

Real Men Are Safe

Developed by the National Drug Abuse Treatment Clinical Trials Network Gender Specific HIV Prevention Intervention Protocol Development Team:

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REMAS:
A Gender-Focused
HIV & Sexual Risk
Reduction Intervention
for Men in Substance
Abuse Treatment



This manual was used by male counselors delivering the REMAS intervention to substance abuse treatment clients enrolled in the National Drug Abuse Treatment Clinical Trials Network protocol 0018, "Reducing HIV/STD Risk Behaviors: A Research Study for Men in Drug Abuse Treatment."

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A Gender Focused HIV Intervention for Men: Real Men Are Safe (REMAS)

Introduction

Real Men Are Safe (REMAS) was developed by the National Institute on Drug Abuse's National Drug Abuse Treatment Clinical Trials Network (CTN) Gender Specific HIV Intervention Protocol Team. REMAS is a five-session group delivered intervention package designed to assist clients in substance abuse treatment reduce their HIV risk. Much of material is taken from the manual **Time Out for Men! A Sexuality and Communications Skills Workshop** (Bartholomew & Simpson, 1996, Texas Christian University Institute of Behavior Research) and **Project Light** (The National Institute of Mental Health Multisite HIV Prevention Group, 1998). In addition, material from Bartholomew and Simpson's (1992) *Approaches to HIV/AIDS Education in Drug Treatment* (HIV-ED) was utilized (Boatler et al., 1992). The development of this specialized treatment intervention for "men only" followed the success of a similar workshops designed for women: **Project Worth: Women on the Road to Health** (Schilling et al., 1991; El-Bassel & Schilling, 1992; Columbia University School of Social Work Social Intervention Group) and **Time Out! For Me: A Sexuality and Assertiveness Module for Women** (Texas Christian University, Institute of Behavior Research; available at <http://www.ibr.tcu.edu>). The modules focus on basic information about HIV transmission, self risk assessment, exploration of safe sex options, assertive communication skills, using I-Statements, negotiation skills, and exploration of ways to have enjoyable sex without drugs. Men are provided a forum to discuss and dispel sexual myths and stereotypes. There is also a focus on relapse prevention related to sexuality.

The manual was used by male counselors delivering the REMAS intervention to substance abuse treatment clients enrolled in NIDA CTN protocol 0018, "Reducing HIV/STD Risk Behaviors: A Research Study for Men in Drug Abuse Treatment." In the clinical trial men in substance abuse treatment were randomly assigned to attend the REMAS intervention or a single session HIV Education (HIV Ed) which served as a standardized control group representing treatment as usual for CTN community treatment programs. The trial provided compelling evidence of the effectiveness of REMAS. REMAS participants had significantly fewer unprotected sexual occasions, than HIV Ed participants, at both 3-months (effect size = .21) and 6-months (effect size = .34) ($p < .0001$) (Calsyn et al., 2009). This effect was heightened for REMAS completers, who attended the majority of their sessions. Men assigned to the REMAS condition reporting sex under the influence at the most recent sexual event decreased from 36.8% at baseline to 25.7% at 3 months compared to an increase from 36.9% to 38.3% in the HIV Ed condition (Calsyn et al, in press).

How to Use the REMAS Manual

The materials in this manual are organized for presentation in five (5) 90-minute group sessions. Ideally, groups should be co-led by male counselors, social workers, or other treatment staff members who have had experience conducting educational workshops. Each session contains instructions for preparing class materials, along with handouts, discussion questions, and ideas for presenting information on each topic.

Text to be spoken to the group is in quotation marks. Text that is instruction or information for the counselor is in italics. Each of the five sessions is laid out in a similar fashion in the manual. Each session section begins with the objectives, rationale, session outline and a list of materials needed for the session. For each session there are materials for preparing flip charts or a slide show which serve as visual aides in presenting information and facilitating brainstorming, role plays and group discussions. Counselors trained in conducting REMAS groups found these visual aides extremely valuable as teaching tools as well as aides in helping them stay on task. These materials appear at the end of each session section. There is guidance in the appendix for utilizing these materials. Also at the end of each session section are copies of client handouts need for that session. Prior to each session the group facilitator should review the objectives, rationale, session outline and a list of materials needed for the session. Each session begins with a welcome, and except for session 1, a review of main takeaway messages from the prior session. The activities to be conducted in each session then are laid out. The estimated time to be utilized in conducting each activity is specified. The activities are lecture and discussion, brainstorming, condom demonstrations and practice, role plays and risk self assessment exercises. These activities are designed to tap all three dimensions in the Information-Motivation-Skill Building model of HIV prevention (Fisher and Fisher, 2000).

Note to Counselors Regarding Diversity of Sexual Orientation

This research study was not limited to males who identify as heterosexual. Thus, Real Men are Safe is intended to be applicable to males of any sexual orientation. During delivery of the intervention it is extremely important you do not assume that your group members are all heterosexual. Regardless of your personal beliefs, views, or possible biases regarding differing sexual orientations, it is your job as counselors to welcome and create a safe environment for all individuals in the study group. When discussing relationships you should be careful to use gender neutral labels such as “partner” or “significant other”, rather than “girlfriend” or “wife”. Given the sexual nature of these discussions and role-plays it is not unusual for homophobic banter to arise during groups. Given that a safe environment must be created for all members, offensive homophobic language on the part of group members must be dealt with quickly and definitively. At all costs counselors should resist any temptation to participate in homophobic banter with group members as a means to “joining” the group. In sessions 4 and 5 there are references to specific partners as being female in examples and role plays. This was done because most men in the group identified as heterosexual.

Please discuss this issue as a treatment team with your supervisor.

Acknowledgements

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Safer Sex for Men Study Research Group: The NIDA Clinical Trials Network (CTN) is made up of “nodes” comprised of a Regional Research and Training Center (RRTC) housed at an academic institution and 5-10 Community Treatment Programs (CTPs). The Pacific Northwest Node served as the lead node. The contributions from each participating CTN node are provided here.

Pacific Northwest Node RRTC, *University of Washington Alcohol and Drug Abuse Institute*, Seattle, Washington. Lead investigator and RRTC investigator: Donald Calsyn; National project managers: Sara Berns and Mary Hatch-Maillette; Lead statistician: Suzanne Doyle; Local project manager: Mary Hatch-Maillette.

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California/Arizona Node RRTC, *University of California San Francisco*, San Francisco, CA. RRTC investigator: Yong Song.

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Southwest Node CTP, *The LifeLink*, Santa Fe, NM. Site investigator: Diana Pallas.

The CTN HIV Special Interest Group also made contributions to the development of the research protocol. The following individuals not mentioned above made significant contributions: Stephen Shop-taw, Ph.D., UCLA; Robert Malow, Ph.D. Florida International University; Deborah Orr, Ph.D., Center for Drug-Free Living, Orlando, FL; George Woody, M.D., University of Pennsylvania.

NIDA Center for the CTN staff assigned to assist with the protocol development, implementation and dissemination of findings also made significant contributions to the REMAS Clinical Trial. These include: Mary Ann Stephens, Ph.D., Ming Shih, Ph.D., Paul Wakim, Ph.D., and Raul Mandler, M.D.

Counselor Training

The REMAS intervention was delivered by male counselors already employed in the study clinics. The treatment counselors received approximately 30 hours of training in conducting the intervention. In addition to training the program counselors, a clinical supervisor at each site was trained in conducting the intervention and supervising the intervention. Groups were conducted by co-leaders who shared responsibility for delivery of the treatment. The training conference was developed by the lead investigator and the national program managers in consultation with the training director from the Pacific Northwest Node of the CTN, John Baer, Ph.D.

A special note of appreciation is extended to Norma Bartholomew (*Institute for Behavioral Research, Texas Christian University*) and Jennifer Sharpe Potter (*Harvard Medical School*) for their assistance in conducting the training conference. Ms. Bartholomew ensured that the counselors received expert training in the REMAS modules that had been adapted from "Time Out for Men!" for which she was one of the original developers. Dr. Potter ensured that the counselors received expert training in the REMAS modules adapted from *Project Light* for which she had been a national trainer.

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¹ Adapted from *Time Out for Men! A Sexuality and Communications Skills Workshop*

² Adapted from *Approaches to HIV Education in Drug Treatment*

³ Adapted from *Project Light*

Session 1

HIV/AIDS Update: Identifying Risks

Session 1

HIV/AIDS Update: Identifying Risks

Session Length: 90 minutes

Objectives

Participant will:

- Establish the goals and purpose of the groups
- Identify behaviors associated with HIV/STD transmission
- Identify risk reduction behaviors
- Demonstrate correct use of condoms
- Identify one's own risk behaviors

Rationale

The session reviews the definitions of HIV/AIDS, how HIV infection progresses, and how HIV is transmitted. Although there is evidence that drug users know more about HIV/AIDS today than they did several years ago, there remain those who still need to have the basic information repeated or clarified. In addition, all clients benefit from a periodic update of information from a rapidly changing field. Changing HIV-risky injection and sex behaviors continues to be a challenge for many drug users. Since changing sexual risk behaviors has been more difficult for drug users than changing injection risk behaviors there is a greater focus on sexual behaviors. It is important to provide opportunities to discuss and practice risk-reduction strategies and to reinforce changes that have already been implemented. Time is allotted for group leader demonstrations of correct condom use.

Session Outline	Procedure	Time
I.	Group Introductions, Goals and Ground Rules	10 minutes
II.	Getting Started	10 minutes
III.	HIV Risky Behaviors Exercise	15 minutes
IV.	HIV/AIDS Update	10 minutes
V.	HIV Transmission: Blood	5 minutes
VI.	HIV Transmission: Semen and Vaginal Fluids	15 minutes
VII.	Condom Demonstration	10 minutes
VIII.	HIV Risky Behaviors Exercise Revisited	10 minutes
IX.	Wrap-up	5 minutes
	Total Time for Session 1	90 minutes

Materials

- Prepared Flip Charts with
 1. Group goals
 2. Group guidelines
 3. Questions to ask yourself
 4. HIV Information Map
 5. AIDS Information Map
 6. HIV Timeline Information Map
 7. HIV Body Fluids Information Map
 8. Blood related HIV risk behaviors
 9. Semen related HIV risk behaviors
 10. Sexually Transmitted Disease
 11. Using Condoms Correctly
 12. Female Condom Insertion
 13. Drug Use Practices Hierarchy
 14. Safe Sex Hierarchy
- Chalk or dry erase markers, or blank sheets and tape to be attached to some prepared flip charts
- **2 sets of *HIV-Risk Behaviors*** cards for **each** participants
- Two envelopes for each participant with one labeled "Participated in the Behavior" and the other "Did not Participate in the Behavior."
- Three boxes (shoe boxes work fine) labeled **DEFINITELY SAFE, PROBABLY SAFE, and DEFINITELY UNSAFE.**
- Latex condom packets (lubricated, non-lubricated, flavored), male and female, and lubricant
- Condom demonstration models (1 penis model, 1 vagina model)
- Scissors.

Information maps

Information maps are used to help focus attention on key information during the HIV/AIDS Update discussion. It's recommended that group leaders use diagrams of the information maps as visual aids during the presentation of the material. These diagrams are prepared on flip chart paper. These prepared maps are then used to direct participants' attention to **key points** (written out in boxes called "nodes") and their **relationships** to each other (written as lines called "links"). The links connect the nodes and are labeled to specify the relationship. A legend on each map describes the link relationships. This kind of map is called a *node-link* information map. For example, you might point out to the group that in the ***HIV Information Map*** the **H** *represents* the word **Human** in the acronym **HIV**. **Human** (in the case of HIV) has as a *characteristic* that it is a *human* infection, in that it is not common to or spread by any other species. Nodes and links are thus discussed in this manner. You'll want to encourage questions and keep the group involved as you work through the key points in each map.

Some group leaders may prefer to have the participants "fill-in" some of the boxes in the maps as part of the group presentation. In this case, the boxes in which participants are to fill-in the answers should be covered prior to the group. The cover is removed when the correct answer for the box is given. For example, in presenting the ***HIV Information Map*** material, you may begin by covering the boxes below **H -I -V**. Then ask participants if they know what each letter in **HIV** stands for, and uncover the boxes as correct

answers are given. If needed, correct information is provided if participants have misinformation.

