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Building Program Acceptability: Perceptions of Gay and Bisexual Men on Peer or Prevention Case Manager Relationships in Secondary HIV Prevention Counseling

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Abstract

There is growing interest in integrating HIV prevention counseling for HIV-infected gay and bisexual men into HIV primary care. HIV-infected peers and professionally trained prevention case managers (PCMs) have been used to provide prevention counseling services. The current qualitative study seeks to examine participant perceptions of the acceptability of HIV-infected peer counselors and of trained prevention case managers from the perspective of 41 HIV-infected gay and bisexual men. Semi-structured interviews were conducted with HIV-infected men who were currently receiving primary HIV health care. Positive peer counselor themes included shared experiences *and* para-professional. Positive themes specific to the PCM relationships included were provision of resources *and* professional skills and knowledge. Common themes identified across both peer and PCM counselor relationships were creating a comfortable environment, non-judgmental stance, *and* rapport building/communication skills. Recommendations for HIV secondary prevention interventions are presented.

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Keywords

secondary HIV prevention; peers; prevention case management; gay and bisexual men

INTRODUCTION

HIV infection in the United States continues to disproportionately impact gay and bisexual men. In 2005, approximately 19,620 men who have sex with men (MSM) were diagnosed with HIV/AIDS, which is an increase of 11% from 2001 (Centers for Disease Control and Prevention [CDC], 2006). With advances in HIV treatment, individuals with HIV are living longer and, accordingly, we now see a large and growing population of HIV-infected gay and bisexual men. In the United States, men who have sex with men (MSM) continue to be the highest at-risk group, accounting for 49% of estimated new HIV cases (CDC, 2006). As of 2005, the CDC estimates that approximately 231,800 MSM are living with HIV. As a result of these alarming statistics, recent government policy initiatives (Health Resources and Services Administration [HRSA], 2005) and behavioral research recommendations (Kelly et al., 1997; Koester et al., 2007; Morin et al., 2004) have emphasized the need to integrate HIV prevention with HIV primary care in order to build the effectiveness and acceptability of HIV prevention programs particularly for high-risk individuals. In order for such interventions to have a public health impact, it is critical that HIV-infected gay and bisexual men are provided with acceptable and tailored prevention/care services to help them manage living with a chronic illness and to maintain safer sexual behaviors to prevent HIV/STD acquisition and transmission.

Crepaz and colleagues (2006) conducted a meta-analysis of 12 existing prevention interventions for HIV-infected individuals, and found them to be generally efficacious. However, only 5 of the studies had statistically significant results, and interventions utilizing trained health care providers or professional counselors fared better. The studies in this meta-analysis did not directly compare the relative efficacy of programs that used peers to those that used trained professionals. Importantly, evidence is emerging for the efficacy of interventions that utilize peer interventionists (Margolin, Avants, Warburton, Hawkins, & Shi, 2003; Rotherman-Borus et al., 2001).

Specific demonstration studies on the implementation of prevention interventions for HIV-infected individuals within clinic settings suggests that peer-led interventions and prevention case management (PCM) models may be effective strategies in reducing high-risk behaviors (Koester et al., 2007; O'Cleirigh et al., 2008). Secondary prevention programs targeting HIV-infected individuals have resulted in significant changes in risky sexual and injection drug use behaviors (Kalichman et al., 2001; Margolin et al., 2003; Rotheram-Borus et al., 2001). However, research on intervention components that address the acceptability of such programs is limited.

HIV-infected peer interventionists have specific potential advantages regarding providing social services to HIV-infected clients. First, it has been suggested that the use of peer interventionists may help participants feel understood and cared for in medical care settings (Raj et al., under review). This may be particularly important to gay men when talking about sensitive sexual information in the context of HIV infection. They also may be more likely to be perceived as credible, trustworthy, and empathic (French, Power, & Mitchell, 2000; Latkin, Sherman, & Knowlton, 2003). In this way the use of peer interventionists may support both the efficacy and effectiveness of secondary prevention interventions.

