Published in final edited form as:

Cogn Behav Pract. 2019 May ; 26(2): 254–269. doi:10.1016/j.cbpra.2018.07.004.

Improving Young Male Couples' Sexual and Relationship Health in the 2GETHER Program: Intervention Techniques, Environments of Care, and Societal Considerations

Kathryn Macapagal,
Northwestern University

Brian A. Feinstein,
Northwestern University

Jae A. Puckett,
University of South Dakota

Michael E. Newcomb
Northwestern University

Abstract

Young male couples are at high risk for acquiring human immunodeficiency virus (HIV). However, few HIV prevention programs meet the needs of young male couples that express an interest in how to maintain healthy relationships. As such, we developed 2GETHER, a couple-based program that integrates HIV risk reduction and sexual health information into a relationship education program specific to young male couples. 2GETHER was guided by cognitive-behavioral theories of HIV risk reduction and relationship functioning and was informed by a social-ecological perspective to address factors within and outside the couple that can impact sexual and relationship health. As a micro-level intervention, 2GETHER intervenes directly with couples via psychoeducation and cognitive-behavioral strategies to change couples' communication patterns, sexual health behaviors, and relationship satisfaction. Successful implementation of 2GETHER requires mezzo-level interventions that create an affirming environment of care for sexual-minority individuals and facilitators who are culturally competent in working with young male couples. Although macro-level interventions to change societal acceptance of and policies germane to sexual-minority couples are beyond the scope of 2GETHER, we discuss how clinicians can advocate for systemic changes to improve sexual-minority couples' health, and how 2GETHER addresses the impact of such macro-level factors on the couple's relationship. Our experience developing and testing 2GETHER indicates that HIV prevention programs for young male couples should reflect the unique contexts shaping sexual-minority individuals' relationships and lives, and

Address correspondence to Kathryn Macapagal, Ph.D., Northwestern University, 625 North Michigan Avenue, Suite 1400, Chicago, IL 60611; kathryn.macapagal@northwestern.edu.

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The authors have no conflicts of interest to disclose.

that programs should intervene within and across multiple levels when possible to improve health for sexual-minority men.

Keywords

relationship education; HIV/AIDS; couples; young men who have sex with men; social–ecological systems

Young adult sexual-minority men in the United States are at high risk for human immunodeficiency virus (HIV), with many new infections occurring in the context of serious relationships (Goodreau et al., 2012; Sullivan et al., 2012; Sullivan, Salazar, Buchbinder, & Sanchez, 2009). Multiple factors influence HIV risk among male couples, including increased trust and intimacy that lead to decreased condom use with a main partner, as well as incorrect assumptions about partner HIV status and ineffective communication about sexual exclusivity and infidelity (Hoff, Beougher, Chakravarty, Darbes, & Neilands, 2010; Hoff, Campbell, Chakravarty, & Darbes, 2016; Mitchell, 2014b; Mitchell et al., 2017; Newcomb, Ryan, Garofalo, & Mustanski, 2014; Starks, Gamarel, & Johnson, 2014). Although couple-based HIV prevention programs may be more effective in reducing HIV risk among dyads (Crepaz, Tungol-Ashmon, Vosburgh, Baack, & Mullins, 2015), most interventions focus on changing risk behavior at the individual level (Centers for Disease Control and Prevention, 2017a; Hoff et al., 2016) and interventions specifically for male couples are lacking (Burton, Darbes, & Operario, 2010; Jiwatram-Negron & El-Bassel, 2014).

In addition, young sexual-minority men in relationships report that HIV prevention programs are often not relevant to their needs, and that they would prefer to learn about maintaining healthy relationships instead (Greene, Fisher, Kuper, Andrews, & Mustanski, 2015). This may be related to the fact that sexual-minority individuals in young adulthood are forming their first serious adult romantic relationships, yet are navigating them in the absence of same-sex relationship scripts and with exposure to relatively few role models of same-sex couples (Macapagal, Greene, Rivera, & Mustanski, 2015). With few exceptions (Whitton & Buzzella, 2012; Whitton et al., 2017; Whitton, Weitbrecht, Kuryluk, & Hutsell, 2016), relationship education programs—which typically focus on information and skills that help individuals and couples sustain stable and healthy relationships (e.g., communication skills, conflict resolution training; Markman & Rhoades, 2012)—are designed for heterosexual people and often pay limited attention to sex and sexuality (Lieser, Tambling, Bischof, & Murry, 2007). Moreover, HIV prevention and relationship programs designed for heterosexual individuals inherently fail to address the unique, multilevel social, cultural, and structural contexts that impact sexual-minority individuals' health and relationships. In response to these needs, we developed the 2GETHER intervention, which incorporates HIV prevention skills and sexual health information into a healthy relationships program for male couples in emerging adulthood (Newcomb et al., 2017).

Contexts Affecting Male Couples' Sexual and Relationship Health

Different contexts affect young male couples' sexual and relationship health, and a social-ecological perspective (Rostosky & Riggle, 2011, 2017) is useful in understanding how different spheres of experience, such as couples' own relationship, their communities, and society interact and shape couples' relationships over time. These diverse influences on couples' sexual and relationship health can be conceptualized as micro-, mezzo-, and macro-level factors (Rostosky & Riggle, 2011). Micro-level factors refer to the couple's immediate intra- and interpersonal contexts, such as the couple's relationship dynamics and individual partner characteristics (e.g., age, HIV status, sexual desire, relationship goals). Mezzo-level factors refer to contexts like the availability of welcoming physical spaces and communities where a couple lives, such as health care settings (e.g., a community clinic that serves the general population vs. lesbian, gay, bisexual, or transgender [LGBT] individuals) and providers' competency in working with LGBT individuals and couples. Macro-level factors include broad sociopolitical and cultural contexts and policies that can impact the couple, such as societal acceptance of same-sex relationships and the availability of legal same-sex marriage.

Interventions can occur at the same or a different level as the problem they are attempting to change (Rostosky & Riggle, 2011; Schensul & Trickett, 2009). For instance, lack of legal recognition of same-sex marriage (a macro-level problem) has been addressed in some countries by statewide or nationwide legalization (a macro-level solution). In contrast, negative societal attitudes toward same-sex relationships (a macro-level problem) can lead to distress that can be addressed in couple therapy (a micro-level solution). Effectively reducing disparities in same-sex couples' health and well-being requires interventions that address these myriad factors within and across levels (Rostosky & Riggle, 2011; Schensul & Trickett, 2009).

