When confronted with such opportunities to use methamphetamine, especially if using means having the kind of sex that typically only occurs while under the influence of methamphetamine or other drugs, many people will relapse even though they intended to seek sober sex. Thus, conversations about relapse prevention must include conversations about the importance of having sex, while, at the same time, preventing relapse to high-risk sex and using methamphetamine. Finally, conversations about relapse prevention must not ignore other drugs and alcohol, as they are often a factor in leading participants to relapse.

Many participants have found this session, and its title, very provocative. Counselors should be ready to contextualize the title and the topic. A simple explanation about the frequency of relapse is usually sufficient. For example, the following statement can be an effective starting point: "Statistically speaking, some of you in this room will relapse. It doesn't have to be you—you get to decide. But because it is likely to happen to some of you, and we want you to get back to this room safe and alive, it is important that we have this conversation."

Goals of the Session

1. Introduce the topic of relapse in a safe and comfortable environment.
2. Help participants to see relapse as a process, not as a specific event.
3. Help participants think about their relapse risk and triggers.
4. Give participants tools and ideas about how to avoid relapse and how to make a relapse safer if it happens.
5. Help participants examine how sex fits into their understanding of relapse.

Handouts & Materials

1. Session 9, pp. 34–37
2. Pens
3. Dots or stickers

Session Format, Presentation, & Timing

1. Check-in and Feedback – 30 minutes (no more than 45 min.)
   - Invite participants to share anything that may have come up for them since the last session.

2. Topic Presentation and Discussion – 60 minutes
   - Introduce the topic. Spend some time contextualizing the session and the title. Explain that relapse is not uncommon and that recovery is a process, not an event, and that people move through the process differently.
   - Participants sometimes “shut down” during this topic, fearing that if they talk about triggers, they will be triggered. Talk about this at the beginning of the session to help prevent it from happening. Remind participants that identifying triggers and talking about them is a way to help create a safety net around them. Also check in with people periodically during the group and at the end to see if someone is “triggered.” If so, do not let the individual leave the clinic until he has used his skills to contain his triggers.
   - Explain the program’s emphasis on abstinence from methamphetamine and how relapse is handled in the program, noting that participants are not punished or excused from the program. In fact, participants who relapse are encouraged to come to group and process their relapse. They may even come to group high, as long as they are not disruptive and allow the counselors to give them feedback. If the program uses contingency management, counselors might take a moment to review the effect of relapse on their contingency management vouchers.
   - Introduce the notion that the consequences of relapse can be made less severe by simply coming back quickly to treatment. This may be a challenging concept for some participants. Remind participants that they can learn important information about their methamphetamine use when they return to abstinence after a relapse and that they can get better at using their skills to interrupt drug use. Participants who are resistant or who find this topic difficult can be encouraged, if they are unable to talk about themselves, to think about what they would say to a friend who

told them they were tempted to relapse.

- Go over the safer relapse principles starting in the middle of Page 34. Participants, especially injectors, are often triggered by this conversation. Take the temperature of the group as the conversation progresses and, if necessary, pause to have participants check in.
- Continue the discussion on Page 35 and read through the advice. Participants sometimes feel that the advice in the middle of the page is condescending or an over simplification. Remind them that ultimately, no matter what tools they use along the way, their goals are to stop using methamphetamine.
- Work through the questions on Pages 36–37, writing brainstorming ideas on the board and asking participants for their experience and ideas about how to stop a potential relapse.
- Participants often need help coming up with ways to stop high-risk sex fantasies, or they are embarrassed by talking about it. Re-learning how to masturbate is often a good place to start. This recommendation is made frequently. Often, participants' sexual fantasies involve using methamphetamine or euphoric recall about sex they had while on methamphetamine. Participants need to start from the ground up, re-training themselves about what kind of sex is hot for them and breaking old associations between methamphetamine sex and erotic fantasy.

Before Next Session:

Although there is no homework for this session, counselors may encourage participants to continue thinking about how they have responded to relapse in the past and in what specific ways they could have responded differently. Remind participants to check in with one another or others in their support system, especially if they find they have been triggered by the conversation and if they start to use the discussion of relapse as a form of relapse justification

Session 10: Your Social Web

It is not uncommon for people who misuse drugs and alcohol to isolate themselves as a result of their using. Sometimes this isolation is the result of shame, guilt, or embarrassment. Over time, people with methamphetamine use disorder may find that their social circle shrinks to only include people with whom they use. As drug and alcohol use becomes more problematic, one may become an inconsistent or absent friend to others, may drop out of previously enjoyed social obligations, or become preoccupied with secrets and lies that increase their isolation. People with methamphetamine use disorder experience this isolation as well. Over the course of their use, their social circle may have become limited to using- or sex-buddies. By keeping their use a secret, barriers are created between them and others, limiting their support system over time.

People who use methamphetamine often compartmentalize their friends and family into those who know about their use and those who do not know about their use. Gay and bisexual men who use methamphetamine are particularly skilled at doing this, as many have spent years compartmentalizing people based on who does and who does not know about their sexual identity. The significance of this cannot be over-emphasized. This compartmentalization is supported by the fact that, at least in the beginning of their using career, many gay and bisexual men manage to use methamphetamine and still remain relatively high functioning. This makes it easier for some people to split off their using self and all of the people involved in their drug use to minimize the consequences of their use for themselves and for the people who love them. The Internet also supports isolation. Online behavior may be limited to cruising for sex partners or looking at online pornography; this can feel like socializing, but it isn’t.

Some participants often feel guilt and shame about who they have become as a result of their using. In sobriety, participants must acknowledge that when using they may have treated others poorly, treated themselves poorly, used others, and let others use them; they may have had inappropriate boundaries and befriended or had sex with people whom they might not be interested in or attracted to if they were sober. Confronting this sort of self-knowledge can be difficult. As people use more and more, their social network changes more and more. Over time, fewer and fewer friends

who do not use methamphetamine are in their social network and more and more friends in the social network do use. Confronting this in sobriety can be painful. Acknowledging relationships that may have been lost or damaged as a result of using, and repairing those relationships, can be difficult. All of this is part of a participant's process of understanding their social web.

In recovery, participants must rebuild a solid network of support to help them stay sober. This session invites participants to look at the people who are, and those who are not, in their social network, and to think about the kind of support they may or may not need. The exercise asks participants to write down the names of people who are in their social web and to think about the qualities they seek in those who are supporting them. The exercise offers a good visual representation for participants of the people they are close to, the people they are not close to anymore (who are "far away" on the chart), whether the people in their life are still using or not, and the people they can best turn to for support. For some participants, their web is sparsely populated and the people in it are positioned far away from the individual. This is helpful information, even if it is difficult to see laid out plainly.

Goals of the Session

1. Help participants identify who is in their social web.
2. Help participants differentiate among people in their web who can be supportive and those who may need to be kept more distant.
3. Help participants identify people in their social support network from whom they can get support and with whom they can do activities.
4. Support participants in structuring time and making plans with people in their support network.

Handouts & Materials

1. Session 10, pp. 38–41. This is another session that should be copied single-sided instead of double-sided as participants may need to refer to each page.
2. Pens
3. Dots or stickers

Session Format, Presentation, & Timing

1. Check-in and Feedback – 30 minutes (no more than 45 min.)
    - Invite participants to share anything that may have come up for them since the last session, especially thoughts or reactions to the previous session.

2. Topic Presentation and Discussion – 60 minutes
    - Introduce the topic. Read the introduction and instructions at the top of Page 38 and instruct participants to begin adding people to their social web. Participants should put both methamphetamine-using and non-methamphetamine-using friends on the web, if they still spend time together. Participants' social web should represent a snapshot of their social network right now. Remind participants that different people have different types of relationships; not everyone on the social web will necessarily be close to you, but knowing where people are gives you helpful information.
    - After giving participants time to complete the web on Page 39, ask participants to answer the questions on Page 38. Facilitate a discussion around these questions.
    - It may be painful for participants to see how compartmentalized their lives are or to acknowledge that their support system contains few people. Remind participants that one of the goals of the session is to help them identify who they could add to their web, or to identify what they lack in terms of support.
    - Introduce the chart on Page 40 and ask participants to complete it. Some participants find it confusing so it can be helpful to explain the matrix and, possibly, to put an example on the board.
    - Remind participants that everyone completes this chart differently and that there is no right or wrong way to fill it in. Also, inform participants that not every category may apply to them and that is okay. They can leave some categories blank.
    - Continue the previous discussion after participants have had a chance to complete the table. Counselors might ask, "What came up for you?" "What might you need to add to your support

system?” or “Is there anyone that you have a relationship with that you may need to remove from your support system?”

Before Next Session:

Introduce the homework listed on Page 41. Inform participants that the homework may or may not be done as a group. Advise participants to choose someone to whom they are not sexually or romantically attracted. If participants are nervous, remind them that they can start small; advise them to choose a short, time-limited activity or a phone conversation.

Session 11: Creating a Safe Space

Misusing drugs and alcohol takes work; this is a truism about substance use disorders. For many people who use methamphetamine, especially as their use escalates, the effort and energy required to maintain such use makes continuing to function in daily life a challenge. Many people with a substance use disorder must begin to lie and tell half-truths, both to themselves and to others, in order to maintain using. Similarly, as mentioned previously, many people who use methamphetamine compartmentalize their lives, and the people they have contact with, as a means of trying to control and bring order to their lives, which may be increasingly out of control. Maintaining this compartmentalization and the lies and half-truths that support it often becomes harder and harder as occasional recreational use turns into chronic use.

In sobriety, lies must be unraveled, compartmentalization must fall away, and relationships repaired. However, this process cannot be done hastily. In order to maintain privacy and boundaries, those in recovery must be thoughtful and selective about whom they tell what to, or not. This is not the same as lying; the goal here is to maximize accountability and integrity while not making one's life “an open book.” Too much honesty makes people vulnerable and can destabilize their sobriety.

This session helps participants think about this process and gives them tools to begin to be as honest as they can with those who can support them best. Participants are encouraged to think about times or areas in their life where they have not been honest with themselves and others, face up to them, and examine the effects on their lives, their relationships, and on their using. This process starts with being honest in group. Participants are encouraged to think about their role in the group and how the group process can best help them and support their goal of stopping methamphetamine use. Counselors should highlight the risks of sharing too much; some participants who share too much about themselves too quickly experience “sharer's remorse,” which can become a trigger to use. Remind participants to pace themselves in the group session in terms of how much they share, and to constantly check-in with their feelings. Also remind them that they can call or check-in with one another or the group counselors if they are feeling remorse or triggered.

