

ADOLESCENTS LIVING SAFELY:

AIDS AWARENESS, ATTITUDES, AND ACTIONS

FOR GAY, LESBIAN AND BISEXUAL YOUTHS

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DEDICATION

This manual is dedicated to DAMIEN MARTIN, a researcher and community activist who dedicated his life to helping gay and lesbian youths, and to the service providers and youths who collaborated with us to produce this manual.

This manual is also dedicated to CALVIN SELFRIDGE, a researcher at the HIV Center and an AIDS activist who contributed significantly to this manual.

PREFACE

Many persons collaborated in generating the ideas and procedures outlined in this manual. Perhaps most important are the lesbian and bisexual youths who shared their lives and themselves with us from 1987-1991. These youths taught us about their daily challenges, the sexual and drug situations common to inner-city streets in New York, and the strengths that enabled them to develop into healthy, contributing adults. We owe these youths a great deal.

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OVERVIEW

This training manual is a guide to help educators provide an intensive HIV prevention program to gay, lesbian, and bisexual adolescents whose behaviors place them at risk for HIV infection. As educators, the challenge before us is to develop a prevention program for adolescents that will bring about behavior change to reduce their risk of contracting HIV/AIDS.

A theoretical model for a preventive intervention is presented, along with 225 session plans to guide adults working with high risk youth. A major strength of this program is that activities are based on a theoretical framework for the intervention. Use of a cognitive-behavioral model in AIDS prevention yields a practical and theoretically-grounded approach for helping adolescents that can be tailored to suit the needs of the client population, institutional setting, and community.

When dealing with adolescents whose behavior places them at high risk of contracting HIV/AIDS, it is important to understand their behavior in a developmental context. In the overview, we describe why adolescents as a group are at-risk, summarize developmental issues, and outline special concerns regarding the prevention of AIDS in adolescents. In addition, we review the theoretical model and the goals and objectives of the intervention.

We have prefaced the practical with the theoretical in this manual because we realize that the practitioner is the best judge of how to handle a particular situation if guided by a theoretical understanding of how and why an intervention activity helps adolescents. We believe it is important that people working with high-risk adolescents understand the rationale for the sequencing of preventive activities and the intended goals of overcoming barriers and increasing motivation to act safely. In particular, we aim to increase adolescents' awareness and understanding of their own feelings before trying to increase knowledge, positive attitudes or behavioral skills, which are the other essential components of the intervention program. If adolescents can not talk about and understand their feelings, they are not going to be able to break through emotional barriers to talk about safer sex with potential partners and avoid drug use. The session outlines in this manual have been designed to stand on their own.

The pressing need for AIDS intervention with lesbian/gay and bisexual adolescents is a consequence of the epidemic's clear impact on their lives. What follows is an examination of the magnitude of the problem, and why lesbian/gay and bisexual youths are at risk.

AIDS and Adolescents: Why Teens are at Risk

By July 1991, 186,895 Americans were reported to have AIDS (Centers for Disease Control, 1991). Only ten years have passed since the first cases of AIDS were reported (mid-1981). Although there has been scientific progress in determining the cause of AIDS infection by a virus called human immunodeficiency virus (HIV), there is still no cure or preventive vaccine available.

As of July of 1991, the CDC reported that 715 of the documented cases of AIDS in the U. S. were diagnosed among adolescents aged 13-19 (CDC, 1991). Although this represents a prevalence rate of less than 1% of all AIDS cases, 20% of all persons known to have AIDS are adults in their twenties (CDC, 1989). The period between infection with HIV and the development of AIDS is estimated to be 11 years on average. Thus, the magnitude of the risk to adolescents becomes clear; many young adults became infected during their teenage years.

Over a fourth (25%) of the documented adolescent cases are female, more than double the rate in the adult population (10%). Sexual activity is the predominant route of transmission for these youth, accounting for at least 39% of the cases (CDC, 1991). Patterns of infection differ among male adolescents, where 38% are due to homosexual activity and 37% are associated with hemophilia (CDC, 1989). Clearly, to reduce the risk of infection to adolescents, we must understand their

sexual behavior. The following overview addresses these issues and their relation to and impact on lesbian/gay and bisexual adolescents.

Definition of lesbian and gay adolescents

In this manual, lesbian and gay male adolescents will be defined as youths who self-identify as lesbian/gay or bisexual. These adolescents may or may not engage in sexual intercourse with same-sex partners. Based on our past research with gay male adolescents, it is likely that about 60% of male youths at gay-identified agencies will label themselves "gay" and will almost exclusively fantasize, become aroused, and be attracted to same-sex partners, and about one-third are likely to self-label as bisexual and will be more likely to have sexual fantasies, become aroused, attracted to, and engage in sexual intercourse with both genders (Rosario, 1991). Retrospective reports indicate that lesbian and gay male adults went through a period where almost half identified themselves as bisexual while only one-fifth currently do so (Jay & Young, 1979).

Adolescents who are actively exploring their sexual orientation and who are seeking services at service agencies or support groups are not representative of all lesbian and gay persons and may comprise only a small subgroup. Similar to their heterosexual peers, gay and lesbian adolescents are a diverse group. The majority of gay and lesbian adolescents make a relatively smooth transition to adulthood. However, it is during adolescence that some lesbian and gay youths become aware of their sexual orientation (Hunter & Schaecher, 1987). Retrospective reports indicate many adult lesbian and gays did not begin to come-out until early adulthood (e.g., Jay & Young, 1979), even if they recognized attractions to same-sex persons. While not representative of all lesbians and gay persons, youths who are experiencing difficulty in coming-out are those most likely to be at highest risk for HIV. Developmentally, adolescents lack the coping skills to deal with a process of exploration that is likely to elicit negative reactions from family, friends and peers. This process demands sophisticated social skills to negotiate difficult interpersonal encounters.

Lesbian and gay youths are at risk for HIV.

Lesbian adolescents. At the beginning of the AIDS crisis until the late 80's, lesbians were believed to be at low risk for HIV infection. The lack of data on lesbians in general, and lesbian adolescents in particular, masks the true picture of their sexual behavior. Because there are very few studies on lesbian adolescents, speculation about their HIV risk behaviors must be based on adult lesbians. According to the CDC AIDS caseload (CDC, 1988), there were 182 women with AIDS who were identified as lesbian or bisexual (Chu et al., 1990). However, the actual number of infected lesbians is likely to be much higher than the reported AIDS cases. Among these AIDS cases, most contracted HIV through injecting drug use (IDU) (85%) and heterosexual transmission (9%). In addition to IDU, higher rates of substance use have been reported among lesbians compared to heterosexual women (Lewis et al., 1982; McKirnan & Peterson, 1989a). It is important to note that one recent report found that 38% of female IDU's are sexually involved with females (Magura et al., 1992), and many self-identified lesbian adults report heterosexual behavior (e.g., Bell & Weinberg, 1978; Chapman & Brannock, 1987; Cochran & Mays, 1988; Hunter et al., 1992; Jay & Young, 1979). Lesbian adults report fewer male partners than heterosexual women, considering they are likely to have heterosexual contact with gay and bisexual men (Reinisch et al., 1988), men with a high HIV seroprevalence rate (cf. CDC, 1992). Lesbians initiate sex with males earlier than with female partners, typically beginning in adolescence (M=16.8 years; Hunter et al., 1992) and continuing for eight years (Chapman & Brannock, 1987).

The very limited data on lesbian adolescents indicate that lesbian girls often report having male and female sexual partners (Savin-Williams, 1990). Lesbian adolescents appear to attend the same social service agencies and programs as gay male adolescents (Gerstel et al., 1989; Martin & Hetrick, 1988; Schneider, 1989), and cross-gender friendships may evolve into sexual experimentation (Savin-Williams, 1990). About half (49%) of the gay male adolescents in our recent study engaged in intercourse with females and males, although the sexual orientation of female partners is unknown; these gay males were far less likely to use condoms with their female partners than with their male partners (Rotheram-Borus, Rosario, Meyer-Bahlburg, et al., 1992). These data confirm clinicians' impressions that many lesbian adolescents engage in heterosexual behavior, sometimes with multiple partners, and infrequently use condoms (Hetrick & Martin, 1987; Hunter & Schaecher, 1990; Schneider, 1989; Trolden, 1989). If the partners of gay boys are lesbians, these girls are at high risk for HIV. Alcohol and drug use among lesbian adolescents (Hetrick & Martin, 1987), which can disinhibit sexual behaviors, also increases sexual risk acts.

Gay male adolescents. Gay adolescent males are at high risk for HIV (e.g., Remafedi, 1987a; Rotheram-Borus, Rosario, Meyer-Bahlburg, et al., 1992). Sexual activity between males is the primary HIV risk factor for one-third of adolescent males with AIDS (CDC, 1992) and accounts for two-thirds of 20-24 year-old males with AIDS, suggesting these young men were infected with HIV during adolescence (Miller et al., 1990). Estimates of HIV infection rates indicate that gay adolescents and young adults are at greater risk than older gay males (Hoover et al., 1991). Older adolescents are more likely to be HIV seropositive than younger adolescents (Stricoff et al., 1991), consistent with increased sexual and drug use with increased age among adolescents with AIDS (Gayle & D'Angelo, 1991). The limited samples of Black, Latino (Rotheram-Borus, Rosario, Meyer-Bahlburg, et al., 1992), and White gay males (Remafedi, 1987a; Roesler & Deisher, 1972) indicate three patterns of risk. First, gay males are exchanging sex for money (Remafedi, 1987a) or money/drugs (Rotheram-Borus, Rosario, Meyer-Bahlburg, et al., 1992), have multiple male sexual partners (Rotheram-Borus, Rosario, Meyer-Bahlburg, et al., 1992; Remafedi, 1987a; Roesler & Deisher, 1972), and engage in high risk sexual behaviors with adult gay men (Remafedi, 1987a; Roesler & Deisher, 1972); adult gay men have the highest prevalence of AIDS (CDC, 1992) and infrequent condom use (Rotheram-Borus, Rosario, Meyer-Bahlburg, et al., 1992). Second, young adult gay men are more likely to engage in risky sexual behaviors than older gay men (Ekstrand & Coates, 1990; Hays, et al., 1990; Joseph et al., 1989; Kelley et al., 1990). Third, alcohol and substance abuse, which has been linked to risky sexual behaviors (Fullilove et al., 1990) and HIV seroconversion among gay men, are high (Rotheram-Borus, Rosario, Meyer-Bahlburg, et al., 1992; Remafedi, 1987a; Penkower et al., 1991). Many adolescents consider themselves drug dependent (Remafedi, 1987a; Rotheram-Borus, Rosario, Meyer-Bahlburg, et al., 1992) and 58% have been diagnosed as substance abusers (Remafedi, 1987a). These data, which emerge from a subgroup of lesbian/gay and bisexual youths who are seeking services, are disturbing and suggest that HIV risk is high among this population.