Theoretical Foundations of 2GETHER

Two theoretical models informed the content of 2GETHER and reflected our dual goals of promoting relationship skills and sexual health. First, the information-motivation-behavioral (IMB) skills model is a cognitive-behavioral model that proposes that cognitive, motivational, and behavioral factors contribute to HIV risk behavior (Fisher & Fisher, 1992), and an extension of the model proposed that there are unique considerations for HIV prevention in serious relationships (Harman & Amico, 2009; Misovich, Fisher, & Fisher, 1997), especially among young male couples (Macapagal, Greene, Andrews, & Mustanski, 2016). To increase sexual health *information*, 2GETHER provides education about HIV/sexually transmitted infection (STI) transmission risk factors in serious versus casual partnerships (also referred to as primary vs. outside partners) and a menu of behavioral and biomedical HIV prevention strategies couples can use. Behavioral strategies include using condoms and creating relationship agreements that describe the conditions under which, if any, the couple is allowed to have sex with outside partners (i.e., an open relationship) or if they are not allowed to engage in sex with anyone other than their partner (i.e., a monogamous relationship; Gass, Hoff, Stephenson, & Sullivan, 2012; Hoff & Beougher, 2010; Mitchell, 2014b). Biomedical strategies include medications HIV-negative individuals

can take to prevent HIV (e.g., pre-exposure prophylaxis [PrEP]; Centers for Disease Control and Prevention, 2016), and adherence to antiretroviral medication as well as viral suppression among HIV-positive individuals, which can prevent transmission to a negative partner (Cohen et al., 2016).

To improve HIV prevention *motivation*, 2GETHER examines individual attitudes, beliefs, and peer norms related to prevention in couples; intentions to use prevention strategies; and barriers to enacting prevention strategies. 2GETHER corrects faulty assumptions about sexual health in serious relationships, such as the beliefs that paying attention to sexual health is less important in a relationship, that knowing one's partner well means he is less likely to have HIV or an STI, or that using condoms reflects a lack of trust in one's partner (Misovich et al., 1997). Finally, to improve HIV prevention self-efficacy and *behavioral skills*, 2GETHER teaches risk reduction skills relevant to couples, such as effective communication about safer sex and sexual pleasure, making behaviorally specific HIV testing plans and relationship agreements, and dealing with breaks in relationship agreements.

Second, the vulnerability–stress–adaptation (VSA) model of relationship functioning (Karney & Bradbury, 1995), a framework rooted in cognitive-behavioral and other theories (e.g., attachment, social exchange) proposes that a couple's ability to cope with external stressors predicts their relationship outcomes. Specifically, the VSA model posits that three factors can interact and influence relationship satisfaction. First, each partner brings certain qualities to the relationship (e.g., communication style, family history) that render them more or less *vulnerable* to relationship challenges. Second, the context in which the relationship occurs may or may not have *stressors* that can impact relationship quality. Finally, the presence or lack of *adaptive processes*—such as cognitions, affect, and behaviors that occur within each partner and the dyad—can also contribute to relationship satisfaction. Among sexual-minority couples, experiencing stress associated with a marginalized sexual identity, or minority stress (e.g., sexual orientation-based discrimination, internalized stigma; Meyer, 2003), can contribute to stress within the relationship, increase partners' negative affect and weaken their ability to cope effectively, and adversely impact communication and relationship satisfaction (e.g., Falconier, Jackson, Hilpert, & Bodenmann, 2015; Frost & Meyer, 2009; Rostosky & Riggle, 2017). As such, 2GETHER provides psychoeducation on minority stress and ways of coping (e.g., Lazarus & Folkman, 1984; Rostosky, Riggle, Gray, & Hatton, 2007), and training in a structured approach to problem solving (Safren, Otto, & Worth, 1999) and how to identify when acceptance strategies may be preferable to problem solving (e.g., when facing societal or familial stressors one cannot control; Whitton & Buzzella, 2012; Yadavaia & Hayes, 2012).

In this paper, we describe the 2GETHER program and how it employs micro- and mezzo-level interventions to address sexual health and relationship concerns among young male couples. We also discuss the need for macro-level interventions to reduce societal stigma toward sexual-minority couples and to provide relationship education and HIV prevention that addresses their needs, and how clinicians can advocate for structural changes.

Intervention Description

2GETHER is a weekly, four-session program lasting 10 hours (see Table 1 for a detailed summary). The first two sessions are psychoeducational groups led by two facilitators and attended by up to eight couples. Group sessions are highly interactive and content is delivered in diverse formats (e.g., slide show, facilitated discussion, skills practice, video) to appeal to different learning styles and to maintain participants' engagement in the material. The final two sessions involve one facilitator with one couple and are described in more detail below. At the end of each session, facilitators assign participants homework focused on generalizing what they have learned through applying skills from 2GETHER to their everyday lives.

Session 1 includes discussing similarities and differences between different- and same-sex couples and characteristics of healthy relationships, identifying ineffective communication (e.g., withdrawal, defensiveness), teaching and rehearsing effective communication skills (e.g., active listening; "I" statements; "we" statements, which reframe problems into something the couple experiences, rather than being one partner's fault), and pleasurable activity scheduling (Buzzella, Whitton, & Tompson, 2012). Facilitators also provide psychoeducation about sexual health in serious relationships (Gass et al., 2012; Hoff & Beougher, 2010; Mitchell, 2014b), behavioral and biomedical HIV/STI prevention strategies (e.g., condoms, PrEP; Centers for Disease Control and Prevention, 2016), and identify and correct assumptions about these topics (Misovich et al., 1997). Couples also learn the "four Ts," a framework for discontinuing condom use in serious relationships aimed at HIV risk reduction (Centers for Disease Control and Prevention, 2017b; Mindel & Kippax, 2013): (a) *talk* to one's partner about HIV status, sexual health, and protection; (b) *test* for HIV as a couple and disclose results to each other; (c) use condoms and *test* for HIV again 3 months later to ensure the "window period"—the amount of time needed after HIV exposure for tests to detect HIV—has passed; and (d) decide whether enough *trust* is present in the relationship to discontinue condom use.

