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Adapting an HIV/STDs Prevention Curriculum to Fit the Needs of Women With Alcohol Problems

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Abstract

Alcohol and drug dependent women are at increased risk for HIV/STDs. This paper discusses how a prevention curriculum, "Safer Sex Skill Building" (SSB), designed to reduce the contraction of HIV/STDs among drug-abusing women, could be modified to fit the needs of alcohol-abusing women in a residential treatment program. Authors modified the SSB by incorporating feedback from expert consultants as well as by engaging study participants in revising the therapy manual in order to create a curriculum that speaks to participants' experiences. Specific steps to assist those who would want to adapt an empirically-based manual-driven treatment intervention are provided.

Keywords

HIV/STDs prevention curriculum; sexual risk behaviors; women; alcohol problems; curriculum adaptation

Research has greatly improved the knowledge base on the etiology and treatment of addiction, however, the transfer of this information into community settings has been slow. Social workers can play an important role in bridging this gap by testing the effectiveness of newly developed interventions in different community contexts and by helping to develop new research questions. The social work person-in-environment perspective offers a valuable contribution to translational research. This article reports on the first phase of a NIAAA funded study that modified an effective HIV/STD prevention intervention to fit a new population and tested it in a new setting. It includes specific steps to assist the reader who wants to adapt and test an empirically-based manual-driven treatment intervention.

One research gap in the field of women's health has been the lack of effective interventions for addressing the increased incidence of HIV/STDs that are associated with sexual risk behaviors. Alcohol and drug dependent women are at increased risk for psychological and medical problems, including HIV/STDs (Des Jarlais et al., 2007; Latkin, Curry, Hua, &

Davey, 2007). Currently, the most effective methods for slowing the spread of HIV/AIDS target changes in sexual and intravenous drug use behaviors, which transmit the virus from one person to another (NIAAA, 2002). While participation in substance abuse treatment has been found to be effective for reducing HIV/STD risks related to substance use and abuse (Metzger, Navaline, & Woody, 2000; Sorenson & Copeland, 2000; Woods et al., 1999), research to date has demonstrated a relatively low success rate with regard to reducing sexual risk behaviors in this population (Calsyn, Saxon, Freeman, & Whittaker, 1992; McCusker, Stoddard, Zapka, & Lewis, 1993).

One evidence-based approach (CDC, 2009; Tross et al., 2008) is “Safer Sex Skill Building” (SSB), a manual-driven 5-session group HIV/STD prevention intervention that was designed for female drug users (El-Bassel & Schilling, 1992; Schilling, El-Bassel, Schinke, Gordon, & Nichols, 1991). It includes role plays and hands-on practical activities that focus on developing skills to reduce sexual risk behaviors and to negotiate condom use. A recent multi-site clinical trial funded by the National Institute on Drug Abuse (NIDA) through the Clinical Trials Network (CTN) found it to be effective in reducing sexual risk behaviors of women at 6 month follow-up (Tross et al., 2008).

The NIDA CTN study, and the original SSB study by social workers at Columbia University (Schilling et al., 1991; El-Bassel & Schilling, 1992), focused primarily on women in outpatient treatment for drug use disorders. Although alcohol is frequently a co-morbid condition, much less attention has been paid to its role in promoting patient engagement in sexual risk behaviors. Therefore, researchers from Addiction & Women’s Health: Advancing Research and Evaluation (AWHARE) adapted the SSB intervention to explore its effectiveness for women with alcohol use problems in a different setting (residential treatment). The target population was primarily African American, low income women at high risk for HIV/AIDS. The project was divided into two phases. In Phase 1 the AWHARE team adapted the SSB to include alcohol content by revising the treatment manual and piloting this enhanced curriculum (SSB+A). Focus groups were used to gather feedback from study participants about the SSB+A curriculum and the need for further improvements. In Phase 2, the AWHARE team conducted a small randomized clinical trial (RCT) of SSB +A in a residential substance abuse treatment setting with women reporting Alcohol Use Disorders (AUDs) and recent sexual risk behaviors. This article reports Phase 1 data.

BACKGROUND

Risky Sexual Behavior as an HIV/STD Risk

Heterosexual transmission is becoming the fastest growing mode of contracting HIV among women, especially alcohol- and drug-dependent and minority women (Amaro, Raj, & Reed, 2001; Cohan, 2003; Pulerwitz, Gortmaker, & DeJong, 2000; Theall, Elifson, Sterk, & Klein, 2003). African American women with and without alcohol and drug use problems have a 10–15 times greater risk of HIV infection than do white women (Williams, Ekundayo, Udezulu, & Omisbakin, 2003). African American women’s greater likelihood of having sex with a man who has multiple partners, rather than their own rates of partner change, is cited as a reason for the different rates (Eriksen & Trocki, 1994). While reasons for higher risk status among women in general are complex, what is clear is that culture and power dynamics influence women’s HIV risk through lower education, lower income, and less power in the partner relationship (Amaro & Raj, 2000).