Substantial ethnic differences in HIV seroprevalence and in HIV-related risk acts among lesbian and gay adolescents may reflect changes in the coming-out process

Substantial ethnic differences have been found in seroprevalence rates and HIV risk acts that are likely to influence the coming-out process, as well as the design of intervention programs. Black and Hispanic adolescents, like their adult counterparts, are over-represented in the AIDS caseload. Blacks comprise 37% and Hispanics 19% of the adolescent AIDS cases (CDC, 1992); each is more than double their representation in the general adolescent population (Gayle & D'Angelo, 1991). Transmission from same-sex contact is much higher for Blacks (63%) than Hispanics (35%) or Whites (26%; Manoff et al., 1989). Differential seroprevalence rates parallel ethnic differences in sexual and substance use behavior patterns. The types of sexual acts in which lesbian and gay male adults engage vary by ethnicity (e.g., Bell & Weinberg, 1978; Magana & Carrier, 1991). There are also ethnic differences in heterosexual behaviors and condom use among adolescents (e.g., Anderson et al., 1990; Aneshensel et al., 1990; Hofferth et al., 1987; Kann et al., 1991; Miller et al., 1990; Sonenstein et al., 1989), as well as in substance use (e.g., Kann et al., 1991; National Institute on Drug Abuse, 1991). When examining adolescents at lesbian/gay identified agencies, it will be important to consider these youths' ethnic backgrounds as a central influence on their pattern of HIV risk acts (sex and substance abuse), as well as in the coming-out process.

The initial coming-out period appears to be a developmental process that may place gay and lesbian youths at increased risk for HIV

Similar to their heterosexual peers, achievement of a personal identity is a central developmental task (Erikson, 1950) for gay and lesbian adolescents. This identity search is reflected in many domains (religious preferences, occupation, political philosophy, and gender roles), including sexual orientation. Among heterosexual adolescents, whose sexual orientation is consistent with the mainstream cultural norm, sexual orientation has little salience, similar to the exploration of ethnic identity for White, non-Hispanic adolescents (Rotheram-Borus, 1989). The exploration of sexual orientation by gay and lesbian youths is labeled "coming-out." Several different stage models of homosexual development, which describe a process of increasing adaptiveness as individuals integrate their sexual orientation into their personal and social identity (e.g., Cass, 1979, 1984; Coleman, 1982; deMonteflores & Schultz, 1978; Gibson, 1989; Lewis, 1984; Rigg, 1982; Savin-Williams, 1990; Savin-Williams & Lenhart, 1990; Troiden, 1988, 1989), have been proposed.

Our review of this literature leads us to anticipate a process that has several cognitive, behavioral and attitudinal dimensions. However, we would not label these dimensions as stages, given stages suggest a linear progression throughout two or more steps. The developmental sequences are likely to be diverse and to prove more stressful for gay and lesbian adolescents who come-out during adolescence than for the vast majority of lesbian and gay persons who come-out during early adulthood when personal resources are greater. We anticipate an initial period of presumed heterosexuality among most children (e.g., Sophie, 1986). When feelings, attractions, fantasies or behaviors with same-sex-peer or adults occur or persist, adolescents begin to question and explore their presumed heterosexual orientation and to identify their sexual orientation as lesbian or gay (e.g., Ehrhardt & Remien, in press; Klein et al., 1985).

These feelings of same-sex attraction conflict with internalized expectations of heterosexuality and negative attitudes towards homosexuality (e.g., Paroski, 1987; Remafedi, 1987b). Denial and suppression are initial coping strategies used to defend against homosexual feelings and desires (e.g., Ehrhardt & Remien, in press; Troiden, 1988, 1989). These coping strategies may have direct implications for HIV risk acts, given they may lead to engagement in unsafe heterosexual behavior, which may result in becoming pregnant or fathering a child, and may include use of alcohol or drugs (e.g., Hetrick & Martin, 1987; Hunter & Schaecher, 1990). Since many lesbian and gay adolescents fear rejection and violence by family, friends, or peers in response to their coming-out to them (Hunter, 1990), these adolescents often hide their homosexual feelings. This secrecy can foster stress, but the fear of negative responses to their homosexuality is justified. For example, among gay male adolescents experiencing disclosure or discovery by family or friends, half found the experience to be negative and the other half positive (Rotheram-Borus, Rosario, et al., 1991). In addition, one-half (46%) of lesbian and gay male adolescents have been physically abused by family for being homosexual (e.g., Hunter, 1990). Thus, the initial process of coming-out may be characterized by unprotected sexual intercourse with opposite-sex and/or same-sex partners, negative attitudes towards homosexuality, and low self-esteem.

At some point in the process of exploring and searching one's identity, adolescents are likely to become sexually active with same-gender partners. Some male adolescents have many male sexual partners (Savin-Williams, 1990). Internalized homophobia, lack of role models, and social and emotional isolation make it particularly difficult for adolescents to identify positive role models for coping with high risk situations that may place them at risk for HIV (e.g., negotiating protected sexual intercourse). Models in the media, especially on television, are typically focused on heterosexual negotiation.

As lesbian and gay youths learn more about homosexuality and the gay community over time, they will begin to acquire more positive attitudes about themselves. It is anticipated that as self-acceptance and positive attitudes towards homosexuality increase, HIV related risk acts will decrease. In addition, gay and lesbian adolescents who have coped with the increased developmental challenges and with negative societal reactions may have higher self-esteem and increased skills to solve interpersonal problems.

Thus, the process of coming-out is characterized by at least four dimensions: recognizing oneself as lesbian or gay, exploring sexual orientation by gaining information about one's sexual orientation and the gay community, disclosing to others, and becoming more comfortable with and accepting of one's sexual orientation. How these dimensions may relate to sexual and substance use acts that place youths at risk for HIV will be addressed in this manual.

Society's negative attitudes place lesbian and gay male adolescents at high risk for non-HIV related risk acts and emotional distress during the coming-out process

The coming-out process is likely to impact not only an adolescent's HIV risk acts, but also her/his emotional resources and other associated risk acts. Gay and lesbian adolescents internalize society's negative attitudes, for example, the perception of homosexuals as unhappy (Bell et al., 1981; Paroski, 1987). Suicide attempts among gay male adolescents are more common than is reported among community-based samples (20%—39%, Hetrick & Martin, 1987; Hunter & Schaecher, 1990; Kremer & Rifkin, 1969; Remafedi et al., 1991; Roesler & Deisher, 1972; Rotheram-Borus, Hunter, et al., 1992; Schneider et al., 1989) and increase when these youths are rejected by others (Schneider et al., 1989) and when coming-out is associated with stress (Rotheram-Borus, Hunter, et al., 1992). Lesbian adolescents are often depressed and anxious (Hetrick & Martin, 1987; Kremer & Rifkin, 1969). Our data (Rotheram-Borus, Hunter, et al., 1992) on gay male adolescents indicate this distress may be associated with revealing one's sexual orientation, specifically the inability to predict others' reactions to disclosure, and the negative responses from family, friends and others to disclosure. We also

found that the inability to predict others' responses to disclosure was correlated to risky behaviors, substance use behaviors, and stress in other areas of one's life (Rosario & Rotheram-Borus, 1992).

Risk acts in adolescence typically cluster (Jessor & Jessor, 1977) and this pattern is similar across most ethnic groups (DiBlasio & Benda, 1990; Ensminger, 1990; Fullilove et al., 1991; Goodman & Cohall, 1989; Mott & Haurin, 1988; Newcomb & Bentler, 1988). It appears that this pattern occurs among gay male adolescents who seek services at gay-identified agencies (Hetrick & Martin, 1987; Remafedi, 1987a; Remafedi et al., 1991). In particular, trouble at school, where youths are likely to be rejected for their sexual orientation, and problems with delinquent acts, reflecting youths' marginalization from peers' social networks, may occur during the coming-out process (e.g., Remafedi, 1987a). Cluster behaviors may be reduced as the coming-out process proceeds.

In addition to increasing comfort with one's sexual orientation, the coming-out process can enhance adaptive outcomes

Having a lesbian or gay sexual orientation presents adolescents with daily challenging problems: how to meet others who share their orientation, how to gauge who would respond to a disclosure of sexual orientation in an accepting manner, and how to escape potentially violent situations by those who stigmatize homosexuals. Few gay and lesbian role models are presented in school or by the media. Consequently, adolescents undergoing the coming-out process may develop considerable skills in interpersonal problem solving. Thus, we expect an increase in interpersonal problem solving skills associated with more positive feelings towards homosexuality and oneself.

Furthermore, feeling positive about oneself in the face of negative information and feedback from others is difficult (Meichenbaum, 1974). As an adolescent accepts her/his sexual orientation, acquires information about homosexuality and the gay community, adopts positive attitudes towards homosexuality, and begins disclosing her/his homosexuality to others, an adolescent's self-esteem is likely to be high (e.g., Savin-Williams, 1990).

Homophobia and social isolation impact adolescents who are gay, lesbian, bisexual or unsure of their sexual orientation

From a very early age, seeking social approval is a basic human need. Initially our self-concepts are based on how others see us, respond to us, reward us and disapprove of us. When new behavioral patterns are being established at each developmental period, we turn to others in our family, friends and peer network, religious groups and our community to learn what is expected of us and where we fit in the social structure. This process is particularly strong in the establishment of gender-linked role behavior and patterns of sexual acts.

What happens when children who consistently have been "good kids" feel different from everyone else? Their feelings are at odds with what their parents, friends, family, teachers, doctors, the media define as "normal." How can they solve the dilemma of being true and honest to themselves and maintain the love and respect of their parents, family, friends and teachers? Lesbian/gay and bisexual youths often deal with this problem by hiding from others, denying their homosexual feelings, being beaten when others discover their homosexuality, and being socially isolated.