Session 2 focuses on cognitive-behavioral and acceptance-based strategies for coping with minority stress and relationship stress. Participants learn about various coping strategies (e.g., emotional or tangible support, self-distraction) and discuss how stress and effective coping can impact relationship functioning (Falconier et al., 2015; Lazarus & Folkman, 1984; Rostosky et al., 2007). Participants also learn a problem-solving framework—articulate the problem, identify possible solutions, make a plan, make a backup plan (AIMM; Safren et al., 1999)—basic principles about acceptance and how to approach problems that cannot be changed (Whitton & Buzzella, 2012; Yadavaia & Hayes, 2012) and practice these skills on hypothetical problems. Finally, participants discuss the importance of social and community support for same-sex couples and identify existing supports (Graham & Barnow, 2013).

In the final two sessions, each couple is paired with one facilitator to focus on in-depth application of the skills to the couple's circumstances. Sessions also provide a space for the couple to discuss relationship details or concerns that they may have been reluctant to share in the larger group. 2GETHER couples' sessions are distinct from couple therapy and

resemble coaching sessions in that facilitators enter sessions knowing little about the couple apart from what was shared in the group sessions, and facilitators inform couples that the purpose of the session is not to identify root causes of relationship issues, but to provide feedback about their use of the skills in real time. Session 3 focuses on rehearsing effective communication and problem-solving skills and applies them to two of the couple's relationship concerns. Session 4 focuses on the couple's sexual health, including communication about sexual satisfaction and negotiating a relationship agreement to reduce HIV transmission risk within the couple and with any outside partners. Participants who are HIV negative or unsure of their status are offered couple-based HIV testing, and a brief motivational interviewing medication adherence intervention is administered to HIV-positive individuals (Safren et al., 1999). At the end of the intervention, couples complete exercises aimed at setting concrete relationship and sexual health goals, anticipating potential problems, and addressing lapses in effective communication and relationship agreements.

Target Population, Feasibility, and Preliminary Efficacy

2GETHER is designed for sexually active, cisgender (i.e., someone who identifies with the gender typically associated with their sex assigned at birth, meaning they are not transgender) male couples in self-described serious relationships in which one or both partners are a young adult (i.e., ages 18–29). The program's feasibility, acceptability, and preliminary efficacy were recently established (Newcomb et al., 2017). In brief, we enrolled 57 young male couples ($N = 114$ individuals) into a pretest–posttest pilot trial with 99.1% retention at 2-week posttest. We assessed acceptability via postsession surveys and exit interviews. The vast majority of participants reported exclusively positive impressions of 2GETHER, and all intervention components received high mean ratings. At 2-week posttest, we observed significant decreases in HIV risk behavior; increases in information, motivation, and behavioral skills related to HIV prevention; and improvement in relationship investment.

Approaches and Case Examples

In this section, we describe in more detail how 2GETHER uses micro- and mezzo-level approaches to improve couples' relationship and sexual health, and illustrate these approaches with case examples. Although macro-level intervention approaches are beyond the scope of 2GETHER, we provide some suggestions for possible macro-level interventions that can improve sexual-minority couples' health, and we describe how 2GETHER addressed the impact of macro-level influences on sexual and relationship health (e.g., negative societal attitudes toward sexual-minority couples) with interventions at other levels. Later, we discuss how individual practitioners can advocate for changes at the macro level.

Micro-Level Interventions

Micro-level interventions refer to “in the room” clinical considerations and strategies, and in 2GETHER this involves the process and content of group and individual sessions. On a process level, facilitators self-disclose relevant experiences when appropriate (e.g., difficulties navigating first same-sex partnerships, examples of their own patterns of ineffective communication), and matter-of-factly talk about sexual behavior and risk.

Facilitators also acknowledge and label their use of ineffective communication in sessions (e.g., interrupting a cofacilitator, incorrectly using “I” statements by expressing cognitions instead of feelings). Together, these actions normalize relationship and sexual health challenges and model effective communication for participants. In addition, the intervention was manualized but allowed facilitators to tailor individual session content to couples’ characteristics such as their relationship agreement, HIV statuses, and communication style, among other factors. Here we present two case examples that illustrate how facilitation of Session 4, which focused on sexual health, varied according to the couple’s relationship agreement—a micro-level intervention for a micro-level factor.

Case Example: Monogamous Relationship—The need to justify the relationship agreement content of 2GETHER is a unique consideration with monogamous couples. Educating young male couples about relationship agreements—regardless of their current agreement—is critical in order to provide comprehensive relationship education and HIV risk reduction strategies that reflect their sexual practices now and in the future. Trey (age 18, White) and Andres (age 19, Latino) had been in a monogamous relationship for 1 year. They expressed the belief that it was unnecessary to discuss their agreement in the session as they had already decided to be monogamous and were confident that it would not change. The facilitator gently challenged these assumptions by sharing findings from research showing that relationship agreements can change over time (Mitchell, 2014a) and that breaks in agreements are common (Gass et al., 2012; Gomez et al., 2012; Mitchell, 2014b), especially among younger men (Perry, Huebner, Baucom, & Hoff, 2016). The facilitator elicited from the couple reasons why communication about one’s relationship agreement may be important. The couple identified that communication can increase intimacy, ensure that partners have the same understanding of their agreement, and promote expression of emotional and sexual needs (Hoff & Beougher, 2010; Hoff et al., 2010). The facilitator also explained that couples can find it difficult to talk about sex, and that doing so can normalize the experience and help them express their needs honestly.

Next, the facilitator led Trey and Andres through an exercise to identify the pros and cons of different agreements and to determine whether their agreement was meeting both partners’ needs. They thought that monogamous agreements promoted emotional security and protection from HIV/STIs, and that open agreements could lead to jealousy and exposure to HIV/STIs from outside partners. The couple struggled to identify drawbacks of a monogamous agreement and benefits of an open agreement. The facilitator encouraged them to consider why others may be interested in open agreements, which helped them think more broadly about open relationships (e.g., they can provide sexual variety and novelty). Examining pros and cons of different agreements both reinforced their decision to stay in a monogamous relationship and highlighted challenges they may face over time (e.g., sex may become less fulfilling).

