# ADOLESCENTS LIVING SAFELY:

# AIDS AWARENESS, ATTITUDES, AND ACTIONS

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*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.*

# OVERVIEW

This training manual is a guide to help adults to provide an intensive HIV prevention program to adolescents whose behaviors place them at risk of becoming infected. Adolescents can be at high risk for a variety of reasons: their sexual or drug use behaviors, their choice of friends and sexual partners, lack of HIV/AIDS information, and sexual abuse. In general, adolescence is characterized by factors that increase the likelihood of engaging in unsafe sex and drug-use practices. The risks for some adolescents are increased because they engage in many problem behaviors; they have trouble with the school and with the law, are depressed and suicidal, and are more likely to engage in early sexual behavior. Life circumstances define risk for some youths; being runaway or homeless, gay, or a sex offender increases the potential for risky behavior. This manual describes a program that currently serves at-risk runaway adolescents in New York City.

A theoretical model for a preventive intervention is presented, along with 20 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 and 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 <u>before</u> trying to increase knowledge, positive attitudes, or behavioral skills, which are the other essential components of the intervention program. If adolescents cannot talk about and understand their feelings, they are not going to be able to break through emotional barriers to talking about safer sex with potential partners, and avoiding drug use. The sessions outlined in this manual have been designed so that they stand on their own.

The pressing need for AIDS intervention with 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 teens 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 [CDC], 1991). Only ten years have passed since the first cases of AIDS were reported (in mid-1981). Although there has been scientific progress in determining the cause of AIDSBinfection 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 the 715 of the documented cases of AIDS in the United States 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 the HIV and the development of AIDS is estimated to be up to 11 years on average. Thus, the magnitude of the risk to adolescents becomes clear; it is probable that many of these young adults become infected during their teenage years.

Over a fourth (25%) of the documented adolescent cases are female, which is more than twice the rate of 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.

**Sexual behavior.** Adolescence is the time for experimentation with personality and personal choices (e.g., friends, use of leisure time). The adolescent is attempting to consolidate a personal identity; sexual identityBone=s perception of oneself as masculine or feminine, and one=s sexual orientation as heterosexual, bisexual, or homosexual, is an important aspect of that development. For adolescents, there are relevant social scripts or roles for how to operate in sexual situations. As part of the development of sexual identity, males are generally socialized to operate withing different roles than females (Bryne, 1977). Males tend to perceive sexual activity as contributing to their sense of masculinity, as well as to perceive that within sexual relationships, their masculinity is dependent upon being the initiator. It is not clear that females come to perceive being sexually active as contributing to their sense of femininity, because they have traditionally viewed femininity as expressed by setting limits on sexuality (Gagnon & Simon, 1973; Peplau, Rubin, & Hill, 1977).

The development of sexual identity entails making decisions about sexualityBwhether and whom to date; once dating, whether to become sexual; once becoming sexual, what kinds of sexual activity to engage in (vaginal or anal intercourse, oral sex, or heavy petting), and whether to have a partner wear a condom.

A major source of risk for contracting HIV/AIDS is from unprotected sexual intercourse. There are several factors concerning adolescent sexuality that are important to focus on when planning an intervention to reduce risky behavior. First, we know from a large body of research on teenage pregnancy that most Americans start having sexual intercourse during their adolescent years (64% of males and 44% of females by age 18; Sorenson, 1973); over 80% of males and 70% of females by age 20 (Hayes, 1987; Zelnick et al., 1981). The data for runaway youth are even higher, with 78% of the females and 92% of the males affirming that they are active. Additionally, this population typically begins to have sex at an early age; average age for first intercourse for males in this group was 12.5; for females, 13.3 (Rotheram-Borus et al., in press). Although the reported percentages vary, it appears that the majority of adolescents, across sex and racial groups are sexually active.

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 for emotional closeness with their sexual partner, which decreases 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 youth may have an even greater number of partners; with males reporting a median of 3 partners in the last 3 months (Rotheram-Borus & Koopman, 1991). Additionally, this group may engage in exchanges of sex for drugs or money, further raising their number of partners, and increasing their risk for 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 partnersBa 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 than females (Adams, 1988).