In contrast to other populations of youths that are stigmatized by society (e.g. African-American, Latino), the issues for lesbian and gay youths are more concealed. While recognizing that racism is strongly entrenched in our society, most people would agree that prejudice against racial and ethnic minorities is wrong. There is no consensus that prejudice against lesbian and gay people is wrong. Children of color were taught to anticipate and cope with racism and prejudice. Lesbian and gay youths have no preparation for their minority status (Hetrick & Martin, 1984). Thus, society's homophobia often leads to social isolation for lesbian and gay youths. While heterosexual youths are learning how to socially interact with peers and adults, lesbian and gay youths are learning how to hide their feelings and desires (Hetrick & Martin, 1984). Hiding can distort the development process. The homosexual youth's internalization of society's negative attitudes towards homosexuality is associated with low self-esteem, depression and suicidal feelings. Society's negative attitude toward homosexuality also places youths at risk for violence and injury.

Knowledge of social routines for successfully negotiating situations that place youths at high risk for HIV are needed to guide future intervention programs

Social competence appears to be critical to the implementation of safer sex practices (e.g. Kelley et al., 1990). Therefore, most successful HIV prevention programs have included social skills training and have attempted to change social norms regarding the way safer sex practices are negotiated. There have been several efforts to assess the social norms of heterosexual adolescents in situations that may place them at high risk. In addition, we need to know the anticipated actions in each situation in order to design interventions to reduce the risk of engaging in unsafe acts in those situations. Thus, there is a need for trainers to identify the situations that are likely to place each youth at risk for HIV. This manual targets this goal repeatedly.

HIV prevention programs for gay and lesbian adolescents must be tailored to consider the impact of the coming-out process

For the past five years, we have been evaluating a preventive intervention delivered to Black and Hispanic, gay male adolescents at one site in New York City. This prevention program has been associated with reducing HIV risk acts, particularly among Black males (Rotheram-Borus, Rosario, & Koopman, 1992). Our clinical observations in implementing the program, staff observations, and youths' reports indicated that HIV risk acts were associated with the coming-out process.

Evidence of bisexual behavior during lesbian adults' adolescence

We recently sampled a group of 141 primarily White (89%), middle and upper-middle class lesbian adults of which 83% were attracted, 92% fantasized, and 80% enjoyed erotica that were entirely or almost always of women (Hunter et al., 1992). The majority of these women had engaged in risky sexual behaviors, particularly during their adolescence. Most had practiced penile-vaginal intercourse (80%), oral sex (72%) and anal sex (23%) with men during their lifetime. By the time these women were 20 years old, the majority (55%) had engaged in penile-vaginal intercourse. Other risky sexual activities with males prior to age 20 included anal sex (7%), active oral sex (47%) and active anilingus (4%), where active means the woman performed the act on her partner. Almost all the women had engaged in oral sex with other women, but less so in anilingus (33%) or vaginal/anal penetration with objects other than tongue or fingers. Sexual activities with females were also prevalent by age 20 for active oral sex (32%) and active anilingus (2%), but not to the same extent as identical experiences with male partners. These women reported lifetime medians of 3.0 male sexual partners and 7.0 female partners, with 80% reporting male sexual partners and all but one woman reporting female sexual partners. By age 21, 45% had come-out to themselves and 36% had come-out to others. Substantial numbers of women had disclosed to family (89%), gay or lesbian friends (90%), heterosexual friends (82%), and co-workers (73%). These data indicate that lesbian adolescents are at high risk for HIV.

Our research efforts with gay male adolescents

During the past five years, our team has been examining the sexual and substance use behaviors of runaways and gay male adolescents and has been delivering an intensive preventive intervention to these youths to reduce their HIV risk behaviors. We have developed a training manual detailing the prevention program (Rotheram-Borus, Miller, et al., 1992), and have received an award from the American Medical Association for excellence in HIV prevention efforts. We have published numerous articles on the HIV risk behaviors of the runaways and gay male adolescents, including an evaluation of the effectiveness of the program with runaways (e.g., Rotheram-Borus, Koopman, et al., 1991).

High prevalence of risky bisexual behaviors, sexual risk with male partners, and substance use behaviors

A consecutive series of new intake cases of 136 gay male adolescents (aged 14-19) to the Hetrick-Martin Institute, a community based agency in New York City providing social and recreational service to gay male and lesbian adolescents, indicated six reasons why these adolescents are at risk for HIV infection (Rotheram-Borus, Rosario, Meyer-Bahlburg, et al., 1992). First, these gay male adolescents reported many sexual partners and encounters [e.g., 56% of our adolescents report

11 or more lifetime male and female partners compared to 7% of a 1988 national survey of predominantly heterosexual adolescent males (Sonenstein et al., 1989)]. Second, they initiated sexual activity at an early age ($M = 12.7$ years with male and female partners). Third, they engaged in risky sexual behaviors (e.g., 79% had engaged in receptive or insertive anal sex; significantly more had engaged in receptive than insertive anal sex). Fourth, nearly a quarter (23%) exchanged sex for money or drugs, usually with male partners. Fifth, condom use was inconsistent given many (52%) reported never, rarely or sometimes using a condom with male partners and it was typically initiated approximately a year after sexual activity began. Sixth, although no adolescents reported sharing needles, the prevalence of alcohol and drug use was much higher than that of national samples of adolescents (National Institute on Drug Abuse, 1991). For example, the frequency of using alcohol, marijuana or cocaine/crack at least weekly was approximately two to five times higher in our sample. In addition, the frequency of using alcohol, marijuana or cocaine/crack was related to number of male sexual partners, as well as ever engaging in oral or anal sex with these partners (r ranges between .16—.29). Further, as the frequency of cocaine/crack use increased among the adolescents, condom use decreased. For the sexual and substance using acts, there were no ethnic differences between Hispanics and Blacks, and the data appeared quite similar to data on White, middle-class homosexual adolescents in Minneapolis/St. Paul (Remafedi, 1987a) and Seattle (Roesler & Deisher, 1972). Lastly, 49% of the adolescents reported engaging in penile-vaginal intercourse and 7% reported anal intercourse with females. Of these heterosexually active adolescents, only 52% reported ever using a condom with a female partner, a significantly lower rate than ever using condoms with a male partner (86%). Age was related significantly to ever engaging in heterosexual activities. A tenth of adolescents were involved sexually with females during the three months prior to the interview. According to discussions with community based agency personnel, many of the female partners were lesbian peers.

Evidence of HIV behavioral change among gay male adolescents

These adolescents benefitted from receiving services at a gay-identified agency and from participating in the HIV preventive intervention we developed to reduce HIV risk acts (Rotheram-Borus, Rosario, & Koopman, 1992). The efficacy of the intervention varied by ethnicity, considering between 6-8% of the variance in protected anal or oral sex was uniquely explained by the interaction effect of intervention dosage by ethnicity. For anal sex with male partners, the data indicated that Black gay males initially engaged frequently in unprotected sexual activities, but improved the most in protected acts within a year (38% and 80%, respectively). Hispanic gay males initially engaged in high rates of protected acts and continued to do so a year later (68% and 75%, respectively). The few white males in the study ($N=16$) began with the highest rate of protected acts (90%) but decreased over time (65% a year later). For oral sex, all groups started at low levels of protection (20% of acts were protected among Black, 31% among Hispanics and 41% among Whites). Over a year, the rate of protected oral acts for Hispanics improved but then leveled off (40%), Blacks improved (63%), and Whites decreased somewhat (30%).

The efficacy of the intervention was apparent in still another way. Two raters independently examined the ratios of number of condom protected acts over total acts, and reliably categorized the pattern of findings as improved (i.e., consistently got better), variable (i.e., a random pattern in which improvement and decline happened continuously), relapsed (i.e., improved and then declined), or declined (i.e., consistently got worse) over time, from baseline to the twelve months follow-up period (a total of four assessment periods). Seventy-nine percent showed improvement in their condom use during anal sex acts. Although condom use during oral sex declined for approximately a quarter (24%), it improved for a majority (59%). Psychiatric distress at the time of recruitment and substance abuse were the best predictors of behavior change. Knowledge of HIV, positive attitudes towards safe sex acts, self efficacy, and perceptions of risk were not found to be related to behavior change.

Need to explore further the stress of coming-out and associated risks and benefits

Gay male adolescents experienced four times the amount of stress across life domains (e.g., school, peers) than other adolescents (Rotheram-Borus, Rosario, et al., 1991). Increased stress associated with the adolescent's homosexuality (e.g., arguments with family or between family members may be over the adolescent's homosexuality). Stress related to coming-out was high, with individual prevalence rates varying between a quarter to one-half for coming-out to others, being discovered by others or someone ridiculing their sexual identity. Moreover, the adolescents could not predict whether others would respond positively or negatively to disclosure or discovery of their homosexuality.

Stress related to coming-out was strongly related to stress in other life domains (r between .40 to .53 for family, peers, school, etc.) and had important implications for HIV prevention (Rosario, Reid & Rotheram-Borus, 1992). Stress related to coming-out also was positively correlated to engaging in unprotected oral and anal sex, including both receptive and insertive anal sex (r between .19 and .23). It was also related to alcohol and drug use, as well as frequency of marijuana and heroin use, and to health problems attributed to alcohol and drug use (r between .19 and .41). Stress at coming-out was significantly more common among suicide attempters compared to non-attempters (Rotheram-Borus, Hunter, et al., 1992), a grave concern given many of these adolescents (39%) reported attempting suicide.

The onset of sexual intercourse is often characterized by a lack of attention to the prevention of pregnancy and sexually transmitted diseases (STDs) (Cates & Rauh, 1985; Finkel & Finkel, 1978; Kegeles et al., 1988; O'Reilly & Aral, 1985; Zelnick et al., 1981). A compounding factor is that adolescents are frequently reluctant to admit that they have become sexually active and, therefore, are unlikely to accept the fact that they are at risk for contracting an STD. Thus, it is not surprising that condom use is low among teens. A 1975 study (Finkel & Finkel), examining adolescent males' use of contraception, found that only 28% had used a condom at the time of their last intercourse, although a recent national survey found that 58% of males reported condom use the last time they had intercourse (Sonenstein, Pleck & Ku, 1989). Consistent use of condoms during sexual intercourse seems to be extremely low among adolescents, although the figures differ according to the population. Reports indicate consistent use anywhere from a low of 2.1% in a group of female teens at a San Francisco health clinic (Kegeles et al., 1988) to 16% among male runaways (Rotheram-Borus & Koopman, 1991), and 28% among male high school students (Anderson et al., 1990).