Goals of the Session

1. Help participants examine the idea of honesty in recovery and think about what this means to them.
2. Help participants examine the challenges and benefits of being honest about drug use and high-risk sexual behavior.
3. Help participants understand and utilize the group process to their best advantage while still protecting themselves.
4. Help build group cohesion.
5. Reinforce and strengthen participants' understanding of and adherence to group guidelines.

Handouts & Materials

1. Session 11, pp. 42–44
2. Pens
3. Dots or stickers

Session Format, Presentation, & Timing

1. Check-in and Feedback – 30 minutes (no more than 45 min.)
   - Invite participants to share anything that may have come up for them in doing the homework. Questions might include: “What was it like utilizing your sober support network?” “What did you notice?” “What was hard about this homework?” or “What was easy?”

2. Topic Presentation and Discussion – 60 minutes
   - Introduce the topic. Read the opening paragraphs at the top of Page 42. Reinforce that being honest does not mean telling everyone everything. The goal is to create appropriate levels of accountability and support with appropriate people.
   - Read through the list in the middle of Page 42, asking participants to think about which of these apply to them. Participants do not need to identify applicable points publicly; they just need to think about each example.
   - After reading through the list, ask participants if there are any other examples they can think of.

- Continue through the session, asking questions, reading the session material, and facilitating a discussion about honesty.
- At some point in the session, it may be appropriate or necessary to reinforce group guidelines, particularly when a participant is speaking for himself; emphasize the use of "I" statements and remind participants that this is not a group where we tell others what to do. A simple statement like the following can be very effective: "This is a group where you get to talk about what is true for you."
- This session also offers the opportunity for counselors to give positive feedback to the participants for making group a safe space for themselves. Acknowledge that although the counselors have a role in creating this safety, participants create this safety for themselves and others in the group as well.

Before Next Session:

Although there is no homework for this session, counselors may wish to remind participants that they can contact one another outside of group for support and to check in. Participants should also be encouraged to keep the exercise in this session as a living document; they can refer back to it from time to time, and add to it as they gain more clarity. Counselors may offer to give participants blank copies of the exercise if they want to repeat it in the future on their own.

Session 12: Where Have We Been & Where Are We Heading?

People seek substance use treatment for a variety of reasons, but the common theme is that the costs of using outweigh the benefits. In early treatment, people are usually aware of this shifting balance but may still be deeply ambivalent about their readiness, ability, and commitment to change their using and sexual behaviors. Even as they begin to make progress, this ambivalence remains. This situation is typical, and it can make it difficult for some to recognize the changes they are making while others might minimize the changes. Either because the changes are small and incremental, or because they happen relatively slowly, people do not recognize them, and therefore do not recognize the value of the work they are doing. Similarly, they often focus solely on continuing challenges, barriers, or their slow progress in recovery instead of seeing these issues in the context of their overall progress.

This session asks participants to look at their progress and what barriers remain, as well as to think about the changes they are making and the work they are doing. Like many of the sessions in Getting Off, this session can serve participants well as a living document to which they can refer to later as a means of recognizing their progress and identifying hurdles. This session also helps participants focus on areas of their life that may need more attention and asks them to set short-term goals in terms of their continuing recovery.

The end of this session includes a visualization that invites participants to let go of their methamphetamine use and other “baggage” associated with their using such as specific people or events, guilt about high-risk behaviors, or shame related to their sexual identity or past. The “Letting Go” exercise offers the opportunity for counselors to introduce the idea that stopping methamphetamine use is a grieving process and to normalize what participants may be feeling. Describing the stages of grief can be helpful. Another helpful analogy is to describe participants' drug and alcohol use as a relationship, and like most relationships, there are good aspects and patterns that work and bad aspects and patterns that do not work. Making changes in a relationship, especially ending a relationship, can be a difficult and painful process, but it is often necessary and healthy. As participants face ending their relationship with methamphetamine, there

may be significant grieving to do.

The Letting Go exercise also re-introduces Auntie Tina. Counselors should spend some time explaining the role of this character in supporting participants' recovery. Refer back to Session 6: "Meet Auntie Tina" for more information and ideas about introducing Auntie Tina to the group.

Counselors must be aware that although this session marks the mid-point of the Getting Off intervention, some participants may have only been in group for a short time, and may have a tendency to think that this session applies less to them. Acknowledge this when introducing the topic and remind participants that, even if they are new to group, this session can create a baseline for understanding where they are now and where they are headed.

Goals of the Session

1. Help participants identify the progress they have made in changing their methamphetamine use and high-risk sexual behaviors.
2. Help new group participants examine their life now and think about what they want to change.
3. Encourage participants to think about and include other health-promoting activities in their schedule that can support their recovery.
4. Help participants begin to let go of negative events, people, places, and feelings associated with their methamphetamine use and to acknowledge and process their changing relationship to methamphetamine and sex.
5. To positively reinforce the changes participants are making.

Handouts & Materials

1. Session 12, pp. 45–49
2. Pens
3. Dots or stickers

Session Format, Presentation, & Timing

1. Check-in and Feedback – 30 minutes (no more than 45 min.)
    - Invite participants to share anything that may have come up for

them since the last session.

2. Topic Presentation and Discussion – 60 minutes
   - Introduce the topic and ask participants to begin thinking about the progress they have made since starting the program. If some participants are new to group, ask them to think about where they are now and the kinds of changes they would like to make.
   - Organizing Your Life: Explain the exercise and ask participants to think about some activities they have put in place since deciding to stop using methamphetamine that have helped organize and structure their time. These can be big or small things such as going to the gym, getting to work on time, or sticking to their HIV medication regimen.
   - After filling these in, ask participants to read through each section and complete them, indicating how well they feel they are doing in each area. Remind participants that the goal is to take stock of what is true for them now so they can identify what is working and what areas may need more attention.
   - After completing the exercise on Pages 45–46, ask participants to complete the question at the top of Page 47, reminding them to be realistic, to set a short-term goal, and to think about some steps for achieving that goal.
   - Facilitate a brief discussion about what goals participants have set for themselves.
   - Briefly re-introduce the character of Auntie Tina and describe her role as an unconditional supporter and ally in their recovery.
   - Letting Go: Introduce the exercise. Counselors may want to implement the exercise as a creative visualization, during which participants close their eyes while counselors read the exercise, or they may wish to facilitate the exercise as group brainstorming.
   - Following the exercise, ask participants to share, if they wish, what they sent away, and ask participants to brainstorm briefly about what other items, people, places, events, or feelings they may want to send away now or in the future when they are ready.
   - Continue with the exercise, reading the material on Page 48 aloud.

- Ask participants to become Auntie Tina and to write a letter of encouragement and support from her, outlining the changes she has seen in you—both big and small—as described on Page 48. Counselors should clarify that this letter is not a “good-bye to drugs” letter.
- At the end of the session, invite participants to share anything that may have come up for them while writing the letter. Counselors may write the changes participants share on the board. Participants often minimize the changes they are making; reinforce that all change is good, even if the changes seem small or insignificant.

Before Next Session:

Although there is no homework for this session, counselors may encourage participants to spend the next couple of days paying attention to the changes, both big and small, they have made since they began this treatment program. Invite participants to appreciate the work they have been doing to make these changes. Participants who are new to the group may wish to look at an area in their life that needs attention or on a specific change they wish to implement as a short-term goal. As participant begin to make positive changes (both big and small), they can continue to add information to their letter from Auntie Tina.

Session 13: Addiction & the Brain; Stages of Recovery

Different models have been developed over time to help explain addiction. Some of these have become outdated, while others have persisted and contributed to building a framework for understanding addictive behaviors. As the study of addiction has matured, researchers and clinicians have increasingly used the disease model to conceptualize and explain how and why substance use becomes a problem for some, but not others. Sharing the science that underlies the disease model with participants not only gives them information, it also empowers them and provides a sense of relief by explaining how and why their using behavior became problematic; it may also help relieve feelings of shame or helplessness that lead people to believe that they are intrinsically flawed or weak. The 12-step model frames addiction similarly: as a physical, emotional, and spiritual disease. These models create a context in which participants can understand their using in cognitive behavioral terms and thereby develop a sense of mastery and agency in managing their recovery.

A similar model that describes the stages of recovery has been developed over time based on the accumulated experience of clinicians and others involved in the treatment of addictive behaviors. Although each person moves through the stages differently, there are common patterns. The stages of recovery help explain changes in the brain and body over time and help participants understand what to expect in terms of their thinking, feeling, and behavior as they begin to recover from drug and alcohol use. The stages of recovery, described in the context of the disease model, help participants understand their methamphetamine use and sexual behavior and help them predict and cope with the changes they will face.

This session explores these topics and gives participants tools for coping with and moving through each stage of recovery. This session is largely didactic, and it is important that counselors know the material well in order to be able to cover it all and to deliver the session clearly. It can be helpful to draw a visual depiction of the stages, like that on Page 53, on the board as a means of helping explain the stages and focus the discussion. It is also useful to draw a larger diagram of the effects of methamphetamine on the brain to help illustrate this activity. Finally, the science that helps explain addictive behavior, especially methamphetamine addiction,

continually changes; therefore, counselors should keep abreast of research as they are able and integrate new information where appropriate.

Goals of the Session

1. Help participants understand the disease model of addiction and think about their own methamphetamine use and high-risk sexual behavior in this context.
2. Help participants understand the stages of recovery, consider what stage they are in, and identify tools that could be effective for helping them cope with and move through each stage.
3. Help participants think about what physical, emotional, and spiritual needs they may have in recovery.

Handouts & Materials

1. Session 13, pp. 50–57
2. Pens
3. Dots or stickers

Session Format, Presentation, & Timing

1. Check-in and Feedback – 30 minutes (no more than 45 min.)
    - Invite participants to share anything that may have come up for them since the last session. Did they notice any other changes they have made or behaviors they have implemented to support their recovery from methamphetamine use?

2. Topic Presentation and Discussion – 60 minutes
    - Introduce the session and explain that this topic covers the science that helps explain addictive behaviors.
    - Read through the first three paragraphs of Page 50 to introduce the concept of the disease model. Ask participants to share briefly if they have heard of this model and what they may understand about it. Ask participants if they know of any other models of addiction.
    - Move to a presentation about the effects of methamphetamine on

the brain. Counselors could read this section, but it is more effective for counselors to know the information well enough to summarize it in their own words. Generally and briefly describe the anatomy of the brain, the structure of nerves in the brain, and the function of neurotransmitters; then explain the effect of methamphetamine on these structures and systems.