I. Group Introduction, Goals and Guidelines

Length: 10 minutes



A. Group Introductions

These need to be kept relatively brief, as this section combined with group goals is only allotted 10 minutes. You may not have time to ask all of the questions below; you may feel free to pick a subset. Begin by introducing yourself, then go around the room and ask each person to introduce himself. Possible questions include:

- "How long have you been with this program?"
- "Are you currently in a relationship?"
- If yes, "How long have you been with your partner?"
- If no, "When were you last in a significant intimate relationship and how long did it last?"
- "What do you hope to get from this group?"

B. Group goals (refer to prepared flip chart #1)

Review each of the goals below by referring to the flip chart. Possible comments to make while pointing out each line are included below.

To learn about ways to prevent HIV transmission.

To gain an understanding of the relationships between our drug use and sexual behavior.

"An improved understanding of these relationships may help to prevent relapse associated with the interplay between drug use and sexual behavior."

To learn more about ourselves.

"We improve relationships by learning more about ourselves, especially our belief systems about relationships between sexual partners. Once we learn more about why we behave the way we do, we can choose to make changes in our behavior if so desired."

To improve communication between ourselves and current or potential sexual partners.

"Relationships often deteriorate due to poor communication."

To strengthen recovery by improving our relationship.



C. Group Guidelines (refer to prepared flip chart #2)

Stick to the topic.

"We'll be covering a lot of information, so it's important that we stay on track and avoid rambling around. As group leaders, we'll butt-in from time to time if the group starts drifting off the topic."

Participate!

"This workshop is a sharing process and we need everyone's attention and contributions to make it work. Stretch yourself a little bit and let us hear about your thoughts, feelings, and opinions."

Respect ourselves and each other.

"Let's avoid put-downs, one-ups, name-calling, and taking things too personally. We all deserve to be heard and we're all responsible for listening to others."

What's said here, stays here!

"We will respect each person's confidentiality. This is VITAL to the success of this group."

Avoid bragging, boasting, and other mind-games.

"This isn't a contest, and there will be no prizes awarded for bigger, better, more often, or being a stud."

Support each other!

"We're all here to learn. We'll be discussing sensitive topics, but we're all on common ground as men. A little understanding can go a long way."

II. Getting Started

Length: 10 minutes



A. Purpose of the workshop.

Use the next 10 minutes to discuss what the workshop is about and the topics to be covered. Read over the following script for ideas on what to say to get started: There is a lot of material in this section. Group leaders are not required to memorize this information word for word. Rather than reading the material the group leader may choose to summarize the points in their own words, which is perfectly acceptable. Key points are highlighted.

1. "This workshop is designed to help us learn more about reducing HIV transmission risk, gender roles, communication in relationships, sexuality, and building stronger, better relationships. Everyone has questions and concerns about love, sex, and intimacy—but we seldom get the chance to talk openly and honestly with one another. It's normal for you to have some doubts about being here and to wonder what you can get out of this group. That's something each person needs to answer for himself—some questions to ask yourself



are: *(Use prepared flip chart #3).*

- a. Am I satisfied and happy with my sex life and my relationships?
- b. Am I keeping myself and my partners safe from sexually transmitted diseases?
- c. Can I communicate effectively with current or potential sexual partners about sexual matters?
- d. Are there any recurring relationship problems that cause me or my partner/partners unhappiness?
- e. Can I have satisfying sexual relationships without using drugs?

2. "If you don't sense you are having problems in these areas—that's wonderful! We encourage you to participate in this group and share with us how you handle relationship problems in a positive way. On the other hand, if you recognize there are things about yourself and your intimate relationships that you would like to feel better about, this group can help. The only requirement is that we agree to be honest with ourselves and each other. We sometimes try to hide our insecurities by boasting, bragging, and playing 'one-up' with each other. We'd like for this group to be a place where we can put all of that aside and work to help ourselves and each other feel better about who we are as men and how we can make our relationships work out the way we want."

3. "As group leaders, we don't have all the answers. In fact, we probably struggle with the same kinds of problems that you do from time to time. But we do have some ideas about why relationship troubles develop and what we can learn to do differently to help solve some kinds of problems. **We believe that relationships are important and worth an investment of time. We also believe that you deserve to have happy, satisfying, intimate relationships and that you have the ability to learn how to make your relationships better.** That's what this group is all about."

4. "Real men" are sensitive, much more so than society allows us to believe. Often it is said that women are the ones who feel, while men are the ones who are logical and levelheaded. The truth is that both men and women have strong emotions and feelings (and both men and women are able to be logical and levelheaded). This is true because both are human beings. However, society does teach men not to express their feelings openly, especially when it comes to the 'softer' emotions. The result is that men often feel alienated, lonely, cut-off, and misunderstood when they try to deal with their feelings. **One thing we'll do in this group is look critically at some of society's 'rules' for men and women to see if we really agree with them. Sometimes relationship problems develop because the partners have never challenged society's stereotypes for men and women.** All we suggest is that you keep an open mind as we explore these issues in the group."

5. "Finally, there's the impact of addiction and recovery on relationships.

As we become stronger in our recoveries, we often begin to see the need for making changes in our relationships. We may be carrying some guilt, shame, and sadness over the things we did to ourselves, our partners, and our families in order to support our habits. We need to explore these feelings in order to regain the self-respect and self-esteem needed for a healthy relationship. Our partners may need some help as well—and hopefully this group will give you some information and skills for helping your partner, too. **Addiction is tough on relationships, no matter how resilient, loving, or forgiving a partner may be.** If both partners have a shared history of addiction, the challenge may be even harder. **The important thing to remember is that change is possible!** In fact, change is inevitable. This time next year, we all will have changed to some degree, for better or worse. Our decision for today might be to guide the progress of these "natural" changes for the better."

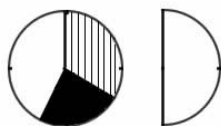
6. "So, over the next few weeks we're going to talk men-to-men, and try to generate some ideas about how we can be happier with ourselves, our sexuality, and our relationships. We'll discuss sexuality issues such as sexual functioning, staying healthy, and the relationship between drug use and sexual behavior. We'll also talk about communicating about sex with potential partners."

B. Seek feedback with the following questions:

1. What do you think about what you've heard so far?
2. Do you have any questions or concerns about this group?

III. HIV Risky Behaviors Exercise

Length: 15 minutes



A. Self Assessment

1. *Begin by telling participants:*

"We'd like you to take part in an activity to review HIV-risky behaviors."

2. *Distribute a complete set of the **HIV-Risk Behaviors cards** (page 44) to each participant and two envelopes, one labeled "Participated in the Behavior" and one labeled "Did not participate in the behavior." Ask participants:*

"Sort the cards into the two envelopes: 1) behaviors in which you have participated in the past year; 2) behaviors in which you have not participated in the past year."

"You will not need to share your responses with the group unless you wish to do so later in the group"

"Set aside your envelopes under your chairs. We will re-

turn to the envelopes later in the session"

B. Risk Estimation

1. *Give each person another set of the HIV-Risk Behaviors cards.*

"Read your cards and decide if the behavior described is "Definitely safe," "Probably safe," or "Definitely unsafe" for HIV infection transmission based on what you know."

2. *While participants are reading their cards, create a continuum by placing three boxes (shoe boxes work fine) labeled DEFINITELY SAFE, PROBABLY SAFE, and DEFINITELY UNSAFE in a row on a table or on chairs in the room.*

3. *Next, ask all participants to:*

"Walk around and place your cards in the box that best describes its level of risk, definitely safe, probably safe, or definitely unsafe."

4. *Encourage group discussion by asking these questions:*

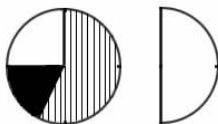
"Was it easy or hard to decide where to place your cards? Why?"

5. *Tell participants:*

"We will revisit this exercise at the end of the session after some basic information about HIV/AIDS has been presented."

IV. HIV/AIDS Update

Length: 10 minutes



A. Introduce topic

This segment focuses on providing basic information about HIV/AIDS. Here is where you should present some general statistics on HIV and AIDS, and some local statistics. These statistics should be updated annually. Examples include:

"As of 2007, there were 551,932 people living with AIDS or HIV infection in the U.S. The Center for Disease Control and Prevention estimated that in 2007 the estimated rate of HIV infection in the US was 21 per 100,000 people. Males accounted for 74% of all cases. African Americans are overrepresented among HIV infected persons, 77/100,000 compared to Hispanics/Latinos (13/100,000) and Whites (9.2/100,000).

"As of 2007, the total number of AIDS deaths in the US has been almost 600,000."

"In the U.S., 1 out of every 3 cases is linked to injection drug use, either injection use itself, or being the sex partner of someone who injects."

"In 2009, In the Seattle (local area) area, there were over 10,000 people living with HIV/AIDS. Five-percent of all cases were related directly to injection drug use. Another 10% of cases were related to heterosexual contact."

Key point to make: "There's no cure for AIDS. For the time being we've got all our chips riding on prevention and education. **The good news is that HIV/AIDS can be prevented.** That's part of what we'll be talking about today."



B. Introduce the *HIV Information Map* (flip chart #4)

Use this Information Map to briefly review the definition of HIV. When presenting these information maps counselors are encouraged to cover up certain parts and ask for group participation. For example, the counselors could cover up the row that shows what H, I, and V stand for, and ask the group if they know what it stands for. Include the following key points in the discussion:

1. "HIV is the name given to the virus that infects people and then goes on to cause AIDS. **The H stands for HUMAN.** This refers to the fact that people (human beings) can get it and pass it on. **It is not common to or spread by any other species.** That is to say, it's not spread by dogs, cats, parrots, mosquitoes, ticks, horses, or rose bushes. It's spread by people."

2. "**The I stands for IMMUNODEFICIENCY.** This is a big word that means **there's a problem with the immune system.** Our immune system is made up of special cells that help protect us from disease. When it doesn't work right (when it's deficient), we lose protection against disease and illness."

3. "**The V stands for VIRUS.** A virus is the smallest microbe that can infect human beings. (A microbe is something like a 'germ' — it can only be seen with a really strong microscope.) **A virus can't live on its own. It invades human cells in order to survive.**"

4. "**HIV survives by invading certain white blood cells in the body's immune system** (called CD4 cells or T-cells). It gets into these cells through blood contact and/or contact with sex fluids (semen and vaginal fluids). A pregnant woman with HIV may pass it to her unborn child during pregnancy or childbirth, or through breast milk if she breast-feeds. Once a person has HIV, he or she can infect others with his/her blood or sex fluids, even if he/she has no symptoms."



C. Introduce the *AIDS Information Map* (flip chart #5)

Use the AIDS Information Map as a visual aid to briefly review the definition of AIDS. Use same technique as on previous information map, of covering up certain parts and asking for group participation. Include the following key

points:

1. **"AIDS is the final stage of HIV infection.** People are said to have AIDS when their immune system has become severely damaged and they are experiencing one or more of the serious illnesses which define AIDS."
2. **"The A stands for ACQUIRED.** This means you can acquire it from an infected person; that is, you can become infected yourself."
3. **"The I stands for IMMUNE.** Again, this is the body's immune system. It's made up of different types of white blood cells that help fight disease. "
4. **"The D stands for DEFICIENCY.** Again, like the definition of HIV, deficiency means it's not working. It lacks the ability to function correctly."
5. **"S stands for SYNDROME.** This is a medical term used by doctors to describe certain symptoms or health problems that are related to a specific disease."
6. "Most people who have AIDS probably carried HIV for many years before becoming ill. **AIDS is defined medically as having HIV, plus one or more serious health problems such as certain types of pneumonia, cancers, infections, or forms of TB.** Also, a person may be diagnosed as having AIDS when the virus has destroyed a large number of their immune system cells called CD4 cells or T cells. If a special lab test shows the person has a "count" of fewer than 200 CD4 cells, then the person is said to have AIDS. The normal range for CD4 cell count is 500-1500."



D. Introduce the *HIV TIMELINE Information Map* (flip chart #6)

Use it to review the progress of HIV infection from exposure to AIDS. Include these key points:

1. **For adults and teenagers today, the primary way they are exposed to HIV is through sharing injection "works"** (such as needles, syringes, cookers, or cottons) **with someone who has the virus, and/or through unprotected sex with someone who has the virus.**
2. **Most people who become infected with HIV do not know at the time of exposure that they have been exposed.** It is only sometime later they find out that a particular risky event led to infection. Often a person does not know which specific risky event led to infection. However, occasionally an individual discovers they have been exposed to HIV very near to the time of exposure. Examples would be a health care worker suffering a needle stick when caring for a person known to be HIV infected, having sex with a person who is HIV infected and having a condom break, or being told afterwards he/she was infected, same with sharing needles with an HIV infected person.