Because adolescents often know little about their partners, it is likely that they do not screen their potential sexual partners regarding previous risk behaviors. Youths often lack the interpersonal skills 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 understand that a person who looks physically healthy can still be HIV-positive (Rotheram-Borus & Bradley, 1988). Lack of knowledge about partners= HIV status may especially put females at risk, as it is the norm in our culture for females to date older men, who are at higher risk for already being infected with HIV.

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 the group, only 20% (or 3% of the total), reported changes that researchers believe actually reduce the risk of infection (Strunin & 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).

**Drug use.** The view of drug use as deviant is being challenged by the view that some exploration may be normative, perhaps even functional in adolescent culture (Wallack & Corbett, 1987). However, it is clear that degree of substance abuse has important consequences. Research (Pandina & Schuele, 1983) has shown that the severity of adolescents= substance abuse is associated with psychological distress (including depression and anxiety), low self-esteem, a greater number of negative life events, and lower levels of perceived parental love. There are strong relationships between drug use, depression, suicide attempts, trouble at school, trouble with the law, and unsafe sex (Esminger, 1986). For example, there is a tendency for depressed adolescents also to use drugs, have unprotected sexual intercourse, and be more likely to attempt suicide. Jessor and Jessor (1977) refer to the pattern of multiple problems as a problem behavior syndrome. Youth who experience severe life stressors, such as those who run away from home, are especially likely to have this pattern of multiple problems. For example, among those runaways studied by Shaffer and Caton (1984) 76% of the males and 74% of the females had engaged in sexual intercourse; 70% of the males and 72% of the females were frequent users of drugs and/or alcohol; 33% of the males and 31% of the females had attempted suicide; and 60% of the males and 81% of the females were depressed. Drugs, alcohol, and sex may all be used by multi-problem adolescents trying to alleviate their distress. It has been suggested that adolescents may be using street drugs to alleviate high levels of depression (Deykin, Levy, & Wells, 1987). It also might be argued that sexual activity is another, perhaps

even more widely appealing, strategy than drug use to provide temporary relief from distress. It is often more readily available, costs less, and may be more effective in some ways. For example, sex provides, at least temporarily, a situation in which a youth gets touched and held, which can meet the need that someone else cares.

Drug use contributes to adolescents= risk for HIV/AIDS for several reasons. Drug use increases risk directly, as intravenous use of heroin or cocaine provides a direct route of transmission for HIV, through the sharing of contaminated needles or syringes, a common practice among IV drug users (National Academy of Sciences, 1986). The prevalence of intravenous drug use among teens aged 12-17 in this country is 1.6% (NIDA, 1991), although some surveys report figures as high as 6.3% among high school students in Washington, D.C. (CDC, 1988). Of adolescents in the United States reported to have AIDS, 11% have used IV drugs (CDC, 1991).

Those youth who are involved with drugs and alcohol are at increased risk for HIV/AIDS in an indirect way as well. The use of drugs and alcohol disinhibits sexual behavior. That is, a teen who is high is more likely to engage in risky behavior, and less likely to implement safe sex practices. A much greater number of adolescents use drugs without injecting them. Recent surveys of high school seniors found that 93% reported use of alcohol, 59% used marijuana, and 16% reported use of cocaine (Clayton & Voss, 1982). Nearly a tenth of adolescents are heavy drinkers by the time they are fourteen. Six percent of all high school students get stoned daily on marijuana (Johnston et al., 1981).

The intervention presented in this manual focuses on sex and substance use risk behavior. However, these behaviors occur within a developmental context, discussed in the following section.

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## Developmental changes during adolescents

This intervention program differs from those designed for adults because it is based on considerations of the developmental changes occurring during adolescence. These changes contribute to the difficulty of effectively intervening to reduce adolescents= risk of contracting AIDS. There are four major domains affected by adolescent development: behavioral, cognitive (awareness), affective (feelings), and social. They evolve as adolescents face carious age-specific tasks for becoming adults, the most important of which is identity development. In a complex society, identity development is also complex (Mussen et al., 1984): it evolves through changes in behavior, cognition, and affect, and in the context of changing norms and social roles. Developmental issues and relevant aspects of the social context in which adolescents liveBtheir environment=s social climate and peer norms, are discussed below.