- Continue on Page 51, emphasizing the concepts of tolerance and withdrawal, explaining the cognitive effects of methamphetamine use, and highlighting the research on HIV and methamphetamine use.
- Often, participants will ask about whether the brain will heal over time and if their withdrawal symptoms will subside. Describe this healing process briefly as a natural transition to describing the stages of recovery.
- It is often helpful for participants to have a general understanding of the stages of recovery before completing the exercise on Page 52, so counselors should skip to Page 53 and introduce the stages of recovery using the model they have sketched on the board.
- When explaining the stages of recovery, remind participants that not everyone moves through the stages in the same way or at the same rate, which is okay. Emphasize that the purpose of defining the stages is to help explain and anticipate common changes in thinking, feeling, and behaving that participants might experience.
- After explaining the stages, and before moving on to Page 54, have participants complete the exercise on Page 52.
- Read the instruction at the bottom of Page 51. Say the following to participants: "In thinking about the stages of recovery, consider what emotional, physical, and spiritual needs you may have. Consider the role methamphetamine and sex played in your life when you were using." Ask participants, "In recovery, what needs, once fulfilled by methamphetamine and sex, can you imagine will come up for you?" and "What are some other needs you may have?"
- One way to help participants think about their needs is to have them think about some of the effects of their using on three domains of their lives: physical, emotional, and spiritual. Tell participants that they can brainstorm some of these effects and

consequences to fill in the chart at the bottom of Page 52; then, using these as a starting point, think about what they may need to help mitigate or reverse some of the effects of their using. For example, if they notice that their using led them to be physically tired, have low energy, or to lose weight, they might identify "getting back in shape" or "building exercise back into my life" or "taking better care of my body" as one of their physical needs.

- After they have completed the exercise, refer back to the stages of recovery and ask participants to share some of their answers. Generally, facilitate a discussion about how some needs are better able to be met in certain stages of recovery. Physical needs generally come first as the body heals. Emotional and spiritual needs are met throughout the stages, but often, people find it easier to examine and work on their mental health after a period of sobriety—after moods and feelings begin to stabilize.
- As the discussion progresses, move on to Page 54 and examine some of the problems encountered at each stage of recovery and brainstorm tools and coping strategies, other than those listed, that participants might consider.
- After covering all the stages, ask participants to consider what stage of recovery they are in (p. 56) and to think about challenges they faced or will face as they move through the stages. Ask participants to share their answers and write them on the board.

Before Next Session:

Introduce the optional homework on Page 57. Remind participants that methamphetamine use can mask physical symptoms and that in recovery they may become aware of signals and symptoms in their body about which they were previously unaware.

Session 14: Drugs, Sex, and Euphoric Recall

Euphoric recall is a term that describes a kind of selective remembering common in those with addictive behaviors. Euphoric recall, as the name suggests, can be defined as only remembering and romanticizing the positive things about using and not remembering the negative consequences of using. In recovery, participants need to be aware of the tendency to experience euphoric recall, and must develop tools to help them cope with the trigger that can develop from euphoric recall in order to prevent relapse. Remembering both the positive and negative consequences of using is training the mind to focus not only on the good things, but the entire experience of using, including coming down, withdrawal, and other consequences such as missed work, sickness, depression, and destroyed relationships.

As stated in previous sessions, there is a strong connection between methamphetamine use and sexual behavior for gay and bisexual men. Thus, euphoric recall is often about both sex and methamphetamine use. Given that euphoric recall can initiate a relapse process, participants need to learn tools to interrupt this process before their cravings lead them to use. Thought-stopping is a tool participants can use to help them make the choice to stop the cycle. Thought-stopping also helps emphasize the positive consequences of remaining methamphetamine-free. This session introduces the idea of euphoric recall and presents a diagram that illustrates this process. Participants discuss euphoric recall and share about the positive and negative consequences of using and then, in teams of two or three, develop a plan for coping with euphoric recall and feeling stuck in a relapse process. It can be useful to draw the relapse process diagram on Page 59 on the board to help illustrate the process.

In doing the exercise, counselors should first ask participants to brainstorm a specific situation they have found themselves in that triggered a relapse cycle. Starting from a concrete real-life example helps participants to develop a more effective thought-stopping plan. Teams are usually able to determine a triggering situation that is common among them.

Goals of the Session

1. Help participants understand the concept of euphoric recall and its role in triggering a relapse cycle.

2. Help participants understand the relapse cycle.
3. Help participants develop a thought-stopping plan to help interrupt the relapse cycle.
4. Help build group cohesion and strengthen connections among group members.

Handouts & Materials

1. Session 14, pp. 58–61
2. Pens
3. Dots or stickers

Session Format, Presentation, & Timing

1. Check-in and Feedback – 30 minutes (no more than 45 min.)
   - Invite participants to share anything that may have come up for them in doing the homework or in terms of their understanding of the stages of recovery or the disease model of addiction.

2. Topic Presentation and Discussion – 60 minutes
   - Introduce the session, reading the opening paragraphs. After reading the list, ask participants if they can think of any other ways in which methamphetamine use was appealing at first.
   - Continue with the next paragraph and the second list of what methamphetamine use turned into. Ask participants if they can think of any other examples.
   - Continue with the topic, reading the text at the top of Page 59.
   - Next, explain the relapse process diagram. Participants are sometimes confused or overwhelmed by this. In explaining the diagram, summarize or read the paragraphs at the top of Page 60. In particular, it can be helpful for counselors to explain that the circle on Page 59 represents the Trigger → Thought → Craving → Use cycle that occurs when experiencing euphoric recall. Explain that any step in the cycle can lead to any other step and that the best way to exit the cycle is by using thought-stopping. It is also possible to exit the cycle out of exhaustion after using.

- After describing the relapse cycle, read the section on positive thoughts on Page 60 and ask participants to brainstorm other positive, reinforcing thoughts about themselves, their future, and others.
- Thought-Stopping Plan Exercise: Have participants pair off, either by counting off, or another method (counselors could choose pairs) and instruct participants to work together to come up with a specific high-risk or triggering situation that they have been in or can imagine being in, and then to develop a thought-stopping plan that will help them cope with the triggering situation. Teams should be made up of two participants, or with an uneven numbered group, three participants.
- After some time, ask pairs to share their situation and plans. Counselors may wish to use the board to write down specific tools that pairs share.

Before Next Session:

Ask participants to think about and practice their thought-stopping plan. Encourage participants to keep a list of their thought-stopping techniques and suggest that they keep the list in a location where it will be seen easily and regularly.

Session 15: Talking Meth, Talking Recovery

When participants enter treatment and begin the recovery process, most begin to share parts of their lives that have been previously hidden or minimized and about which they may feel shame, embarrassment, or pain. Often, because their methamphetamine use and sexual behaviors have been so skillfully hidden or compartmentalized, participants are unsure how to begin to talk about these topics. Sharing the history of their methamphetamine use with others means committing to recovery in a new way, and participants often need help and support strategizing about how to navigate this process. Many participants struggle with decisions about whom to tell what and may need help anticipating and coping with others' reactions. This process also means helping participants exercise judgment about who can best support them around different issues. Finally, participants need to identify any topics or areas in their life that they are not talking about, examine what this might mean for their recovery, and strategize about whether and how they might begin to talk about these topics.

This session helps participants examine their current support system—the people in it, and the kinds of support they offer—and invites participants to think about what other support they may need. It also helps them look at what they are and are not talking about. This session also, again, re-introduces Auntie Tina. If necessary, counselors should spend some time explaining the role of this character in supporting participants' recovery. Refer back to Session 6: “Meet Auntie Tina” for more information and ideas about introducing Auntie Tina to the group.

In completing the exercises in this topic, especially the exercise on Page 63, participants should be instructed to think about people currently in their support system.

Goals of the Session

1. Help participants examine their support system.
2. Help participants identify what they are and are not talking about in recovery, and think about the implications of this.
3. Help participants strategize about what support they have and what support they may need.

Handouts & Materials

1. Session 15, pp. 62–65
2. Pens
3. Dots or stickers

Session Format, Presentation, & Timing

1. Check-in and Feedback – 30 minutes (no more than 45 min.)
    - Invite participants to share anything that may have come up for them in practicing or refining their thought-stopping plan.

2. Topic Presentation and Discussion – 60 minutes
    - Introduce the session, reading or summarizing Page 62 and explaining that in recovery it can be hard to be honest about using and sexual behaviors and it can be difficult to figure out whom to tell what.
    - Invite participants to share briefly about how they have navigated this process in recovery and if they have noticed any difficulties or challenges. Has there been anything that surprised them about the reactions of people they have told?
    - Introduce the table on Page 63 and ask participants to complete it. This exercise can appear complicated to participants. Explain the purpose of the table and remind participants that they may not have three people in each category and that not all categories may apply to them. Also, remind participants to fill in the table with people who are currently in their support system.
    - After participants have completed the table, continue to the questions at the top of Page 64, asking participants to share anything they noticed in completing the exercise. What did they notice about things they may be talking enough about and things they may need to be talking about more?
    - Ask participants if there is anything they may want to change about their support system.
    - Re-introduce Auntie Tina. Explain her role in the program and

explain that Auntie Tina represents the best aspects of their support system—she gives the participant unconditional support and encouragement.

- Complete the exercise on Page 65. Ask participants the following: “To whom in their support system might they want to introduce to Auntie Tina?” and “Who else do they anticipate could be helpful or important?

Before Next Session:

Although there is no homework for this session, counselors may invite participants to continue thinking about their support system. What kind of support is available to them and how might they continue to add to and strengthen their support system. Counselors can also encourage participants to think of one small step they could take to build and/or add to their support system in the next week.

Session 16: Coming Out All Over Again: Reconstructing Your Identity

Coming out is significant in the development of a gay or bisexual identity. Coming out means not only acknowledging internally that one is gay or bisexual, but it means navigating how to share this information with others. Coming out to others is a life-long process. While some aspects of a person's identity are external and may be discernible (such as race/ethnicity or other physical characteristics), one's sexual identity is generally not in that category. Thus, gay and bisexual men must decide, with every person they meet and in every new situation, whether or not to share their sexual identity. Although, over time, coming out may become easier and more intuitive, it is always a choice with unknown consequences, and fear and nervousness can be part of that process. While rejection, stigma, and the threat of violence always exist, most gay and bisexual men take the risk to come out to those to whom they feel close as a way to help ease isolation and deepen and strengthen relationships. Repressing or hiding such an important aspect of identity is unhealthy and can become destructive.