Then, the facilitator asked them to discuss their risk reduction strategies. They described using condoms at the beginning of their relationship and then discontinuing condom use when they agreed to be monogamous. In addition, they were tested for HIV/STIs and disclosed their results to each other but did not wait until the window period had passed before discontinuing condom use. The facilitator normalized not following the four Ts (i.e.,

talk, test, test, trust) and discussed the implications of prematurely discontinuing condom use (e.g., uncertainty about whether initial HIV test results accurately detected an infection). The facilitator reminded them of the best practices for making this decision in the future if their risk for HIV changed.

Finally, although Trey and Andres labeled their relationship as monogamous, they had not defined what that meant to them. As the facilitator guided them through the relationship agreement worksheet (Figure 1), Trey and Andres recognized that they had focused exclusively on sexual behavior (i.e., they were not allowed to have sex with others). The facilitator encouraged them to consider other aspects of their relationship, including emotional intimacy and nonsexual contact, like flirting. Despite believing that it was unnecessary to revisit their agreement at the beginning of the session, they decided that it was helpful to broaden their agreement to include emotional and nonsexual contact. In sum, this case highlights common issues that arise with monogamous couples, such as questioning the relevance of the relationship agreement content, difficulty with perspective taking about different agreements, and discontinuing condom use after deciding to be monogamous.

Case Example: Open Relationship—David (age 29, Black) and Chris (age 34, White) had been in an open relationship for 6 months. In discussing the pros and cons of different agreements, Chris expressed feeling jealous when David had sex with someone else, but also feeling conflicted because this was allowed per their agreement. The facilitator normalized Chris's feelings and explained that coping with jealousy was a common concern, especially in open relationships. The facilitator encouraged Chris and David to use effective communication skills to address this problem (e.g., Chris could use "I statements" to express his feelings, David could use validation to comfort Chris). They also discussed using the AIMM problem-solving method to identify strategies to promote intimacy when Chris felt insecure.

Next, the facilitator instructed David and Chris to review their agreement and consider whether it was meeting their needs. They described their agreement as allowing sex with others as long as they used condoms with those partners. While completing the relationship agreement worksheet, the facilitator encouraged them to be more specific about their rules (e.g., define "sex" as oral, anal, and/or vaginal) and to broaden their agreement to include rules about disclosing sex with outside partners to each other, regular HIV/STI testing, using PrEP for HIV prevention, and addressing potential breaks in their agreement (e.g., when and how to tell each other, changes to risk reduction strategies). David and Chris did not realize all of the potential issues to discuss as part of an agreement. Further, their knowledge of PrEP was limited, so the facilitator provided them with more information and referred them to a medical provider.

Finally, the facilitator reminded the couple that sexual health was broader than risk reduction and also included pleasure and communicating about each other's needs. The facilitator asked David and Chris to share with each other what they liked about their sex life and what they wanted to improve. David expressed that he liked how Chris knew his preferences and Chris expressed that he liked how connected he felt during sex. David also stated that he

wanted to have threesomes with Chris, but Chris preferred to keep sex with each other separate from sex with outside partners. The facilitator encouraged David to reframe the problem as a “we problem” (e.g., “We have different sexual interests”) and suggested using problem-solving skills to generate potential solutions. In sum, this case highlights common issues that arise with open couples (e.g., jealousy, vague agreements, different preferences for sex with outside partners).

Mezzo-Level Interventions

Unlike micro-level factors, which reflect the couple’s characteristics and immediate context, the broader mezzo level includes aspects of the couple’s environment, such as clinics, health care providers, and community-based organizations (Rostosky & Riggle, 2011, 2017). In 2GETHER, mezzo-level interventions included training facilitators to increase their LGBT cultural competency, developing study materials (e.g., forms, questionnaires) using language that was inclusive of diverse relationship structures, and providing an affirming environment of care for the sexual-minority couples that participated.

Facilitator Characteristics and Training—Emerging research on low-intensity CBT indicates that nonclinicians can be trained to effectively deliver interventions including psychoeducation, skills training, and guided self-help to individuals with mild to moderate mental health concerns, which increases access to evidence-based psychological treatments (e.g., Branson, Myles, Mahdi, & Shafran, 2018; Clark, 2011). Following this model, we designed 2GETHER so that individuals with diverse educational and professional backgrounds can facilitate the program. Facilitators in the pilot study and our ongoing randomized controlled trials (RCTs) of 2GETHER varied in their baseline knowledge and experience related to sexual health, male couples, and intervention facilitation. Training was responsive to these backgrounds and not only ensured facilitators’ familiarity with the intervention and basic therapeutic skills but competency in and comfort with areas of 2GETHER specific to the study population (e.g., sexual health in young male couples, sexual-minority stress, terms commonly used in the LGBT community) as well.

Facilitators with prior clinical experience participated in a 2-day training led by KM and MEN that explained the theoretical framework and rationale for the intervention, provided a detailed session-by-session content review with demonstrations led by the trainers, and engaged trainees in role plays for each session. Role plays focused on rehearsing segments of the intervention that were dependent on the facilitator’s knowledge about and comfort with male couples’ sexual health and relationships. New facilitators also observed group sessions and listened to audio recordings of couples’ sessions to illustrate how intervention delivery varied with regard to different relationship agreements; couples’ comfort talking explicitly about sexual behavior; and partners’ baseline ability to communicate effectively and ineffectively, among other factors. Training for facilitators without clinical experience lasted 8 full weeks and included the aforementioned activities as well as training in basic cognitive-behavioral therapy skills (e.g., collaboration; structuring; labeling thoughts, feelings, and behaviors) and motivational interviewing skills (e.g., rolling with resistance, highlighting ambivalence; Beck, 2011; Miller & Rollnick, 1991). In the RCT, facilitators

received continuing education on topics like PrEP and HIV medication adherence, and worked with patient simulators to refine delivery of the couples' sessions.

During the intervention, two facilitators oversaw each group session, and at least one facilitator identified as a sexual or gender minority. This decision was based on findings from a previous couple intervention indicating that sexual-minority men expressed a preference for LGBT-identified facilitators (Buzzella et al., 2012). However, facilitator competence in working with sexual-minority individuals and in the content areas of 2GETHER is more important for intervention success (Boroughs, Bedoya, O'Cleirigh, & Safren, 2015) than for them to identify as a sexual or gender minority. Finally, facilitators participated in weekly group supervision overseen by two clinical psychologists. Future implementation research should assess the feasibility and effectiveness of administering this intervention without the formalized support of clinicians.