Sexual risk behaviors exhibited by alcohol- and drug-dependent women substantially increase their likelihood of contracting HIV and other STDs. Impulsivity and trading sex for drugs are often cited as reasons for risky sexual behaviors, as well as being in a relationship with an abusive, drug-using, or HIV-infected partner (Schilling, El-Bassel, Gilbert, &

Glassman, 1993). A history of alcohol use has been related with a lifetime tendency toward high-risk sexual behaviors, including multiple partners, unprotected intercourse, sex with high risk partner, and the exchange of sex for money or drugs (Boscarino et al., 1995; Malow, Dévieux, Jennings, Lucenko, & Kalichman, 2001; Tross et al., 2009; Windle, 1997).

In their review of 42 studies, Cook and Clark (2005) found associations between problem drinking and STD risk across a variety of populations, concluding that alcohol consumption may increase STD risk by: Influencing behavior, changing perceived sexual arousal, or negative effects on the immune system. In a review of studies of specific drinking events, Weinhardt and Carey (2000) concluded that women have a greater likelihood of drinking prior to having sex with a less-well-known partner than do men. The reasons for the association between alcohol and risky sexual behaviors may be alcohol's impact on the brain to reduce inhibitions and diminish risk perception and a belief that alcohol enhances sexual arousal and performance (Cooper, 2002; Dermen & Cooper, 2000; George, Stoner, Norris, Lopez, & Lehman, 2000; MacDonald, MacDonald, Zanna, & Fong, 2000). While alcohol influences risky sexual behavior and the likelihood of HIV infection, it also influences the consequences of HIV infection including: 1) patient delays in testing and initiating treatment; 2) hastening the progression of the disease to full blown AIDS through its influence on medications used to treat HIV; and 3) patient non-compliance with treatment regimens (Bryant, Nelson, Braithwaite, & Roach, 2010).

HIV Prevention Programs

Alcohol and drug treatment and HIV/AIDS prevention programs have helped reduce risks of HIV associated with substance use behaviors (Metzger et al., 2000; Woods et al., 1999), yet programs aimed at sexual risk behaviors for substance abusing populations have had mixed results (Prendergast, Urada, & Podus, 2001). In a survey of 250 at-risk women, Sterk and colleagues (2003) found that drug using women reported significantly lower levels of condom use efficacy than nonusers. Research also cited reluctance to initiate discussions of sexual behavior or condom use with male partners as a factor associated with HIV risk. Barriers to women's ability to negotiate safer sex include lower social status and economic dependence on men; value placed on relationships; cultural imperatives not to appear knowledgeable about sex or to know their partners' sexual history; and fear of relationship conflict or violence (Amaro, 1995; O'Leary, 2002; Pulerwitz et al., 2000). Alcohol and drug dependent women with abusive partners are an especially vulnerable group. Further, there is a large health disparity and critical need for health services, including HIV/STD prevention and substance abuse treatment, for high-risk groups including African American women in whom rates of infection are at epidemic levels. African American females comprise 13.9% of the U.S. female population yet account for over 60% of all AIDS cases among women in the U.S. (Williams et al., 2003).

A survey of community-based drug treatment programs participating in the NIDA Clinical Trials Network (CTN) found most programs offered HIV education/intervention that often consisted of a brief (90-minute) single-session HIV education module presented in a lecture format. Such methods showed little or no change in sexual risk behaviors reported by women at follow-up (cited in Tross et al., 2008). Further, results indicated that HIV awareness was not an issue, as women demonstrated understanding of HIV risks and methods to reduce the probability of HIV infection. Rather, socio-cultural and contextual factors were reported as barriers to condom use and sexual negotiation (Exner, Seal, & Ehrhardt, 1997).

Subsequently, investigators sought to develop interventions that incorporated socio-cultural and contextual factors and the issues of power in relationships, including sexual negotiation skills building strategies within a multiple-session, gender-specific format. Such strategies

have shown promise in modifying sexual behaviors (Logan, Cole, & Leukefeld, 2002). In particular, prevention strategies that utilize empowerment approaches with the focus on increasing women's choices and control over sexual decision-making are gaining favor on both individual and community levels.

On an individual level, Theall and colleagues (2003) found that women reporting higher levels of condom use were significantly less likely to describe physical and sexual victimization during the 6-month follow-up period. Further, women in the enhanced intervention condition experienced significant declines in rates of emotional, sexual, and physical abuse. Thus, HIV interventions that enhance sexual negotiation skills may not only reduce HIV/STD risks in women with alcohol and drug problems, but also contribute to reductions in victimization. Similarly, Artz and colleagues (2000) studied 1159 women in a STD clinic and focused on increasingly consistent and correct use of male and female condoms. Participants were primarily African American and single. At 6-month follow up, 79% of participants reported using the female condom at least once, and more than one-third of the women who completed follow-up noted using them consistently.

Safer Sex Skill Building (SSB) Intervention

Safer Sex Skill Building (SSB) is an HIV/STD risk reduction intervention that is female-specific and is delivered over 5 sessions with an emphasis on skills building. SSB attends to female-male power issues, as recommended by Exner and colleagues (1997), by focusing on women's negotiation skills around safer sex and assertiveness training and increasing women's choices over sexual decision-making through male and female condom use skill building. It also addresses the risk of partner abuse through partner abuse risk assessment and safety planning skill building (Tross et al., 2008). Through active problem solving, behavioral modeling, role-play rehearsal, troubleshooting, and peer feedback and support, this intervention builds cognitive, affective, and behavioral skills for safer sexual decision-making and behavior. The 5-session curriculum includes:

Session 1: Coverage of HIV/STD definitions, transmission, testing, counseling, treatment, and prevention.