The CDC has supported PCM as a model for HIV-infected patients (CDC, 1997). Prevention case management is designed to be implemented by trained, professional case managers or medical social workers. Accordingly, prevention counseling is integrated or paired with the provision of case management services to address psychosocial, financial, or legal issues. These additional issues can impact HIV risk behavior, and the counselor can focus on helping patients with referrals and accessing services. Research on the efficacy of PCM is in its infancy. However, several demonstration studies provide some initial evidence of the effect on reducing high-risk sexual behaviors and lowering incidence of sexually transmitted infections (STIs) (e.g., Gasiorowicz et al., 2005; Rollison, Higginson, Mercier, & Weir-Wiggins, 2002; Sebesta, Marx, & Liu, 2006).

The standard in establishing an evidence base for an intervention is to implement a successful randomized controlled efficacy study. Randomized controlled efficacy studies for HIV prevention focus on HIV transmission behaviors or HIV incidence as outcomes. Several HIV-related studies have been proven to be efficacious and acceptable in changing HIV risk behaviors among gay and bisexual men (Bowen, Williams, Daniel, & Clayton, 2008; Dilley et al., 2007; Spielberg, Branson, Goldbaum, Kurth, & Wood, 2003). However, many interventions that show efficacy do not get picked up in service organizations. In randomized control trials, less attention is paid to the experience of the participant per se as an outcome, in terms of their preferences, such as interventionist type. Looking at the participants' perspectives is important in terms of extending these interventions into real-world settings, because characteristics of counseling interventions (e.g., participants' perception of their counselor) may play a role in the actual implementation of intervention in settings that provide HIV care or HIV-related services.

The purpose of the present study was to examine the relative acceptability of a multi-session intervention delivered by peer counselors and prevention case managers from the participants' point of view as current standards of HIV-related care do not consistently address prevention. This analysis was undertaken with a subsample of HIV-infected gay and bisexual men who participated in secondary prevention interventions. The interventions were similar in content, but one had trained HIV-infected peers as counselors and the other had trained (master's-level) prevention case managers as counselors. Both were implemented at the clinic level, where participants were receiving primary medical care. We sought to characterize the participants' experience of these relationships so as to inform the relative acceptability of the respective interventions. This is the first study of which we are aware to examine the acceptability of these differing relationships concurrently and to do so in a sample of HIV-infected gay and bisexual men.

METHODS

Study Design

The present study is based on two parallel secondary HIV prevention studies targeting HIV-infected gay and bisexual men, both of which are referred to as "Project Enhance." The first is a peer-led demonstration project funded by the Health Resources Services Administration (HRSA), and the other a randomized controlled trial funded by the National Institutes of Mental Health (NIMH) and facilitated by a medical social worker. The study comprised9 sessions, which lasted approximately 50 minutes and took place over a 12-month period. The intervention sessions were guided by a client-centered workbook which contained topics relevant to the needs of HIV-infected gay and bisexual men (e.g., HIV disclosure, managing stress, party drugs, and getting the relationships you want). The workbook was developed by the research team using the Information, Motivation, Behavior Change model (Fisher, Fisher, Williams, & Malloy, 1994).

The two intervention counseling roles were conceptualized differently. The medical social work role was conceptualized as an "enhanced" PCM model. The PCM model included both case management services and prevention counseling. This model utilized a randomized approach targeting high-risk HIV-infected gay and bisexual men. Both prevention case managers held master's degrees and between had 5 to 8 years' experience in conducting behavioral counseling. In contrast, the peer counselor intervention did not include case management. The men in this group reported engaging in either high-risk or non-high-risk HIV-related behaviors. The peer counselors themselves have been living with HIV for 3 to 10 years. Two of the peer counselors had limited formal education while one had a Bachelors of Science degree. Of the three peer counselors, only one had any previous HIV-related counseling experience. However, counselors from both the peer and PCM model all received the same behavioral counseling training prior to the implementation of intervention. Further details of the methods and conceptualization of the intervention are published elsewhere (Knauz et al., 2007).