Sexually active adolescents typically have sexual experiences with a variety of partners before establishing a long-lasting monogamous relationship. This behavior pattern is unlikely to provide youth with the opportunity to become emotionally close to their sexual partner, decreasing the likelihood that a condom will be used during intercourse (Ewer & Gibbs, 1975). In a population of high school youngsters, 21% reported having two or more partners in the past year (Anderson et al., 1990). Runaway youths may have an even greater number of partners, with males reporting a median of 3 partners in the last three months (Rotheram-Borus & Koopman, 1991). Additionally, this group may exchange sex for drugs or money, further raising their number of partners and increasing their risk of infection (Rotheram-Borus et al., in press).

Moreover, cultural norms and sex roles may contribute to placing adolescents at risk for infection. Assertiveness and conquest-seeking are aspects of the masculine identity that can be associated with seeking to maximize the number of sexual partners—a practice which increases the risk of getting HIV from an infected partner. In contrast, feminine identification is not generally associated with having a large number of sexual partners. Therefore, cultural norms of masculine identification may result in more high-risk behavior among male adolescents (Adams, 1988).

Because adolescents often know little about their sexual partners, it is unlikely that they screen their potential partners regarding previous risk behaviors. Youths often lack the interpersonal skills needed to ask about their sex partner's sexual history (Rotheram-Borus et al., 1987). They also acknowledge that they would be quite uncomfortable if asked about their own sexual history. Moreover, adolescents do not always understand that a person who looks physically healthy can still be HIV positive (Rotheram-Borus & Bradley, 1990).

At the present time, it appears that adolescents have not responded to the AIDS epidemic by changing their risk behaviors. In a telephone survey of 656 adolescents, only 15% reported that they had changed their behavior in response to the epidemic. Of this group, only 20% (or 3% of the total), reported changes that researchers believe actually reduce the risk of infection (Strunin and Hingson, 1987). Furthermore, in a recent multi-city survey, 21% of high school students reported having sexual intercourse with four or more partners (CDC, 1991).

Intervention with Adolescents

Adolescents must cope with difficult interpersonal encounters if they are to avoid engaging in risky behavior. Stress related to coming-out is one source of difficulty. The excitement and lure of new experiences, coupled with the pressure to maintain social status, makes decision making around sex and drugs particularly difficult. Adolescents, keenly sensitive to peer pressure, tend to be limited in their ability to cope with peers who suggest involvement with sex and drugs. To be effective, adolescents need to be able to make refusals and stick to them, to make requests (e.g., "I want you to wear a condom") and to negotiate safe behaviors successfully. Many adults lack these skills; it is not surprising that adolescents need help in developing them.

In research with adolescents in both high schools and runaway sites (Rotheram & Bradley, 1990; Rotheram-Borus et al., 1989), we found that adolescents often "knew" on the abstract level the safest alternatives for a given situation (e.g., use a condom during sexual intercourse), but they did not have the social skills needed to implement this knowledge. Research in developmental psychology (reviewed in Mussen et al., 1984) shows adolescence to be the optimum time for building social skills. Therefore, addressing risk behaviors from a social skills perspective is an effective intervention approach. In particular, adolescents need assistance in building skills to allow them to behave safely at high stress times.

Specific knowledge of HIV and AIDS. If teens are to act safely, they must have accurate information about HIV/AIDS and they must be able to apply it. Adolescents need to know general facts about HIV/AIDS, its transmission, prevention, HIV testing, and so on. Adolescents lacking such knowledge are more likely to engage in sexual risk behaviors, such as having two or more sexual partners and inconsistently using condoms (Anderson et al., 1990). Early studies of adolescents' general knowledge about HIV/AIDS found that adolescents were uninformed (DiClemente et al., 1986; Downer et al., 1987; Price et al., 1985). For example, DiClemente and associates (1986) found that only 60% of their adolescent sample in San Francisco were aware that using condoms helps reduce the likelihood of contracting HIV/AIDS. However, recent evidence (Helgersson & Sabella, 1987; Koopman et al., 1990; Strunin & Hingson, 1987) suggests that adolescents are gaining moderately high levels of general HIV/AIDS knowledge.

A useful distinction in describing general knowledge is that of hot and cold. Hot information is highly meaningful and emotionally laden, having implications for a person's well-being (Folkman, Schaefer, & Lazarus, 1979), whereas cold information is neutral and not affectively laden. The general knowledge adolescents need to learn about HIV/AIDS is hot. It is about highly emotion-laden issues—disease, death, sex, and drugs. It is likely that emotions about these issues can block or disrupt learning about AIDS, just as they can also motivate learning. For example, an adolescent who is highly anxious about the illness and death associated with AIDS may not be easily convinced that HIV/AIDS cannot be transmitted through casual contact. On the other hand, an adolescent who begins to feel positively about her/his own ability to cope with emotional issues will be more likely to change her/his behavior.

Affective awareness. In conveying information about AIDS, it is important to recognize and accept the emotions elicited by the material. Since AIDS is a painful topic—both scary and depressing, it is tempting for adolescents to deny its personal relevance and ignore AIDS information that is presented to them. For adolescents to be able to learn and use this information effectively, they need to be aware of the feelings it elicits. Additionally, adolescents need to be aware of their feelings that are elicited in different risk situations; they need to be able to relate general knowledge about HIV/AIDS to the kinds of situations they personally face.

Youths with multiple problems often lack a general sense of well being. They are also frequently unclear about the source and nature of their feelings. Therefore, one implication for intervention with these youths is that they need help to recognize, label, control, and assess the intensity of their emotional responses. This is an essential aspect of the cognitive-behavioral intervention program presented in this manual; taking one's "emotional temperature" through the use of a "feeling thermometer" and building a personal "risky situation pyramid" are important skills if youths are going to be capable of assessing their responses to varying situations in a step-wise fashion.

Coping skills. The "Just Say No" programs that have been used to try to prevent pregnancy and substance abuse with teenagers have a critical flaw: they fail to consider the power of the social context in which high risk behavior occurs

(Wallack & Corbett, 1987). This cognitive-behavioral intervention program recognizes that adolescents need to have adequate interpersonal problem solving skills in this area, and focuses on activities to improve these skills. A teen-age male attending a party with friends who are smoking crack is faced with a situation in which he needs to make use of several kinds of interpersonal problem solving skills: identifying the risks in the situation, generating alternative actions for dealing with the situation, weighing the likely consequences of these alternatives, and choosing and implementing a course of action. Programs for preventing smoking, alcohol and drug use have demonstrated the importance of interpersonal problem solving skills in prevention programs (Botvin et al., 1984a, 1984b; Schinke, Gilchrist, & Snow, 1985).

Access to services and Resources. Another implication for intervention with multi-problem youths is that they need a comprehensive service network, one that reduces their life stress by meeting their needs across all areas of life—medical, educational, legal, vocational, financial, social, and so on. This program contains specific information and skill building exercises to help youths navigate complicated service networks, recognize where resources are located, and helps them gain access to these resources (e.g., condoms, drug and alcohol services or counseling regarding HIV testing). By having their needs met and experiencing less negative life stress, adolescents will be less prone to the kinds of psychological problems that are likely to mediate risky behavior—depression, anxiety, low self-esteem, and conduct problems.

Summary

Intervening successfully with adolescents to change behavior and reduce risk is rewarding, yet difficult. The following points were highlighted in the preceding section and may prove helpful as a guide for those implementing the Stay Safe program:

- Adolescence is a time of experimentation; this frequently means engaging in unprotected sexual intercourse with multiple partners and use of drugs and alcohol. These are behaviors that increase youths' risk of HIV infection.
- Adolescence is also a time of developing awareness of sexual orientation.
- Developmental changes in behavior, cognition, affect and social norms must be considered as essential elements in understanding risk behavior and effecting change.
- Intervening with adolescents must encompass provision of specific knowledge about HIV/AIDS and homosexuality and must build their affective awareness so they can begin to apply this knowledge to their own lives. Building coping skills and providing access to resources are other essential elements of successful intervention programs.

In this overview, we described why adolescents as a group are at-risk, summarized developmental issues and outlined special concerns regarding the prevention of AIDS in adolescents. In addition, we reviewed the theoretical model and the goals and objectives of the intervention. In the following pages, we present a twenty-five-session plan to guide educators with high risk youths. A major strength of this program is that activities are based on a theoretical framework. Use of a cognitive-behavioral model in AIDS prevention yields a practical and theoretically-grounded approach for helping adolescents. It can be tailored to suit the needs of lesbian and gay clients, institutional settings, and communities.

We present this manual as a method of intervening with adolescents at risk for HIV/AIDS. It was developed through our own work with high-risk adolescent runaways and gay youths. We feel it is of particular importance that the intervention be tailored to the individual needs of teens and the unique stressors they face in their environments. Thus, we encourage program planners to be creative and adapt this intervention to the needs of their own population, thus creating an environment that is positive and most likely to result in lasting change.

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INTRODUCTION

"Stay Safe" is a training manual for programs working with youth at risk for HIV/AIDS. This intensive intervention is based on a cognitive-behavioral model that has been the basis of many previous health promotion efforts with adolescents. A report of the training's effectiveness was recently published (Rotheram-Borus et al, 1991) and later reports are available from the authors .

At the beginning of the manual, group leaders will find brief highlights of what is behind the approach and how to lead the twenty sessions which are the core of the training. These highlights are to prepare group leaders by providing cognitive maps which will guide them through the exercises regardless of the content in any given session. They cover such topics as what assumptions underlie the training, objectives, how to handle problems during the sessions, and how to use the manual. Typically a single page lays out the basics for group leaders. Where greater explanation is needed, there are notes with more detail.

To create a clear, easily understood and implemented training, manual group leaders are provided with a step-by-step description of what to do and say. In reality the highly skilled group leaders who worked with the adolescents in the research study (Rotheram-Borus et al, 1991) were innovative, flexible and spontaneous on the spot. No manual can capture fully the way they would make use of situations brought to them by group members each day.