Session 2: Use of vignettes to discuss internal and external triggers to HIV sexual risk behavior; examination of role of partner (pressure, threats); identification of sources of support and ways of seeking help.

Session 3: Focus on male and female condom handling, insertion and removal; use of SODAS (Stop, Options, Decide, Action, Self-praise) problem solving model to discuss relationship safety, break-up and strain.

Session 4: Use of behavioral modeling to explore and rehearse safer sexual behavior/sexual negotiation tactics and partner abuse risk assessment and safety planning.

Session 5: Review of previous sessions, wrap up, and graduation as well as use of worksheets to summarize cognitive-behavioral techniques for relapse prevention of unsafe sexual behavior.

Purpose of Adapting SSB to Include Alcohol

As stated above, women with alcohol use disorders are at high risk for HIV/STD infection through direct and indirect influence of alcohol on risky sexual behavior and potentially compromised immune function that increases susceptibility to infection. In addition, alcohol is often not seriously addressed as a risk factor in HIV prevention studies, and women who use alcohol in addition to other substances may underestimate the influence of alcohol on their sexual risk behavior (Tross et al., 2009). Furthermore, researchers have recommended that behavioral research needs to address alcohol's role in HIV transmission risk and

therefore HIV prevention programs should target alcohol as well as opiate and cocaine use problems (Bryant et al., 2010).

Previous investigations have demonstrated the efficacy of the SSB intervention in reducing HIV risk behaviors in drug-dependent women in outpatient treatment programs (El-Bassell & Schilling, 1992; Schilling et al., 1991; Schilling et al., 1993; Tross et al., 2008). However, this intervention has not been studied in women with alcohol use disorders. The current study sought to further enhance a gender-specific, skills-building intervention, Safer Sex Skill Building (SSB) to target needs of women with alcohol use disorders in a residential setting. The current study was a therapy development study, which required the participants to receive an adequate “dose” (Rounsaville, Carroll, & Onken, 2001), which is attendance of 3 or more of the 5 sessions for SSB (Tross et al., 2008). The residential treatment setting was chosen because as a controlled environment it could be considered a “laboratory” to test new interventions and provides the necessary dose for this small study where attrition was an important issue.

In addition, the study targeted women who are highly vulnerable to HIV and other STDs: African American, low-income women, many of whom belong to groups with high health care disparities. The AWHARE team enhanced the validated SSB model by adding information and experiential exercises and alcohol-specific contexts to clarify the connection between alcohol and drug use and sex risk behavior. The resultant SSB+A intervention allowed women to create and discuss their personal “alcohol use context,” which assisted them in subsequent goal setting and problem-solving skills practice. The current study will add an important and often overlooked alcohol use dimension to the SSB HIV/STD prevention intervention.

STEPS FOR ADAPTING TREATMENT INTERVENTION

The specific steps taken for the Phase 1 modification were drawn from a frequently cited reference in the field of addiction treatment (Rounsaville et al., 2001) that describes a stage model for development of behavioral therapies. Rounsaville and colleagues noted that the pilot phase is critical in advance of a clinical trial. The present study sought to provide an intervention that included both alcohol and drugs and resonated with the women’s “lived experience.” Objectives of the study were to:

- Develop and pilot test an enhanced curriculum (SSB+A) in a residential treatment sample of women with alcohol use disorders (Steps 1 & 2).
- Obtain qualitative focus group feedback from women who participated in the pilot sessions of the SSB+A in order to further modify and finalize the intervention (Steps 3, 4, & 5) prior to conducting Phase 2 of the study, a small randomized clinical trial comparing SSB+A to a one session standard HIV education group.

Figure 1 depicts specific steps taken for the adaptation.

Step 1: Staff Training and Manual Modification

During the initial startup phase, researchers were trained and certified in delivery of the SSB intervention by the training director for the SSB intervention within the NIDA CTN. Substance use risk behaviors are identified in the SSB manual; however, mention of drug use is more prominent than alcohol use in assessments and participant exercises. Therefore, using methods for manual development (Rounsaville et al., 2001), the AWHARE team, which includes researchers with extensive experiences in developing women’s substance abuse programs and manuals, reviewed SSB materials and identified areas where alcohol context and alcohol awareness supplements were needed. Next, the AWHARE team added

alcohol content to the treatment manual and solicited feedback from three experts in the area of HIV prevention and substance abuse and modified SSB. Modifications occurred in three forms: 1) Addition of three assessment measures focusing on alcohol use - Timeline Follow-back (Sobell & Sobell, 1992), Reasons for Drinking Questionnaire (Zywiak, Connors, Maisto, & Westerberg, 2002), and Alcohol Effects Questionnaire (Rosenow, 1983); 2) Separation of drug use and alcohol use questions to make consideration of alcohol use more intentional than in the current SSB intervention; and 3) Changes in participant exercises. These were as follows:

1. Alcohol risk awareness content was added throughout Session 2 to 5 and the following points were highlighted.
 - a. Risks regarding sexual behavior
 - Alcohol alters perception of risk, problem-solving and decision making ability
 - Alcohol interferes with clear, assertive communication about safe sex practices
 - b. Particular risks for low-income and minority women
 - Epidemiological studies of proportion of alcohol vendors in low income areas and marketing to minority communities and women
 - Statistics on percentage of women with moderate to heavy alcohol use
 - c. Medical risks
 - Alcohol compromises immune function increasing susceptibility to HIV and other diseases
 - Differences in men and women in metabolizing alcohol
 - Risks to fetus of alcohol related birth defects (ARBD)
 - Health care disparities: How and where to access help for alcohol treatment
 - d. Other substance use and mental health risks
 - Depression and violence risks related to alcohol
 - Alcohol as a trigger for other drug use
2. Addition of “Alcohol Use Context” exercises (completed in group at the end of Session 2)
 - a. Review personal *Timeline Followback* (Sobell & Sobell, 1992) calendar that was filled out at Baseline.
 - b. Identify what was learned from this calendar. Review *Reasons for Drinking Questionnaire* (Zywiak et al., 2002) completed at Baseline.
 - c. Complete *Alcohol Use World Eco-map* exercise in group. Identify thoughts and feelings that preceded their last drinking occasion, persons around them whose alcohol or drug use might be a trigger and discuss risky places/occasions associated with use.
3. Addition of empowerment and culturally-specific material

- a. Information as a form of power
- b. Summary of evidence regarding effectiveness of Safer Sex Skill Building (SSB) and other interventions.
- c. Power and Control Wheel for Women with Substance Abuse (O'Neil, 1996)
- d. '24 things a sista should never apologize for' ("HypeGyrl Entertainment Blog," 2007)

Step 2: Pilot Testing of Modified Intervention, SSB+A

The study was approved by the Institutional Review Board of the authors' university. The agency where the research was conducted was an urban, non-profit, residential substance abuse treatment facility for women and their children with typical treatment stays of 60 days to six months or longer for pregnant women. Participant eligibility criteria included: (1) Older than 18 years; (2) able to understand and speak English; (3) having met DSM-IV criteria for alcohol abuse/dependence (past 12 months); and (4) reported sexual risk behaviors for HIV/AIDS, defined as having unprotected heterosexual intercourse in the last 60 days before entering the treatment facility. Participants were recruited via flyers posted in the waiting area and on bulletin boards at the agency. In addition, researchers attended daily morning meetings for residents and introduced the study. Interested residents came to the research office of the study located within the residential treatment facility, and residents who met eligibility criteria were recruited to the study. A total of ten women were recruited for pilot testing of SSB+A, but one participant dropped out of the treatment unexpectedly, leaving two cohorts of five and four women each for the two SSB+A pilot groups. Demographically, final study participants (N = 9) were 67% African American, which was representative of the study site; mean age - 39.7 years; and mean education – 12.7 years. The participants were assured of their confidentiality and provided written informed consent after detailed review of study procedures. Participants were informed they would participate in focus groups to provide feedback about SSB+A.

After informed consent, participants completed a 2–3 hour baseline assessment. This afforded researchers the opportunity to pilot test various baseline assessment measures prior to the Phase 2 randomized clinical trial. The AWHARE team decided to include an opportunity in SSB+A for women to personally reflect on what they might have learned about their risk behaviors from the assessments. Assessment measures included: Addiction Severity Index (McLellan et al., 1992), DSM-IV Checklist – Alcohol and Drug Abuse/Dependence Module (Helzer et al., 1985), Condom Barriers Scale (St. Lawrence et al., 1999), Condom Use Self Efficacy (Female Version) (Marin, Tschann, Gomez, & Gregorich, 1998), Biological measures (urine drug toxicology and alcohol breathalyzer screens), Risk Behavior Survey (NIDA Clinical Trials Network), Timeline Follow-back Interview (Sobell & Sobell, 1992), Reasons for Drinking Questionnaire (Zywiak et al., 1996), Sexual Relationship Power Scale (Pulerwitz et al., 2000), and the Alcohol Effects Questionnaire (AEQ-2) (Rosenow, 1983). After completing baseline assessments two cohorts of five and four women each received the 5-session SSB+A intervention. Each of the five sessions for each cohort was scheduled once per week to allow time for skills practice, thus requiring a total of 5 weeks to complete each cohort.

Step 3: Focus Groups

For each cohort, the first focus group occurred 2–3 days following Session 2, and the second focus group occurred after Session 5 (2 focus groups for each cohort totaling 4 focus groups overall). Focus group participants were compensated \$25 (in the form of gift cards) for their time and effort following each focus group, for a possible total of \$50 if they participated in

both focus groups. Each SSB+A session contains skills building exercises focusing on different aspects of the curriculum, except Session 5, which 1) reviews problem solving skills and applies them to relapse prevention, 2) soliciting participant feedback, and 3) graduation. Therefore, post-Session 2 and post-Session 5 were selected as data collection points as the half way point for the intervention, so participants could comment on Sessions 1 and 2 during the first focus group and on Sessions 3, 4, and 5 during the second focus group.