Data for this study were obtained from qualitative exit interviews. The interviews took place within first three months of enrollment. More specifically, interviews occurred after the fourth (final) intervention session and prior to a three-month follow-up session. A set of semi-structured open-ended questions was used to guide the interview. The guide contained questions that explored participants' perceptions of their relationship with their counselor. All participants were asked the following questions in addition to probing questions: (1) "Tell me about your experience in the program." (2) "What was your relationship like with your counselor?" (3) "Were there any specific characteristics of your counselor that shaped your experience?" and (4) "In what ways was the relationship helpful or not helpful?" The interviews lasted anywhere between 30 and 75 minutes. Participants received an incentive of either $25 cash or a $25 gift card.

In order to minimize bias, interviews were conducted by trained interviewers who were not the participants' primary counselor. All interviews were audio-recorded, transcribed verbatim (striking out any unique identifiers), and reviewed for quality assurance purposes. All study procedures were reviewed and approved by the institutional review board at Fenway Community Health.

Sample

A purposive sample of 41 HIV-infected gay and bisexual men (peer = 18, prevention case management = 23) who represent each of the two groups were approached and invited to complete face-to-face exit interviews. Table 1 lists participant demographics. Participation in the exit interview was optional. Interested participants met with Project Enhance staff to learn about this opportunity. The inclusion criteria included participants who (1) are HIV infected, (2) are over 18 years of age, (3) completed at least the first four intervention sessions, (4) are involved with primary HIV-related care, and (5) signed the informed consent.

Data Analysis

NVIVO software was used for data management and organization. A grounded theory approach was utilized for data analysis, which allowed for the "discovery" of meaning without any prior assumptions (Strauss and Corbin, 1990). To ensure authenticity, accuracy of data interpretations and for quality control, strategies to ensure rigor were implemented (Padget, 1998). First, prior to implementing the coding process, all exit interview transcripts were reviewed by multiple coders for quality purposes. This involved listening to the audio-recorded session while following along with the transcribed material. Second, a total of three individuals from the research team independently conducted open coding of the transcripts,

which resulted in the identification of initial categories and themes related to participant perceptions of peer and medical social work counselors. Third, a preliminary codebook which contained the initial codes and definitions was developed. Prior to the final analysis, conversations among the coders occurred in order to address any discrepancies in one another's findings. Consultation among the coders occurred until they agreed on the final coding system and standardized code definitions. All transcripts were coded based on codebook codes and definitions, which were modified on an as-needed basis. Last, to address inter-rater reliability and reduce coder bias, multiple coders were used to enhance accuracy of the conversational text (Denzin, 1978). This iterative process allowed the study team to identify and detect patterns, themes, experiences, and concepts relevant to the phenomenon under investigation.

RESULTS

Themes related to HIV-infected gay and bisexual men's acceptability of their counselors are described below. Accordingly, we first describe responses regarding both types of counselors, and then describe themes that emerged from participants who had trained professional prevention case managers as counselors, followed by themes from participants who had peers as counselors.

Themes Related to Participant Acceptability That Emerged Across Both Types of Counselors

Comfortable environment—A component of Project Enhance addressed sexual health as it relates to gay and bisexual men living with HIV. Participants who had HIV-infected peers as counselors and those with professional prevention case managers were appreciative of the way in which the counselors made them feel comfortable within the context of these sessions. A medical social work participant expressed the following:

> I never felt like I couldn't talk to her about anything. And, you know, if I had any issues or anything, I would have felt comfortable bringing it up to her and talking to her about it. If I knew that there was a problem I would have able to talk to her about it.

Similarly, a peer participant had the same experience.

> He (counselor) explained everything to me. We made lots of eye contact; I liked the eye contact. He made me comfortable, where I could just talk to him about anything.

Non-judgmental stance—HIV-infected gay and bisexual men in the study discussed both their sexual and drug use behaviors with their counselors. Some of the discussions involved behaviors in the past that could have resulted in infecting someone else with HIV. Participants discussed their appreciation of the counselor's non-judgmental approach when these discussions occurred. A medical social work participant stated,

> I enjoyed coming to talk to him (counselor). He was very polite and he heard some of my darkest things and did not give me a shocked look on his face. So, I enjoyed it.