3. For health care workers exposed to HIV the standard intervention is to provide post exposure prophylaxis (PEP) with a 30 day course of antiretroviral treatment. There is some evidence that such an intervention may provide protection from infection.

Whether PEP is available in the other examples listed above varies by community and health care institutions. **But in most cases PEP would only be provided if the medical provider was convinced the risk behavior was an isolated incident** and there were mechanisms in place to assure further risk behaviors would be unlikely.

4. About 2-4 weeks after exposure some people experience very mild, flu-like symptoms. They may feel a little run down, have a low fever, and feel fatigued. For most, it's so mild they hardly notice it. What's happening is the immune system is reacting to the invasion of the virus.

5. After about 3 months, the immune system will produce something called antibodies in its attempt to fight off the virus. Unfortunately, HIV is so powerful the antibodies don't help. However, these antibodies can be detected by a blood test, called the HIV Antibody Test. This test is used to help people know whether or not they have been infected with HIV.

6. After the person is infected, it may take up to 10 years before he/she becomes seriously ill. It all depends on many factors, including how healthy the person was to start with and how well they take care of themselves after exposure. Drug and alcohol abuse combined with years of neglecting one's overall health may shorten this time. Even though the infected person feels fine, he or she can still spread the virus through unprotected sex or by sharing needles/works.

7. At some point, the infected person can expect to experience symptoms. This is referred to as *HIV-related illnesses*. This is the point at which most people finally see a doctor. The CDC reported in 2007 that 36% of people diagnosed with HIV infection progressed to AIDS within one year of learning they were HIV infected.

8. Without treatment most people will be diagnosed with AIDS, which is the late stage of HIV illness within 6 months to 2 years after the first symptoms of HIV-related illnesses. By then, they may have developed cancers such as Kaposi's Sarcoma (women may develop cervical cancer), lung infections such as Pneumocystis Carinii Pneumonia (PCP), brain disorders such as AIDS dementia, "wasting syndrome" (severe diarrhea and loss of appetite), TB, or uncontrollable outbreaks of herpes or candida infection. They may also show evidence of a severely destroyed immune system with a CD4 cell count under 200. Without treatment most people with AIDS eventually die from the disease. However, a handful of people have been HIV infected for many years, have not received treatment and have yet to develop AIDS.

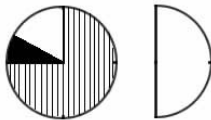
9. There is no cure for AIDS itself. However, in the mid 1990's highly active anti-retroviral treatment, also known as HAART, was intro-

duced. HAART consists of a 2 - 4 medication cocktail of different types of anti-retroviral drugs. **HAART has greatly extended the life expectancy of HIV infected individuals. Exactly how long HAART will extend an individual's life is currently unknown. One should not assume it is indefinite.** HIV often will mutate within an infected individual. Sometimes the mutant forms of the virus become resistant to the HAART medications and they no longer are effective. In addition the HAART medications have many unpleasant side effects. These can be severe enough in some individuals that HAART has to be discontinued.

10. With the success of HAART at prolonging life it has become very important for people who think they may have been exposed to HIV to have an HIV test. The sooner they know if they have HIV, the sooner they can begin following a health and treatment plan that may help prolong their lives.

V. HIV Transmission: Blood

Length: 5 minutes.



A. Introduce the ***BODY FLUIDS Information Map (flip chart #7)***

Use this information map to review the ways by which HIV may be transmitted. Include the following key points:

1. "HIV invades and takes over some of the cells of the immune system. This results in the virus being present in some of the body's fluids. HIV can be spread from one person to another through contact with infected body fluids. However, **not *all* body fluids are a problem. Let's separate the 'risky' ones from the 'not risky' ones."**

2. "The blood of an infected person will have the highest concentration HIV. If their blood gets into your bloodstream, you may become infected with HIV, too. Even a tiny amount can lead to infection."

*Go to **FLIP CHART #8.***

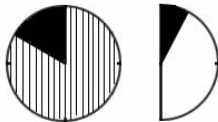
*Sharing injection equipment, cookers, cotton, rinse
Sharing drug snorting equipment
Piercing, tattoos, "blood brother/sister" rituals
Accidental cuts or sticks (for example, doctors, nurses, EMTs)
Transfusions (clarify that HIV risk is very low nowadays)
Hemophilia treatment (risk also very low nowadays)
Exposure to blood during childbirth may infect a newborn infant
Clarify misinformation*

3. "The primary blood-to-blood transmission risk today is shared drug injection equipment. The second most common is blood exposure to newborn infants during childbirth when the mother is infected with HIV. An infected mother has about an 18-26% chance of passing HIV to her unborn child, either during pregnancy or during childbirth without anti-retroviral therapy. With anti-retroviral therapy the transmission rate is less than 2%."

4. "Besides HIV there other serious infections that are transmitted by blood. The most common among drug users are Hepatitis B and Hepatitis C. The viruses that cause these diseases are much more infectious than HIV and are more easily transmitted by the risk behaviors identified here than HIV. For example **among injection drug users in the U.S. from 70-90% of injection drug users have been infected with HCV and 60-80% of them have a chronic infection.** People with chronic HCV infection have a higher risk for liver disease including liver cancer. So even if you live in an area where the rates of HIV infection are low, there is a very high likelihood of high rates of HBV and HCV infection."

VI. HIV Transmission: Semen & Vaginal Fluids

Length: 15 minutes.



A. Return to the *BODY FLUIDS Information Map* (flip chart #7)

1. "The semen (cum) and vaginal fluids (juices) of HIV infected people also contain high concentrations of the virus. If these fluids come in contact with cuts, sores, or irritated skin, HIV can be transmitted. Also, if these fluids come in contact with *membrane* tissues, the virus can enter the immune system. A membrane is a special type of soft, moist, delicate skin, like the inside of the mouth, the inside of the vagina, the rectum, and the opening at the tip of the penis. Identify ways HIV may be spread through infected semen or vaginal fluids (*go to flip chart #9*).

Cover the following:

a. Anal sex (penis in rectum). HIV in semen can penetrate the membranes that line the rectum. Small cuts or tears may allow HIV in semen to pass directly into the bloodstream. Blood in rectum may enter the soft tissue at the opening of the penis.

b. Vaginal sex (penis in vagina). HIV in semen can penetrate the membranes that line the vagina. HIV in vaginal fluids can penetrate the thin, delicate skin of the penis and urinary opening at the tip of the penis or through skin breaks on the penis that may not be noticeable to the naked eye.

c. Oral sex (mouth on penis or vagina). HIV in semen or vaginal fluids can penetrate the mouth's membranes. Small cuts or sores in the mouth allow HIV in semen or vaginal fluid to pass directly into the bloodstream. If the person performing oral sex has mouth sores, bleeding gums, or crack pipe burns, then there may be blood in his/her mouth. If they have HIV, they could spread it via blood while performing oral sex.

d. Discuss comparative risks between vaginal, anal and oral sex. Infection from sexual behavior is based on a three factors: 1) likelihood that your partner is HIV infected, 2) infectiousness of the sexual act, 3) use of condoms. The more certain you are your partner is not infected the lower your assumed risk. If partner's status is unknown then the risk could be as high as the

highest risk individuals in the community. **Receptive anal sex is the riskiest of the sexual behaviors followed by receptive vaginal sex, insertive anal sex, insertive vaginal sex, receptive oral sex, and insertive oral sex.** However in some studies receptive and insertive vaginal sex were equally risky. Condom use is estimated to reduce infection risk by 20 fold.



Return to flip chart #7

2. The breast milk of an infected mother may expose her infant to HIV. Women with HIV infection or AIDS who give birth are advised to not breast-feed their infants.

3. The saliva (spit) of an infected person does not have enough HIV to worry about. HIV cannot be spread through contact with saliva. However, if there is blood mixed with the saliva, then there's a potential problem. In this case, the transmission risk is from the blood, not the saliva. Blood may be in saliva from gum disease, mouth sores or cuts, crack pipe burns, etc. Urine, sweat, tears and feces do not contain enough HIV to worry about. Therefore, HIV cannot be spread through contact with these body fluids. In rare cases, blood may be present in urine or feces, creating a risk.

B. Summarize the discussion by reviewing the ways HIV can and cannot be transmitted.

Include the following key points:

1. HIV can be transmitted by an infected person. It can be spread via blood contact (especially shared drug injection equipment), and by contact with sex fluids during vaginal, anal, and oral sex. The breast milk of an infected mother may also expose her infant if she breast-feeds.

2. HIV cannot be transmitted by saliva, tears, sweat, urine, or feces. It cannot be spread by touching, hugging, eating utensils, toilet seats, swimming pools, food, clothing, sneezing, or coughing. It is caused by a human virus, so it can't be spread by dogs, cats, monkeys, or other animals. Neither can it be spread by mosquitoes, ticks, or fleas.

3. You cannot catch HIV by donating blood. However, if you have reason to suspect that you may have been exposed to HIV, don't donate blood. Do **not** donate blood just to see if you have HIV. If you want an HIV test, go to the health department or other HIV testing site.

4. HIV can be prevented. You can help reduce your chances of getting HIV by using latex condoms every time you have sex (vaginal, oral, or anal sex) and by never sharing works (needles, syringes, cottons, etc.).

5. *Encourage participants to ask questions before moving on.*
"What have I failed to cover that you still have a question about?"

C. Other sexually transmitted diseases

1. "There are other diseases besides HIV virus that can be passed from one person to another through sexual contact. These diseases are called STDs: Sexually Transmitted Diseases"

2. "Can anyone tell me the names of some STD's?"



Write responses on blank newsprint or board.

Show Flip chart #10; *answer should include those in chart:*

STD	Symptoms	Treatment
<i>Gonorrhea</i>	<i>yellow/white discharge</i>	<i>Antibiotics</i>
<i>Syphilis</i>	<i>sores on genitals</i>	<i>Penicillin/antibiotics</i>
<i>Chlamydia</i>	<i>painful urination, pain in testicles</i>	<i>Antibiotics</i>
<i>Genital warts</i>	<i>warts in genital area</i>	<i>Removal</i>
<i>Herpes</i>	<i>sores/blisters in genital area</i>	<i>No cure</i>

3. "We know how to treat many STDs, **if left untreated however, they can cause serious health problems.** Some can be life threatening."

4. "**We can have an STD and not feel it.** There are many symptoms to warn us that we have an STD which we will review in a moment, but sometimes we can have an STD and have no symptoms."

5. "**Common symptoms** include a burning when you urinate, an itchy or burning penis, sores/rashes on the penis and other genital areas, a penile discharge, pain in the testicles."

6. **What can we do if we think we have any of the symptoms mentioned above? See a health care provider.** Many people feel embarrassed about going to see a doctor until the discomfort and pain become so severe that they have no choice but to seek medical help.

7. **Many of the STDs can be successfully treated** with penicillin, other antibiotics or creams.

There are treatments for the symptoms of Herpes, but no cure.

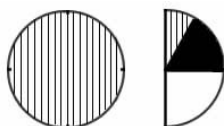
9. **It is important to get medical attention as soon as you have symptoms.** It is important especially in the prevention of contracting HIV. Because HIV is transmitted through body fluids and blood, STDs

(which leave open sores or cuts) increase a person's risk of getting or giving HIV. Untreated, many of the STDs can cause serious other medical problems.

10. If you are getting treatment for an STD **it is important to make sure your partner gets treated** so you don't keep on passing it back and forth to each other (re-infection).

VII. Condom Demonstration

Length: 10 minutes



A. Overview

1. "Sometimes denial about being at risk for HIV and other STDs can interfere with our decision-making. Accepting our right to protect ourselves from HIV is the first step toward planning how we'll protect ourselves from sexual risks. If using condoms makes sense to you, then you'll give them a try. "

2. "If you're not ready to use condoms, then you'll want to think seriously about other ways to protect yourself from sexual risks. As we discussed earlier, monogamy with a non-infected partner who avoids other HIV-risky behaviors is an option. For this option to work, both partners should be tested for HIV and counseled about risk reduction."

3. "The key to successful condom use is communication. Talk with your partners and agree about using condoms before having sex. If you wait until you're caught up in strong sexual feelings, you may forget to use a condom. Talking about it ahead of time will help strengthen your decision. Remember, you have the right to protect your health by using a condom or asking your partner to use a condom."