Research Materials—Although 2GETHER does not use intake forms given its delivery in the context of a research study rather than a clinic, we took care to ensure our eligibility screener and surveys used language inclusive of sexual-minority individuals and a variety of relationship structures and sexual practices. For example, survey questions distinguished between participants' sex assigned at birth and current gender identity, rather than asking only about sex or gender; surveys assessing relationships and sexual behavior that originally were written in a manner that assumed male–female partnerships were revised to be either gender neutral or reflect male–male partnerships (e.g., Buzzella et al., 2012); and survey questions that assumed the partners were married were broadened to describe long-term or serious partnerships (e.g., Sprecher & Felmlee, 1992). We also selected measures designed to assess sexual behavior among sexual-minority populations that, for example, made distinctions between primary and outside partners and insertive or receptive anal sex (Mustanski, Starks, & Newcomb, 2014).

Environment of Care—2GETHER can be implemented in a variety of settings. During the pilot trial, sessions were most often delivered in an LGBT community center through an ongoing partnership between our university and the community organization. The program was also integrated into existing services at the community center. For example, we received referrals from the center's HIV testing clinic and behavioral health programs. In turn, we agreed to refer our participants to further care through the organization in the event that the couple desired more counseling or couples-based HIV testing. As such, the partnership was mutually beneficial, which is critical when establishing a partnership with a community-based organization (Israel, Schulz, Parker, & Becker, 1998). Housing our program at the community center may have provided participants with implicit assurance that it was inclusive of their identities and relationships, and it may have decreased barriers to participation for some. We also recognize that not all places have access to LGBT community centers, and for a variety of reasons, some couples may prefer seeking services in locations that are less visibly associated with the LGBT community. For example, some individuals may not be out about their sexual orientation identity or may experience internalized stigma that may make them uncomfortable participating in a space explicitly for members of the LGBT community. Thus, we also offered the option of holding 2GETHER

sessions in our university-based offices, and we continued to refer couples to behavioral health and HIV testing services at local organizations if they desired. These referrals provided a much-needed service to participants and helped to build goodwill with our community collaborators.

Addressing Macro-Level Factors With Multilevel Interventions

Individuals and couples are shaped by the broader contexts in which they live. For example, despite increased societal acceptance of sexual-minority individuals in the United States in recent years (Pew Research Center, 2017) and related political changes (e.g., the passage of marriage equality laws), negative views and stereotypes of sexual-minority individuals persist. Unfortunately, sexual-minority individuals internalize these attitudes (Herrick et al., 2013; Puckett, Feinstein, Newcomb, & Mustanski, 2018), and this internalized stigma is associated with a variety of negative health outcomes, such as depression and anxiety (Newcomb & Mustanski, 2010). Macro-level interventions that target changes in policies, laws, and societal attitudes have the potential to increase visibility and acceptance of sexual-minority individuals and couples, which can help reduce population health disparities among this group. For instance, prominent media campaigns featuring sexual-minority couples and families could normalize their relationships and reduce stigma, population-level HIV prevention efforts could focus more on relational influences on HIV risk behavior, and nondiscrimination laws can protect sexual-minority couples from being denied housing or terminated from jobs due to their identity or relationship.

Yet it can take years for such macro-level shifts to occur and impact couples' daily lives. As such, interventions like 2GETHER can address the impact of macro-level factors on couples at the more proximal micro- and mezzo levels. For example, our decision to include group sessions was based on formative work that showed that sexual-minority couples lacked social support for their relationships and were interested in learning about relationships from other couples like them (Greene et al., 2015). Connections with other sexual-minority men in the groups can help normalize their relationships in communities that may hold negative views of sexual-minority couples. As described above, holding sessions in the LGBT community center with facilitators who identified as LGBT individuals or allies may have helped mitigate concerns about unaffirming providers or environments of care for some couples.

We explicitly address macro-level issues in the group sessions when participants engage in discussions of personal experiences of minority stress and its impact on their relationships (Frost & Meyer, 2009; Rostosky et al., 2007). Common examples include concerns about coming out as a couple (e.g., bringing a same-gender partner to family events makes one's sexual-minority orientation more visible), or discrimination experienced by one or both partners that impact the relationship. During the coping skills section, the facilitators present a vignette describing a fictional couple in which one partner is worried that he will lose his job if his coworkers find out that he is gay, and the other partner is upset that he cannot attend work-related social events with his partner. Participants identify potential stressors and coping strategies the couple could engage in together. This exercise allows participants to consider how macro-level factors may influence their own relationships, and that micro-

level strategies can help them cope with their ensuing relationship concerns together. The following case example illustrates how 2GETHER addresses negative societal attitudes about LGBT individuals when this topic arises during the communication skills session.

Case Example—Ricky (age 23, Hispanic) and Michael (age 22, White) had been in a relationship for 1 year. At the beginning of Session 3, Ricky and Michael discussed having different levels of comfort with public displays of affection (PDA). Michael felt very comfortable with PDA and believed that it validated their relationship. Ricky was hesitant about engaging in PDA, especially in certain contexts like when around friends or family. Ricky grew up in rural Alabama and met Michael immediately upon moving to Chicago. Ricky also had only recently come out to his family, and based on his parents' strong negative reactions, he had not disclosed his relationship with Michael.

In opening the discussion, Ricky shared that he felt very uncomfortable holding hands, hugging, and kissing in public. He expressed concerns that other people would judge him negatively if they saw him engaging in PDA with Michael, that it would make other people uncomfortable, and that someone might say or do something aggressive or violent in response to seeing his PDA. Ricky attributed these fears to the social and religious climate in which he was raised, and having seen other LGBT people in the South be victimized or harassed. He felt somewhat more comfortable engaging in PDA in neighborhoods that were known to be LGBT-friendly. Ricky was often preoccupied with these concerns, but he rarely shared them with Michael. As a result, Michael felt rejected when Ricky would resist his acts of affection, and Michael felt that not acknowledging their relationship to Ricky's family undermined its legitimacy.