The manual is designed to show group leaders what can be done with real or simulated situations, what areas need to be addressed, and how to increase specific skills that lead to safer sex behaviors. The constant emphasis is on skill building and enhanced self-efficacy in an environment of peer support. Active practice, participation and sharing are all critical ingredients.

In the training manual are exercises and materials which capture the intent and spirit of the original intervention while they may not have been actually employed in their current form. Preparing this version of the manual was an opportunity to clarify, supplement, edit, and enhance the earlier work. Where possible, there are indications about which material is updated.

A MODEL FOR UNDERSTANDING PEOPLE'S ACTIONS

PEOPLE WILL CONTINUE TO BEHAVE IN A CERTAIN WAY IF.....

- 1. THEY EXPECT SOMETHING GOOD TO COME OUT OF IT.**
- 2. SOMETHING THAT THEY WANT DOES COME OUT OF IT.**
- 3. SOMETHING GOOD COMES OUT OF IT OFTEN.**
- 4. ANYTHING NEGATIVE THAT COMES OUT OF IT HAPPENS A LONG TIME AFTER THE GOOD PART.**

PEOPLE WILL BEHAVE EFFECTIVELY IN THEIR BEST INTERESTS IF.....

- 1. THEY KNOW WHAT IS IN THEIR BEST INTEREST.**
- 2. THEY HAVE THE SKILLS.**
- 3. THEY HAVE OPPORTUNITIES TO LEARN SKILLS IN MANY WAYS: OBSERVING, IMITATING, AND PRACTICING.**
- 4. THEY BELIEVE THEY CAN BE EFFECTIVE AND HAVE EFFECTIVE TOOLS.**
- 5. THEY FIT INTO THE ENVIRONMENT IN WHICH THEY LIVE AND THE ENVIRONMENT SUPPORTS THEM.**

NOTE

The model of human behavior used in this project to understand the issues surrounding adolescents at risk for HIV grows out of social learning theory. Similarly, the interventions selected reflect a cognitive-behavioral approach which also stems in large part from social learning theory.

The emphasis in the twenty-five sessions was to change behavior; therefore, it appeared desirable to present a very simple model of how behavior is acquired and changed. The purpose of this model would be to provide a road map which both group leaders and group members could use.

The preceding page contains the essential ingredients of that elementary model. Embedded in the brief points are concepts about reinforcement, how time affects the strength of rewards, the importance of expectancy, coping, coping skills, the role of beliefs (thought), the value of knowledge, and the role of environmental fit and supports. Later in Session 1 this page is used and explained to the participants.

The following page expands the model for the group leaders. Implications for training are made explicit as well. Some of the ideas are repeated from the model of people's actions, but the essence of "What Are the Underlying Principles of the Workshop" is applying social learning theory and cognitive-behavioral approaches to reducing the risk for HIV in the targeted adolescent population. From these principles can be seen the importance of practicing, observing, and modeling as vehicles for learning new skills and improving old ones.

The development of coping skills are a constant theme. Intellectual skills such as analyzing a risky situation, physical skills such as putting on a condom and using a dental dam, and social-emotional skills such as recognizing one's discomfort level and being able to refuse a request for unsafe sex are all included.

Thoughts are another key factor in the training. How a person appraises threat and determines if she or he can handle it effectively; expectations, beliefs, and dysfunctional thoughts; and self-reward, social problem solving, and self-talk as a guide through provocative situations are an ever present focus of the interventions. The training exercises all flow from the basic tenets of the model.

The training environment itself becomes an intervention. In a safe atmosphere peers support each other, learn from each other, and build each others' self esteem. Thus, group cohesion is developed in every session.

On page 9, group leaders will find the workshop's objectives. These too tie together HIV prevention and the principles of social learning theory. Competency development and self-efficacy are the central themes. The objectives stand on their own without further comment.

THE UNDERLYING PRINCIPLES OF THE WORKSHOP

1. THE BETTER AN EXPERIENCE YOU HAVE, THE MORE LIKELY YOU ARE TO REPEAT IT.
2. THE MORE TIMES YOU HAVE THAT GOOD EXPERIENCE, THE MORE LIKELY YOU ARE TO REPEAT IT.
3. THE LONGER THE TIME BETWEEN THE GOOD EXPERIENCE AND ANY NEGATIVE CONSEQUENCES, THE MORE LIKELY YOU ARE TO REPEAT IT.
4. WHAT MAKES AN EXPERIENCE GOOD IS THE REWARDS YOU GET FROM YOURSELF AND OTHERS.
5. WHAT MOVES YOU IS A DESIRE TO MAXIMIZE YOUR REWARDS.
6. WHAT MAKES YOU EFFECTIVE IN GETTING REWARDS IS EMOTIONAL, BEHAVIORAL, AND COGNITIVE SKILLS.
7. WHAT ALSO MAKES YOU EFFECTIVE IS BELIEVING THAT YOU CAN BE EFFECTIVE.
8. WHAT FURTHER MAKES YOU EFFECTIVE IS HOW WELL YOU FIT INTO THE ENVIRONMENT IN WHICH YOU ARE OPERATING.
9. YOU LEARN THOSE CRITICAL SKILLS THROUGH IMITATION, OBSERVATION AND PRACTICE.

APPLICATIONS TO THE TRAINING

1. IN THIS TRAINING PROGRAM YOUTH ARE FREQUENTLY REWARDED FOR SUCCESSFUL EFFORTS TO PRACTICE SAFER SEX AND ARE TAUGHT HOW TO SELF REWARD.
2. THE ENVIRONMENT IS SUPPORTIVE.
3. SKILLS ARE DEVELOPED.
4. APPROPRIATE BEHAVIOR IS MODELED, AND THERE ARE OPPORTUNITIES TO PRACTICE.
5. YOUTH WORK ON FINDING OUT WHAT THEIR IMMEDIATE EXPECTATIONS AND REWARDS ARE FOR UNSAFE SEX.
6. YOUTH LEARN HOW TO MAKE USE OF THEIR REAL-LIFE ENVIRONMENT.

THE GOALS AND OBJECTIVES OF THE TRAINING

OVERALL GOAL: TO REDUCE HIGH RISK BEHAVIOR

1. YOUTH WILL BE ABSTINENT AND DELAY THE OCCURRENCE OF UNSAFE BEHAVIOR IF THEY HAVE NOT YET HAD SEXUAL INTERCOURSE.
2. YOUTH WILL USE A CONDOM OR DENTAL DAM WHEN ENGAGING IN SEXUAL ACTIVITIES WHERE AN EXCHANGE OF BODY FLUIDS IS POSSIBLE.
3. YOUTH WILL SCREEN POTENTIAL PARTNERS AND AVOID SEX WITH THOSE WHO ARE RISKY OR OF QUESTIONABLE HIV STATUS.
4. YOUTH WILL NOT GET HIGH ON ALCOHOL OR DRUGS BEFORE HAVING SEX.

OBJECTIVES:

1. YOUTHS WILL ACQUIRE GENERAL KNOWLEDGE ABOUT HIV/AIDS: DEFINITIONS, CONSEQUENCES, ROUTES OF TRANSMISSION, HIGH RISK BEHAVIOR, PREVENTION STRATEGIES AND TESTING.
2. YOUTHS WILL BELIEVE THEY CAN GET AIDS, THEY CAN PREVENT THEMSELVES FROM GETTING AIDS, AND THAT THEY CAN CHANGE THEIR OWN BEHAVIOR.
3. YOUTHS WILL LABEL, ASSESS AND CONTROL THE INTENSITY OF THEIR FEELINGS IN HIGH RISK SITUATIONS.
4. YOUTHS WILL REWARD THEMSELVES WITH POSITIVE FEEDBACK FOR THINKING AND BEHAVIOR PATTERNS THAT ARE LIKELY TO REDUCE RISK.
5. YOUTHS WILL USE SELF-TALK TO GUIDE THEMSELVES SUCCESSFULLY THROUGH SITUATIONS THAT ARE SEXUALLY RISKY.
6. YOUTHS WILL IDENTIFY AND CHANGE DYSFUNCTIONAL THOUGHTS.
7. YOUTHS WILL SOLVE INTERPERSONAL PROBLEMS THROUGH CLARIFYING THEIR GOALS, IDENTIFYING RISKS, COSTS AND OPPORTUNITIES, EVALUATING ALTERNATIVE STRATEGIES FOR FIXING THE SITUATION, TRYING OUT AN ALTERNATIVE, AND ANALYZING SUCCESS.
8. YOUTHS WILL EXPRESS THEIR NEEDS ASSERTIVELY, SAY "NO" IN RISKY SITUATIONS, AND COMMUNICATE WITH CONFIDENCE.
9. YOUTHS WILL DETERMINE THE ADVANTAGES AND DISADVANTAGES OF BEING TESTED FOR HIV.

10. YOUTHS WILL DEAL WITH BEING GAY, LESBIAN OR BISEXUAL BY DEFINING THEMSELVES POSITIVELY, COMING-OUT TO SELF AND OTHERS, IMPROVING RELATIONSHIPS WITH FRIENDS AND LOVERS, AND COPING WITH STIGMA.

11. YOUTHS WILL IDENTIFY COMMUNITY RESOURCES AND ACCESS THESE RESOURCES AS NEEDED, PARTICULARLY FREE CONDOMS, DENTAL DAMS, HEALTH AND MENTAL HEALTH CARE.

WHAT DOES THE TRAINER NEED TO KNOW ABOUT AT-RISK YOUTH?