Another medical social work participant described his experience by not being afraid to be open and honest with his counselor about his behaviors by stating,

> It was still kind of nice to just have someone to talk to who you know has a lot of experience in this field. And like I said, she was very easy to talk to, and I think very approachable. And I didn't feel like I had to really hold anything back with

> her. Like, I felt like I could say anything and I wouldn't be embarrassed, or you know; feel like I had to sugar coat anything. So it has been a good experience.

Similarly, peer participants experienced the same thing regarding non-judgmental attitudes of their counselors. One peer participant reported,

> He [counselor] seemed very open and he didn't seem confrontational or judgmental or he didn't come into this with any preconceived notions or anything.

Rapport and communication skills—Participants who had trained prevention case managers and those with HIV-infected peer counselors discussed rapport and communication skills of their counselors as being important and positive aspects of the intervention approach. One medical social work participant put it this way:

> We had a really good rapport. I really liked my counselor. I really liked working with him because he was funny and our conversations felt more just like that, conversations. It wasn't really forced and he kind of went with the flow like wherever the direction took us. He was very easy to talk to.

In addition, remembering and recalling facts from previous sessions was discussed. A medical social work participant stated,

> Um, he's very well, he's very, um, like I said, throughout the four weeks that I came in, it wasn't like it was a big catch-up on what I had spoke about last week. He seemed to remember everything that we went through without having to, without me having to feel like, you know … he must have spoken to about 30 other people [during] the week and I didn't have to refresh him. And so, he was very easy to deal with in that way.

A peer participant expressed that his counselor was so skilled at listening that he could have been a licensed therapist. He stated,

> So evidently he is good at whatever he does, because I mean, I wouldn't even know that he's not a licensed therapist. He seemed to know a lot. And he has very good listening skills. And then being able to show empathy and rephrase what you have said. To me, it means … that's a skill. How to listen to people and how to talk to people.

Themes Related to Participant Acceptability from Participants Who Saw Trained Professional Prevention Case Managers

Provision of resources—Several medical social work participants expressed that their counselors were proactive and helpful in assisting them with meeting their case management needs, including community resources. One participant described his experience by stating,

> I think he has done a lot of work as far as like helping me start going to the crystal meth group; I've started doing acupuncture through his advice, suggestions. A bunch of different things that he has suggested I've been able to follow up on.

Providing case management in a proactive way was also identified. One participant stated, "Well, when I had to get things done, I think she did follow through. It was actions, not just saying. I mean, there were results I guess." In contrast, a participant felt empowered by his medical social worker:

> I liked that she gave me information. She didn't hold my hand. She said, here's the information, you should call this number and check. I didn't want her to do everything for me, but she, I really got motivated enough to do what I was supposed to do by myself.

Professionally skilled—Although the intervention was not considered formal therapy, many participants felt as if it was, given the skills of their counselors as well as what they took from the experience. One participant said,

> It was helpful because I think in a way his skill has allowed me to answer the questions on my own. You know what I mean? He put it in a way that was easy for me to answer. I feel comfortable being honest.

Participants also discussed experiencing a sense of compassion from their trained prevention case managers. For example, one participant said,

> I think she's certainly qualified, and knew exactly what she was doing, and was, you know, very professional. But at the same time, there's warmth that came across with her.

Another participant who was experiencing some suicidal ideation verbalized,

> He (counselor) was concerned. He actually didn't want me to leave. He gave me a couple of options, you know, meeting with some therapist, whatever, and I met with his boss and we actually came up with a plan. It was a Friday, we came up with a plan for the weekend and for me to come back and meet with him on Monday. So I saw that he was concerned.

Gender—The PCM component of Project Enhanced had two medical social work staff; one male and the other female. Some study participants expressed initial concern about having a female counselor with whom they would be discussing their sexual health while others felt it was easier to have a female counselor. One participant expressed,

> I don't have an issue with it now [referring to female counselor]; I'll tell her anything she needs to hear. I don't think there's anything anyone can do about it. I mean, she's perfectly qualified and I enjoy talking to her and telling her stuff. I don't feel uncomfortable now. It's just that initial hesitation, oh my God, I got to tell a woman … because you know … I definitely have things that I certainly don't tell a lot of my good friends. So for me to tell a woman, I was kind of hesitant.