In coming out to others, gay and bisexual men get to know themselves better by sharing a core part of their life with others. Discussing HIV status creates another layer of self-disclosure that may also be fraught with anxiety, shame, and the fear of rejection but that also helps increase intimacy, honesty, and authenticity.

Telling others about problems with methamphetamine, other drugs, and alcohol can be likened to a coming out process. Coming out about methamphetamine use often means acknowledging and talking about behaviors that were risky, dangerous, or embarrassing. It means talking about sex and HIV and sexual identity all over again. There are many unknown factors in sharing this information. Participants likely fear rejection, or being misunderstood, judged, or labeled. Nonetheless, framing disclosure about methamphetamine use and sex as a coming out process can be a very helpful analogy for participants. They likely understand the feelings associated with coming out and have experienced them first-hand.

This session invites participants to think about what it is like to come out as person that uses methamphetamine and how this process mirrors coming

out as a gay or bisexual man and, for those for which it's applicable, disclosing an HIV-positive serostatus. Participants examine who they have and have not told about their methamphetamine use and consider who else they may need to tell in order to move forward in their recovery. It also helps them think about, anticipate, and process the response they might get when coming out as a person who uses methamphetamine. Participants practice talking about their methamphetamine use and think about how to handle unexpected reactions. Auntie Tina reappears in this session, and participants think about how their external environment supports the internal work they are doing in recovery. If necessary, counselors should spend some time explaining the role of this character in supporting participants' recovery. Refer back to Session 6: "Meet Auntie Tina" for more information and ideas about introducing Auntie Tina to the group.

Goals of the Session

1. Help participants consider how coming out as a person who uses methamphetamine is analogous with coming out as a gay or bisexual man.
2. Help participants examine who they have and have not told about their methamphetamine use and think about who they may need to tell.
3. Help participants anticipate and handle reactions from others.
4. Help participants practice coming out as a person who uses methamphetamine.
5. Help participants examine how their physical environment supports their recovery.

Handouts & Materials

1. Session 16, pp. 66–71
2. Pens
3. Dots or stickers

Session Format, Presentation, & Timing

1. Check-in and Feedback – 30 minutes (no more than 45 min.)
    - Invite participants to share anything that may have come up for

them since the last session.

2. Topic Presentation and Discussion – 60 minutes

- Introduce the session, reading the paragraphs at the top of Page 66 and facilitating a quick discussion about similarities of coming out as a gay or bisexual man and coming out as a person who uses methamphetamine.
- Ask participants to complete the exercise indicating whom they have come out to about their methamphetamine use. Ask participants if there is anyone else they have come out to who is not on the list.
- Discus the range of reactions participants anticipated and experienced from others.
- Continue on the top of Page 67, repeating the exercise for those people participants have not told about their methamphetamine use. Participants often realize as a result of this exercise that there are new people that they want or need to tell.
- The questions that follow can be answered in a discussion format, moving naturally from question to question.
- As the discussion progresses, focus on techniques participants can use to discuss their methamphetamine use with others, as indicated in the middle of Page 68.
- Depending on the size and cohesion of the group, counselors may wish to do the script exercise at the bottom of Page 68 in pairs or as a whole-group discussion.
- Have participants share their ideas and scripts. During this discussion, it can be useful to describe the tool of "bookending," that is, creating support and accountability around a difficult event. If a participant plans to meet and tell someone new about their methamphetamine use, they may make a plan to bookend this conversation with support by calling and checking in with a group member or someone else in their support system before and after the conversation. Bookending is also handy if a participant knows that he may be in a situation that might trigger him. He can make a plan to call someone before and after, and to schedule the calls so his support system agrees to a plan of action if he has not called

by a specific time.

- Re-introduce Auntie Tina. She is also coming out...for a visit!
- The question about living space and changes to physical environment can be facilitated as a discussion. Help participants think about what in their physical environment may be triggering.
- Finally, complete the exercise at the top of Page 70. Ask participants if there were things they used to enjoy doing that they stopped doing because of their methamphetamine use, or if there are things they may have wanted to do but did not do because of their methamphetamine use. Brainstorm this list on the board. Remind participants that these are activities they can begin to do with people in their support system.

Before Next Session:

In discussing the homework assignment, emphasize the importance of having a non-using friend or someone with a strong recovery program available to help participants to go through their living space and remove all drug paraphernalia. It is strongly recommended that participants not do this alone. However, if a participant must do this assignment alone, instruct him to be on the phone with a non-using friend or someone with a strong recovery program throughout the whole process and, if possible, to schedule structured time such as going to a 12-step meeting or meeting someone for a meal or coffee, immediately following. Also, remind participants that they may find things they were not expecting to find as they locate and remove items. They should discuss a plan in advance for how to cope with the unexpected.

Session 17: Preventing Relapse

Relapse to methamphetamine use or to high-risk sex is a process, not a single event. Learning to recognize this process in advance is vital for those in recovery. After a relapse happens, many people believe that their relapse started when they lit up a pipe or a foil, or started snorting a line. It is often difficult for participants to identify and acknowledge that the relapse started hours or even days before the actual event. This is because relapse generally happens when people with a substance use disorder become lax with some aspect of their program of recovery. When people begin to drift toward a relapse, it is often because they are beginning a return to old habits or triggering people, places, things, events, or feelings, but are not acknowledging this drift or seeing the potential danger. This is called "relapse justification." Relapse justification is subtle and potentially dangerous because all those in recovery are vulnerable to the belief that it is not necessary to adopt certain tools such as scheduling their time, calling friends in recovery, attending 12-step meetings or other support groups, and exercising. Yet it is precisely these behaviors that help participants to live successfully without using methamphetamine. When people "forget" or discount the tools of recovery, methamphetamine use is usually not far away.

Learning to recognize and dispute relapse justification is another important tool that gay and bisexual men who use methamphetamine must learn in recovery. Furthermore, they must be able to recognize justifications for relapse to both methamphetamine use as well as high-risk sexual behaviors. As mentioned in previous sessions, this can be complicated because, although participants may attempt to seek sober and safe sexual situations, they never know if a potential partner is high or has drugs. In this way, sex can become an unwitting and accidental justification to relapse to methamphetamine use. Participants must be very aware when their thinking shifts to relapse justification and when their best laid plans for recovery begin to drift toward relapse.

This session introduces the idea of relapse justifications and invites participants to identify relapse justifications they have used in the past as well as relapse justifications that might be dangerous for them in the future. Participants also learn to begin to dispute and talk back to their relapse justifications in order to disarm them. Similarly, participants are asked to

brainstorm and practice thought-stopping techniques to interrupt the Trigger → Thought → Craving → Use pattern.

Goals of the Session

1. Discuss relapse in a safe environment.
2. Help participants understand and identify relapse justification.
3. Help participants identify relapse justifications that are particularly relevant or dangerous for them.
4. Help participants learn new tools and techniques for interrupting, disputing, and stopping relapse justification.

Handouts & Materials

1. Session 17, pp. 72–77
2. Pens
3. Dots or stickers
4. Wrist-sized rubber bands

Session Format, Presentation, & Timing

1. Check-in and Feedback – 30 minutes (no more than 45 min.)
    - Invite participants to share anything that may have come up for them since the last session or to share any experiences they had while assessing their living environment or removing paraphernalia.
2. Topic Presentation and Discussion – 60 minutes
    - Read the introductory paragraph facilitating a brief discussion about relapse justification, checking for participants' understanding of this concept.
    - It is usually better to read through all of the categories and examples of relapse justifications and then discuss them, rather than doing one category at a time. Ask participants to write down any others that come to mind for them. It is okay if they are not sure what category they fall under, just have them write them down and tell them that they will categorize and discuss them at

the end.

- Read through each section of relapse justifications. Participants often nod or acknowledge that they identify with many of the relapse justifications, recognizing some they may have used in the past.
- After reading through all of the examples (through to the top of Page 76) facilitate a discussion. Ask participants which of the relapse justifications resonated for them. Were there any others they thought of or experienced that were not listed? It can be useful, especially for gay and bisexual men, to emphasize weight gain as a common relapse justification for a specific purpose (Page 74, Number 1, at the top). Body image and weight are often powerful triggers, but participants often avoid discussing this.
- Emphasize that while it is impossible to avoid every triggering situation, identifying them and getting to know which triggers are the most difficult to fight gives participants power to better avoid those that can be avoided.
- Move the discussion to talking about thought-stopping techniques. Although other sessions cover thought-stopping, it is important for counselors to be mindful of whether or not there are new group members, and to briefly discuss what thought-stopping is. Repetition is never bad.
- Talk about the thought-stopping techniques described on Page 76 and ask participants to think of others. Explain that some participants sometimes prefer to imagine a dimmer switch instead of an on/off switch because it takes more time and gives them more control. Counselors might ask participants to think about the last time they had a craving and used thought-stopping to deal with it.
- Emphasize the importance of scheduling time. Again, if there are new group members, assure them that there are other topics that cover scheduling in more detail and that the usefulness of this tool cannot be over-emphasized.
- Counselors can cover the last question on Page 77 as an all-group discussion asking, for example: “Which of the tools we have discussed will be most useful for you in preventing relapse?” and “What justification stood out for you in the exercise and how might

you dispute it in the future?"

Before Next Session:

Although there is no homework for this session, counselors may suggest that participants spend the week focusing on relapse justifications. For example, "Are you aware of any 'relapse justifications' that you have used?" or "Are there any 'relapse justifications' that you have heard other people use?" and "How can you 'talk back' to the relapse justification?"

Session 18: Relapse Analysis

Often, when participants relapse to drugs or alcohol or high-risk sex, their first impulse is to want to erase, deny, minimize, or ignore the relapse and move on. While part of this instinct is good, such as moving on and getting back on track with recovery, ignoring or wishing to erase the relapse also means missing the opportunity to look at the relapse and learn from it. Examining the relapse to help understand and prevent it in the future is called relapse analysis. Some people are afraid of relapse analysis either because they are paralyzed by shame or guilt or because they are afraid that if they look at the relapse, it will happen again. Indeed, part of the threat of relapse is the fear participants have that they are unable to truly stop using methamphetamine, and if that is the case, then uninterrupted use cannot be far off. In fact, the opposite is true: When a person is able to learn from a relapse, they have strengthened their defenses against another relapse.

Because relapse can feel so inevitable and people feel out of control when it happens, participants often balk at the idea that a relapse is based, deep down, in a choice. It is important to remember that relapse is a process that begins and is a decision that is made when people are sober. As participants learn to identify behaviors and strategies that help support their recovery and keep them sober, any move away from those healthy behaviors becomes a choice to move toward relapse. This is sometimes called relapse drift. Relapse analysis uses all the relapse related tools that participants will learn in the program: understanding the Trigger → Thought → Craving → Use model, identifying relapse justification, and preventing relapse drift.