**Behavioral changes.** At the onset of puberty, adolescents, anxious about heterosexual and homosexual fantasies, typically attempt to manage this anxiety by refraining from personal disclosure, striving for high structure in personal relations, and forming same-sex pairings. The decision to initiate sexual behavior will depend upon the attitudes communicated by a teen=s parents, as well as community norms and pressure from peers.

The concept of **psychosexual milestones** is of special relevance here. A sexual milestone is a specific kind of sexual behavior (e.g., first kiss, first time genital petting, first sexual intercourse), for which a single first experience is considered to permanently change the person=s sense of self and relationship to others. For example, as people experience sexual intercourse for the first time, their sexual identity changes from virgin to non-virgin. Furthermore, once the person has attained a particular sexual milestone, he or she is likely to continue to engage in that kind of sexual activity. For Whites, especially for White females, the research has shown a gradually escalating series of sexual milestones, in which holding hands and kissing precedes behaviors such as petting, which, in turn, precedes the onset of sexual intercourse (Hayes, 1987). For adolescents proceeding through this graduated series, there is some time to learn from earlier psychosexual milestones before tackling the more complicated issues involved in having sexual intercourse

(e.g., planning and using contraception; reducing risk of HIV transmission). Hence, an important goal for reducing adolescents= risky behavior is to delay the onset of sexual milestones to later ages.

There may be a greater need for early intervention with adolescents who typically do not proceed through the graduated series of sexual milestones. For example, this progression does not seem to describe the sexual development of Black youth (Smith & Udry, 1985), and many do so before reaching puberty (Westney et al., 1984).

**Cognitive changes.** One of the most significant changes that occurs during adolescence is a shift in the quality of cognition. Piaget proposed that as youth enter adolescence, they begin to develop what he termed **formal operational thought**. Formal thought is abstract reasoning ,the capacity to imagine hypothetical situations and to anticipate the consequences of different courses of action. It is the capacity to Aplay out@ different possibilities in one=s head before choosing the most suitable response. The development of formal operational thinking is important to reducing youths= risk of becoming HIV-infected. Formal operational thinking is involved when youth apply abstract principles about the transmission and prevention of HIV infection to actual high-risk situations.

The capacity for formal operational thinking takes time to mature; many persons do not fully develop it even by adulthood. Researchers have found that fewer than half of all adolescents have made the transition to formal operational thinking by age 18 (Long & Cobb, 1985). Although young adolescents are more advanced in cognitive development than are children (Piaget, 1972), they generally reason with less awareness of cost-benefit ratios than do adults. They underestimate the potential costs associated with certain actions; for example, they tend to believe that they are immune to risks such as unwanted pregnancies (Chilman, 1983; Cvetkovich et al., 1975). Even among young adults, there is a tendency to evaluate one=s personal risk of health problems optimistically, as lower than for others of the same age and sex. The lower this perceived risk, the less interest there is in receiving information about preventing health problems (Kulik & Mahler, 1987).

Adolescents vary considerably in how much their sexual behavior is guided by rational thinking and conscious decision making. For adolescents to engage in strictly low risk behavior, they need to know what this behavior is and how they can define it in their own lives. They need to be able to construct several hypothetical courses of actions to takeBsome safer than othersBand to be able to simultaneously evaluate these alternatives on the basis of considering several possible outcomes of each course of action. This systematic search for alternative solutions to a problem is part of formal operational thinking. Adolescents need to develop realistic appraisals of the costs and benefits of alternative courses of action involving sex and drugs. They need help with thinking about how they will handle situations that are likely to elicit high-risk acts.

**Emotional changes.** Adolescence is a time of increasing emotional energy. Adolescents tend to experience their emotions more intensely, and often undergo rapid fluctuations in mood. Additionally, the are frequently confused about the origin of their feelings: Are they internally generated, or a consequence of an external situation? Is the current feeling likely to pass quickly, or will the mood extend over time? Not only are youth often unable to identify the source of their feelings, they are also unlikely to be able to differentiate and label them accurately. This emotional liability can lead to erratic and impulsive behavior, as youth respond to a flood of emotions that they can neither identify, express, or adequately cope with.