Contrary to some initial resistance to working with a female counselor, a number of participants were open to the idea. This was supported by a number of comments from participants.

> There was a gender difference as well you know. But, I was perfectly comfortable with her. … I was never uncomfortable with her.

> But when I met my counselor, I was glad it was a woman and not a gay man. I have good relationships with women.

Themes Related to Participant Acceptability That Emerged from Participants Who Had HIV-Infected Peer Counselors

Age—Peer participants identified the concept of age as a potential barrier to the counseling relationship. Some felt that the larger the age gap, the less likely they would be able to relate to their counselor. However, the majority of participants who discussed age had an overall good experience. For example, one participant stated,

> I don't think we're the same age, but you know, the same age bracket, I guess. That was helpful. Not somebody that's too young and inexperienced or too old, and maybe a little bit out of the loop.

The participant followed up by expressing, "Not to say that I wouldn't have been as comfortable, but I think it's just easier talking to somebody that is in your age bracket."

Although age differences may be a factor in the client-counselor relationship, it does not always lead to an ineffective counseling relationship. This was supported by a peer who stated,

> I think that he tries to be helpful, which is nice from anyone. And, aaah, it was a good experience. I mean, he's younger than I am. I'm sure he's a lot younger than I.

Although age of the peer counselor is important, having a reciprocal relationship where both parties self-disclose appeared to be one of the biggest drivers of the participant-counselor relationship.

Shared experiences—Traditional client-counselor relationships have well-defined boundaries. In the Project Enhance study, the boundaries between the participant and the peer counselor were flexible, allowing for reciprocal self-disclosure of specific information relevant to the study. These shared experiences encapsulated not only having a peer counselor with the same HIV-positive status, but also having similar lived experiences as an HIV-positive gay man. The majority of peer participants commented on the shared life experiences they had in common with their counselors. For example, a peer participant expressed,

> Well, I liked the fact that he was willing to share a little bit about himself as well, so it wasn't like he was just here to record and ask questions. That wouldn't have worked for me because I could do that over the phone or with a tape recorder. So I liked the fact that he was willing to kind of share parts of himself as well, and at least bring to the table the commonalities which did create a sense of ease.

Even having knowledge of the peer counselor's HIV status was beneficial and helped establish a working relationship. "I was glad that he shared some of his experiences. I was glad that he said that he was in the same boat as me in terms of being HIV positive." This was supported by another participant, who stated, "Uh, and because he's also HIV that helps a lot." Similarly, some participants stated that a benefit beyond knowledge of their counselors' HIV status was the interactive conversations that took place. One participant said, "I guess the tacit agreement that we shared certain aspects of ourselves, experiences, maybe gave the relationship a certain quality." In addition, another participant held the same thought by expressing,

> When you're telling somebody that, you've had this experience, and they say, yeah, I've actually had that too, and this is how I deal with it, or this is what happened in my situation, that's helpful. It's spontaneous and genuine.

Para-professional—Oftentimes, peer counselors are identified as para-professionals because they are trained to provide individual support/counseling without having a professional license. In relation to Project Enhance, the para-professional identity allowed peer counselors flexibility in their working relationships and to implement skills often associated with licensed professionals. Several participants identified the skills and compassion brought forth by peer counselors. One participant expressed,

> I just felt a connection to him. He was a caring person; a very compassionate person and I felt that that's somebody that I would love to have around me all the time. I felt that it wasn't just a counselor.

In referencing the professional credibility of the counselor, a participant stated,

> I think the sort of one-on-one conversations were good. It was sort of like therapy but then not because I knew that this person didn't have a PhD or LSCSW or whatever. Also, unlike therapy, I could ask him questions.

Similarly, another participant verbalized,

> You know, whether he was a therapist or not a therapist, I didn't even know. I wouldn't have even known. So evidently, he's good at whatever he does.

DISCUSSION

This is the first study of which we are aware that examines HIV-infected gay and bisexual men's experience of their relationships with peer or prevention case managers in secondary HIV prevention counseling services. Our findings show that participants responded very positively to both peer and prevention case management relationships. However, several emergent themes differentiated the participants' experience of the two interventionists.