4. Condoms provide protection by covering the penis, keeping semen and vaginal fluids from coming in contact with membranes or broken blood vessels.

5. Latex condoms provide the best protection — "natural" condoms made of animal membranes aren't as effective in blocking the virus (and they're unbelievably expensive as well). Latex condoms are inexpensive in stores and may also be available through many drug treatment centers, public health and family planning clinics at low cost or no cost.

6. Believe it or not — **not all condoms are shaped the same. Condoms are available in different shapes and sizes.** Many men prefer a condom that allows a bit of friction at the tip and is thin enough to conduct warmth. Latex is strong, so even thin condoms offer good protection. *Demonstrate how much a condom can be stretched without breaking by inserting your hand into a condom.*

7. Know how to use a condom. Also, know how to prevent them

from breaking and how to make them comfortable and pleasurable.



B. Demonstrate the correct way to use a condom (show flip chart #11).

Encourage questions and comments. Use a condom demonstration model, condoms, and lubricants. If a model is unavailable, demonstrate by rolling the condom over two fingers). Cover the following key points:

1. Open the condom package at the corner being **careful not to damage** the condom (and make sure to **check the expiration date!**).
2. The condom is **put on when the penis gets hard**, not before. Always use a new condom. Condoms are used the same way for vaginal sex, oral sex on a man, and anal sex.
3. Place the rolled condom over the end of the erect penis, then **pinch the tip of the condom and squeeze it gently to push out any trapped air**. (Trapped air in the tip is like a little balloon — it could burst during sex.)
4. **Be careful not to tear it.** Be careful with fingernails, jewelry, rings, or anything sharp that could break or tear a condom while it's being put on.
5. Once the air is squeezed out, **roll the condom down over the shaft of the penis. Leave space at the tip** of the condom to catch the semen (cum).
6. Take care when you take it off: **After coming or climaxing, the penis should be pulled out soon.** One partner should reach down and hold on to the condom at the base of the penis while pulling out. This will **prevent the condom from slipping off**.

Pull out carefully and take off the condom so that nothing spills out. You can tie a knot at the top so the cum can't spill out.

Wrap it in some tissues and **throw away in the trash can.** Don't flush it down the toilet because it can clog up your pipes.

C. Some key points to make

1. **Try out several brands until you find the one that's most comfortable.** Try out different colors and flavors. Flavored condoms are especially popular for oral sex.
2. **Condoms and lubricants containing nonoxynol-9, a type of chemical used in some birth control foams and gels, may help protect against HIV.** However, many people are allergic to nonoxynol-9, and may develop irritation, burning, or a rash. If you develop irritation, switch to a condom or lubricant that doesn't have nonoxynol-9.

Nonoxynol-9 products are not recommended for women in the commercial sex trade as it appears to irritate vaginal tissues and actually increase the chance for sexual transmission of disease.

3. If using a lubricant, before putting the condom on, put a tiny dab of lubricant (like K-Y[®] Lubrins, etc.) in the tip. (Don't use too much or the condom might slip off). Then roll the condom on as discussed before. The tiny dab in the tip of the condom will help the head of the penis move smoothly inside the condom, and provide extra pleasure and sensations for the man. **Use only water-based lubricants** with condoms. For example, K-Y[®] or any kind of lubricant sold in the condom section of stores. Some brands are called "personal" lubricants. When you read the box, it will say that the product is "safe for use with condoms." Oily lubricants (like Vaseline[®], baby oil, hand lotion, or massage oils) can actually weaken latex and make it easier to break. So don't put anything greasy/oily on your condom.

4. If possible, keep several condoms "peeled" (with the wrapper off), and ready to go when you have sex. This way, if you are interrupted or if you like to start and stop while having sex, you'll have a new condom ready and waiting. You can use more than one condom per sex act — there's no rule that says one condom is the limit when you have sex.

5. Keep the condom from breaking: Latex is a strong type of thin rubber, strong enough to bear up to even the most passionate love-making. However, it can be weakened — so be careful. **Never store condoms in extreme heat** and don't freeze them. Don't use a condom that's been exposed to heat (for example, left for hours in a car in the summer time) or has been frozen (especially if it hasn't thawed out yet!).

D. Demonstrate how to create an oral sex barrier

"A condom can be used to create a barrier for covering the vaginal or anal area during oral sex. You'd want to use a non-lubricated or flavored condom for this. Dental dams are another option."

If time, pull out a non-lubricated or flavored condom and cut length-wise down one side to create a barrier for covering the vaginal and anal area during for oral sex



E. Demonstrate the use of the FC[®] "female condom" (vaginal pouch)

*Cover the following key points using **flip chart #12**:*

1. First, we need to identify some of the parts of a woman's body on the model. Here is the vagina, the cervix, and the pelvic bone.

Point to the vagina, cervix, and pelvic bone on the pelvic model.

Any questions?

2. OK, now open the package containing the female condom **without tearing the condom**. Make sure to **check the expiration date** on the package.

3. Now, unroll the condom, and **separate the two rings**. **Rub the condom gently to evenly spread the lubricant**. The loose ring inside the pouch is called the inner ring and the ring connected to the opening of the pouch is called the outside ring.

4. Next, you **grab the inside ring with your thumb and your middle finger, and pinch the edges together** (like a diaphragm). [*Point to the chart*]

5. **Place your index finger between the thumb and middle finger** to prevent the condom from slipping.

6. Now, you **use the index finger to guide the condom into the vagina**, being careful not to twist the condom. **Push the ring in until the cervix is completely covered**. The ring will fall into place once it is correctly inserted.

7. **The outside ring remains outside the vagina**, protecting the labia, or lips outside the vagina. [*Point to the labia on the model.*] Insert your index finger through the inside of the condom to make sure the condom is not twisted or loose. **Make sure it is completely covering the labia and that it isn't twisted**.

8. **Insert penis into FC® thru outer ring.**

9. **Do NOT use with male condom.**

Immediately after ejaculation and withdrawal of penis:

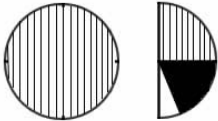
10. **Twist the end of the condom** that is protecting the labia. **Remove the condom by pulling**, being careful not to spill its contents.

11. Dispose of the condom in a **trash can**.

Review all of the steps using the chart to show participants the proper way to use a female condom. Pass a sample around for participants to handle. Encourage questions and comments. Let participants know if and where the female condom is available in your community.

VIII. HIV Risky Behaviors Exercise- Revisited

Length: 10 minutes



A. Review of cards

Pull out the cards that were placed in the "definitely safe" box. Read off some of the behaviors that were put in that box, particularly ones that you know are not definitely safe. Ask group participants:

1. "Are any of these cards out of place, in your opinion? Why?"
2. "Does anyone feel strongly that a card should be moved?"

Discuss any placement changes suggested by the group. Allow participants to offer opinions and engage in friendly debate over changing card placements. Respond to suggestions by moving cards if there's a consensus to do so.

3. "How does having information about one's partner, or the type of sexual partner, affect how much risk you're willing to take?"

4. Point to make: "Risk is reduced if a person has good reason to believe their partner is not infected. **However, what one thinks they know about their partner could be inaccurate or have recently changed.** In addition a partner may not be HIV infected, but have a sexually transmitted infection (STI) or be Hepatitis C virus (HCV) infected. Unless we can be 100% sure that the other person is not infected with an STD, we have the *right* to assume there's a potential risk to our health."

B. Flip Chart #13: Drug Use Hierarchy

"Where on this hierarchy would you draw a line separating definitely safe, probably safe and definitely unsafe?"

C. Flip Chart #14: Safe Sex Hierarchy

"Where on this hierarchy would you draw a line separating definitely safe, probably safe and definitely unsafe?"

D. Conclusion

1. "It's clear that many items might be better thought of as being between categories. For example unprotected oral sex is in the Probably Safe group, although it clearly more risky than most of the Probably Safe items. It is clearly less risky than unprotected vaginal or anal intercourse.
2. "It's important to view risk behavior on a continuum and each person needs to know the risks and must decide how much risk they are willing to take."

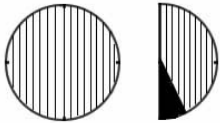
E. Examination of your own behavior

"Take your envelope marked 'Participated in the Behavior' and look at the cards inside. Remember, you are not required to say out loud what you put on the cards. For those of you feel comfortable sharing this, how are you feeling about their risk of HIV infection, and has there been a change

in your self assessment today?"

IX. Wrap-Up

Length: 5 minutes



- A.** Thank participants for their input. Reinforce them for their hard work.*
- B.** REVIEW THE DATE, TIME, and LOCATION OF THE REMAINING GROUPS. HAVE GROUP MEMBERS WRITE THIS DOWN.*

Session 1

Flip charts & Session
Materials/Handouts

Group Goals

- To learn about ways to prevent HIV transmission.
- To gain an understanding of the relationships between our drug use and sexual behavior.
- To learn more about ourselves
- To improve communication between ourselves and important other people in our lives.
- To strengthen recovery by improving our relationships.

Group Guidelines

- Stick to the topic.
- Participate!
- Respect ourselves and each other.
- What's said here, stays here!
- Avoid bragging, boasting, and other mind games.
- Support each other!

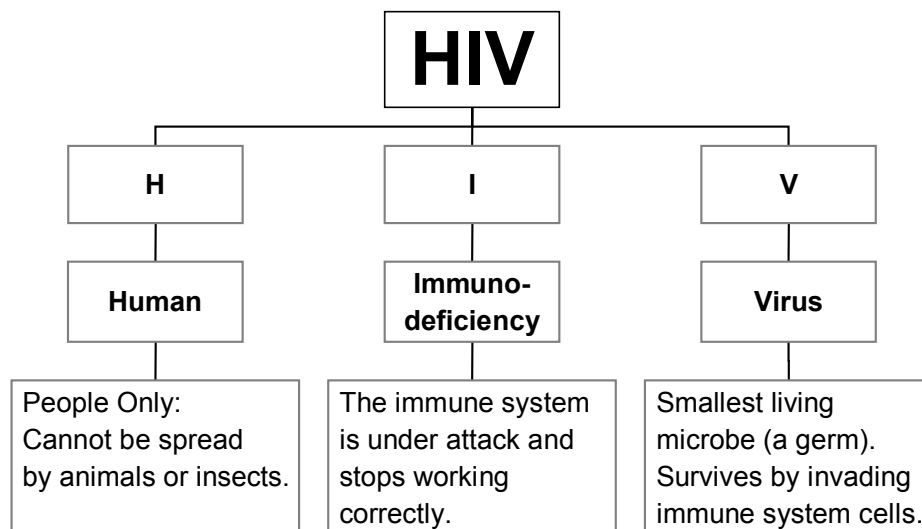
Questions to Ask Yourself

- Am I satisfied and happy with my sex life and my relationships?
- Am I keeping myself and my partners safe from sexually transmitted diseases?
- Can I communicate effectively with current or potential sexual partners about sexual matters?
- Are there any recurring relationship problems that cause me or my partner/partners unhappiness?
- Can I have satisfying sexual relationships without using drugs?

Flip Chart #4

HIV Information Map

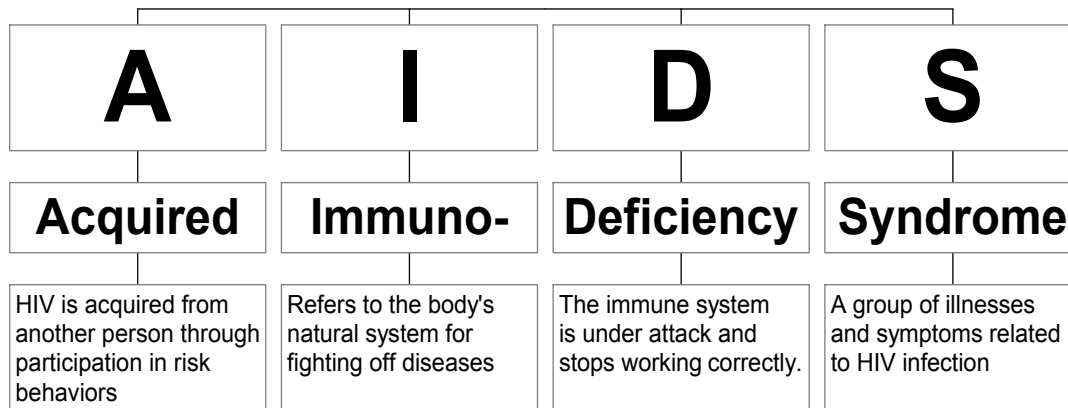
HIV is a human virus that invades and destroys the cells of the immune system.