**The changing social climate.** An understanding of the powerful influence of social climate and peer norms on adolescents is relevant to this HIV/AIDS intervention program. It appears that what youths believe peers to be doing is more related to their own behavior than what their peers are actually doing (Newcomer et al., 1980). This suggests that norms, which are perceived standards of behavior for one=s subgroup, are important determinants of behavior. Influence by peers can take a variety of forms, such as challenges and dares, social desirability, or coercion (Lewis & Lewis, 1984). White females seem to be particularly influenced in their sexual behavior by peers than younger adolescents, because of the relatively greater influence that parents have on their children when they are younger.

The social climate affects adolescent sexuality. Societal trends in the 1970s and early 1980s were sexually

permissive. With the AIDS epidemic, the trends have moved toward a Anew morality@ of the 1990s that condemns premarital sexual activity by youths. Adolescents in the 1990s not only have to sort through these various trends in deciding how to manage their sexuality, but they also must respond to pressures from their socioeconomic and ethnic groups (Hayes, 1987).

Adolescent peer norms have a strong impact on how youth behave in sexual situations. For instance, it is a common adolescent norm that females are responsible for protection against unwanted pregnancy and STDs. The risk-reduction provided by condom use implies that the female is now especially dependent on the male=s cooperation for her protection (Rotheram-Borus & Bradley, 1987). The male may refuse this cooperation because he does not see protection during sex as his responsibility.

However, males= willingness to use condoms may be underestimated. In at least one study, more males reported consistent condom use than females reported among their partners (Kegeles et al., 1988). Males reported that they thought their partners wanted them to use condoms, and they were intending to use them. However, the females were not planning to use condoms and were uncertain about whether or not their partners wanted to. Females have misperceptions about their male partners= willingness to use condoms. Thus, HIV programs must address these perceptions.

The tendency for adolescents to engage in high-risk behaviors, and the developmental changes that characterize the teenage years have implications for how to successfully intervene with this population. In what follows we address how these issues influence the development of an intervention program suited specifically to adolescent needs.

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## Intervention with adolescents

Adolescents must cope with difficult interpersonal encounters if they are to successfully avoid engaging in risky behavior. 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 are keenly sensitive to peer pressures, yet 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., AI 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 on adolescents in both high schools and runaway sites (Rotheram-Borus & Bradley, 1987; Rotheram-Borus et al., 1989), we found that adolescents often Aknew@ on the abstract level the safest alternatives for a given situation (e.g., use a condom during sexual intercourse). However, they did not have the social skills to use such knowledge to guide their behavior. Research in developmental psychology (reviewed in Mussen et al., 1984), however, shows that adolescence is 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 not consistently 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 may help reduce the likelihood of contracting HIV/AIDS. However, recent evidence (Helgerson et al., 1987; Koopman et al., 1990; Strunin & Hingson, 1987) suggests that adolescents are gaining moderately high levels of 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 does not. The general knowledge that needs to be taught to adolescents about HIV/AIDS is hot. It is about highly emotionally-laden issuesBdisease, 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, if an adolescent begins to feel positively about their own ability to cope with emotional issues, they will be more likely to change their behavior.

**Affective awareness.** In conveying information about AIDS, it is important to recognize and accept the emotions that are elicited by the material. AIDS is a painful topicBboth scary and depressing, and so it is tempting for adolescents to deny its relevance to their lives and ignore information about AIDS 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 the feelings that get elicited within them in different risk situations; they need to be able to relate general knowledge about HIV/AIDS to the kinds of situations they personally face.

Often, youth with multiple problems may 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 youth is that particularly 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 here; the ability to take one=s Aemotional temperature@ through use of a Afeeling thermometer,@ and building a personal Arisky situation pyramid@ so that youths can assess their responses to varying situations in a stepwise fashion.