1. WHILE KNOWLEDGE OF HIV AND AIDS MAY BE AT MODERATE LEVELS, AT-RISK YOUTH DO NOT KNOW HOW TO APPLY SAFER SEX PRACTICES.
2. FEW USE CONDOMS/DENTAL DAMS.
3. SEXUAL CONTACT IS FREQUENT AND BEGINS EARLY.
4. BELIEFS ABOUT WHAT OTHER YOUTHS DO ARE BASED MORE ON THE AT-RISK YOUTHS' OWN BEHAVIOR THAN ON REALITY.
5. AN ADOLESCENT'S UNDER-DEVELOPED CAPACITY FOR CRITICAL THINKING LEADS HIM OR HER TO UNDERESTIMATE RISKS.
6. IDENTITY AS MALE OR FEMALE AND HETEROSEXUAL, GAY OR BISEXUAL IS NOT FULLY FIXED FOR MANY YOUTH. SOME ADOLESCENTS HAVE BEEN AWARE OF THEIR GAY OR LESBIAN ORIENTATION FOR A NUMBER OF YEARS.
7. LACK OF KNOWLEDGE ABOUT PARTNERS IS TYPICAL.
8. CHARACTERISTICS SUCH AS BEING DEPRESSED, EMOTIONALLY DISTRESSED, OR IN TROUBLE AT SCHOOL OR WITH THE CRIMINAL JUSTICE SYSTEM INCREASES THE UNSAFE SEX PRACTICES.
9. DRUG AND ALCOHOL USE REDUCES ADOLESCENTS' SELF CONTROL IN SEXUAL SITUATIONS.
10. MALES ARE AT GREATER RISK THAN FEMALES BECAUSE THEY HAVE A LARGER NUMBER OF PARTNERS.
11. GAY MALE ADOLESCENTS ARE AT GREATER RISK BECAUSE THEY TEND TO ENGAGE IN UNPROTECTED ANAL INTERCOURSE AND HAVE PARTNERS WITH HIV POSITIVE STATUS.
12. SEXUAL MILESTONES DIFFER BASED ON ETHNICITY: WHITES ARE MORE LIKELY TO BEGIN WITH KISSING AND PETTING WHILE BLACKS START WITH SEXUAL INTERCOURSE.
13. HAVING BEEN SEXUALLY ABUSED INCREASES THE RISK OF THESE YOUTHS PRACTICING UNSAFE SEX.

NOTE: THESE FACTS HAVE BEEN SELECTED FOR HIGHLIGHT FROM THE "OVERVIEW" SECTION WHICH PRESENTS RESEARCH FINDINGS AND THEIR IMPLICATIONS. FOR A MORE COMPREHENSIVE AND DETAILED EXAMINATION, PLEASE READ THAT SECTION.

GROUP LEADERS' ROLES AND ACTIONS

1. USE TWO GROUP LEADERS: ONE MALE, ONE FEMALE
2. ONE GROUP LEADER DIRECTS ACTIVITIES.
3. THE OTHER GROUP LEADER MONITORS THE PROCESS, GIVES FEEDBACK, KEEPS FOCUS ON TASKS AT HAND.
4. CO-LEADERS SWITCH ROLES REGULARLY.
5. SAME-SEX LEADERS WORK WITH SAME-SEX SUB-GROUPS WHEN USED IN THE TRAINING.
6. CO-LEADERS ESTABLISH CONTROL FROM THE BEGINNING INDICATING THAT THEY WILL:
 - DIRECT THE ACTIVITIES
 - SET THE PACE
 - ENSURE GROUP MEMBERS' SELF-CONTROL
 - PREVENT SELF-HARM, HARM TO OTHER GROUP MEMBERS, AND DESTRUCTION OF PROPERTY

KEY ELEMENTS IN EACH SESSION

IN EVERY SESSION REGARDLESS OF THE CONTENT CO-LEADERS SHOULD

1. REINFORCE POSITIVE BEHAVIOR.
USE TOKENS TO CATCH SOMEONE DOING SOMETHING GOOD.
2. ELICIT GROUP MEMBERS' ASSESSMENT OF THEIR FEELINGS.
USE THE FEELING THERMOMETER TO HELP GROUP MEMBERS RECOGNIZE HOW THEY FEEL—
THEIR LEVELS OF DISCOMFORT.
ALSO HELP GROUP MEMBERS LABEL WHAT FEELING THEY ARE EXPERIENCING—ANGER,
DEPRESSION, GUILT, PLEASURE, SEXUAL AROUSAL, ETC.
3. ENCOURAGE TALKING.
USE TALK IN A SAFE ENVIRONMENT TO DESENSITIZE GROUP MEMBERS' ANXIETY AROUND
TABOO TOPICS.
4. MODEL EFFECTIVE COPING SKILLS
DEMONSTRATE COPING SKILLS.
USE ROLE PLAYING BASED ON THE GROUP MEMBERS' EXPERIENCES TO ENHANCE
OBSERVATIONAL LEARNING.
USE PROBLEM SOLVING FREQUENTLY.
5. CREATE CONCERN OVER
UNSAFE SEXUAL BEHAVIORS AND
INVOLVEMENT IN RISKY SITUATIONS AND WITH RISKY PARTNERS.
6. BUILD GROUP COHESION THROUGH
HAVING GROUP MEMBERS SHARE AND
GIVE APPRECIATION TO OTHER GROUP MEMBERS FOR THEIR CONTRIBUTIONS.

NOTES ON THE "KEY ELEMENTS IN EACH SESSION."

Tokens

Behaviors that are noticed and encouraged by others increase in frequency. Those which are not noticed or punished usually decrease. This process generally occurs without awareness, and encouragement can be as simple as a smile. To help group leaders make this process explicit in the groups tokens are used. You have probably participated in group discussions or activities (with friends, family members, associates or formal groups) when you heard someone say or do something that you liked or agreed with. However, because you may not have wanted to stop the person at that moment to tell them how you felt, your feelings went unexpressed until after the discussion was over or may never have been expressed at all. Adolescents, who are just developing awareness of their own feelings, are often even less likely than adults to give affirming statements to each other. Adolescents sometimes affirm themselves by communicating in a disrespectful or negative manner towards each other. They find it easier to give negative rather than positive feedback. To facilitate the building on strengths, group leaders should use tokens in each of the sessions to encourage positive affirmation of the group members by each other and by the group leaders.

Tokens are pieces of 2" X 2" colored construction paper that anyone can make. Group leaders give each group member a stack of the tokens at the beginning of each session. Participants sit in a close circle as a discussion or activity is underway. The process leader brings the tokens in a plastic container (a sandwich container is fine) and counts for each participant an equal number of tokens with which to begin. When any member says or does anything someone else likes or agrees with, finds encouraging, causes him/her to think, etc., he or she hands the person a token. It is best when the person explains why the token is being given. The tokens are not "turned in" at the end of the session for something of value. Simply receiving a large number of tokens from their peers and making others feel good about themselves leaves most participants at the end of the session with positive feelings about themselves.

The key to **everyone** using the tokens rests with the group leaders' comfort with tokens. If the group leaders take tokens seriously and use them at every opportunity to offer positive encouragement, the adolescents will also respect their value and will actively use them. Note that we recommend using "tokens" in every session, to encourage all participants to give positive feedback to each other.

White tokens are not recommended. In our experience with minority youths if "white" is associated with "good," the leader loses credibility. This is particularly true when working with African-American and Latino adolescents.

Feeling Thermometer

Adolescents, while becoming more aware of their feelings, often need help to recognize, name, discuss and appropriately express those feelings. Learning these skills is important because without them adolescents' intense feelings can interfere with their abilities to make good decisions and act safely. Improving and honing their affective skills is essential to be able to recognize and appropriately express their feelings of anger, excitement (sexually or otherwise), nervousness, anxiety, etc. Only when adolescents can recognize their feelings are they able to use self-calming techniques to allow them to make sound decisions about high-risk behaviors.

Group leaders should use a Feeling Thermometer to allow adolescents to better assess and discuss their feelings. The Feeling Thermometer ranges from 0 to 100, with 100 representing the most discomfort: extreme anger, anxiety, excitement, nervousness, depression, happiness, etc. Zero represents a total lack of discomfort whether, it be "happy" comfort or the "blues" comfort. The person at or near zero is better able to think and make decisions regardless of the particular emotion. After reviewing the Feeling Thermometer with the group, group leaders ask them to identify ways to reduce their level of emotion and regain control and practice techniques in different exercises in the group.

Role Playing

Instructions for role playing are as follows: After asking the group members to identify risky behaviors and situations, ask them to choose one of the situations to act out.

- a) Provide the description of a risk situation, e.g., "You are at a party and your date wants to go make out in an empty bedroom."
- b) Assign two persons as the principle actors: e.g., two persons who are newly dating each other. One wants to make out in an empty bedroom and the other does not.
- c) Assign coaches: One is assigned to each of the principal actors to offer suggestions on what to say during the role play.
- d) Assign one person to be the director of the scene: He or she determines who is to play which part, where the scene is taking place, and who will speak first.
- e) Assign other group members to monitor the interaction, a person to watch eye contact, a person to watch body language, and a person to operate the video camera.

The rest of the group should be asked to pay close attention because group leaders will be asking for their suggestions about other ways to play the scene. Be sure that each person understands his or her role. If the role play is being video-taped, as is recommended, the first time the scene is shot ask the actors to play the characters realistically and without resolving the conflict. For example, if the scene is of two persons on a date at a party in which one wants to make out and the other does not, tell the actors the first time through they will not be able to agree. At the point when the tension seems the highest, stop the action by saying, "freeze".

There is a recommended sequence for delivering feedback at this point:

1. Ask the principal actors to tell where their feeling thermometers are at this moment.
2. Ask the actors what one aspect of their behavior they liked.
3. What one word or act would they change?
4. Sequentially ask group members observing eye contact and body language to report one positive aspect they observed and what these observations suggest the person was feeling.
5. Ask the coaches to express what they think the principal actors may have been thinking but not saying to the other person.
6. Ask coaches and other group members to share where their feeling thermometers are.
7. Ask group members to make suggestions to the principal actors or coaches on how to resolve the impasse.
8. Finally, role play the scene again with a different stated outcome.

Continue filming while this is being discussed. Some of the most interesting and useful comments come out during this exchange of ideas. Then ask each actor to choose one of the suggested ways for resolving the conflict in "Videotape Take 2." After the scene is over, play back the scenes and ask group members to react.

Group leaders should make every effort to avoid stereotyped role playing. Many of the activities involve role plays between persons with specific characteristics. Be sure that these exercises do not stereotype individuals by gender, age and/or race. Reverse stereotype roles whenever possible. For example: "Let's have the woman this time be the one who doesn't want to use a condom." Also have girls role play as boys and boys role play girls. Fast pace changing during these role-reversals can help to reduce adolescent's slipping into stereotypical roles.

Problem Solving

Whenever possible, group members are encouraged to apply problem solving to a situation. Typically problem solving has nine steps to it after the situation has been sharply defined. Those steps are 1) define the problem; 2) determine what is important to the person; 3) set a goal; 4) list at least three ways to solve the problem and reach the goal; 5) weigh

the pros and cons of each alternative approach to reaching the goal; 6) select the one which will be tried; 7) decide how to implement that approach; 8) try it; and 9) evaluate what happened.