Open-ended and semi-structured questions were designed to elicit participant feedback. The purpose of the focus groups was two-fold: 1) To solicit feedback from the participants with regard to overall participant satisfaction with the SSB+A intervention, with particular emphasis on the alcohol risk awareness and alcohol use context portion and its usefulness; and 2) to elicit feedback with regard to socio-cultural factors that may influence effectiveness of the intervention. In a review of literature on culturally competent HIV prevention efforts for women of color, Scott and colleagues (2005) concluded that race/ethnicity and gender along with population-specific, culturally based attitudes, beliefs and behaviors must be considered. Additionally, a qualitative study of twenty-five low income African American women 18–29 participating in focus groups in a metropolitan area concluded that HIV prevention programs must address the life demands and social problems that these women encounter (Essien, Meshack, Peters, Ogungbade, & Osemene, 2005).

Focus group facilitators were two African American researchers not connected with the intervention but experienced in conducting focus groups. Groups were audio taped and a research assistant took notes. Audiotapes were transcribed and focus group leaders provided written comments. Data were analyzed by the first and second authors using content analysis. Research assistant notes and intervention group leader notes were examined separately and comments were incorporated and noted. All the qualitative data were broken down into meaning units, which are units of text that contain one idea each. Once meaning units were identified, these meaning units were compared with one another and grouped based on their similarities into categories that describe shared characteristics. These categories were then analyzed for themes and sub-themes (Padgett, 1998). Content analysis has good reliability as it has consistency and objectivity in its coding and categorizing process (Rubin & Babbie, 2005).

Step 4: Focus Group Findings

Analysis of focus group data resulted in a total of seven themes (See Table 1 for summary and examples): Increased knowledge and skills; usefulness of role plays; important role of group leaders; different reasons and circumstances for alcohol and drug use; partner abuse in women with substance use; support for culturally-specific material; and complaints about assessments and length of SSB+A sessions.

Analyses of data found that participants reported increased knowledge about HIV/STDs transmission, symptoms and treatment as well as male and female condom use. Most of them had never seen female condoms and pointed out that practicing male and female condom use was one of the most helpful skills they acquired from the SSB+A and that they felt empowered to be able to protect themselves from HIV/STDs without relying on their partners. Participants also found role play exercises to be useful in bringing awareness of their behaviors under influence of alcohol and drugs and learning how to negotiate safe sex with partners. They felt that group leaders created an atmosphere of caring and openness where they could talk about their alcohol and drug use and sexual risk behaviors freely.

Participants reported that they became more aware of different reasons and circumstances for their alcohol and drug use, noting that the nature of relationships with sexual partners

often determines their alcohol or drug use. For example, several participants commented that their alcohol use is often related to their seeking romance and having sex with boyfriends, whereas drug use is mostly related to getting high and tricking. Some participants also mentioned that alcohol is worse than drugs because it is legal, more accessible, and less expensive. In addition, Participants found the Power and Control Wheel for Women with Substance Abuse (O'Neil, 1996), which researchers added to the original SSB, to be an accurate description of what many of them experienced, helping them recognize their experiences of partner abuse. It also prompted discussion among participants regarding special circumstances under which women with substance abuse experience partner abuse.

As Table 1 illustrates, there were a few suggestions from the participants to make the SSB +A more effective. Most importantly, participants suggested adding more culturally-appropriate materials. Although participants found role play exercises in general reflecting realistic relationship situations from their lives, they advocated for more street talk to be included in the role play exercises in order to make the scenarios real to them. They also discussed feeling uncomfortable and “corny” when reciting the WORTH affirmation, some members stating that it seems far removed from their realities on the street or “a little white” for black women. The primary negative feedback focused on the length of each SSB+A session and the time required to complete baseline assessments.

Step 5: Further Manual Modifications

Three researchers with expertise in SSB clinical trials, women and HIV/AIDS, alcohol co-morbidity, community based research, women's substance abuse treatment, and group intervention provided consultation and feedback on focus group summaries, participant comments and proposed revisions. Consultant recommendations and participant feedback were used, along with lessons learned during pilot testing of SSB+A to make additional modifications to the therapy manual. First, in response to participant suggestion to include more culturally-appropriate materials reflecting “street” culture, researchers consulted with several African American HIV prevention educators and researchers as well as the lead trainer for the CTN SSB study. Through these consultations, the following modifications to the SSB+A intervention were made. Group leaders would introduce the material by saying to the participants that the language of the role plays may not fit for them; they can change it to make it real; and give them a few minutes to change the language and practice. Researchers did not assume that everyone would find the language of the role play far removed from their everyday life, yet street talk and changing names of characters could make it more lively and fun, and therefore it was decided not to formally change the language of the role plays. As long as participants stick to the main content of the role plays, improvising/changing the names and some minor content of the role plays was considered to be helpful in making the material more culturally relevant to participant experiences. In addition, researchers decided to give an option of closing any sessions with the Serenity Prayer instead of the WORTH affirmation. It was reasoned that it is more important for participants to believe in what they say than forcing them to recite something to which they cannot relate and therefore close sessions in a dispirited mood.