Flip Chart #5

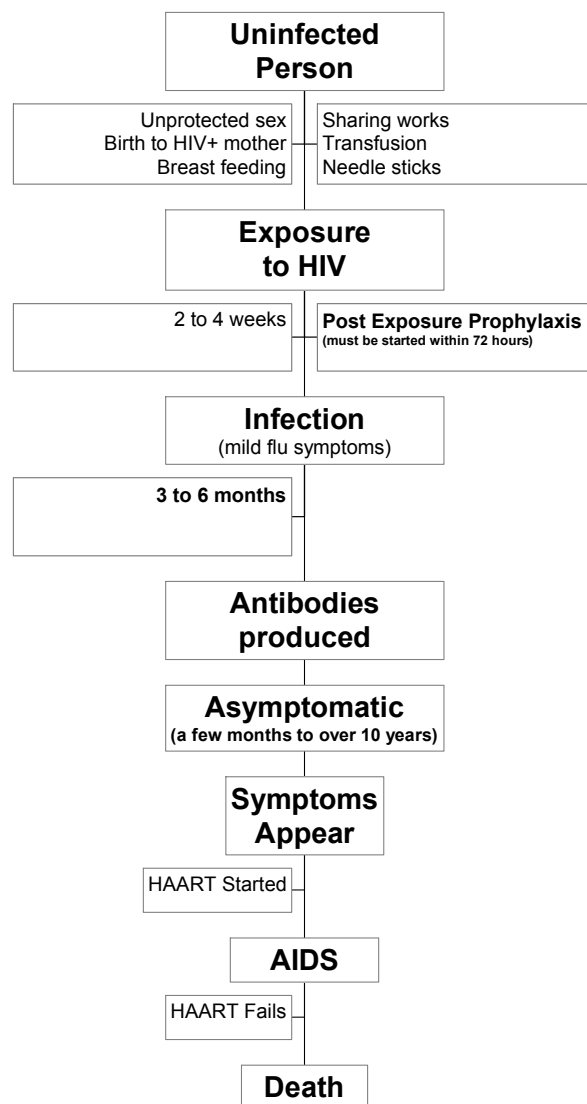
AIDS Information Map

AIDS is the late stage of HIV infection,
resulting in illness and infections the
body can no longer fight off.



Flip Chart #6

HIV Progression Information Map



Flip Chart #7

AIDS/HIV Body Fluids Information Map

HIV

Body Fluid Present Risk Behaviors

Blood	Yes	Sharing Works, Needle Sticks, Tattoos, Piercing, Pregnancy/birth
Semen	Yes	Vaginal, Anal & Oral Sex
Vaginal Fluids	Yes	Vaginal & Oral Sex
Breast Milk	Yes	Breast Feeding
Saliva	No	None, unless Blood in Saliva
Tears, Sweat	No	None
Urine, Feces	No	None, unless Blood in Urine or Feces

7

Blood Related HIV Risk Behaviors

- Sharing injection equipment, needles, syringes, cookers, cotton, rinse
- Sharing snorting equipment
- Piercing, tattoos
- “Blood brother/sister” rituals
- Accidental cuts or sticks (e.g. doctors, nurses, EMTs)
- Transfusions (hemophilia)
- Exposure to blood during childbirth

Sexual Related HIV Risk Behaviors

- **Anal sex (penis in rectum)**
 - Semen in rectum walls
 - Anal blood into penis
- **Vaginal sex (penis in vagina)**
 - Semen into vagina walls
 - Vaginal fluids or menstrual blood into penis
- **Oral sex (penis in mouth)**
 - Semen into mouth sores/cuts
 - Mouth sores/cuts blood into penis
- **Oral Sex (mouth in vagina)**
 - Vaginal fluids/blood into mouth sores/cuts
 - Mouth sores/cuts blood into vagina

Sexually Transmitted Diseases

Gonorrhea

Sx: yellow/white discharge

Tx: Antibiotics

Syphilis

Sx: sores on genitals

Tx: Penicillin/antibiotics

Chlamydia

Sx: painful urination, pain in testicles

Tx: Antibiotics

Genital warts

Sx: warts in genital area

Tx: removal

Herpes

Sx: sores/blisters in genital area

Tx: no cure, Antivirals for Sx

Flip Chart #11

Using Condoms Correctly

Have condoms available at all times
Latex or polyurathane only
Try different shapes, sizes, color, texturs and flavors
Store at room temperature, away from extreme heat or cold

Open package without damaging condom
Fingernails, rings, jewelry and teeth can puncture
Determine direction in which the condom rolls

Place condom over tip of erect penis
Pinch tip of condom to squeeze air out
Roll condom down over erect penis to the base
Keep pubic hair away from condom ring as it is rolled

If a lubricant is desired: water based only
Put a tiny dab in tip of condom before rolling it on
Be sure all air pockets are eliminated prior to insertion

Insert, thrust, enjoy
If lovemaking is interrupted and erection is lost, use a new condom
After climaxing & ejaculation withdraw prior to loss of erection

Hold onto ring of condom at base of penis when withdrawing
Turn away from partner, take condom off carefully so nothing spills
Tie off end of condom with knot like with a ballon
Wrap in tissue, throw in trash, not toliet

Flip Chart #12

Female Condom Insertion

- Open package without tearing the condom
- Check the expiration date
- Unroll the condom & separate the two rings
- Rub the condom gently to evenly spread the lubricant
- Grab the inside ring with your thumb and middle finger, and pinch the edges together
- Place index finger between the thumb and middle finger
- Use the index finger to guide the condom into the vagina
- Be careful not to twist the condom
- Push the ring in until the cervix is completely covered
- Outside ring remains outside the vagina protecting the labia
- Make sure FC is completely covering the labia and isn't twisted
- Insert penis into FC thru outer ring
- Do not use with male condom
- Removal: twist part of the FC outside of vagina and gently pull to remove
- Dispose in trash (not toilet)

Drug Use Practices Hierarchy

- Abstinence from drug use
- No injecting of drugs
- Injecting drugs with a new syringe and using own cooker, cotton, rinse
- Injecting drugs with a new syringe, but sharing cooker, cotton, rinse
- Injecting drugs with a “cleaned” syringe
- Injecting drugs with an “non-cleaned” syringe

Safe Sex Hierarchy

- Abstinence
- Romantic non-orgasmic activities
- Massage, bathing, dancing, stripping
- “Outer-course” (“grinding,” masturbation)
- Oral sex with protection
- Oral sex without protection
- Vaginal intercourse with a condom
- Anal intercourse with a condom
- Vaginal intercourse without a condom
- Anal intercourse without a condom

HIV RISK BEHAVIOR CARDS

Abstinence from sex or drugs	Massage/ body-to-body rubbing	Kissing
Solo or Parallel Masturbation	Using vibrators and sex toys	Shooting drugs with a new syringe
Mutual masturbation	Grinding	Oral sex with a barrier
Vaginal sex with a condom	Anal sex with a condom	Oral sex with a condom
Cleaning injection equipment with bleach	Vaginal sex without a condom	Anal sex without a condom
Shooting up second/sharing works/needles		

Models Used for Condom Demonstrations



Session 2

HIV/AIDS Update: Planning Prevention

Session 2

HIV/AIDS Update: Planning Prevention

Session Length: 90 minutes

Objectives

Participants will:

- Identify options for safer sex and safer injection practices.
- Practice condom application.
- Identify barriers to condom use and ways to overcome them.
- Identify triggers for unsafe sex.
- Explore personal perceptions of risk.
- Develop problem solving skills for unsafe sexual situations.

Rationale

Session 1 focused on providing basic information on HIV transmission risks. In this session the focus is on developing healthy options to high risk behaviors. Since condom use is a central feature of safe sex, overcoming barriers to condom use is a focus of the first half of the session. Time is spent with participants practicing applying condoms to models and becoming more comfortable with condoms. In the second half of the session the focus is on identifying triggers for unsafe sex and developing subsequent problem solving strategies, which can then be used.

Session Outline	Procedure	Time
	I. Welcome, redo introductions	5 minutes
	II. Healthy Options	10 minutes
	III. Barriers to Condom Use Brainstorming	20 minutes
	IV. Condom Practice	25 minutes
	V. Identifying Triggers	15 minutes
	VI. Risk Reduction Problem Solving	15 minutes
	Total Time for Session 2	90 minutes

Materials

- Prepared flip charts
- 15. Healthy Options Information Map
- 14. Safe Sex Hierarchy
- 16. Barriers to Condom Use
- 17. Overcoming Barriers to Condom Use
- 11. Using Condoms Correctly
- 12. Female Condom Insertion
- 18. Types of Sexual Partner

19. Risk Reduction Problem Solving

- Markers or chalk, masking tape (or regular tape or thumb tacks), pencils/pens and clipboards for participants
- Condom six-pack (one pack per participant, ideally pack should include one non-lubricated, one colored, one black, one large, one Japanese brand and one basic lubricated condom along with 3 lubricant packages).
- Female Condoms
- Penis models (4) and Vagina model (1)
- Condom use tally sheets (one for each participant)
- Identifying Risky Sex Triggers exercise sheet (one for each participant)

I. Welcome

Length: 5 minutes



A. Group Introductions

Begin by introducing yourself, then go around the room and ask each person to reintroduce himself.

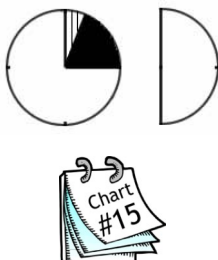
B. Review of last group

"Last group we covered basic information about HIV transmission. We discussed and rated the risk of several behaviors. Each participant also identified their own recent involvement in risk behaviors. Has anyone thought more about these issues since the last group?"

If so, encourage a brief discussion. If participants express concern about their risk tell them that today's and future sessions will provide some assistance on helping them to reduce their risk. Remind them of HIV testing options if it appears they have engaged in risk behaviors since the last time they were tested.

II. Healthy Options

Length: 10 minutes



A. Introduce the **HEALTHY OPTIONS** Information Map (flip chart #15)

Use the map to briefly review options for HIV risk reduction. Encourage participants to ask questions or share experiences as you cover the information. Include the following key points:

Avoiding exposure to HIV is not about luck. It's about exercising your right to take action, avoid exposure, and protect your health. There are lots of choices and options that can work for us.

Abstinence or quitting use of injection drugs is the most effective way to reduce HIV risk. Stay in treatment. This will help reinforce your decision to quit using and help you learn how to reduce cravings. Methadone treatment can help ease withdrawal and heroin cravings. Since you are all in treatment we would hope all of you have the

goal of abstinence from illicit drug use. However, we are also realists and realize that total abstinence may not be everyone's goal, and for some there will be relapses even when the goal is abstinence.

If you inject drugs again always use new syringes (sterile, never used before). This protects you from HIV as well as other infections (abscesses, endocarditis, etc.). Refuse to share any injection equipment (needles, syringes, cookers, cottons, water) with anyone, even your best friend.

In the past you may have been taught to bleach injection equipment as a way to prevent HIV transmission. **Bleaching is effective against HIV if done correctly, but may not be effective against the Hepatitis C virus.** Thus we do not teach bleaching in this course.

The other ideas often put forth for reducing injection risks all assume a person has some control of their drug use pattern. We feel it is very unlikely that most people in treatment could obtain this level of control. We are going to present these ideas to you, but do not recommend them since we do not think they will be realistic for most folks in treatment. Cut back on your habit. Reduce the number of times you inject. Smoke, sniff, or "eat" drugs, rather than inject them. **If you aren't ready to quit, at least quit shooting.**

Ask participants to comment on these options. Go around the room and ask each person to share with the group which injection risk-reduction option seems the best or the easiest to do.

B. Summarize the best choices for reducing sex risks:

Abstinence or not having sex. In some circumstances it's the right choice. For example, we might choose to put off having sex until we know someone better.

Exclusivity or monogamy with a partner we're sure is not infected. If both partners are free of HIV and avoid future exposure (through injection or sex), then there's no risk. Of course you can never be absolutely sure your partner is not engaging in HIV transmission risk behaviors.