While the steps of problem solving appear quite logical, problem solving is often not successful because of a wide variety of human biases and limitations. Examples of biases include: paying attention to things presented first or last rather than in the middle, getting suckered into competition, being trapped by superficial elements (being willing to pay more for the same product but from a "high class" establishment), and taking greater risks depending on whether we are trying to gain or protect against a loss. Limitations refer to a lack of information, time pressures, limited resources, imperfect perceptions, short term memories, and that there are levels of complexity we do not understand. These biases must be considered and guarded against while practicing problem solving.

Videotaping Exercises

Videotaping exercises such as role playing foster effective decision-making, problem-solving skills, and behavioral change. Many of the exercises throughout the manual are easily adapted for use in video workshops. Significant behavioral changes can occur through simply watching oneself act. The strength of video is that it allows individuals to actually see themselves as others see them. It is important, therefore, to allow the adolescent to first see himself or herself in realistic circumstances, playing the scene as they think most adolescents will act. Then it is important to have the participants act out alternative ways of handling the situation.

TIPS FOR THE TRAINER

1. REWARD FREQUENTLY ANY OBSERVABLE POSITIVE BEHAVIOR—"CATCH YOUTH DOING SOMETHING GOOD!"
2. BE SUPPORTIVE.
3. GIVE COMPLIMENTS.
4. BE NON-JUDGMENTAL.
5. CREATE A HAPPY GROUP.
6. ENCOURAGE GROUP COHESION.
7. MODEL APPROPRIATE ASSERTIVE BEHAVIOR.
8. BE FIRM.
9. ILLUSTRATE POINTS THROUGH MODELLING.
10. SHARE PERSONAL EXPERIENCES (NOT CURRENT HANG-UPS)
11. KEEP LANGUAGE SIMPLE.
12. ENCOURAGE GROUP MEMBERS SHARING OF THEIR OWN EXPERIENCE.
13. BUILD ON STRENGTHS.
14. LISTEN.
15. LET THE GROUP MEMBERS DO THE REACTING, RESPONDING, THINKING AND ANALYZING.
16. BE FLEXIBLE.
17. KEEP TRYING. IF ONE APPROACH DOESN'T WORK, FIND ANOTHER ONE.

GROUP INTERACTIONS

ADVANTAGES OF GROUPS FOR ADOLESCENTS

1. CAN SEE OTHER ADOLESCENTS STRUGGLING WITH THE SAME ISSUES WHICH COUNTERACTS "I AM ALL ALONE."
2. THE HEIGHTENED IMPORTANCE OF PEER NORMS CAN BE TURNED TO AN ADVANTAGE FOR ENCOURAGING SAFER SEX BEHAVIORS.
3. GROUP SUPPORT CAN ENHANCE SELF-ESTEEM.
4. OBSERVING OTHERS LEARN NEW SKILLS CAN INCREASE THE ADOLESCENT'S EFFECTIVE ACQUISITION OF NEW SKILLS.
5. THE PRESENCE OF OTHER ADOLESCENTS WHILE PRACTICING A SKILL TENDS TO IMPROVE PERFORMANCE.
6. GROUP INTERACTION PROMOTES A STRONG EMOTIONAL EXPERIENCE WHICH FACILITATES LEARNING AND GENERALIZATION.
7. LEARNING IN A PARTICIPATORY, NON-JUDGMENTAL, FUN STYLE WITH OTHER ADOLESCENTS CAN INCREASE MOTIVATION.

STRATEGIES FOR IMPROVING GROUP COHESION AND PERFORMANCE

1. HAVE CLEAR EXPECTATIONS BOTH WITH REGARD TO HOW GROUP MEMBERS TREAT EACH OTHER AND HOW TO PARTICIPATE—TALKING, SHARING, ROLE PLAYING, CHECKING FEELINGS.
2. ENCOURAGE SELF-DISCLOSURE THROUGH REINFORCEMENT (TOKENS), TEACHING COMMUNICATION SKILLS, MODELING PRIVATE MATERIAL, FEELING THERMOMETER READINGS, AND ACCEPTANCE OF GROUP MEMBERS REGARDLESS OF THE FEELINGS AND CONTENT EXPRESSED.
3. BUILD COHESION THROUGH GROUP MEMBERS GIVING STROKES, RECOGNIZING WHAT IS POSITIVE ABOUT EACH OTHER, CONSTRUCTIVE FEEDBACK, AND SHARING.

PHASES IN GROUP DEVELOPMENT

1. BE PREPARED FOR DIFFERENT PHASES AS THE GROUP DEVELOPS: A) ORIENTATION PHASE; B) INITIAL WORK PHASE; C) CONFLICT PHASE; D) RESOLUTION PHASE; E) SECOND WORK PHASE AND; F) TERMINATION PHASE.
2. ADJUST LEADERSHIP STYLES WITH THE DIFFERENT PHASES OF THE GROUP.

NOTES ON THE PHASES IN GROUP DEVELOPMENT

As mentioned above, there are stages of development that almost all groups go through, even if they meet for a brief period of time. Group cohesion is being built, and exercises on improving competency are involving group members in interactions which can be highly emotional. It may be useful to group leaders to provide more detailed information on what happens in those phases. What follows is the process that typically occurs. This process may not happen exactly as listed. The process may occur within sessions as well. Furthermore parts of it may be hidden. The reason for exposing the process is so that group leaders know what to expect and can be prepared. Outlining the phases is not meant to provide group leaders with a list of what they **should** do.

Orientation Phase

The Leader: Describes the approach. Presents cognitive models. Introduces members. Orients members to what will happen. Present rules and expectations. Encourages participation. Communicates that this environment is a safe one. Stimulates moving quickly to the work phase.

The Group: Communicates in a factual—not emotional manner. Shares only a little about him/herself. Has high anxiety. Is concerned about giving feedback. Does not fully accept the rules and norms. Looks to the leader for all leadership functions.

Initial Work Phase

The Leader: Encourages self-disclosure. Models desirable behavior. Explores problem situations. Teaches basic concepts. Starts role playing. Facilitates effective feedback. Rewards desirable behavior.

The Group: Self-discloses more. Becomes more cohesive. Focuses on the leader. Searches for clarification. Increases participation. Gives feedback in a polite and descriptive manner. Some sub-groups are beginning to form.

Conflict Phase

The Leader: Identifies what is not working. Gets into what members are thinking more. Deals with cognitive distortions and dysfunctional thoughts. Exposes risky behaviors and risky situations. Presents coping skills exercises. Becomes more at ease and flexible. To some extent, passes leadership around among members.

The Group: Less homework is completed. Feedback becomes very critical. Anger and withdrawal increases. Goals and objectives are reconsidered. Cohesion slips. Roles are challenged. Questions the leader's authority.

Resolution Phase

The Leader: Introduces problem solving. Increases efforts to build individual competencies. Encourages leadership in the members. Deals with more complex situations. Modifies sessions in line with members requests. Feels more comfortable again.

The Group: Challenges the rules and norms. Uses more constructive feedback. Appreciation of other group members becomes more genuine. Self-discloses more often and with greater ease. Interactions include everybody. New norms, rules and communication patterns are established. Cohesion increases.

Second Work Phase

The Leader: Reduces his own leadership activity. Encourages group members to work on complex situations. Reduces the frequency of disclosure where appropriate. Encourages increased frequency of group members giving each others strokes. Points out what has been learned, is being learned, and the principles underneath it.

The Group: Assumes the leadership. Self-discloses freely. Is highly interactive. Applies learning. Lessens cohesiveness slightly.

Termination Phase

The Leader: Explains how to use new learning in many situations. Prepares for termination. Increase activities slightly. Summarizes progress. Helps members deal with what will happen after the group. Gains commitment to continued change.

The Group: Plans how to use what has been learned. Becomes less cohesive. Shows concerns about stopping the group. Becomes more oriented to outside the group.

Forces beyond the control of both group leaders and group members may mean that group members are leaving the group before completion. Also it may be necessary to admit new members. Unplanned comings and goings may mask the group's movement through the standard phases.

(Adapted from S. D. Rose (1989) Working with adults in groups, San Francisco: Jossey-Bass)

HANDLING PROBLEMS IN THE SESSIONS

GENERAL

1. IGNORE INAPPROPRIATE BEHAVIOR AND
2. REDIRECT PARTICIPANT TOWARD APPROPRIATE BEHAVIOR AND
3. REWARD EVEN THE SLIGHTEST MOVEMENT TOWARD APPROPRIATE BEHAVIOR.

SPECIFIC BEHAVIORS

(Note: for each situation group leaders will need to decide which leader responses fit best. Some of this material was adapted from American Business, 1954.)

DISRUPTIVE

POSSIBLE REASONS FOR THE BEHAVIOR: 1) Causing trouble has resulted in having attention paid to the person. 2) Angry about something and doesn't know another way to express it. 3) Hides feelings of insecurity. 4) Looking for peer respect. 5) In a lot of pain.

LEADER'S RESPONSES: 1) Ignore, redirect and reward. 2) Give tokens when the person is calm. 3) Ask the person to role play. 4) Break into small groups and put the person with strong peers. 5) Stay physically close in order to reinforce through touching. 6) Ask the person to take a five minute break. 7) Ask the person to leave and come back next time.

OVERLY TALKATIVE

POSSIBLE REASONS FOR THE BEHAVIOR: 1) Eager to share and earn tokens. 2) Needs to show-off and receive attention. 3) May know a great deal and wants to show it. 4) Typically talks a great deal.

LEADER'S RESPONSES: 1) Don't put the person down. 2) Ask thoughtful questions to make them pause. 3) Interrupt with "That's an interesting point. What is the group's reaction?" 4) Take the person aside and say that you need help in letting other group members have the experience of coming up with answers.

ARGUES FREQUENTLY

POSSIBLE REASONS FOR THE BEHAVIOR: 1) Likes to be the center of attention. 2) Keeps people from getting close. 3) Is angry about something. 4) Upset by personal problems. 5) Needs to dominate people. 6) Thinks that arguing demonstrates intelligence. 7) Doesn't know any other way to interact socially.