Although participants from both intervention types identified counselor demographics as a key element, these characteristics differed. Peer participants saw age as an initial barrier to the therapeutic relationship. A number of participants expressed concerns that their peer counselors were too young. This suggests that participants felt that their peer counselors were unrelatable and inexperienced. This is not surprising considering the cultural norm within the gay community that divides younger and older cohorts of gay and bisexual men. Although age was an initial concern for many peer participants, they continued with the intervention and were able to find the benefits of working with a younger peer counselor. Contrarily, participants who were closer in age to their peer counselors found it easier to establish a working dynamic, indicating they could better relate. Although age was an initial concern for some, self-disclosure on behalf of the peer counselor was a bigger driving force behind their relationship.

In contrast to the peers' perceptions on age, participants involved with PCM were concerned about the gender of their counselor. One female prevention case manager worked with a number of PCM participants. Those working with the female counselor were initially resistant and unsure of this working relationship. Again, this suggests that a female counselor is unable to relate to gay or bisexual men. As a result of this stereotype, several participants were hesitant to continue with the intervention, as they felt it would be easier to relate to a male counselor. Based upon self-reports, the initial resistance gave way to acceptance, which helped facilitate a working participant-counselor relationship. Although it was the participants' preference to work with a male counselor, those who ended up with a female counselor expressed that they found benefit in working within this dynamic, as it actually made the conversations easier than expected. Gender was not an issue within the peer model; all peer counselors were male, making it challenging to compare the two interventions.

Similar to other peer-led studies, peer participants in the current study expressed an appreciation of the flexible boundaries between the participant and counselor illustrated by the mutual sharing of personal information related to living with HIV/AIDS. Less rigid boundaries may enable peers to be perceived as more credible and more influential as they can relate on a cultural level (Dickson-Gomez, Weeks, Martinez, & Convey, 2006). This finding is consistent with results reported by both Raj and colleagues (under review) and French and colleagues (2000).

Implications of having more flexible boundaries in terms of the intervention content and levels of self-disclosure, which was possible with the peer interventionist, ought to be noted.

One is that the peer counselor has to be comfortable with the level of information being shared, as participants are not bound by confidentiality agreements. Second, the level of disclosure on behalf of the peer counselor may somehow empower participants to feel more comfortable sharing their own stories. Last, this level of flexibility may be contradictory to other counseling experiences the peers may have participated in making it challenging to initially engage in this level of flexibility. Peer participants in turn may become a bit confused and see this dual relationship as more of a friendship versus a working relationship. These findings underscore the importance of self-disclosure within the peer intervention model but with the intent that all information will be kept confidential if it is within legal parameters.

Although many peer participants appreciated the open dialogue between them and their peer counselor, contrary to this model, participants involved with PCM appreciated the professional skills of their counselors. In that, this model had a more structured therapeutic approach where the boundaries and the role of the counselors were clearly defined. The skills that illustrate this level of professionalism included the ability to conduct a crisis intervention, assessment, as well as listening and reflecting skills. All of these are important elements in the counseling profession. Implications of this model indicate that self-disclosure on behalf of the PCM is not a concern. This is based on the more traditional patient-professional relationship. This is contrary to the peer model, where self-disclosure on behalf of the peer counselor can be a concern.

In addition to the professional role of the PCM, participants responded very positively to the dual role of case manager and counselor. This comprehensive approach underscores the need for a service delivery model that integrates issues of sexual health into basic, but proactive, case management. Participants were appreciative of the prevention case manager's knowledge of community resources (e.g., dental programs, housing support programs, local mental health referral). In addition to having knowledge of resources, participants expressed an appreciation of the proactive role of their prevention case manager in fulfilling their case management needs. A number of participants expressed that the medical social workers were highly skilled and came across as experienced counselors. Consistent with this theme, many participants reported deriving therapeutic benefit from their sessions with their prevention case manager based on their working relationship. The integration of case management with HIV prevention provides an opportunity for the participants to not only address multiple needs at once, but to do so in a safe environment with skilled professionals. Participants frequently have competing basic needs and, as a result, sexual health-related needs often go unaddressed. More importantly, social service systems can be complicated, demanding, and difficult to navigate. As part of the prevention case management role, it is critical to empower participants to become familiar with, and knowledgeable about, available community resources while at the same time addressing their sexual health-related needs. This finding highlights the importance of training case managers not only with basic assessment skills and knowledge of resources but with basic counseling and behavior skills training.