As it is rare that people who use methamphetamine can stop using and immediately remain abstinent from drug use, many gay and bisexual men in the program will have some history of relapse. Most people struggle to control their use on their own for a period of time before seeking treatment. They may have had several frustrating relapse experiences and may be fearful that they will never be able to stop relapsing. This session asks participants to examine their experiences with relapse more closely and to learn from these relapse experiences. Relapse to methamphetamine use and high-risk sex is a process, and participants are asked to look at how this has happened in the past, thinking about the types of events and

feelings that have triggered previous relapse. They are asked to identify warning signs that they may be drifting into dangerous waters and brainstorm tools that can be used as anchors for keeping them safely away from relapse to methamphetamine use or high-risk sex.

Goals of the Session

1. Discuss relapse in a safe environment.
2. Help participants understand the concept of relapse analysis and how it can be useful in recovery.
3. Help participants look at past relapses and analyze triggering events and feelings.
4. Help participants identify potentially dangerous people, places, things, events, feelings or behaviors that can cause them to drift toward relapse.
5. Help participants identify positive people, places, things, events, feelings, or behaviors that help keep them anchored to recovery and committed to safer sexual behaviors.

Handouts & Materials

1. Session 18, pp. 78–83
2. Pens
3. Dots or stickers

Session Format, Presentation, & Timing

1. Check-in and Feedback – 30 minutes (no more than 45 min.)
   - Invite participants to share anything that may have come up for them since the last session. This is a lengthy and thorough session, so counselors should stay aware of time.

2. Topic Presentation and Discussion – 60 minutes
   - Introduce the session by reading the paragraphs on Page 78. Explain that relapse is a process and that understanding past relapses provides useful information for avoiding relapse in the future.

- Go through the list and ask participants to think back and consider what categories of events and what specific things or events triggered their most recent relapse.
- Ask participants to think back even before these triggering events and consider what led up to these events that may have contributed to the relapse. Instruct participants to use the chart on Page 80 to write down these "pre-lapse" events or triggers and the feelings related to them. It may be useful to have a list of feelings or a "feeling poster" as a means of helping participants identify their feelings. Some participants are so disconnected or alienated from their feelings, they have trouble completing the exercise.
- After participants have had a little time to fill in the chart, facilitate a discussion about what participants noticed, what stood out for them, or anything they realized in looking at their "pre-lapse" events.
- Introduce the concept of relapse drift and describe dangerous waters. Using the work they have done in the session so far, have participants identify people, places, things, events, feelings, or behaviors that put them at highest risk for moving toward relapse. Also ask participants to identify which dangerous waters lead to methamphetamine use, high-risk sex, or both. If they can identify times in the recent past that they have found themselves in such waters, they may fill in the date, but they should not fixate on trying to remember. The general goal of looking at the date that these events occurred is to identify whether they happened around the time they relapsed, or just before. This exercise can be completed on the board as a whole-group discussion.
- Read on and explain the concept of "anchors" as being those people, places, things, events, feelings, or behaviors that help support and ground participants in their recovery.
- Ask participants to come up with a list of their most powerful or reliable anchors. Ask them to think about whether they have different anchors for helping them avoid methamphetamine use as opposed to high-risk sex and which ones work for both. As in the last part of the exercise, ask participants to think back to the last time they used an anchor. This exercise can be completed on the board as a whole-group discussion.

- Participants can use the dangerous waters and anchors checklist to monitor how well they are doing in avoiding triggers and staying on track with recovery.
- In discussing anchors and giving themselves positive feedback, participants are often hesitant to acknowledge when they are doing a good job. They often express fear that if they give themselves positive feedback, they are getting cocky. Counselors can explain that learning what tools help them stay sober and being confident that they can use those tools to stay on track is confidence, not cockiness. "Cockiness" more aptly applies to participants who know the tools that can help keep them stay sober but believe that they do not need to use them. Being on the look-out for this contradiction, that is to say, knowing the tools that work but not using them, can be a great help to participants.

Before Next Session:

Go over the homework as described on Page 83, asking participants to try to consciously use their anchors for the next week and to pay attention to which anchors work well for them and which ones do not.

Session 19: What About These Feelings?

Abusing drugs or alcohol often causes people to become disconnected from their feelings. This disconnection is part of why people begin using in the first place: using takes them out of themselves, creates new sensations, helps them to escape pain, panic, anxiety, and boredom, and intensifies experiences. At the beginning this feels good, and the changes drugs create are positively reinforcing (they do the trick) with few negative consequences. People also find that their using helps them cope with or forget about negative emotions and feelings. Over time, methamphetamine stops working quite as well, especially as one moves from recreational use to chronic use. The substance that was once used for fun becomes the tool people rely on to erase, mask, or defer uncomfortable, painful, and confused feelings. When people stop numbing their feelings with substances or sex, they may find themselves faced with very powerful feelings. Sometimes the feelings are so strong, they lead people to use again just to minimize these strong feelings. Moreover, their ability to process and cope with feelings has been stunted, and those in recovery must relearn how to identify their feelings and process them with new tools.

Gay and bisexual men use methamphetamine for many reasons. Many men are first introduced to methamphetamine as a club drug used to enhance the fun of partying. Other gay and bisexual men report that they are first introduced to methamphetamine by a casual sex partner or boyfriend to enhance and prolong sexual encounters. Regardless of why one starts using methamphetamine, what starts out as fun often turns darker as people realize how effective methamphetamine is at taking them out of themselves and numbing their feelings. Methamphetamine gives gay and bisexual men the ability to have sex unburdened by feelings that may have inhibited their full expression in the past. Methamphetamine also helps them forget about HIV, a disease that has further complicated and stigmatized the expression of gay male sexuality. Methamphetamine helps erase the fatigue that comes from having to be concerned about HIV. Methamphetamine sweeps away all of these negative feelings and inhibitions and makes it easier to stop taking responsibility for protecting against STIs. Often, it starts out as a perfect fit for helping gay men to be gay men.

This session focuses on feelings. As participants enter recovery they are

usually afraid of or intimidated by their feelings, afraid that if they feel them, they will be triggered to use. In the absence of methamphetamine, their favorite coping mechanism, many gay and bisexual men struggle to even find words to describe what they feel. This session gives them tools to help them determine what their feelings are, provides a vocabulary for describing those feelings, and provides tools for helping them cope with uncomfortable feelings in new ways.

It is important to also let the participants know about the anatomy of feelings: one cannot change a feeling. One can wait for the immediacy of a feeling to pass. One cannot stop a feeling without causing other problems. But when feelings happen, they invoke types of thoughts (for example, depressed feelings lead to negative thoughts). An effective way to manage feelings is by managing thoughts. Identifying negative thoughts and swapping those out for more appropriate thoughts (for example, thinking "Things are not as bad as they were previously; this will pass.") can lead to more appropriate feelings.

Goals of the Session

1. Create an opportunity for participants to talk about feelings in a safe environment.
2. Help participants identify, recognize, and describe their feelings.
3. Help participants talk about what feelings are uncomfortable for them and how their feelings may have led them to methamphetamine use and high-risk sex.
4. Help participants identify tools for coping with strong or uncomfortable feelings.

Handouts & Materials

1. Session 19, pp. 84–89
2. Pens
3. Blank paper
4. Several sets of colored pencils
5. Dots or stickers

Session Format, Presentation, & Timing

1. Check-in and Feedback – 30 minutes (no more than 45 min.)
   - Invite participants to share anything that may have come up for them since the last session. Did they become more aware of their anchors? What did they notice about their anchors?

2. Topic Presentation and Discussion – 60 minutes
   - Introduce the session, reading the material on Page 84. Facilitate a brief discussion about feelings and using. Explain that as gay and bisexual men, we not only carry around feelings and "baggage" about who we are, but we also have complicated feelings and baggage about who we are not. That is, we receive all the messages growing up about how men are supposed to be, and we often never quite feel like we fit.
   - Remind the group that it is normal to want to avoid or numb uncomfortable feelings, especially if they are triggering, but there are better ways to do this and there are less than ideal ways to do this. This session aims to give participants tools to better cope with their feelings.
   - Conversations in Color: Introduce the exercise. Explain that we grow up in a society that expects men to stuff away or negate feelings and, as a result, most boys grow up to be men without the vocabulary to talk about their feelings. This exercise gives participants the opportunity to express their feelings without words.
   - Divide the group into pairs. Assure participants that there is no right or wrong way to do this exercise, but the idea behind it is to use the colored pencils to express emotion without using words. Read the instructions on Page 85 and ask the pairs to complete the exercise. Explain that after both partners have expressed their feelings through drawing in silence, then each partner should reflect back what they understood about their partner's emotions based on what they drew. This usually works better if both partners draw first and then discuss. Some participants resist this exercise; others really love it. Counselors should consider this as they choose pairs.
   - Afterwards, ask participants what it was like for them to complete

the exercise. What came up for them?

- Feeling Your Feelings: After reading the material, ask participants, as instructed at the top of Page 87, to think of a feeling that they know they do not deal with very well. Counselors can write these on the board if they wish and facilitate a discussion about this. Anger and loneliness are common answers. It can be helpful to identify for participants that anger is often one of the most comfortable of the uncomfortable emotions to feel and that usually anger is masking other feelings. Ask participants if they can identify with this. The analogy of peeling away layers of an onion is a helpful feeling analogy, especially regarding anger.
- New Coping Strategies: Facilitate a discussion around the question at the bottom of Page 87. Sometimes participants, especially when they are new, cannot think of an example of a situation in which they talked about their feelings. Remind participants that this is what they are doing in group, and that even though it is a safe place to talk about feelings, it still may be new for many group members. Counselors might ask them how it feels to share about themselves in group. Remind participants that sometimes feeling uncomfortable emotions is not bad; sometimes it is just new.
- In talking about this, participants often give examples of occasions where they displayed passive-aggressive behavior. Counselors should give positive feedback and ask how they might have handled those situations differently. A good model to give participants is: “When you did ____, I felt ____, and what I need from you is____.” as a model for having proactive communication around conflict.
- This can also be a good time to mention the concept of “sharer's remorse” and normalize that this may happen for some participants as they get comfortable in group and share more and more.
- Continue reading the other coping strategies at the top of Page 88 and discuss them briefly.
- Participants have sometimes shared that “feeling surfing” feels like waiting. Remind them that the point is that feelings change, they do not stick around in the same form forever. Counselors might

introduce the mindfulness technique of naming and acknowledging emotions as a way to enhance surfing as a coping mechanism. Some participants find this silly, but it can be extremely effective to verbalize this in the form of, “Hi [uncomfortable emotion]. I see you there, but I do not have to do anything about you. You just are; you will pass.”