LEADERS'S RESPONSES: 1) Keep your temper in check. 2) Don't let the group get excited. 3) Find points in what the person is saying that are of merit. 4) Engage the person in an assertiveness role play. 5) Have the person practice self-talk in a provocative situation. 6) Have the group brainstorm pros and cons regarding the points being made. 7) Use problem solving to resolve the conflict. 8) At a private moment try to find out if something is bothering the person.

WON'T TALK

POSSIBLE REASONS FOR THE BEHAVIOR: 1) Frightened. 2) Insecure. 3) Bored. 4) Indifferent. 5) Feels superior. 6) Knows all the answers. 7) Wants to be drawn out. 8) Depressed.

LEADER'S RESPONSES: 1) Give tokens for any small response. 2) Ask for Feeling Thermometer readings and explore the assessment. 3) Ask for help in reading a script or role playing. 4) Assign work in pairs. 5) Encourage group's giving the person strokes for participation. 6) If person is depressed, provide an individual counseling session.

COMPLAINS FREQUENTLY

POSSIBLE REASONS FOR THE BEHAVIOR: 1) Has a legitimate reason to complain. 2) Has a pet peeve. 3) Gripping is a consistent personal style. 4) Uses a great many dysfunctional thoughts.

LEADER'S RESPONSES: 1) See if appropriate changes can be made. 2) Point out what can be changed and what can not. 3) Use Feeling Thermometer and explore thoughts behind the feelings. 4) Involve the group in addressing the issues. 5) Create a role play where someone is unhappy and wants to bring about a change, using "I" Statements. 6) Discuss the complaints privately.

RAMBLES ON AND ON

POSSIBLE REASONS FOR THE BEHAVIOR: 1) Anxious. 2) Is not clear about the topic. 3) Wants to contribute but doesn't know how. 4) Has trouble concentrating. 5) Is bothered by dysfunctional thoughts. 6) Trying to impress but unsure.

LEADER'S RESPONSES: 1) Orient to the topic. 2) Refocus the group. 3) Interrupt with a question about the topic at hand. 4) Ask the group to respond to the person's comments. 5) Give tokens for any comments that lead back on topic. 6) Say, "That's interesting, but I don't think I am clear about how that relates to ____." 7) Give the person a task to respond to and ask the person to think aloud, helping them stay focused. 8) Model staying on target.

TAKES A STRONG STAND AND REFUSES TO CHANGE

POSSIBLE REASONS FOR THE BEHAVIOR: 1) Believes strongly. 2) Connects position with self-esteem. 3) Is opinionated. 4) Hasn't understood other points of view. 5) Feels threatened.

LEADER'S RESPONSES: 1) Ask the person to argue against his or her own view point. 2) Have the group respond to the point of view. 3) Ask the person to repeat back the other positions that have been stated. 4) Get a Feeling Thermometer reading and explore where any discomfort is coming from. 5) Give out a token for believing strongly and for expressing other positions.

FOCUSES ON THE WRONG TOPIC

POSSIBLE REASONS FOR THE BEHAVIOR: 1) Doesn't understand the direction of the session and the group. 2) Has a personal agenda. 3) Needs to feel assertive. 4) Doesn't want to deal with the topic group members were working on.

LEADER'S RESPONSES: 1) Take the blame. "Something I said must have got you off the topic. We are talking about ___" 2) Try to find out if the topic the person is on has a personal significance. 3) Ask the group if the person's topic is one that needs to get dealt with. 4) Ask the person to think about the correct topic and then give a Feeling Thermometer reading. Explore discomfort.

CONSTANTLY SEEKS THE GROUP LEADER'S POINT OF VIEW

POSSIBLE REASONS FOR THE BEHAVIOR: 1) Wants attention and tokens. 2) Looking for advice. 3) Trying to model the leader's behavior. 4) Doesn't understand what position is the best one to take. 5) Wants to challenge the leader. 6) Trying to put the leader on the spot.

LEADER'S RESPONSES: 1) Reward for participation and paying attention. 2) Throw questions back to them and to the group. 3) Give direct answers if appropriate. 4) Don't take away the person's opportunity to solve his or her problem. 5) Ask for situations that demonstrate the question and role play them.

MAKES AN INCORRECT STATEMENT

POSSIBLE REASONS FOR THE BEHAVIOR: 1) Doesn't know the facts. 2) Believes in certain myths about the topic. 3) Goes along with peer group distortions.

LEADER'S RESPONSE: 1) Ask the person what the consequences of the statement would be. 2) Ask the group to react to the statement. 3) Accept that the person does believe it with "I can see how you feel" or "That's one way of looking at it." 4) Say "I see your point but how does it fit with ___?" 5) Have the group try to figure out how such a belief got started. 6) Make sure the person doesn't end up feeling stupid or embarrassed.

SPEAKS IN AN INARTICULATE WAY

POSSIBLE REASONS FOR THE BEHAVIOR: 1) Feels awkward speaking in a group. 2) Doesn't have the skills to put thoughts into the right words and the right order. 3) Has ideas but is unsure how to express them.

LEADER'S RESPONSES: 1) Don't say, "What you mean is this." 2) Say, "Let me repeat that" and then use better language. 3) Have the person write it out and coach them. 4) Pair the person with someone else who will model the desired language when they work together on a task. 5) Reinforce close approximations. 6) Have the person make very small presentations and gradually increase them.

CAN NOT READ WELL

POSSIBLE REASONS FOR THE BEHAVIOR: 1) Never had the opportunity to learn. 2) Is dyslexic. 3) Needs glasses. 4) Has an eye ailment.

LEADER'S RESPONSES: 1) Have another student assist with prompting. 2) Have another student be the person's shadow and take over only the reading part of exercises. 3) Give out tokens for trying. 4) Arrange for outside assistance on the basic problem.

IS PHYSICALLY ABUSIVE

POSSIBLE REASONS FOR THE BEHAVIOR: 1) Doesn't know other ways to cope with anger. 2) Feels threatened. 3) Controls have been loosened through drugs or alcohol. 4) Wants to prove something to the other group members.

LEADER'S RESPONSES: 1) Firmly exert authority and indicate what behavior will not be tolerated. 2) Create a calm atmosphere through speaking softly, slowly, and clearly while talking the person down. 3) Give the person plenty of physical space. 4) Avoid confrontational gestures such as pointing and staring. 5) Keep other group members away. 6) If necessary, send the other group leader out for help. 7) Socially reinforce the person for any steps taken to reinstate emotional control and resolve the conflict with words. 8) If the person can calm down, have her/him give a Feeling Thermometer reading, describe the upsetting situation and have others role play it, using problem solving. 9) Do a role play on anger control, using self-talk. 10) Remove the person from the group, either for a little while or for the rest of the session. 11) Make sure the person knows the group wants her/him back if she/he can keep control.

CONFLICT BETWEEN GROUP MEMBERS

POSSIBLE REASONS FOR THE BEHAVIOR: 1) Don't like each other. 2) Members of opposing cliques. 3) Lack of skills in social problem solving. 4) Few assertiveness skills.

LEADER'S RESPONSES: 1) Emphasize points of agreement. 2) Point out objectives which cut across both positions. 3) Create role plays for others to perform on resolving the conflict. 4) Have members find positive qualities in the opponents. 5) Give out tokens for positive behavior. 6) Emphasize that group members can be good and still present troublesome behaviors.

ARRANGEMENTS FOR THE SESSIONS

NUMBER OF PARTICIPANTS:

6 TO 10 adolescents of both genders

NUMBER OF SESSIONS:

25 plus an individual counseling session

FREQUENCY OF SESSIONS:

2-4 times per week, but can be less frequent according to the program and participants' needs.

LENGTH OF SESSIONS:

90-120 minutes

PHYSICAL SPACE:

Large, comfortable room protected from interruptions and an additional room for when same-gender exercises are being held at the same time.

SEATING:

Sit in a closed circle so that eye contact and interaction is encouraged. Create balance (not all boys sitting together). Split up cliques. Place a disruptive youth next to the leaders.

EQUIPMENT:

Video recorder and vcr playback unit.
Stands for newsprint pads

MATERIALS:

Tokens
Feeling thermometers
Newsprint and marking pens
3 X 5 cards and pencils
Xeroxed handouts, scripts and work sheets
Practice cards

HOW TO USE THE MANUAL

1. REVIEW EACH SESSION AHEAD OF TIME.
2. THE FORMAT CONSISTS OF OBJECTIVES, RATIONALE, PROCEDURES, MATERIALS, AND A WORD FOR WORD PRESENTATION OF WHAT YOU SAY.
3. IN THE TEXT OF EACH SESSION CAPITALIZED WORDS ARE INSTRUCTIONS TO THE GROUP LEADER AND the small lettered words are what you say to the participants.
4. AS YOU BECOME FAMILIAR WITH WHAT YOU ARE TO SAY AND FEEL COMFORTABLE, USE YOUR OWN WORDS RATHER THAN WHAT IS WRITTEN FOR YOU TO SAY.
5. CHECK TO MAKE SURE YOU HAVE THE NECESSARY EQUIPMENT AND MATERIALS.
6. LEARN HOW TO USE THE PRACTICE CARDS:
EACH HAS ON IT THE NUMBER, FRONT OR BACK, AND THE SESSION.
SHUFFLE THE CARDS.
GIVE THE CARD TO THE FIRST GROUP MEMBER.
THE GROUP MEMBER PASSES THE CARD.
THE CARDS SAY "PASS TO THE PERSON WHO....." MAKE SURE SOMEONE AGREES TO ACCEPT THE CARD.
THAT PERSON THEN READS WHAT IS ON THE CARD TO THE GROUP MEMBER WHO PASSED IT.
THE GROUP MEMBER ANSWERS.
OFTEN THE BACK HAS ON IT A SUGGESTED ANSWER WHICH THE PERSON WHO READ THE CARD CAN GO OVER.
MOVE ON TO THE NEXT PERSON.
COLLECT THE CARDS AT THE END.
7. BE CREATIVE. USE THE MANUAL TO SUIT THE NEEDS OF YOUR YOUTH AND YOUR OWN STYLE, BUT MAKE SURE THAT WHEN A SESSION IS OVER, GROUP MEMBERS ARE MORE COMPETENT IN SOME OBSERVABLE WAY THAN THEY WERE BEFORE THE SESSION BEGAN.