The facilitator helped Ricky and Michael to describe their experiences with PDA to each other and guided the couple to consider each other's feelings and perspective (i.e., Ricky's fear, Michael's feelings of rejection). By doing this, the couple developed a deeper appreciation for how macro-level factors (e.g., stigma) influenced their connectedness and, in turn, they were able to brainstorm potential solutions to this problem. For instance, they discussed avoiding PDA in neighborhoods where Ricky felt uncomfortable, and Ricky taking more initiative to express affection in environments in which he felt safe. They also acknowledged the fact that Michael's parents were more accepting of their relationship than Ricky's parents would be, that this was unlikely to change anytime soon, and decided to accept this for now rather than struggle with it. Ricky acknowledged that other family members may be more accepting, and that he would consider disclosing his relationship with Michael to his sister, with whom he was close, as a first step. This example illustrates how societal stigma and family acceptance can impact sexual-minority couples, and how micro-level interventions such as encouraging the use of effective communication, problem solving, and acceptance skills can help couples identify ways to cope with macro-level factors that they may be unable to control.

Conclusion

HIV disproportionately affects young sexual-minority men in relationships (Goodreau et al., 2012; Sullivan et al., 2009, 2012). Effectively addressing HIV risk among young male

couples necessitates approaches that move away from focusing on individual risk factors and toward broadly improving the couple's relationship and sexual health. As a range of micro-, mezzo-, and macro-level factors can shape sexual-minority men's romantic relationships, interventions must recognize and address how such factors may influence relationship functioning and HIV risk to be maximally effective.

Clinical Considerations

We developed 2GETHER in response to the lack of evidence-based, integrated relationship education, sexual health, and HIV prevention programs available for male couples, and as such, it is intended to be administered as an intervention package. To this end, we are currently examining 2GETHER's efficacy in two large-scale RCTs—one in person and one online. For clinicians and community-based organizations (CBOs) interested in implementing 2GETHER as a standalone intervention, results from our pilot study provide support for its feasibility, acceptability, and preliminary efficacy (Newcomb et al., 2017). Yet we recognize some potential barriers to 2GETHER's implementation. For example, some clinics or CBOs may prefer to not adopt an intervention package before larger trials demonstrate its efficacy and effectiveness, some may be reluctant to use manualized interventions or come from training programs that do not prioritize evidence-based interventions, many clinics or CBOs may not have the patient population or infrastructure to feasibly implement the entirety of the intervention where they practice, and logistical considerations for group interventions (e.g., scheduling, recruitment) may make adherence to our program a challenge. In these cases, our work and the emerging literature on couples-based HIV prevention and relationship education interventions for sexual-minority men (Hoff et al., 2016; Whitton & Buzzella, 2012; Whitton et al., 2016; Wu et al., 2011) points to several concrete recommendations that clinicians can integrate into their practice instead of implementing the entire intervention protocol.

Micro-Level Considerations—There are numerous micro-level factors to consider when providing HIV prevention and relationship education to young male couples, and sex and sexuality are among the most important areas for clinicians to address (Mitchell, 2014b; Newcomb et al., 2017; Whitton & Buzzella, 2012). Although sexual satisfaction is strongly linked with relationship satisfaction (Byers, 2005), many relationship interventions inadequately address couples' sex lives (Lieser et al., 2007). Thus, it is critical for clinicians to be knowledgeable about sexual health promotion in the context of relationships. Those working with young male couples should be familiar with topics such as relationship agreements (e.g., LaSala, 2001), how couples' relationship dynamics and HIV statuses may impact sexual practices and HIV/STI preventive behaviors (e.g., Darbes, Chakravarty, Neilands, Beougher, & Hoff, 2014), preferences for being the insertive versus receptive partner during anal sex or for engaging in both roles (e.g., Moskowitz, Rieger, & Roloff, 2008), and combining biomedical and behavioral approaches for HIV prevention such as PrEP and condoms (U.S. President's Emergency Plan for AIDS Relief, 2011).

When working with young male couples, clinicians should proactively assess the couple's relationship agreement and sexual satisfaction, as couples may be reluctant to express dissatisfaction with their sex life or be uncomfortable discussing sex. In addition, some male

couples do not have relationship agreements or may disagree about the rules of their agreements, which can promote conflict and increase the likelihood of engaging in HIV risk behaviors (e.g., Gomez et al., 2012; Hoff et al., 2010; Mitchell, 2014b; Mitchell et al., 2017). Questions like “What is your understanding of your current relationship agreement with your partner?”; “How satisfied are you with that arrangement?”; and “What is going well and what changes, if any, would you like to make in your sex life together?” can be incorporated into the clinician’s initial evaluation of the couple, which can help determine whether the relationship agreement and sexual satisfaction are central areas of concern. It is helpful to ask these questions of each partner, rather than allowing one partner to serve as the spokesperson for the couple, to assess for discrepant perspectives on these issues. Other questions about each partner’s HIV/STI status and what HIV/STI prevention methods they are currently using with their primary partner and any outside partners are important to ask for the clinician to guide conversations about sexual and relationship health. As it may be uncomfortable for some people to disclose sensitive information, clinicians can gather details about the couple’s sexual health, satisfaction, and agreement from each partner separately in intake forms or questionnaires. If collected during an interview, clinicians should take care to ask such questions in a matter-of-fact and nonjudgmental fashion.

Clinicians should consider the extent to which mental health and substance use could influence couple functioning and treatment response. Sexual-minority men are at increased risk for mental health problems (e.g., depression, anxiety, substance use) compared to heterosexual men (e.g., Bostwick, Boyd, Hughes, & McCabe, 2010; Marshal et al., 2011; Meyer, 2003; Talley, Hughes, Aranda, Birkett, & Marshal, 2014), and such concerns are associated with worse relationship functioning in the general population (Whisman & Baucom, 2012) and among same-sex couples (Whitton & Kuryluk, 2014). Therefore, it is likely that couples presenting with relationship problems will also present with individual mental health concerns, which could influence responsiveness to 2GETHER. As we did not design 2GETHER to address mental health, if a couple presents with relationship problems and mental health concerns, then trained clinicians who are implementing the intervention should determine whether it is appropriate to proceed with 2GETHER or whether mental health symptoms require more immediate attention. In our ongoing RCTs, nonclinician facilitators consult with clinically trained supervisors about an appropriate course of action when concerns about individuals’ mental health arise. If the clinical supervisor determines that an individual or couple may benefit from more intensive intervention, the nonclinician facilitator utilizes motivational interviewing strategies (e.g., asking for permission to provide information) to provide referrals to mental health providers.