- Brainstorm other coping strategies and write them on the board.

Before Next Session:

Go over the homework as described on Page 89. Remind participants that we often get signals about what we are feeling from our bodies. This can be useful, especially if identifying feelings is new and we might not yet have the words to describe them. Sometimes our body gives us the words in the form of a physical sensation.

Session 20: Setting Goals and Solving Problems

Addictive use of methamphetamine, as well as other drugs and alcohol, has serious consequences and very often leads to financial strain or ruin, unemployment, social isolation, and loneliness. As using becomes primary in one's life, other things fall away. In recovery, people can be left broken and unsure of how to rebuild their life. Strengthening self-efficacy is a key component of recovery. Many people with methamphetamine use disorder lose sight of skills they may have had before they started using. They forget how to solve problems effectively, and any goal may feel too overwhelming to attain, especially when starting from so low a point. In recovery, participants slowly learn how to avoid problem situations and can plan proactively for their future. This is done by setting realistic goals and implementing them step by step.

Change is a process, not a single decision. In order to make changes, people must believe that the change is important, that the timing is right to implement the change, and that they have the ability and resources to do the work to implement the change. This process requires resolving the ambivalence that is natural when considering making changes. Looking at goal setting as a process achieved through small steps makes resolving this ambivalence easier, thus strengthening self-efficacy.

This session is about setting goals and solving problems in recovery, and it offers an opportunity for participants to think about changes they want to make and to consider their ability to make these changes. This session helps participants think about problem-solving and, in particular, helps them think about problem-solving around triggers. The session helps participants set realistic and attainable goals for where they are in recovery, and gives participants tools to break down their goals into smaller steps.

Goals of the Session

1. Help strengthen participant self-efficacy.
2. Help participants build problem-solving skills.
3. Help participants think about how to cope with unavoidable triggers.
4. Help participants set recovery goals that are realistic and attainable.
5. Help participants identify smaller, intermediate steps they can implement towards achieving their goals.

Handouts & Materials

1. Session 20, pp. 90–94
2. Pens
3. Dots or stickers

Session Format, Presentation, & Timing

1. Check-in and Feedback – 30 minutes (no more than 45 min.)
   - Invite participants to share anything that may have come up for them since the last session and invite them to share their experience with the homework if they wish. Also pay attention in check-in to see if any participant shares a problem that might be a good fit for the group exercise in this session.

2. Topic Presentation and Discussion – 60 minutes
   - Introduce the session by reading Page 90 and facilitating a brief discussion about problem-solving and self-efficacy when faced with unavoidable triggers.
   - Encourage participants to follow the advice at the bottom of Page 90 and to make a list for themselves of their relapse prevention successes and refer and add to it frequently.
   - Continue reading at the top of Page 91, explaining that it is normal to feel overwhelmed sometimes, but that feeling overwhelmed can also mean that participants are taking on too much.
   - Continue to the exercise on Page 92 and explain that goals can and should be broken down into smaller steps, and although some of the examples may seem insignificant, when taken together, they all contribute to the goal of recovery. All goals can be broken down this way. This exercise is aimed at helping participants look at some areas in their life where they may already be making changes, and asks them to think about how confident they are that they can make the changes.
   - After participants have had time to work through the exercise, remind them that setting goals is only one part of the equation. They need to believe and have confidence that they can actually implement the plan to attain their goal. In other words, a great goal

does not attain itself. Participants need to look at their own self-efficacy. One way to build self-efficacy is to start out small and achieve the overall goal one piece at a time.

- Introduce the exercise at the top of Page 93. This can be done as a whole-group exercise. In discussing this problem-solving technique, participants often express shame about not being able to solve their problems on their own. Remind them that most people, in recovery or not, are not very effective problem-solvers. This is a skill that everyone should learn. Emphasize the importance of breaking a problem down into smaller steps. If the smaller steps are not almost uncomfortably small, they probably are not small enough.
- Usually, someone has shared during their check-in a problem that would be appropriate for the group to consider for this exercise. Counselors may need to refine or re-frame the problem slightly in order to make it fit the exercise, but using a real-life, real-time example is always a good idea. A goal such as, “I want to feel better” is usually too vague. Counselors should choose a problem that can be solvable in the short term. Counselors should also make sure to ask the participant whose problem they wish to use if it is okay with them. Some participants find this uncomfortable, but usually they are willing to have the group support them in finding solutions.
- Next, work through the problem using the steps listed at the top of Page 93, writing on the board as necessary.
- During the brainstorming session, write everything that is suggested. Participants may need a reminder about what brainstorming is and to not judge responses.
- After a good number of responses are on the board, ask the participant whose problem is being considered what the possible outcomes of different options might be and to then choose which solutions feel like they might work best. Work down the list on the board, discarding those solutions that do not work.
- After the list has been narrowed down, have the participant choose the solution that he thinks might be the most manageable and have the best outcome. Ask the participant if there is anything else the group can help with in support of solving his problem.

Sometimes participants will want to further break down the chosen solution into its component steps. It is okay to do this or not. Encourage the participant to check in about how the problem turned out. This allows the group to complete the fourth step together.

- Complete the exercise at the top of Page 94. Participants may pair up or do this individually. If done in pairs, partners can often identify a problem they both share and can work together to think through and brainstorm solutions.

Before Next Session:

Go over the homework as described on Page 94. Ask participants to focus on a smaller step toward a larger goal and to work on just that step in the next couple of days. Also remind participants that if the online site Craigslist is a trigger for them, they should choose a different site to surf. Remind participants the value of making small changes. Participants may be quick to minimize a small change, particularly if compared to a major change made by another group participant.

Session 21: Why You Use and Low-Tech Sex

This session invites participants to explore some of the reasons why they used methamphetamine, to think about their HIV risks, and to consider changes they may need to make in their sexual and online behaviors and relationships. The introduction to Session 19 described some common reasons why gay and bisexual men begin to use methamphetamine. Some gay and bisexual men use as a means of coping with feelings and attitudes about HIV. Men who are HIV-positive may use to numb their feelings about their diagnosis, or to help ease anxiety about disclosure. Men who are HIV-negative may use to help ease their anxiety about contracting HIV or perhaps because they equate hot sex with barebacking, and being high “gives them permission” to have unprotected sex. Some older gay men have shared that in a culture that values and sexualizes youth, methamphetamine helps ease their anxiety about their attractiveness or aging, and that offering methamphetamine to younger sex partners means that they can hook up with men who might not otherwise be attracted to them.

In exploring why people use, the significance of the Internet in gay communities cannot be overstated. For some, especially those who are just coming out, the Internet offers a relatively safe way to find and connect with others. Social networking sites such as Facebook or MySpace, affinity sites around hobbies or events, and dating and cruising sites bring together a huge network of gay and bisexual men who previously might never have met, or if they had, it would only have been in a bar or other venue where they knew they could be relatively anonymous. Although gay visibility and acceptance has increased over time, making it relatively safer for some gay people to come out in some places, the Internet is among the safer places to come out, and many gay men begin exploring their sexual identity with the support of this virtual community. The Internet also broadens the sexual lives of gay men. Looking at pornography as well as dating and cruising online is more commonly the rule than the exception for gay and bisexual men. This will likely become even more common as technology-savvy gay adolescents grow up to become young adults.

Additionally, methamphetamine has become a fixture on the Internet, and finding methamphetamine and anonymous sex online is, as the text of the session describes, about as easy as ordering a pizza. Online cruising and

hook-up sites (there are sites for every niche and nuance of gay male sexuality and fetish culture) make connecting for sex easier than ever. Terms such as “party and play” (meaning using methamphetamine and having sex) have been pervasive online; as online cruising sites have tried to police the language used by people who use drugs, other terms such as “party favors” have developed. Online profiles might say, “Looking to hook up if the chemistry is right.” Depending on the site, this is often a reference to methamphetamine. Counselors need to educate themselves about online slang, code and websites and should ask participants to explain if they do not understand something.

This session asks participants to examine their online behaviors and to think about how these behaviors may need to change in sobriety. Similarly, participants consider what “low-tech” sex and relationships might look like for them. Talking about masturbation is a great place to start. As has been mentioned in previous sessions, gay and bisexual men in recovery need to re-teach themselves what is hot and this starts with creating a fantasy life that does not include methamphetamine. In addition, participants may be hesitant to change their online behaviors. For many, getting online is a double-edged sword: it connects them to other gay men and helps ease their isolation, but the anonymity and sex-focus makes this connection ultimately feel less authentic. In addition, cruising online has been described by some as an addictive behavior. For some participants, the hours spent online in a trance-like state of cruising for sex and looking at profiles creates powerful using and sexual cravings. Thus, the association between getting online, using methamphetamine, and high-risk sex is strengthened and, therefore, getting online becomes a risky decision. Despite this, the Internet provides such a quick way to hook up and meet people for sex, participants are not always eager to give it up, even if hooking up with others may mean putting themselves at sexual risk or at risk for using methamphetamine. One strategy to help participants is to suggest that they set a timer for a limited amount of time. They allow themselves to cruise online for a specific amount of time, but when the time is up, they agree to masturbate to discharge that energy and move on to other things.

Goals of the Session

1. Help participants identify some of the reasons why they use methamphetamine.

2. Help participants think about the connections between HIV and methamphetamine use.
3. Help participants think about the connection between methamphetamine use and the Internet, and to understand and articulate how their online behavior, sexual activities, and methamphetamine use overlap.
4. Help participants begin to think about "low-tech" relationships and what those might mean.

Handouts & Materials

1. Session 21, pp. 95–97
2. Pens
3. Dots or stickers

Session Format, Presentation, & Timing

1. Check-in and Feedback – 30 minutes (no more than 45 min.)
    - Invite participants to share anything that may have come up for them since the last session and invite them to share their experience with the homework, if they wish. In particular, did they notice anything about achieving an intermediate step towards a larger goal? Also, check in with the participant whose problem was used during the last session.

2. Topic Presentation and Discussion – 60 minutes
    - This session is best accomplished in a discussion format. The conversation is often rich and develops naturally, although some people may be hesitant to speak openly. Remind participants to speak for themselves.
    - Introduce the session, reading the material on Page 95 and facilitating a discussion about why people use.
    - Explore reasons for use related to HIV.
    - Read through the rest of the text to the middle of Page 96 and invite participants to discuss their own reasons for using. What reasons or motivations do they identify with? Are there others that

have not been named? Counselors may wish to write these on the board.