**Coping skills.** The AJust Say No@ programs that have been used to try to prevent pregnancy and substance abuse with teenagers have a critical flaw: they fail to take into consideration the powerful influence of the social context in which high-risk behavior occurs (Wallack & Corbett, 1987). A teenage 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: to identify the risks in the situation, to generate alternative actions for dealing with the situation, to weigh the likely consequences of these choices, and to choose and implement a course of action. Programs for preventing smoking, and alcohol and drug use, have demonstrated the importance of interpersonal problem solving skills in prevention programs (Botvin et al., 1984a; Botvin et al., 1984b; Schinke, Gilchrist, & Snow, 1985). 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.

**Access to services.** Another implication for intervention with multi-problem youth is that they need a comprehensive service network, one that will reduce their life stress by helping them to meet their needs across all areas of lifeBmedical, educational, legal, vocational, financial, social, and so on. This intervention program contains specific information and skill-building exercises to help youth navigate complicated service networks, recognize where resources are located, and help them to gain access to these resources, whether they be condoms, drug and alcohol services, or counseling regarding HIV testing. By getting 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 behaviorBdepression, anxiety, low self-esteem, and conduct problems.

## Summary

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

$ Adolescents 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 youth=s risk of HIV infection.

$ 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 providing them with specific knowledge about HIV/AIDS, 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.

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. 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' effectiveness was recently published (Rotheram-Borus et al, 1991).

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 a 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.

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## 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 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. Imbedded 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 is a constant theme. Intellectual skills such as analyzing a risky situation, physical skills such as putting on a condom, 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 tenants 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 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 delay the occurrence of unsafe behavior if it has not yet begun.
2. Youth will engage only in protected sexual intercourse with a condom whether vaginal, anal or oral.
3. Youth will screen potential partners and avoid sex with those who are risky or questionable.
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 appropriate thinking and behavior.
5. Youths will use self-talk to guide themselves successfully through sexually risky situations.
6. Youths will identify and change dysfunctional thoughts.
7. Youths will solve interpersonal problems through clarifying the problem, 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 their being tested for HIV.
10. Youths will identify relevant community resources and access these resources as needed.

# WHAT THE TRAINER NEEDS TO KNOW ABOUT AT-RISK YOUTH

1. While knowledge of HIV and AIDS may be at a moderate levels, at-risk youth do not know how to apply safer sex practices.

2. Few use condoms.

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 underdeveloped critical thinking capacity leads to underestimating risks.

6. Identity as male or female and heterosexual, gay or bisexual is not fully fixed.

7. Lack of knowledge about partners is typical.

8. Other characteristics such as being depressed, distressed, or in trouble increase the absence of safer sex practices.

9. Drug and alcohol use reduces controls in sexual situations.

10. Girls are at greater risk because they follow cultural norms and go out with older men who are more likely to be HIV-positive.

11. Males are at greater risk because they have a large number of partners.

12. Gay male adolescents are at greater risk because they tend to engage in anal intercourse and have partners with HIV-positive status.

13. Sexual milestones differ based on race: whites are more likely to begin with kissing and petting while blacks start with intercourse.

14. 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

    Insure 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 which 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 group 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 is 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 others. 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 if 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 <u>everyone</u> 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 others. The possible exception is video workshops, where tokens may disrupt the flow of the taping.

White tokens are not recommended. In our experience with minority youths if "white" is associated with "good," the leader loses credibility.

### 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 want to make out in an empty bedroom and the other doesn't.

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 aspect did they liked about what they did?
3. What words or acts 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 sex, 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 play boys and boys girls. Changing pace fast during these role-reversals can help to reduce adolescents playing 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 pro's and con's 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 limitation. 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 complication we can't handle. 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 perform. 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 modeling.
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 f) termination phase.
2. Adjust leadership styles with the different phases.

## 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 isn't 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.

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 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 a part. 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.

Leader'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 pro's and con's 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) Griping 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't. 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) Isn't 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.

**Cannot 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 re-instate 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 sexes

Number of sessions:
20 plus an individual counseling session

Frequency of sessions:
4 times per week, but can be less frequent according to the program and participants' needs.

Length of sessions:
90 to 120 minutes

Physical space:
Large, comfortable room protected from interruptions and an additional room for when same sex 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.
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, <u>use your own words rather than what is written for you to say</u>.

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, <u>but</u> make sure that when a session is over, group members are more competent in some observable way than they were before the session began.