In the pilot trial, 2GETHER did not lead to significant reductions in depression and alcohol use problems from pre- to posttreatment (Newcomb et al., 2017). Although the intervention did not specifically target substance use, it was a frequent area of conflict between partners, and some of the coping skills included in the intervention were relevant to reducing substance use problems. Also, as substance use is associated with condomless anal sex, especially in serious relationships (Newcomb & Mustanski, 2014; Vosburgh, Mansergh, Sullivan, & Purcell, 2012), we recently added content to 2GETHER to target substance use in serious relationships, which we are testing in our ongoing RCTs with couples that report recent binge drinking or illicit drug use.

Mezzo-Level Considerations—Clinicians can address mezzo-level factors in their practice by making efforts to ensure their environment of care is inclusive of sexual-minority individuals, as well as to increase their competency in working with these groups, which together can promote a sense of trust and safety for clients and set the stage for intervention success. Although graduate programs in psychology and other helping professions generally provide minimal, if any, training on sexual-minority health and HIV prevention, efforts to improve and evaluate cultural competence are increasing (Boroughs et al., 2015). In addition, there are numerous resources clinicians can use to begin to familiarize themselves with these topics.

For instance, the National LGBT Health Education Center (<http://www.lgbthealtheducation.org>) and the American Psychological Association's Practice Guidelines for LGB Clients (<http://www.apa.org/pi/lgbt/resources/guidelines.aspx>) have excellent, provider-centric online resources about health-related issues facing the LGBT community in the United States, as well as suggestions on creating a welcoming environment of care. In addition, Matza, Sloan, and Kauth (2015) provide a list of reports and webinars aimed at increasing provider knowledge about LGBT patients and rate how well they address topics such as terminology, health and health disparities, and differences within LGBT populations. For an in-depth overview of LGBT health research and health disparities, the Institute of Medicine's landmark report, *The Health of Lesbian, Gay, Bisexual, and Transgender People*, is an excellent guide (Institute of Medicine, 2011). For HIV testing, prevention, and treatment recommendations, reliable provider- and consumer-centered websites include the Centers for Disease Control and Prevention's "HIV Basics" (<https://www.cdc.gov/hiv/basics/index.html>) and AIDS InfoNet (<http://www.aidsinfonet.org>). Although many of these resources focus on individuals, many of their principles are relevant to couples. Finally, scholarly articles can orient clinicians to common concerns facing male couples specifically (Greene et al., 2015; Hoff et al., 2016; Mitchell, 2014b; Whitton & Buzzella, 2012). That said, as sexual-minority couples in many ways are more similar than different to heterosexual couples (Macapagal et al., 2015), clinicians should be mindful of the fact that their presenting concerns may not always be related to their sexual-minority identity.

Macro-Level Considerations—Clinicians should be cognizant of the current sociopolitical climate and societal attitudes toward sexual-minority individuals and whether members of the couple live or were raised in more conservative or progressive areas or households. Clinicians should also remain informed about current and proposed policies that may affect sexual-minority individuals and couples, such as those defining marriage or domestic partnerships; restrictions about parenthood and family building (e.g., adoption laws); and legal rights involving property, finances, health care, housing, or employment. Together, these larger contexts can shape how sexual-minority couples approach different aspects of their relationship, including public acknowledgment of their relationship; expectations regarding monogamy, marriage, or family planning; and adherence to gender roles.

Clinicians themselves can also be agents of social change (Rostosky & Riggle, 2011). For instance, clinicians may become active in their local communities to make school-based sex

and relationship education programs medically accurate and more inclusive of sexual and gender minorities. Further, clinicians can engage others in social change or speak out against social injustices that impact LGBT couples. This might include rallying clinicians or researchers to become politically involved, speaking at public hearings and to the media, or writing in popular outlets about the psychological impacts of heterosexist legislation on LGBT couples and families (Rostosky & Riggle, 2011). As research has shown, structural stigma in sexual-minority individuals' immediate social context and in legislation at the state and national levels can have significant effects on their health outcomes (Hatzenbuehler, 2014; Hatzenbuehler, Phelan, & Link, 2013). For instance, prior to the establishment of marriage equality laws in the United States, sexual-minority adults in states that banned same-sex marriage had worse mental health than those in states with inclusive marriage policies (Hatzenbuehler, McLaughlin, Keyes, & Hasin, 2010). These findings highlight the importance of expanding how clinicians think about promoting change for their individual clients as these larger macro-level shifts have the potential to change individuals and couples at the micro level as well.

Limitations and Future Directions

Although 2GETHER was not designed for couples assigned female at birth or couples that include at least one gender-minority (e.g., transgender or nonbinary) partner, many aspects of the program are relevant to all sexual- and gender-minority couples, such as the focus on minority stress and its impact on relationships, effective communication and coping skills, and sustaining sexual pleasure in a long-term relationship (Whitton & Buzzella, 2012). However, other elements of the program may need adaptation to reflect the partners' genders and sexual identities as well as their sexual behavior. For example, among sexual-minority female couples, HIV prevention strategies may be de-emphasized provided the individuals do not have sex with male partners, and barriers to engaging in sexual and reproductive health care could be covered (Scott & Rhoades, 2014). For clinicians working with couples that include at least one gender-minority partner, relationship and sexual health programs should incorporate content addressing stressors related to gender transitions (whether social, physical, or medical), navigating sexual intimacy, and victimization and marginalization experienced by gender minorities, among other areas (Gamarel, Reisner, Laurenceau, Nemoto, & Operario, 2014; Platt & Bolland, 2017).

Finally, many individuals in rural or isolated areas may not have access to a university, community center, or health care system that is equipped to provide LGBT-affirming care (Ard & Makadon, 2012). In addition, some may feel uncomfortable attending in-person interventions due to factors like social anxiety, internalized stigma, or concern that others will find out about their sexual orientation. To overcome these issues, we recently adapted 2GETHER for an online format that involves delivery of group and individual sessions remotely via videoconferencing technology. We are currently in the process of evaluating the feasibility, acceptability, and efficacy of this approach, but we believe it has tremendous potential to reach young male couples who are most in need of affirming, couple-based services.

Taken together, our experience developing and testing 2GETHER indicates that HIV prevention programs for young male couples should reflect the unique contexts shaping sexual-minority individuals' relationships and lives, and that programs should intervene within and across multiple levels when possible to improve health for sexual-minority men. In turn, programs that better suit the needs and experiences of sexual-minority couples can set the stage for healthier relationships and families in the LGBT community.