Participants expressed several themes across both interventionist types. The majority of the participants expressed not having an opportunity to have conversations with their peers or case managers on the subject of sexual health prior to their involvement in the program. This suggests that among HIV-infected gay and bisexual men, prevention counseling services may provide a unique and important opportunity to address sexual health and safer sex issues that are not otherwise addressed by other informal/formal supports. Several common themes were specific to counselor engagement. Participants reported that they found it easy to engage with counselors who created a comfortable/empathic environment and took a non-judgmental approach, which led to open and productive conversations specific to sexual

health and current sexual behavior. Historically, HIV-infected gay and bisexual men have experienced various forms of oppression even within the health care system, and providing the opportunity to discuss potentially stigmatizing topics is empowering and good for their overall mental and sexual health.

A second common theme referenced was the counselors' communication style. A number of communication skills were identified, including the following: active listening, flexibility in the direction of the conversation, and rephrasing and recalling details from previous sessions. Participants from both intervention groups reported having appreciated nonverbal skills including eye contact, attentive posture, and maintaining an interest in the conversation. The counselor's communication and engagement skills identified by the participants are basic counseling skills common to many therapeutic systems including social work training and general supportive therapy training (e.g., Mattaini, Lowery, & Meyer, 1999). These skills have also been identified as important for building credibility of peer-delivered, health-related messages in other patient populations (Brownstein, Cheal, Ackerman, Bassford, & Campus-Outcalt, 1992).

The findings from this analysis are most appropriately interpreted in the context of the studies' limitations. Although qualitative data provide rich and detailed information about the topic under investigation and may provide a useful guide for future hypothesis testing, the limited sample size warrants caution when generalizing these findings to other groups. Although participants were sampled across two prevention studies, it is possible that there may be additional peer counselor and prevention case manager characteristics that were not captured, as participants were drawn from one specific urban clinic.urthermore, we were unable to compare the relative acceptability of the intervention based on counselor type, as we did not randomly assign participants to a peer counselor or PCM.

In conclusion, the results of this qualitative analysis suggest that the participants experienced their relationships with both peers and prevention case managers very positively. It is also important to underscore and reconfirm the importance of involving HIV-infected consumers in the development of prevention interventions, as their voice gives guidance to the acceptability of such interventions. These findings may provide some guidance in the development and delivery of secondary prevention interventions tailored to the needs of HIV-infected gay and bisexual men within the context of a health care setting. Implications of these findings suggest that as a result of the high number of clients that most case managers have on their caseload a hybrid model utilizing both peers and prevention case managers could be of benefit in designing prevention interventions within the care setting. This hybrid model approach could capitalize on the merits of both intervention types. The use of peer interventionists may also contribute to cost-effectiveness of prevention programs, which may in turn support their sustainability in primary care and other community settings.

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TABLE 1

Participant Demographics ($N = 41$)

Characteristics	Mean (SD) or Number (%)	
	Peer ($N = 18$)	**Medical Social Work ($N = 23$)**
Age	46.1(9.8)	41.8(8.7)
Race		
Black/African American	2(11.1%)	2 (8.7%)
Hispanic/Latino	1 (5.6%)	3(13%)
White	15(83.3%)	18(78.3%)
Education		
High school or less	5 (27.8%)	3(13%)
Some college	7 (38. 9%)	10(43.5%)
College graduate	2(11.1%)	7(30.4%)
Graduate degree	4(22.2%)	3 (13%)
Number of months living with HIV/AIDS	146.7(85.8)	57.3(58.6)
Relationship status		
Single	7 (38. 9%)	15(65.2%)
Partnered	11(61.1%)	8(34.8%)