Second, the initial modifications to the SSB included adding alcohol risk awareness content throughout Session 2 to 5, highlighting alcohol risks regarding sexual behavior, risks for low-income and minority women, medical risks, other substance use and mental health risks, and empowerment (see details on alcohol risk awareness content added to the SSB on p. 12–13). After pilot testing the SSB+A, further modification was made to streamline alcohol risk awareness content by including a verbal true-false group quiz of 3–4 questions in each session regarding different aspects of alcohol risks, which covers all the relevant information and at the same time makes it more fun for participants to learn the content.

Third, the initial modification added reviews of *Timeline Follow-back* and *Reasons for Drinking Questionnaire* that were completed at baseline at the end of Session 2. However, the AWHARE team decided to make this exercise more informal, considering participant feedback of disliking baseline assessments, as well as the ability of participants to talk about their alcohol use context at the personal level during the pilot testing. Fourth, in response to participant feedback on the length of baseline assessments, a modification was made to the SSB+A, replacing one 2–3 hour baseline assessment session with two 45–60 minute baseline assessment sessions.

Finally, another alcohol use context exercise, *Alcohol Use World Eco-map*, was replaced by *A Roadmap of My Risks* exercise. During pilot testing, it was discovered that *Alcohol Use World Eco-map* had an unintended consequence of making the personal use environment a little too real by providing a visual picture of their alcohol use world (e.g., remembering corner stores where they used to get liquor, a porch where they used to drink). A few participants gave useful feedback stating this was too real and could potentially trigger an urge to drink. Instead, “*A Roadmap of My Risks*” exercise would provide a similar opportunity for participants to enlarge the People, Places, Things exercise that was part of SSB Session 2, which asked them to list thoughts/attitudes/events in their life for alcohol and drug use and discuss how that was connected with unsafe sex. In “*A Roadmap of My Risks*” exercise, participants were asked to take the additional step of thinking about their risks by placing the people, places and things on a “timeline” to see what “people, places or things” typically came first, what came next and where unsafe sex fit into the picture. They were also asked to explicitly identify where alcohol fit on the timeline. The intent was to help participants contextualize and individualize the connection between alcohol and drug use and high risk sexual behaviors by looking at the timeline of their alcohol use and drug use and unsafe sex and interconnections among them. For example, for some women alcohol worked as a “gateway drug,” leading them to the use of illegal drugs, and then they tricked to get drugs or money for drugs. For some women, sex with abusive partners worked as a trigger for alcohol use to numb themselves, whereas for some other women, alcohol use led to sex. Table 2 presents an outline of SSB intervention, the 1st modified SSB+A, and the final version of SSB+A.

DISCUSSION

Researchers adapted “Safer Sex Skill Building” (SSB), an intervention found to be effective in reducing sexual risk behaviors for HIV/STDs of women in outpatient treatment for drug problems, to use with women with alcohol use problems in residential treatment setting. Adaptation of SSB to include opportunities to focus on women with alcohol use disorders was warranted due to the role alcohol can play in HIV transmission. Two main means of HIV transmission, injection drug use and high risk sexual behaviors, are both associated with alcohol use (NIAAA, 2002). Furthermore, alcohol use has been found to increase the risk for HIV/STD transmission independent of other risk factors such as sexual behaviors, STD history, and other substance use (Ericksen & Trocki, 1992; Zenilman et al., 1994). As our study participants expressed during the SSB+A sessions and focus groups, with its legality, cheap price, and easy access, alcohol affects a larger population than drugs do and therefore puts more people at risk for HIV/STD contraction. Especially in urban residential neighborhoods with low socioeconomic levels, from which most of our study participants came, alcohol is readily available in corner stores, as we learned from the pilot testing of the SSB+A. This is particularly alarming considering there is a geographic relationship between alcohol outlet density and high risk sexual behavior in urban residential neighborhoods (Scribner, Cohen, & Farley, 1998). In addition, a residential treatment setting was chosen because it provides a controlled environment for the necessary dose for a small study.

Adaptation of the SSB occurred in five steps: Staff training and initial manual modification to include alcohol risk awareness and alcohol use context material; pilot testing of modified intervention, SSB+A; focus groups with study participants to further modify SSB+A; analysis of focus group feedback; and final modification to SSB+A to incorporate focus group and expert panel feedback. Reviews of HIV risk-reduction interventions for drug users suggest that gender specificity of intervention content and technique, skills building in contrast to information only, and at least four intervention sessions are three core features for effective HIV interventions. Additionally, Prendergast and colleagues (2001) found seven features of effective HIV interventions for changing sexual risk behaviors: Presence of predominantly nonminority samples, the use of didactic lecture, the presence of peer group discussion/counseling, utilization of six or more types of techniques, separate sex sessions, and skills training. The SSB incorporated almost all core features of effective HIV interventions discussed above, in addition to utilizing empowerment approaches aiming at the issues of female-male power in relationships and increasing women's choices and control over sexual decision-making, which have shown promise in modifying sexual behaviors.