Latex condoms and barriers, including the new women's condom, protect both partners against HIV and other sexual infections. We'll talk more about condoms later in today's session.

'Outer'-course (versus intercourse) includes mutual masturbation, using vibrators/sex toys, and other forms of sexual satisfaction that do not involve exposure to semen, vaginal fluids, or blood.

Other ideas for reducing sexual risks:

a. Have fewer sex partners. You'll have fewer chances of being exposed to someone who may carry the virus.

b. Avoid sex with injection drug users. If you can't do this, at least use condoms when you have sex with someone who injects.

c. If your sex partner shoots, ask him/her to use clean needles and not to share works. This is an indirect way to reduce your sex risk. Encourage your partner to use new syringes every time."



C. Present the Safe Sex Hierarchy again (flip chart #14)

"Since condom use is one of the primary ways to stay higher on the hierarchy we will spend more time focusing on condom use later in the session."

D. Encourage HIV testing

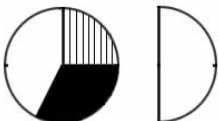
1. "If we **know our HIV 'status'** (whether we are infected or not), we're better able to take steps to preserve our health and prevent passing the virus to others."

2. Early testing is especially important for women who suspect they are pregnant and for couples who are planning a pregnancy. Anti-retroviral treatment may help a woman avoid passing HIV to her unborn infant, but this treatment should be started very early in the pregnancy for maximum effectiveness."

***Provide testing option information** in your local community.*

III. Barriers to Condom Use Brainstorm- ing

Length: 20 Minutes



A. "Despite knowing that condoms can help prevent the transmission of HIV and other sexually transmitted diseases, research has shown that **many people at risk for sexual transmission do not use condoms during sexual activities.** Over the next few minutes we are going to brainstorm on why that might be and what, if anything, can be done about it."

"What are some reasons **why people do not use condoms?**"

*Write the reasons on blank paper/chalk board. Go to **Flip Chart #16** and see how their responses compare to what is on the flip chart.*

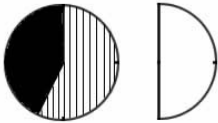
B. "Now, **how might people overcome these barriers** to condom use?"

*Write the reasons on blank paper/chalk board. Go to **Flip Chart #17** and see how their responses compare to what is on the flip chart.*

Lead a discussion focused on which of the above participants could see themselves doing in the future.

IV. Condom Practice (with coaching & feed- back)

Length: 25 minutes



A. Male condom

"In Session 1 we demonstrated the correct way to apply a male condom. Today we are going to have each of you practice applying condoms to the models."

Have participants get into pairs. *If there is an odd number of participants make up one group of three.*

Provide each participant with a condom six pack (pack should ideally include one non-lubricated, one colored, one black, one large, one Japanese brand, and one basic lubricated condom along with 3 lubricant packages).

Provide each group with folded **correct condom use tally sheets** and **penis models**.

Ask each group:

"One person (two people if a group of 3) should take the tally sheet, and the other person the model and one condom of their choice from their six pack."

"Apply the condom to the model following the instructions we provided in the last session. Those with the tally sheets should mark the sheet yes or no as to whether the person correctly did the behavior that is listed. Show how to correctly put on the condom, and how to correctly take it off."

*Before removing the condom from the model, **have each participant put their finger under the outer ring of the condom so it is between the condom and the model. Have them push their finger out from the model so they can get a sense of the condoms' strength. Ask them to use their thumb to feel the ridges on their finger through the condom to get a sense of thinness and sensation.** Facilitators may need to demonstrate this activity. **Clearly point out how strong and sensitive condoms can be.***

Have participants **exchange roles** and repeat #4-6 above using a different condom from their six packs. Collect tally sheets.

Display **flip chart #11 Using Condoms Correctly.**

Ask participants:

"Was any aspect of this difficult or hard to remember? How did your partners do in putting on and taking off the condom? Did they forget anything?"

NOTE: *During this section walk around the room and observe how the participants are doing with this task. Provide coaching and feedback as needed.*

B. Female condom

"Now we're going to try the female condom."

"We'd like someone to volunteer to try inserting a female condom into the model. Everyone else should watch and coach if they notice something that wasn't done right."



*Display **flip chart #12 "Female Condom Insertion."***

"Now we'd like you to get into pairs again."

Pass the vagina model through the groups so each person practices at least once with a female condom.

C. Condom Preference

"Open up any brand of condom that you haven't yet used in your practice."

Ask participants:

"Which condoms do you prefer? Why do you prefer that particular condom?"

D. Lubricants

Pass around examples of a variety of types of lubricants from any store. Allow participants time to "experience" the lubricants: read the box/bottle, smell, touch, etc. Hand out safe and unsafe lubricants, ask participants to identify them. The participants should be able to identify water-based lubricants as the safest kind to use with latex condoms. (The facilitator should mention that nonoxynol-9 is no longer considered any safer than any other water-based lubricant.)

E. Lead a brief discussion. Ask:

"What did you learn today about condoms that you didn't know before?"

Make sure the following key points have been made:

"Male and female condoms are barriers for making oral, vaginal, and anal sex safer. They should be used every time you have sex.

For oral-vaginal or oral-anal sex, you should use a non-lubricated (or flavored) condom cut length-wise down the middle as a barrier. These barriers should be placed over the entire vaginal and/or anal area.

For oral sex on men, the penis should be covered with a non-lubricated (or flavored) condom. (Lubricated condoms will work, but they may have an unpleasant taste).

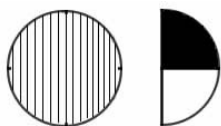
Other types of **contraception**, such as diaphragms, contraceptive sponges,

or contraceptive gels and foams **are not effective by themselves in stopping HIV**. They must be used with a condom for complete protection.

If you and your partner are moving into a steady or serious relationship, **both of you may want to have HIV tests**, and if that shows you are both non-infected, you may want to switch to exclusivity/monogamy as your safer sex choice. Don't stop using condoms until you both have been tested and given a clean bill of health. However, even in this case you can never be absolutely sure of your partner's non-involvement in risk behaviors."

V. Identifying Triggers

Length: 15 minutes.



"So far in this workshop we have provided you with information about what you need to do to be safe from HIV and other sexually transmitted diseases. However, we understand that knowing what to do to be safe doesn't mean you will always be safe when a potentially risky situation arises. For the rest of today's session we are going to focus on identifying triggers for being unsafe sexually and how we might deal with these situations."

Note: Most patients in substance treatment will have little trouble with the concept of "triggers." It is usually easy for them to generate drug use triggers related to people, places, things, activities, feelings and thoughts. They may find it difficult to think about triggers related to unsafe sex without thinking about drug use triggers. Facilitators should be aware of the distinction between triggers for sex and triggers for not using condoms. These triggers are not always the same. While triggers for sex might be going to a bar or feeling horny, a trigger for not using condoms would more likely be specific to condoms, such as not liking how condoms feel, fear of partner rejection or thinking that the partner looks healthy. Some triggers may apply to both; an example might be sexual arousal, which both leads to sex and may also deter stopping to put a condom on. Of course, if the person's preferred safer sex strategy is to not have sex, then condom related triggers would not apply and sex triggers would. During this session, people who have never tried condoms may only be able to identify triggers that led them to have risky sex. During later sessions, after they have attempted condom use, they should be encouraged to identify the triggers that were responsible for their not being able to use condoms.

A. DEFINE SKILL: Defining Triggers

1. "Has there been a situation in the past six months in which you had not intended to use drugs, but did anyway? Describe the situation."

If use triggers are obvious identify them; if not, help the person to identify the use triggers. Most men in treatment are able to do this without much prompting because it is a common focus in treatment.

2. "In the next section we are going to focus on identifying similar triggers for involvement in risky sexual behavior. During the past six months has anyone intended to not engage in risky sexual behavior, but did any-

way? *If no one volunteers increase the time window.*

3. "Events, feelings, and things around you that occur before you have sex can have a major influence on your actions. These may include people, places, moods, and substances. We call these triggers. Triggers may lead us to behave in certain ways based on our past experiences with the trigger.

Write "People" on a page of blank newsprint or board.

4. "**People** who influence our behavior can be triggers. Who are some of the people that influence you concerning your sexual behavior? Examples might be an old girl/boy friend, the guys you hang with in your neighborhood, your family, your husband or wife. People triggers are some of the hardest triggers to deal with because, as you learned the first day in group, it's hard to talk about risky behaviors (sex and drugs) with other people.

Why else might it be hard to bring up practicing safer sex with certain people?"

Encourage group to brainstorm. Write ideas on the newsprint.

Some possibilities:

- *Don't want to lose the relationship*
- *Very attracted to that person*
- *Don't want to look stupid*
- *Hard to go against the crowd*

Write "Places" on a page of blank newsprint or board.

5. "**Places** involve where you are or what is going on around you. These can be powerful triggers because they are not always obvious to us, and can catch us off guard. "

Encourage group to brainstorm. Write ideas on the newsprint.

Some possibilities:

- *At a particular bar*
- *Sitting outside in the sun listening to a "special" song*
- *A place where you've had sex before*
- *A place that makes you feel very good about yourself - or very bad*

Write "Moods and Feelings" on a page of blank newsprint or board.

6. "**Moods and feelings** can also be triggers with very powerful reasons for risky behaviors".

Encourage group to brainstorm. Write ideas on the board.

Some possibilities:

Love, Trust, Fear (of rejection, of violence), Loneliness, Horny, Depressed, Confused, Happy.

7. "Thoughts and temptations" may also be a part of trigger moods and feelings. Thoughts like, I'm bored and want to meet someone new and exciting tonight; or I always do everything wrong; or I deserve a reward; I wish I had someone to love. These are the excuses we make or perhaps the things we think about when making a decision. Temptations like "Gee, I really like having sex without a condom --I just want to do it!" or just feeling really hot and wanting to enjoy having sex; not wanting to think about being responsible.

Encourage group to brainstorm thought and temptation triggers. Write ideas on the newsprint. Some possibilities:

- *She looks clean*
- *It can't happen to me*
- *I really like sex without a condom!*
- *This might be my only chance to have sex with him/her*

Write "Substances" on a page of blank newsprint or board.

8. "Substances" can be triggers to risky behavior. Drugs, and alcohol can affect the ability to make decisions or judgments and lower inhibitions. The need to get drugs or alcohol can also influence behavior. How do drugs and alcohol affect your sexual risk behavior?"

Examples:

- *When I get high I want to have sex and I don't think*
- *When I'm drinking I'm less likely to bring up using a condom*
- *When I'm high I feel like nothing can touch me, not even HIV*

B. REVIEW SKILL COMPONENTS for IDENTIFYING TRIGGERS

1. "How do you know what's a **trigger** problem for you?"

"When identifying triggers, some general things to keep in mind are:

- a. We must know when we're doing risky behavior.
- b. We must think back and ask ourselves what TRIGGERED or led me to do this risky behavior? Remember, people, places, moods, and substances are trigger problems. Try to figure out the most important trigger, the thing that would have made the biggest difference if it changed.
- c. We must try to keep track of these triggers for the "next time."

C. PERSONALIZING RISKY SEX TRIGGERS

1. "Think about the "barriers to condom use" and "identifying personal comfort with sexual risk behavior" discussions from earlier in the session."



Pass out the "Identifying risky sex triggers" handout.

2. "Take a few minutes to complete this worksheet. On the worksheet you come up with lists of personal triggers for the headings, 'People,'

'Places,' 'Things,' 'Mood & Feelings,' 'Thoughts & Beliefs,' 'Substances.'"

To assist participants in completing the worksheet ask them to think back to the last times they had unsafe sex. Ask them to consider what was going on and if they identify your most important triggers

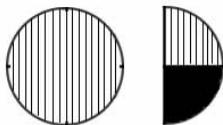
The facilitators should walk around the room and help anyone having trouble generating their lists of triggers.

Ask participants to report on their trigger lists. Facilitators generate a group list of triggers writing them on the board or blank newsprint. Group members may keep the lists they generated or turn them back in.

3. "Which triggers do you guys feel would be the most difficult to manage so as to maintain your own desired sex risk comfort level? We will come back to these difficult to handle triggers latter in the session."

VI. Risk Reduction Problem Solving

Length: 15 minutes



A. DEFINE SKILL: Problem-Solving

"A trigger doesn't automatically cause risk to happen, doesn't make risk happen. But, a trigger can make risk more likely if the trigger isn't handled correctly or avoided."