- Read the text starting in the middle of Page 96 and facilitate a discussion about the role of the Internet in the lives of participants.
- The conversation often naturally evolves into a discussion about sex and relationships, but counselors may need to catalyze this process.
- There are a number of different directions to go with this session depending on the mood and cohesion of the group. Often, having a very frank and open discussion about concrete ideas for coping with sexual triggers is a great place to start. Participants have a great need for concrete ideas about how to change their sexual behavior. It is important for facilitators to be honest and state that for many, sex without methamphetamine will not be the same as sex on methamphetamine, but it can be hot in different and new ways. Exploring and implementing new behaviors around sex and relationships makes participants feel very vulnerable and possibly triggered.
- Re-introduce the character of Auntie Tina. Recall for participants that she recently came to visit and is writing to you upon her return home. Read the letter on Page 97.
- End the session by discussing low-tech ways to meet guys. This can be a rapid brainstorm put on the board.
- Some participants are triggered by conversations about sex. Allow time to de-escalate the group and transition to other topics. Counselors should take the temperature of the group and maybe take a quick spin around the room and ask each participant to identify a feeling. Counselors might also check in about participants' plans following group and for the rest of the evening.

Before Next Session:

Although there is no homework for this session, counselors may ask participants to continue thinking about low-tech sex and relationships. What are some other low-tech or "unplugged" ways participants can socialize with other gay and bisexual men?

Session 22: A Community Changed

HIV has been a part of the cultural experience of the United States and the world for several decades. Although it happened slowly, gay culture changed in response to HIV and almost everyone, in some way or another, shifted in their understanding of, and beliefs about, behaviors around sex.

All gay and bisexual men are affected by HIV/AIDS. As the disease was first identified among gay and bisexual men, communities responded with awareness campaigns, activism, and care for the sick and dying. In a way, AIDS accelerated the gay rights movement and catalyzed a collective cultural coming out, as gay men found their voice and their power in response to the epidemic. In the 1980s, AIDS became the defining cultural trauma in the lives of gay and bisexual men. Although more treatable and manageable than ever before, HIV/AIDS continues to impact the lives of gay and bisexual men, and the cultural memory of the initial epidemic hangs over us, continuing to shape and change our attitudes about sex and relationships.

Those who became HIV infected early on never expected to live very long. Today, these long-term survivors are coping with new challenges and health problems related to aging that they never thought they would face. Older survivors of the initial AIDS epidemic describe a paralysis—equated to living in suspended animation—in which they have essentially put planning their life on hold and lived in the moment, expecting that death was right around the corner. Now, having lived through and beyond their expectations, many find that they still conduct their life as if they are going to die tomorrow. Methamphetamine use helps both ameliorate and facilitate these feelings. If you believe you are going to die tomorrow, why not self-destruct today? Today, gay men come out and begin to explore their sexuality in a very different cultural climate—they come out in an AIDS culture. Additionally, depictions of LGBT people are more prevalent in popular culture and, in terms of HIV, the disease is not the death sentence it was initially. Treatment with highly active anti-retroviral therapy (HAART) has changed the life expectancy and quality of life for those with HIV infection. The perception and reality that HIV is now a manageable chronic disease has meant that younger gay men may be less careful and place less value on safer sex, assuming that if they contract the disease, they will just deal with it.

This session invites participants to share how HIV has affected them, their behavior, and their perception of themselves as part of a community, and how HIV and methamphetamine use are connected. It is a relatively short session, but the conversation facilitated is often very rich. Some participants, especially those who are not HIV-infected, may not participate in the discussion as much, believing that the discussion is less relevant to them. Counselors may wish to remind participants that all gay and bisexual men have been affected by HIV, whether or not they are HIV-infected.

Goals of the Session

1. Help participants articulate the effects of HIV on their lives, their identity, and their sexual behavior.
2. Help participants understand the connections between methamphetamine, HIV, and sex.

Handouts & Materials

1. Session 22, pp. 98–99
2. Pens
3. Dots or stickers

Session Format, Presentation, & Timing

1. Check-in and Feedback – 30 minutes (no more than 45 min.)
    - Invite participants to share anything that may have come up for them since the last session.

2. Topic Presentation and Discussion – 60 minutes
    - This session is best accomplished in a discussion format. The conversation usually develops naturally, although some people may be hesitant to speak openly. Remind participants to speak for themselves.
    - Introduce the session, reading the material on Page 98 and facilitating a discussion about HIV and its impact on the gay and bisexual male culture and on their identities as gay or bisexual men.

- Move through the questions and continue the conversation. Usually all the questions are absorbed and covered in the conversation and there is no need to go through them one by one.
- This can be a sensitive topic for some participants. It is not uncommon for participants' judgments of themselves or others to find expression either as anger or in silence. Counselors should remain aware of this and remind participants that the goal of the session is to talk openly and frankly about participants' individual experiences. There are no right or wrong answers and no right or wrong way to express sexuality. Some behaviors carry more risk than others, but only when talking honestly about what is true can we assess the actual risk and begin to make changes, if we choose to make changes.
- Some participants are triggered or challenged by the feelings that come up during the discussion. Allow time to de-escalate the group and transition to other topics. Counselors should take the temperature of the group and quickly ask each participant to identify a feeling. Counselors might also check in about participants' plans following group and for the rest of the evening.

Before Next Session:

It is not uncommon for this session to trigger intense feelings. Counselors should normalize this for participants before the end of the session. Although there is no homework for this session, counselors may remind participants that they can check in with one another, or others in their support system, if they are feeling triggered.

Session 23: Socializing vs. Isolating

As mentioned in previous sessions, those who misuse methamphetamine tend to isolate themselves. Seeking, using, and recovering from methamphetamine takes a lot of time and may not leave room for many other activities. Additionally, coming down and going through withdrawal is typically done in isolation. Guilt and shame about using also compel people who use methamphetamine to isolate themselves. As lives become more fragmented and less manageable, people may hide these consequences from others by dropping out of relationships, minimizing social responsibilities, or limiting contact with family. Getting close to others might mean acknowledging the impact of using, and recognizing this might mean making changes in one's life. Without others, using becomes the primary relationship, and self-empathy diminishes when no one is there to reflect it back.

People that use methamphetamine often isolate themselves for the same reasons and face the same consequences. Hanging out with using buddies and getting online or going to a bathhouse for sex may look like socializing, but most people describe intense feelings of isolation and disconnectedness. As their use increases, even when in a room filled with people or while having sex, a time when one might expect to feel intense connection, people feel isolated. This illusion of socializing can make it difficult for people that use methamphetamine to see the real toll their use takes on their lives and social relationships.

Several sessions in Getting Off deal with creating and maintaining a social support system, examining the quality of the relationships in participants' lives, and doing the hard work of being honest about using with others. This session deals specifically with isolating and gives participants specific tools for helping them cope with new or potentially triggering social situations. It is a useful session, not just in terms of recovery, but also for helping participants develop general social skills and coping strategies around socializing. It also helps reinforce that in recovery, participants' lives can and do return to normal. They can still go out or do some of the things they did before methamphetamine got in the way, they just have to learn new ways of doing these activities safely and avoiding triggers. It becomes a "new normal."

Goals of the Session

1. Help participants understand and examine socializing vs. isolating in their recovery.
2. Help participants understand the difference between needing alone time and isolating.
3. Help participants develop tools for helping them cope with social situations.

Handouts & Materials

1. Session 23, pp. 100–103
2. Pens
3. Dots or stickers

Session Format, Presentation, & Timing

1. Check-in and Feedback – 30 minutes (no more than 45 min.)
   - Invite participants to share anything that may have come up for them since the last session.

2. Topic Presentation and Discussion – 60 minutes
   - Introduce the session, reading Page 100. Facilitate a discussion about socializing vs. isolating.
   - Continue on Page 101, reading the examples of the difference between staying home and getting out. Ask participants to come up with any other examples of their own.
   - Continue in the discussion, having participants answer the questions at the bottom of Page 101. Answers can be put on the board.
   - Ask participants to share their thoughts about the difference between isolating and having alone time. How can they tell when needing to spend time alone becomes isolating? Answer the question at the top of Page 102.
   - Read and brainstorm a list of coping strategies for dealing with different situations and triggers. Put these on the board.

- Ask participants to complete the chart on Page 103 using some of the strategies they came up with and any others they can think of. After participants have had a few minutes to work through the chart, have them share their answers.
- Remind participants that they can hang onto this chart and update it with new strategies as they think of them.

Before Next Session:

Although there is no homework for this session, counselors may suggest that participants pay close attention to their feelings in social situations and practice using a coping strategy, particularly if they find themselves in a new social situation.

Session 24: Auntie Tina Moves In

Those in recovery are often quick to minimize the positive changes they are making. Either because they fear disappointment, they have had too many experiences of relapse, or they are nervous about getting cocky and failing, many people struggle to take credit for and pride in the positive steps they are taking. When expectations are lowered and hard work is minimized, one is guarded, or emotionally protected, in the event of a relapse. The distance they fall is shorter. For many, minimizing their successes is a small price to pay for cushioning a fall. Unfortunately, ignoring or minimizing progress can also feel like failure. Therefore, participants must learn to walk the sometimes uncomfortable line between being honest about where they have been, being realistic about where they are, and being proud of getting themselves there.

This is the second opportunity in the Getting Off intervention for participants to check in and take stock of where they are in their recovery and to think about their goals as they rebuild their life free from methamphetamine. This session repeats the exercise from Session 12 and amplifies it, offering participants the opportunity to think about other shorter- and longer-term goals or plans that they can imagine in their life without methamphetamine. This session also encourages participants to think about their life beyond the Getting Off group and asks them to begin planning for what kind of structure and support they will put in place to help them continue their recovery after treatment. Even participants who are brand new to the group need to be thinking about this.

The Getting Off intervention introduces the character of Auntie Tina, who represents their strongest ally in support of the participant's recovery. Auntie Tina re-appears in this session to help participants think about their support system and about the skills and strength they have developed internally and externally to help them continue in recovery. If necessary, counselors should spend some time explaining the role of this character in supporting participants' recovery. Refer back to Session 6: "Meet Auntie Tina" for more information and ideas about the role of Auntie Tina for the group.

Goals of the Session

1. Help participants identify and articulate positive changes they have

made in their recovery.