Two factors contributed to the AWHARE team's decision to include study participant feedback, obtained through focus groups, and to use it to inform subsequent SSB+A modifications for women with alcohol problems. First, it was important in developing an intervention that incorporates socio-cultural and contextual factors of the target population. Second, it was an empowering strategy for participants as it recognized them as active contributors to the research rather than data points or passive subjects. Current literature suggests the importance of identifying and including the socio-cultural and contextual factors of the target populations in HIV education and intervention/prevention efforts (Scott, Gilliam, & Braxton, 2005; Sterk et al., 2003; Stroman, 2005). In order for the information delivered in interventions to be relevant to participants and prevention efforts to achieve the greatest effects, it is important to frame messages that reflect norms, values, and language of the target populations. Researchers of this study concluded that the best way to reflect the socio-cultural and contextual reality of participants' lives is to ask them if the SSB+A reflects their daily life context such as the meaning of alcohol in their lives, relationship between substance use and risky sexual behaviors, gender dynamics, their economic reality and everyday language.

The SSB utilizes empowerment approaches in its role plays and skills building activities, and researchers of this study wanted to go a step further to make the process of modifying the curriculum more participatory. Traditional health education assumes that the educator is an expert on the subject and transfers knowledge to the learners who merely deposit the information, however, education based on empowerment and participatory approaches helps participants gain control over their daily lives through dialogue and critical thinking (Amaro, 1995). Following this tradition, researchers purposefully selected the focus group method, as it provides a structural framework while giving space for discussion and reflexivity about the collective experience of participating in the SSB+A. This open exchange of opinions and ideas between participants was a strength. Surrey (cited in Amaro, 1995) argues that the centrality of relationships for women make this kind of connection with other people an empowering experience for women.

The final SSB+A, which was modified based on research, expert feedback, and most importantly participant input from focus groups, resulted in a prevention intervention that incorporated participants' socio-cultural and daily life context and therefore was sensitive to the participants' needs. Fraser and Galinsky (2010) advocate for cultural and contextual adaptation of interventions through a collective process involving practitioners and community members. We wholeheartedly agree with their statement and add that target

populations should also be involved in adaptation of interventions to enhance efficacy. Following Phase 1 of the study, in Phase 2 the AWHARE team tested the final version of SSB+A using a small randomized clinical trial and longitudinal design and compared it to one session standard HIV education (HE) session in a residential substance abuse treatment program for women with alcohol problems. The results of Phase 2 will be reported in a subsequent manuscript.

Our five-step adaptation process of the SSB intervention can be utilized in different social work settings, such as child protection services, domestic violence services, or medical setting. We suggest that researchers and practitioners, who would like to use the SSB+A, adapt it to their populations and settings, so it reflects target populations' life, culture, and contexts accurately, which in turn would make the intervention more effective for their target populations. In addition, in this study while some women participated in the focus groups actively and responded to most questions, others' participation was limited. Future research that aims at adapting the SSB would benefit from including both focus groups and individual interviews to obtain participant feedback.

As mentioned at the outset of this article, social work can contribute to the transfer of the knowledge base on treatment into community settings by adapting interventions for use in different community contexts. In doing so, it is crucial for social workers to incorporate a real world context through participant feedback into intervention to improve its relevance to the target population.

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Figure 1.
Steps for adapting treatment intervention

Table 1

Themes Emerged from Focus Group Feedback

Themes	Examples
1. Increased knowledge and skills	
Increased knowledge about HIV/STD	Increased knowledge about HIV/STD transmission, symptoms and treatment. (e.g., "Detailed educational materials on HIV/STDs were useful," "I learned different ways you can catch HIV and STDs and some of them don't have any symptoms," "I learned that you can be tested [HIV] for free," "It was the money that draw me to it, but it was the information that kept me here.")
Increased knowledge about condoms & acquired skills on condom use	Learned about female condoms and correct use of male/female condoms. (e.g., "Never heard of female condoms, never seen them," "Liked female condoms because it gives the woman power," "I'm gonna know how to put a condom on, I mean both ways, the women's and men's," "Learned skills on how to negotiate such as how to get the men to put the condoms on.")
2. Usefulness of role plays	
Realistic depiction of situations	Roles plays reflected realistic relationship situations from participants' daily lives. (e.g., "The way it was written, the script itself, from where it was written, I would understand it; it was on target," "I can recall being in that situation and things they said I know the circumstances that the character was saying, cause I said them, so it was kind a real," "It was real and hit home.")
Awareness of their own behaviors under influence	Became aware of how their own behaviors, like drinking, can contribute to catching HIV/STDs. (e.g., "It made me feel that I rationalized it, thinking it is okay when it really isn't. Just goes to show the way your mind works when it's sick with alcohol and drugs," "When we was out there drugging and drinking, we never thought about our health.")
3. Important role of group leaders	Group leaders created a milieu in which women felt free to talk openly about "tricking" and substance use. (e.g., "Two ladies who do this group, they are real sincere, they're caring, and they've got our best interest at heart. That's the way I feel," "Liked that the group leader was interpreting for me (woman with hearing problem). I often miss a whole lot of important information in a group.")
4. Different reasons and circumstances for alcohol and drug use	Reason women use alcohol or drugs varies depending upon the nature of relationship with sexual partner. (e.g., "When I'm dope seeking, it's about money, when I am drunk, it's about pleasure or romance," "When I drink, I just wanna lie down," "I cut corners when I am drunk. A lot shit that would be important to me when I am out working, wouldn't be when I was drunk," "Learned that having sex with my boyfriend was a trigger for me to drink," "Alcohol is a major drug. The fact it is legal, easy to get, no real consequences unless driving or attack someone makes it worse," "Alcohol intensifies effects of drugs," "Sometimes I just settle for alcohol because it is more accessible and less expensive, and I do that to get over the hump.")
5. Partner abuse in women with substance use	
Prevalence of partner abuse	Many participants experienced partner abuse and found the Power and Control Wheel for Women with Substance Abuse depict their experiences accurately. (e.g., "I have gone through a few of different sections of the wheel," "Liked the Wheel because it relates to women who use drugs," "For the woman, it often ends up leading to using some type of substance to try to deal with the stuff that happens when things get crazy.")
Special circumstances of women with substance use	(e.g., "Drugs make situations worse. I'm not going to call the police on this abusive man because I feel too bad about all the drug use," "Drug/alcohol use make you look like less of a victim to those who are supposed to help you such as health care professionals or court people," "Provide information on protection from violent men. How to get necessary resources such as protective orders, shelters, domestic violence advocates.")
6. Support for culturally-appropriate material	
"Street" culture and talk	Supports for culturally-specific material with more "street" culture to make things natural. (e.g., "It is – WORTH affirmation- corny. I feel stupid saying it," "Seems so far removed from what we were talking about. I'm talking about a trick and the next minute I am sitting there reading this little phrase....," "I prefer the Serenity Prayer," "I liked '24 things a sista never should apologize for' better than WORTH affirmation. It made more sense, it was more direct to the point, it was realistic," "The only thing I would change is like a few more scenarios, different situations, and maybe a little more street-like, to make the scenarios fit for the group (rural v. city)," "More scenarios that they can use with SODAS (how to go about getting what you need but in a safe way)."