"So, learning to handle triggers in ways that keep you safe is a very important part of reducing risk for getting or giving AIDS."

"We will now focus on learning one way to handle triggers that can lead to participating in risky sex."

B. MODELING: Risk Reduction Problem-Solving

Ask for a volunteer who will pick a trigger from his list.

1. "Choose one of the triggers from the list generated in the previous section on which to apply the Risk Reduction Problem Solving strategy (**show flip chart #19**). We are all going to approach this problem from a problem-solving perspective."
2. "Let's see if we can approach the problem from a problem-solving perspective."
 - a. "What is the trigger or problem?"
 - b. "What are possible goals in this situation? When faced with almost any problem, there are a variety of goals that a person might have in that situation. Some people may wish to avoid having sex all together; others may wish to avoid sex with those whom they would be most likely to meet in a particular situation; others may choose outercourse; and others may wish to have sex

with a condom.”

- c. “What are some of the steps that a person could take to achieve the desired goal?”

Facilitator Note: *Whenever steps are generated in risk-reduction problem-solving in response to triggers, ensure that options include at least one of these possibilities:*

1. condom use
2. not having sex in the circumstance
3. outercourse

If the group members do not generate all of these as options, the facilitator should propose them as possible options.

3. “Now, not every plan is equally likely to work well, and some might have better success, cause fewer problems, or be easier to take. Let's try to evaluate each solution.”
4. “Which solution do you think is best to take, and why? What are the pros and cons of each step? Given this, which strategy would be best to follow?”
5. “What exactly would need to be done to implement this plan of action?”

Facilitator Note: *Always check back with the group members suggesting the problem to make sure that they are comfortable with the plan. If they are not comfortable or are unsure, ask what plan would be comfortable for them.*

C. REVIEW SKILL COMPONENTS

“We've seen an example that showed a practical way to go about solving a problem or handling a trigger that could lead to unsafe sex. In each situation, the problem was solved by:

- a. Identify the trigger
- b. Identify your goal
- c. Think of different possible steps to handle trigger
- d. Evaluate the steps and pick the best
- e. Act on the best solution

D. PRACTICE WITH COACHING AND FEEDBACK

“Now, we'd like to invite each of you to try this out, and do just what we did as a group. Let's break down into two smaller groups for practice.”

Subdivide group, with one facilitator for each half, going to different areas of the room.

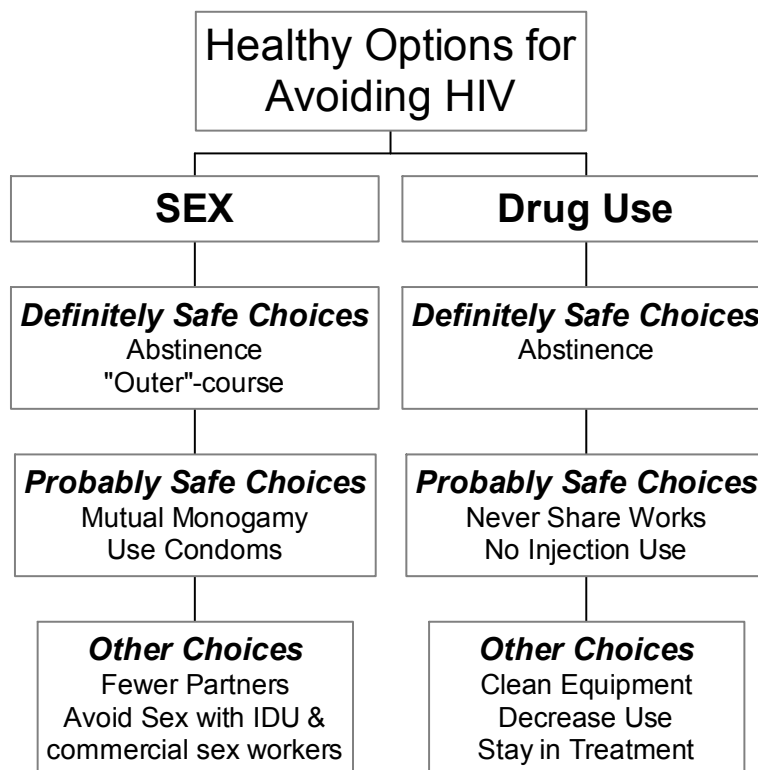
Facilitators ask the members of each group to provide personal examples of difficulties with triggers or problems with that they have had in the past. Use 2 or 3 of these examples as the focus for problem-solving with each group. Let each participant practice problem solving at least once.

Reconvene the large group and use the best example from both groups for a brief discussion and reinforcer for problem-solving.

Session 2

Flip charts & Session
Materials/Handouts

Healthy Options Information Map



Safe Sex Hierarchy

- Abstinence
- Romantic non-orgasmic activities
- Massage, bathing, dancing, stripping
- “Outer-course” (“grinding,” masturbation)
- Oral sex with protection
- Oral sex without protection
- Vaginal intercourse with a condom
- Anal intercourse with a condom
- Vaginal intercourse without a condom
- Anal intercourse without a condom

Barriers to Using Condoms

- Don't like the feel
- They make it harder to reach orgasm
- They ruin the mood, interrupt the passion
- They are messy or a hassle
- Want to get pregnant
- My partner will think I'm diseased or promiscuous
- My partner will think, I think s/he is diseased or promiscuous
- Cost too much
- Not readily available
- Too drug or alcohol affected

Overcoming Barriers to Using Condoms

- Improve feel by trying different brands and lubricants
- Practice reaching an orgasm with a condom while masturbating
- Increase the amount of foreplay to heighten sexual tension
- Make using a condom part of lovemaking, including having your partner put the condom on you
- Communicate about safe sex before becoming sexually intimate/aroused
- Challenge faulty interpretations about being diseased or promiscuous
- Most communities have access to free condoms

17

Flip Chart #11

Using Condoms Correctly

Have condoms available at all times
Latex or polyurathane only
Try different shapes, sizes, color, texturs and flavors
Store at room temperature, away from extreme heat or cold

Open package without damaging condom
Fingernails, rings, jewelry and teeth can puncture
Determine direction in which the condom rolls

Place condom over tip of erect penis
Pinch tip of condom to squeeze air out
Roll condom down over erect penis to the base
Keep pubic hair away from condom ring as it is rolled

If a lubricant is desired: water based only
Put a tiny dab in tip of condom before rolling it on
Be sure all air pockets are eliminated prior to insertion

Insert, thrust, enjoy
If lovemaking is interrupted and erection is lost, use a new condom
After climaxing & ejaculation withdraw prior to loss of erection

Hold onto ring of condom at base of penis when withdrawing
Turn away from partner, take condom off carefully so nothing spills
Tie off end of condom with knot like with a ballon
Wrap in tissue, throw in trash, not toliet

Flip Chart #12

Female Condom Insertion

- Open package without tearing the condom
- Check the expiration date
- Unroll the condom & separate the two rings
- Rub the condom gently to evenly spread the lubricant
- Grab the inside ring with your thumb and middle finger, and pinch the edges together
- Place index finger between the thumb and middle finger
- Use the index finger to guide the condom into the vagina
- Be careful not to twist the condom
- Push the ring in until the cervix is completely covered
- Outside ring remains outside the vagina protecting the labia
- Make sure FC is completely covering the labia and isn't twisted
- Insert penis into FC thru outer ring
- Do not use with male condom
- Removal: twist part of the FC outside of vagina and gently pull to remove
- Dispose in trash (not toilet)

Types of Sexual Partners

- Steady/Main Sexual Partner
- New Sexual Partner
- Casual Sexual Partner, Non-Drug User
- Casual Sexual Partner, Drug User
- A Sexual Partner Providing Sex in Exchange for Drugs
- Prostitute

Risk Reduction Problem Solving

- Identify the trigger
- Identify your goal
- Think of different possible steps to handle trigger
- Evaluate the steps and pick the best
- Act on the best solution

CORRECT CONDOM USE TALLY SHEET

Did he choose a latex condom?	YES	NO
Did he choose a water-based lubricant?	YES	NO
Did he check the expiration date?	YES	NO
Did he open the package carefully?	YES	NO
Did he check the condom for damage?	YES	NO
Did he determine which way the condom rolls?	YES	NO
Did he roll the condom directly downward?	YES	NO
Did he roll the condom to the base of the penis?	YES	NO
Did he remove air from the condom?	YES	NO
Did he leave space at the tip of the condom?	YES	NO
Did he put lubricant either on the penis or to the inside tip of the condom?	YES	NO

TRIGGERS FOR RISKY SEXUAL BEHAVIOR

PEOPLE	PLACES	MOODS/ FEELINGS	SUBSTANCES

Session 3:

Sex Without Drugs: Can It
Happen? Is It Pleasurable?

Session 3

Sex without Drugs: Can it Happen? Is it Pleasurable?

Objectives

Session Length: 90 minutes

Participants will identify how drug use has impacted their sexual lives. Alternative to drug use for enhancing one's sex life will be generated. In addition ways to cope with sexual impairment will be discussed. By sessions end it is hoped participants will be convinced they can have healthy and enjoyable sex lives without drug use.

Rationale

Previous research literature has indicated that many drug abusers combine sexual behavior with drug use. For many users there is a belief that sex is more enjoyable, more likely to happen or in some cases more tolerable under the influence of drugs. For many drug abusers sexual needs can serve as drug use relapse triggers. This session focuses on developing alternatives to drugs as ways to enhance one's sexual experience. Sexual dysfunction is also common among drug users. In this session information is provided about ways to cope with dysfunction.

Session Outline

Procedure	Time
I. Welcome, Redo introductions	5 minutes
II. Personalizing Commitment to Sexual Safety	15 minutes
III. Experience with Sex & Drugs Enhancements Impairments	35 minutes
IV. Enhancing Sex without Drugs	20 minutes
V. Coping with Sexual Impairment without Drugs	15 minutes
Total Time for Session 3	90 minutes

Materials

- Prepared flip charts are used in this session.
 - 20. Ways Drugs Makes it Easier to Obtain a Sexual Partner
 - 21. Ways Drugs Improve the Sexual Experience
 - 22. Ways Drugs Make It Harder to Obtain a Sexual Partner
 - 23. Ways Drugs Impair the Sexual Experience
 - 24. Ways to Obtain a Sexual Partner without Drugs
 - 25. Ways to Improve the Sexual Experience without Drugs
 - 26. Sexual Dysfunctions
- Markers for chalkboard or dry-erase, or blank newsprint pages
- Sexual Risk Hierarchy cards (one set of 6 cards for each participant)

I. Welcome

Length: 5 Minutes



Review of last group.

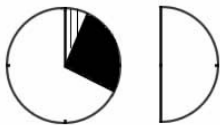
Some possible questions to follow up from the previous session:

"Did anyone identify any triggers for unsafe sex since last session?"

"Did anyone wish to use a condom, but faced a barrier to its use?"

II. Personalizing Commitment to Sexual Safety

Length: 15 minutes



In a previous session we asked participants to identify their involvement in sexual risk behaviors. In this section we ask participants to identify with what level of sexual risk are they comfortable. Much of the rest of the workshop is focused on teaching skills to help them obtain and remain below this risk level. We will also encourage participants that identify being comfortable with a high level of sexual risk to reconsider committing to lowering their risk.

A. Identifying Personal Comfort with Sexual Risk Exercise

1. "We are going to begin today's session with a brief exercise in which we want you to think about how much sexual risk are you wanting to take in different situations."

2. "The amount of sexual risk a person is willing to take (**show flip chart #14**) is determined by several factors including the risk of sexual transmission of disease associated with the behavior and the type of sexual partner (**show flip chart #18**). In this exercise we will focus on these two factors. Other important factors may include drug or alcohol use, strength of sexual desire, risk willingness of the sexual partner, availability of condoms."

Handout the sexual risk hierarchy sheet – each person gets a sheet.

3. "Each sheet contains 6 sexual risk hierarchy lists; one for each type of sexual partner. For each type of partner the lowest risk behavior, abstinence/no sex, is at the top of the list and the riskiest behavior, receptive anal sex without a condom, is at the bottom. The top of the list identifies a type of person with whom you might be having sexual relations in the future."