2. Help participants examine their progress in recovery.
3. Help participants think about activities they can do to strengthen their recovery.
4. Help participants implement new support structures to help them in their recovery after treatment.

Handouts & Materials

1. Session 24, pp. 104–108
2. Pens
3. Dots or stickers

Session Format, Presentation, & Timing

1. Check-in and Feedback – 30 minutes (no more than 45 min.)
   - Invite participants to share anything that may have come up for them since the last session. Did they find themselves using any of the coping strategies from the previous session? If so, what was it like?

2. Topic Presentation and Discussion – 60 minutes
   - Introduce the session and re-introduce the character of Auntie Tina. For participants who are new to the group, briefly discuss the role of Auntie Tina.
   - Read the letter from Auntie Tina on Page 104.
   - The questions on Pages 104 and 105 can be facilitated as a discussion, which can be moved along fairly quickly. The group can brainstorm the list of activities at the top of Page 105 and counselors can write answers on the board if they wish.
   - Participants are often hesitant to give themselves positive feedback or feel proud of the positive changes they have been making (question on Page 104). Sharing their successes with the fictional character of Auntie Tina makes it easier for some participants to identify and take pride in the changes they have made.

- Participants who are new to the group may struggle to identify answers to some of these questions. Counselors can ask new participants to identify changes they have already made and changes they anticipate making.
- Ask participants to consider the last question on Page 105, "For you, who is Auntie Tina?" and to share this aloud if they wish. If participants struggle with this question, counselors may ask other open-ended questions to get participants thinking about the qualities they desire in the people in their support system.
- Checking In: Ask participants to complete this exercise on their own. Afterwards they can share anything that might have come up for them. Sharing aloud the examples under "Organizing Your Life" can be useful for the group, especially for giving new group members ideas.
- The remaining questions on Page 108 can be facilitated and answered as a discussion, although it can be helpful to read all of the questions aloud and give participants time to think about them and jot down any notes before proceeding with the conversation.
- Counselors should spend some time brainstorming ideas about activities, people, programs, and other resources for seeking ongoing recovery support after the group is over. Encourage participants, regardless of how many sessions they have attended and what stage of group they are in, to think about what things they can start putting in place now so that the transition out of the group is cushioned by other support systems.

Before Next Session:

Although there is no homework for this session, participants should be encouraged to keep this session as a living document to keep track of the progress they are making in different areas of their lives. As with all of the assessments in the manual, participants may wish to revisit it every couple of weeks. Counselors may offer to give participants blank copies of the exercise if they want to repeat it in the future on their own.

Appendix 1:
Glossary of Terms Used in the Getting Off Manual

BISEXUAL: Someone who experiences attraction towards more than one gender.

COMING OUT: For LGBTQ+ people, coming out is the process of self-identifying and self-acceptance that entails the sharing of their identity with others, sometimes referred to as disclosing. Individuals often recognize a lesbian, gay, bisexual, transgender/gender-expansive, or queer identity within themselves first, and then might choose to reveal it to others. There are many different degrees of being out, and coming out is a lifelong process. Coming out can be an incredibly personal and transformative experience. It is critical to respect where each person is within their process of self-identification, and up to each person, individually, to decide if and when and to whom to come out or disclose. The Getting Off program recognized that for many, disclosing their methamphetamine use to family members and/or friends can be compared to the coming out process (Session 16).

GAY: Synonymous with same-sex or same-gender attraction. Primarily defines men who are attracted to men, though many women who are attracted to the same sex or same gender also identify as gay.

HETEROSEXUAL/STRAIGHT: Someone who experiences attraction towards those of a different gender than their own.

IN THE CLOSET: Refers to someone who will not or cannot disclose their sexual identity or gender identity.

SEXUAL IDENTITY: An individual's internal experience of sexual/romantic/emotional attraction towards others.

Appendix 2: Tailored Cognitive Behavioral Therapy

The Getting Off intervention is based on gay-specific cognitive behavioral therapy. The cognitive behavioral therapy (CBT) used in this program includes education for participants on internal and external triggers for methamphetamine use, how to recognize emotions that indicate a potential relapse, cognitive skills such as stopping negative thoughts, handling cravings, examining relapse and using it as a learning opportunity, and engaging in healthy activities. The gay-specific CBT (GCBT) in this program draws on traditional CBT techniques and, also, incorporates specific cultural and behavioral components of gay, bisexual, and other sexual minority men (e.g., triggers such as bathhouses and sex clubs). GCBT also simultaneously focuses on substance use and sexual behaviors that increase risk of HIV transmission (Shoptaw, Reback, et al., 2005; Shoptaw, Reback, et al., 2008; Reback, Veniegas & Shoptaw, 2014; Reback & Shoptaw, 2014).

Appendix 3: Other Considerations: Minority Stress and Intersectionality

The minority stress framework (which Dr. Virginia Brooks originally described in her book, *Minority Stress and Lesbian* Women in 1981 and which Dr. Ilan Meyer advanced in 1995 and 2003) is useful for contextualizing substance use and disorders among lesbian, gay, bisexual, transgender, queer, and other non-heterosexual, non-cisgender (LGBTQ+) communities. All people experience stress. This general stress can come from a variety of sources such as being laid off from a job, the death of a family member, a physical illness, or a mental health problem. In addition to general stress, LGBTQ+ individuals experience other unique and chronic stressors related to societal marginalization of their sexual and gender identity. These can take the form of both distal stressors like anti-LGBTQ discrimination or harassment as well as more proximal stressors like feeling pressured to hide one's LGBTQ+ identity or being afraid of rejection from family members and friends. LGBTQ-affirming social support and other coping strategies can help to mitigate the negative impact of minority stress. Some LGBTQ+ people may use substances like methamphetamine, alcohol, and other drugs to cope with minority stress, which increases their risk of developing a substance use disorder. For this reason, it's important that addiction treatment programs implement policies and programs that affirm LGBTQ+ participants.

LGBTQ+ individuals may be marginalized by society for other aspects of their identity (e.g., race and ethnicity, ability, body shape, religion, socio-economic status). In 1991, Kimberlé Crenshaw coined the term "intersectionality" to describe the multiple systems of oppression that individuals may experience and how this shapes their everyday lived experience. Further, individuals who exist within multiple marginalized communities may experience discrimination and stigmatization within one of their communities, due to their identification with another marginalized community. For example, LGBTQ+ Black, Indigenous, People of Color (BIPOC) individuals may experience racism within the LGBTQ+ community and likewise, may experience heterosexism or transphobia within their racial or ethnic community (Levitt & Ippolito, 2014). Given this, LGBTQ+ individuals who hold multiple marginalized identities may experience higher rates of minority stress, which can negatively impact health and well-being.

Appendix 4: HIV, HCV & Fentanyl

There have been multiple advances in HIV prevention and treatment, including the availability of long-acting injectable pre-exposure prophylaxis (PrEP), on-demand PrEP rather than oral-daily PrEP, and the concept of undetectable=untransmittable (U=U). Below, we outline these advances so they can be shared with participants in the context of the Getting Off program. Visit https://www.hivguidelines.org/ for more information on HIV prevention and treatment:

- PrEP: pre-exposure prophylaxis, or PrEP, is an antiretroviral medication that can be taken orally once a day, or by injection every two months, or on-demand to prevent the transmission of HIV

Note: On-demand PrEP is *not* recommended for people who use drugs. Getting Off program participants should only consider using on-demand PrEP once a period of abstinence from methamphetamine use is achieved.

- Undetectable=Untransmittable (U=U): U=U means that people with HIV who reach and continue to have an undetectable viral load (i.e., the amount of HIV in the blood is so small that it cannot be detected through blood tests) by taking antiretroviral therapy (ART) as prescribed cannot sexually transmit HIV to other people. See: https://www.niaid.nih.gov/diseases-conditions/treatment-prevention.
- Hepatitis C Treatment: In addition to HIV transmission, there is a risk of contracting hepatitis C (HCV) through shared drug injection equipment, including syringes and needles. People often do not have any symptoms of HCV until they have reached the stage of advanced liver disease. Although there is no vaccine for HCV, there are effective treatments that can cure HCV in 8 to 12 weeks. Visit the following CDC website for more information on HCV testing, diagnosis, and treatment: https://www.cdc.gov/hepatitis/hcv/index.htm
- Fentanyl: Methamphetamine and other stimulants are sometimes adulterated with fentanyl, an opioid that is 50 times as strong as heroin and that can dramatically increase one’s risk of a drug overdose. Fentanyl test strips can be used to test substances before they are ingested to determine the presence of fentanyl and to ensure that participants take steps to avoid overdose. Visit the National Harm Reduction Coalition’s website to learn more about drug use safety related to fentanyl: https://harmreduction.org/issues/fentanyl/fentanyl-use-overdose-prevention-tips/.

References

Brooks VR. *Minority stress and lesbian women.* Lexington, MA: Lexington Books; 1981.

Crenshaw, K. (1991). Mapping the margins: Identity politics, intersectionality, and violence against women. *Stanford Law Review*, *43*(6), 1241-1299.

Levitt, H. M., & Ippolito, M. R. (2014). Being transgender: Navigating minority stressors and developing authentic self-presentation. *Psychology of Women Quarterly*, *38*(1), 46-64.

Meyer, I. H. (1995). Minority stress and mental health in gay men. *Journal of Health and Social Behavior*, 36, 38-56.

Meyer, I. H. (2003). Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: conceptual issues and research evidence. *Psychological Bulletin*, *129*(5), 674-697.

Reback, C.J., & Shoptaw, S. (2014). Development of an evidence-based, gay-specific cognitive behavioral therapy intervention for methamphetamine-abusing gay and bisexual men. *Addictive Behaviors.* 39(8): 1286-1291.

Reback, C.J., Veniegas, R., & Shoptaw, S. (2014). Getting Off: The development of a model program for gay and bisexual male methamphetamine users. *Journal of Homosexuality.* 61: 540-554.

Shoptaw, S., Reback, C.J., Peck, J.A., Yang, X., Rotheram-Fuller, E., Larkins, S., Veniegas, R.C., Freese, T.E., & Hucks-Ortiz, C. (2005). Behavioral treatment approaches for methamphetamine dependence and HIV-related sexual risk behaviors among urban gay and bisexual men. *Drug and Alcohol Dependence, 78,*125–134.

Shoptaw, S., Reback, C., Larkins, S., Wang, J., Rotheram-Fuller, E., Dang, J., & Yang, X. (2008). Outcomes using two tailored behavioral treatments for substance abuse in urban gay and bisexual men. *Journal of Substance Abuse Treatment*, 35(3): 285-293.