Themes	Examples
Ethnically appropriate material	Participants supported more ethnically appropriate material. (e.g., "If the target group is only black women, then the WORTH Affirmation is just a little white," "Maybe if you have a sister to come along with the other lady, it might help. It is just they have a way of relating things so that I can understand it better.")
7. Complaints about assessments and length of sessions	Participants didn't like assessments they did before participating in the SSB+A and thought a 90-minute group session was a little bit too long. (e.g., "Too long," "A lot of them was unrealistic. When I'm drinking, I couldn't tell you how much I drink if my life depended on it," "It was almost like a test," "Found myself shutting down because I was getting so pissed off being asking the same questions 14 different ways," "Group was long, stretched out".

Table 2

Outlines of SSB, Initial SSB+A, and Final SSB+A Interventions

	SSB Intervention	Initial SSB+A Intervention	Final SSB+A Intervention (Listed only additional changes from the initial SSB+A)_
<i>Assessments</i>	Addiction Severity Index, Composite International Diagnostic Interview (CIDI), Condom Barriers Scale, Condom Use Self Efficacy, Sexual Experiences and Risk Behavior Assessment Schedule (SERBAS), Sexual Relationship Power Scale	<ul style="list-style-type: none"> DSM-IV – Alcohol and Drug Abuse/Dependence Module replaced CIDI Risk Behavior Survey replaced SERBAS Addition of <i>Timeline Follow-back Interview, Reasons for Drinking Questionnaire, Alcohol Effects Questionnaire</i> to SSB assessment battery Separation of drug use and alcohol use questions to make consideration of alcohol use more intentional 	<ul style="list-style-type: none"> Two 45–60 minute assessment sessions replaced one 2–3 hour assessment session
<i>Overall</i>		<ul style="list-style-type: none"> Inclusion of alcohol risk awareness content throughout Sessions 2 to 5 	<ul style="list-style-type: none"> Inclusion of verbal quiz (3–4 questions) in each session regarding different aspects of alcohol risks Make the material more culturally relevant to participant experiences <ol style="list-style-type: none"> Allow participants to change the language of role plays to reflect their daily lives Give an option of closing each session with Serenity Prayer instead of WORTH Affirmation
<i>Session 1</i>	HIV/STDs definition, transmission, testing and counseling, treatment and prevention		
<i>Session 2</i>	HIV personal risk assessment and awareness building, including triggers for sexual risk, sources of support and ways of seeking help	<ul style="list-style-type: none"> Addition of reviews of <i>Timeline Follow-back Interview</i> and <i>Reasons for Drinking Questionnaire</i> Addition of <i>Alcohol Use World Eco-map</i> 	<ul style="list-style-type: none"> Reviews of <i>Timeline Follow-back Interview & Reasons for Drinking Questionnaire</i> became informal & conversational <i>A Roadmap of My Risks</i> replaced <i>Alcohol Use World Eco-map</i>
<i>Session 3</i>	Condom skill building and safer sex problem-solving skill building, including male and female condom demonstration and rehearsal		
<i>Session 4</i>	Safer sex negotiation skill building and partner abuse risk assessment and safety planning skill building	<ul style="list-style-type: none"> Addition of <i>Power and Control Wheel for Women with Substance Abuse</i> in Session 4 	
<i>Session 5</i>	Wrap-up, review, and Graduation, including practice vignettes focusing on “slip” behavior and resource discussion		