Acknowledgments

This research was supported by grants to Michael Newcomb from the Sexualities Project at Northwestern University, the National Institute on Drug Abuse (DP2DA042417), and the National Institute on Alcohol Abuse and Alcoholism (R01AA024065). Brian A. Feinstein's time was supported by a grant from the National Institute on Drug Abuse (F32DA042708). We would like to acknowledge the facilitators for this project: Ryan Coventry, David Drustup, John Frank, Kelsey Howard, Darnell Motley, and Tyson Reuter. We are also grateful to Sam McMillen, Brian Mustanski, Sarah Whitton, Julia Dudek, George Greene, Gregory Phillips, and Zenaida Rivera for their support and contributions to various stages of the project. Finally, we would like to thank all the couples that participated in this program for their time and perspectives.

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Highlights

- Few programs to improve sexual-minority couples' sexual and relationship health exist
- 2GETHER is a cognitive-behavioral relationship education program for male couples
- The program addresses macro-, mezzo-, micro-level factors affecting relationship health
- These include partner factors, affirming care environments, and sociopolitical climate
- Case examples show how 2GETHER addresses multilevel influences on couples' health

2GETHER Relationship Agreement

This signifies that _____ & _____
created/revised a relationship agreement on _____, 20____.

Together we have decided to have a relationship that is
(e.g., open, monogamish, monogamous, other)

For us, that means that...

(Who you are allowed to have romantic, sexual, and/or emotional encounters with? Are there any limitations to these encounters?)

Our decisions on risk reduction options are:

(Who will you use condoms with now? How will you determine if it's safe to change your plan?)

Our policy on HIV and/or STI testing is:

(How often will you get tested? Will you tell your partner? If you are HIV-positive, time for VL test.)

If one or both of us breaks the agreement, then we will:
(Will you tell your partner? Under what circumstances? How does this affect HIV/STI testing and condom use?)

We will revisit this agreement every:
(How often? How will you remember or remind each other? Where will you keep this agreement?)

Anything additional:

Signature: _____ **Date:** _____

Signature: _____ **Date:** _____

Figure 1.
 2GETHER relationship agreement worksheet.

Table 1**Summary of 2GETHER Intervention Content**

Topic	Content
Session 1 (4 hours)	
Orientation and agenda setting	<ul style="list-style-type: none"> Set agenda, describe 2GETHER purpose, structure, and ground rules Discuss motivations for participation
Healthy relationships and being in a same-sex relationship	<ul style="list-style-type: none"> Describe features of healthy and unhealthy relationships Summarize similarities and differences in same- and opposite-sex relationships
Communication skills training, Part 1	<ul style="list-style-type: none"> Discuss learned nature of communication and how it may differ in opposite-sex versus same-sex couples (e.g., increased possibility of withdrawal among male couples) Identify ineffective and effective communication skills Role-play effective and ineffective communication related to common relationship problems
Sexual health overview	<ul style="list-style-type: none"> Discuss variability in sexual desire, needs, and frequency in long-term relationships Review HIV/STI risk behaviors and epidemiology for young male couples Discuss behavioral (e.g., condoms) and biomedical HIV prevention methods (e.g., PrEP, viral suppression) Define the HIV test “window period” (i.e., amount of time needed for a test to accurately detect HIV after exposure to HIV) and couple-based HIV testing Present “four Ts” (i.e., talk, test, test, trust), a decision-making tool to guide condom discontinuation decisions in serious relationships
Pleasurable activities	<ul style="list-style-type: none"> Discuss how pleasurable activities can improve connectedness in long-term relationships Practice effective communication skills while planning a date
Session 2 (2.5 hours)	
Agenda setting and homework review	<ul style="list-style-type: none"> Set agenda, review homework (communication practice), barriers to completion
Coping skills training	<ul style="list-style-type: none"> Describe impact of minority stress (e.g., stigma, unaccepting families, gender role expectations) and relationship stress (e.g., conflict) on relationships Review ways of coping and impact of coping on couple functioning Evaluate ways each partner helps the other to cope with stress
Problem solving	<ul style="list-style-type: none"> Teach AIMM problem-solving framework and apply it to hypothetical problems
Social and community support	<ul style="list-style-type: none"> Discuss importance of social and community support for sexual- minority individuals Describe changes in each partner’s social life after entering the relationship (e.g., less time spent with friends, at bars, on sex/dating smartphone applications) Analyze existing sources of social support and ways to strengthen these supports if desired
Acceptance	<ul style="list-style-type: none"> Discuss acceptance and identify situations that may benefit from it
Session 3 (1.5 hours)	
Agenda setting and homework review	<ul style="list-style-type: none"> Set agenda, review homework (communication/problem-solving practice), barriers to completion
Communication skills training, Part 2	<ul style="list-style-type: none"> Identify individual strengths and weaknesses related to communication Name two problems a couple would like to use to rehearse communication in the session

Topic	Content
	<ul style="list-style-type: none"> • Demonstrate effective communication skills while discussing each problem • Obtain feedback about the couple's use of effective and ineffective communication • Apply AIMM problem-solving framework to problems identified in session
Session 4 (2 hours)	
Agenda setting and homework review	<ul style="list-style-type: none"> • Set agenda, review homework (communication/problem-solving practice), barriers to completion
Healthy sexuality and HIV prevention for couples	<ul style="list-style-type: none"> • Discuss sexual satisfaction and meeting each partner's sexual needs • Couple-based HIV testing or medication adherence counseling (depending on HIV status) • Appraise whether "four Ts" were followed in couple's relationship
Creating a relationship agreement	<ul style="list-style-type: none"> • Discuss current relationship agreement and satisfaction with agreement • Negotiate details of relationship agreement using effective communication skills • Construct agreement to reduce risk behavior within the couple and with outside partners (see Figure 1), define relationship boundaries (i.e., monogamous or open relationship), discuss HIV/STI preventive behaviors and HIV/STI testing frequency • Role-play potential breaks in agreements, discuss impact on sexual health and relationship
Goal setting, troubleshooting, and wrap-up	<ul style="list-style-type: none"> • Set three goals to improve relationship and sexual health in the future • Anticipate potential lapses in skills • Reflect on lessons learned in 2GETHER