4. "Let's start with the first type of person, one who exchanges sex for drugs. **Circle the highest level of risk behavior you would be willing to take with this type of sexual partner. Answer not for what has been the case in the past, but for what you want it to be in the future.** It is important for you to mark what level of risk you want and feel comfortable with, and not what level of risk you think the co-therapists or others think you should strive for. For example, if you would not have any type of sex with a person who exchanges sex for drugs you would circle the lowest risk item, 'abstinence' at the top of the card. If you would be willing to take the risk of having this person perform oral sex on you without a condom, but no riskier behaviors further

down on the card, then circle 'have partner perform oral sex on me without a condom.'"

Have participants repeat this task for each type of sexual partner. Collect the sheets and have one counselor study what was handed back in. That counselor may want to make some notes as to how the group generally responded.

B. Review of group member's desired level of sexual risk

While one counselor is busy reviewing the cards, the other can lead a discussion

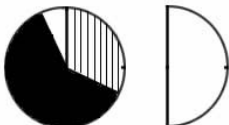
1. "With which types of individuals would it be the most difficult to maintain the sexual risk exposure level you marked?"
2. "How might drug use affect your ability to maintain the level of risk you have set for yourselves?"
3. "How would your partners' desire for a higher level of risk affect your ability to maintain the level of risk you have set for yourselves?"

Have the counselor who reviewed the cards present the results from the exercise by commenting on any patterns noticed on the sheets or by discussing the level of risk people were willing to take (such as if there are any tallies indicating vaginal or anal sex without a condom). Ask people to discuss if they are at all surprised by the results.

4. "Why are people willing to identify such obvious high risk sexual behaviors as acceptable risks?"
5. "Later on in the workshop you will learn skills to help you achieve and maintain the level of risk for which you are comfortable. In addition we may challenge you to consider resetting their risk comfort level to a less risky level."

III. Experience With Sex & Drugs

Length: 35 minutes



Use the next 30-40 minutes to discuss participants experience with combining sex and drugs. Here are some ideas for starting the discussion:

"Some of you indicated it might be difficult to maintain the level of sexual risk at which you desire when sex and drugs are being combined in some fashion." *(If no one endorsed this concern, then state that many people have indicated this was a concern).* "Now we are going to focus more directly on the relationship between drug use and sexual behavior.

How common is combining sex and drugs for you guys?

Has anyone relapsed to drug use as part of a sexual encounter?

In this first exercise we want to focus on your personal experience with the effect of drugs on sex. Let's start by focusing on how drugs may enhance or improve sex, or assist in making a sex partner available."

A. Enhancements



1. Use a blank sheet of paper/board, or use **flip chart (#20) "Ways drugs make it easier to obtain a sexual partner"** with all but the title covered by a blank newsprint sheet.

"We're going to make a list of different types of drugs, and the types of sexual enhancements people get from them. For each drug type we come up with, we want you to identify ways in which the drug made it easier to obtain a sexual partner."

Write down each enhancement mentioned along with the drug(s) associated with the enhancement. Uncover the remaining part of the flip chart and compare to what group came up with.



2. Use a blank sheet of paper/board, or use **flip chart (#21) "Ways drugs enhance the sexual experience"** with all but the title covered by a blank newsprint sheet.

"Now we're going to identify ways in which each drug type improved or enhanced the sexual experience itself."

Write down each enhancement mentioned along with the drug(s) associated with the enhancement. Uncover the remaining part of the flip chart and compare to what group came up with.

B. Impairments



- Use a blank sheet of paper/board, or use **flip chart (#22) "Ways Drugs Make It Harder to Obtain a Sexual Partner"** with all but the title covered by a blank newsprint sheet.

"Now we're going to generate a list of the ways drugs make it harder to obtain a sexual partner."

Write down each of the ways drugs make it harder to obtain a sexual partner, and the drugs associated with each of the ways. Uncover the remaining part of the flip chart and compare to what group came up with.



- Use a blank sheet of paper/board, or use **flip chart (#23) "Ways Drugs Impair the Sexual experience"** with all but the title covered by a blank newsprint sheet.

"The last list we're going to make is a list of the ways drugs impair the sexual experience."

Write down each of the ways drugs impaired the sexual experience and the drugs associated with each impairment. Uncover the remaining part of the

flip chart and compare to what group came up with.

C. What is the situation recently?

"Think about the lists of enhancements and impairments that we've come up with.

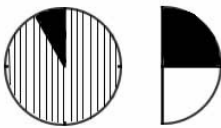
Which of these enhancements have been more true for you recently?

Which of these impairments have been more true for you recently?"

Hopefully they will list more impairments which will make drug use look less attractive. The enhancements they list provide an introduction to the next session.

IV. Enhancing Sex Without Drugs

Length: 20 minutes



Use the next 20 minutes to discuss participants experience with enhancing sex without drugs. Here are some ideas for starting the discussion:

A. Identifying alternatives: finding a partner without drugs

"Looking at the list of we generated of the sexual enhancements you get from drugs, which ones would you most want to be able to obtain without drugs?"

"First we're going to think about ways to obtain a partner without drugs. Let's start generating a list of ideas."

*Use a blank sheet of paper/board, or use **flip chart 24 "Ways to Obtain a Partner without drugs"** with all but the title covered by a blank newsprint sheet.*

Write down the ideas the group generates. Uncover the remaining part of the flip chart and compare to what the group came up with.

B. Identifying alternatives: enhancing the sexual experience without drugs

"Now we're going to generate a list of the ways you can enhance the sexual experience without drugs"



*Use a blank sheet of paper/board, or use **flip chart 25 "Ways to enhance the sexual experience without drugs"** with all but the title covered by a blank newsprint sheet.*

Write down the ideas the group generates. Uncover the remaining part of the flip chart and compare to what group came up with.

"What do you think prevents you from doing these activities without drugs?"

"If anyone is interested in exploring this further, popular press books such as *The Joy of Sex* by Alex Comfort provide tastefully done ideas for how to en-

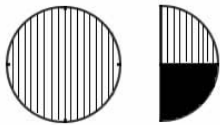
hance one's sex life. Most of the ideas in these books require good communication and tenderness between partners. It is difficult for a man and his partner to know what each other likes without good communication. One should never assume that your current partner enjoys what past partners enjoyed."

C. Final point

"When it comes to having a satisfying sexual relationship without drugs, the bottom line is that it's more important to focus on how you treat someone and communicate with them. Without a doubt, the most important sexual organ is the one between your ears."

V. Coping with Sexual Impairment Without Drugs

Length: 15 minutes



Use the next 15 minutes to discuss ways to cope with sexual impairment without drugs. Begin by identifying the primary forms of sexual impairment and their frequency among drug & alcohol users. This should help to normalize the problems.

A. Problems with sexual functioning

"Earlier today a number of you indicated at times drug use can lead to some sexual performance problems. **As men we are often reluctant to discuss sexual functioning, afraid that our manliness may be drawn into question.** Many men grow up believing that a 'real man' is willing and able to make sex happen whenever the opportunity presents itself."

"Unfortunately, **men still receive these unrealistic sexual messages from the media, music, and society in general.** Although this has changed recently with advertising for anti-impotence medications."

"In truth, **all men experience problems with sexual functioning** sometime during their lives. A man's body is not a machine—there are many physical, emotional, and/or drug-related reasons why sexual problems occur."

B. Most frequent types of sexual dysfunction

*Using the "Sexual Dysfunctions" prepared **flip chart (#26)**, begin a discussion about the following sexual dysfunctions:*



1. Erectile Dysfunction

a. Definition. "Erectile dysfunction (ED) is the inability of a man to achieve or maintain an erection sufficient for penetration."

b. Causes. ED can be caused by many different factors or a combination of factors.

i. A number of medical conditions (diabetes and hypertension are examples) are associated with ED.

ii. Some medications such as antidepressants are associated with ED.

iii. Acute and chronic alcohol, opiate and cocaine use is associated with ED.

iv. ED also increases with age.

c. Frequency. The frequency ranges from 7-18% of men in the

general population. Among men reporting addiction to various drugs of abuse the rate of ED was 3-4 times higher than in the general population.

2. Difficulty achieving orgasm

a. Definition. "Being able to delay reaching orgasm can often be a way individuals enhance their sexual experience. **However, being unable to reach orgasm or having extreme difficulty achieving orgasm can become a very frustrating experience.**

b. Causes.

- i. Again medications such as opiates, antidepressants and antihypertensives can contribute to difficulty achieving orgasms.
- ii. Drugs of abuse, cocaine, opiate and amphetamines have all been associated with difficulty achieving orgasm.

c. Frequency. Among adult men in the general population 7-9% report this problem. Among adult women in the general population 22-28% report difficulty achieving orgasm. Among men addicted to various drugs of abuse the rate is 3-5 times the rate in the general population. For drug addicted women the rate is about twice as high as in the general population."

3. Decreased sexual desire

a. Definition. "Interest in sex varies across different relationships and varies over time within individuals. Because of this wide variability in sexual desire it is often difficult to define what is abnormal decreased sexual desire. **In general if the individual feels his/her sex drive is low for them and they are dissatisfied with it, then it is a problem for them.**

b. Causes.

- i. Low testosterone levels which are often associated with chronic opiate use.
- ii. Any medical condition associated with decrease testosterone such as testicular cancer.
- iii. Losing interest in one's partner because of a change in attractiveness.

c. Frequency. Among adult men in the general population between 13 and 17% report decreased sexual desire. Among adult women in the general population between 27 and 32% report decreased sexual desire. **Among men addicted to various drugs of abuse the rate is 3-5 times the rate in the general population.** For drug addicted women the rate is about twice as high as in the general population."

4. Premature Ejaculation

a. Definition. "Premature ejaculation is defined as a man achieving orgasm and ejaculation sooner than desired. What constitutes achieving orgasm too soon is somewhat subjective.

b. Causes. In general premature ejaculation is viewed as being due to having not learned to voluntarily control ejaculation. In general premature ejaculation has not been associated with drug and alcohol use. **However, some research has indicated that use of drugs that delay ejaculation, such as the opiates, improved sexual**

functioning of premature ejaculators initially. Unfortunately, the problem reoccurs when the drug use is discontinued unless the individual has learned techniques for voluntary control of one's ejaculation.

c. Frequency. In the general population survey between 28 and 31% of men reported climaxing too early. Of all of the male sexual dysfunctions premature ejaculation is the most easily treated."

C. The relationship between sexual dysfunction and drug use

"Sexual dysfunction can be caused by many different factors. For example a person may be taking more than one medication or drug that contributes to sexual dysfunction. A person may have a medical condition such as diabetes or hypertension and is taking an antidepressant. For today's discussion it maybe helpful to think of sexual dysfunctions in the following categories:"

1. Sexual dysfunction caused by drug use

- a. "Sexual dysfunction caused by drug use may be the easiest to treat since it may resolve with discontinuing drug use.**
- b.** On the other hand since the brain is the most important sex organ, sometimes these problems will not resolve because of performance anxiety related to past dysfunction."

2. Sexual dysfunction improved (at least in the part) by drug use (most likely decreased sexual desire or premature ejaculation).

- a. "Although drug use can sometimes reduce sexual dysfunction, these dysfunctions can also be treated in other ways.**
For example,
 - i.** Some people may use cocaine or amphetamines to treat decreased sexual desire. However, low sexual desire may resolve if participants develop a relationship with tenderness and good communication.
 - ii.** Couples may increase their desire with pursuing some of the activities in the enhancement section above.
 - iii.** Premature ejaculation is easily treated in most men. There are exercises devoted to teaching men to bring their ejaculations under voluntary control. Popular press books such as *The Joy of Sex* give instructions. If these do not work most men can gain satisfactory voluntary control of their orgasms with a few weeks of therapy from a qualified sex therapist."

3. Sexual dysfunction unrelated or only partially related to drug use.

- a. "In cases wherein the sexual dysfunction has little or nothing to do with drug use, it is first important to get a medical evaluation.**
 - i.** Medication adjustments may be sufficient in some cases to solve the problem.
 - ii.** In addition some men, especially as they age, may have dysfunction related to a testosterone deficiency. The sexual dysfunction may improve with replacement therapy.

iii. With the advent of erectile dysfunction medications, such as Viagra™, Levitra™, and Calais™, many men with erectile dysfunction have been able to return to normal sexual functioning. These medications have potentially serious side effects and should never be taken without a prescription and a medical evaluation.”

Take home points regarding sexual dysfunction:

“All men suffer some sexual dysfunction during their lifetime. It is always unsettling when it happens. **Except for premature ejaculation, sexual dysfunction is more common in drug users than non-users.** Unfortunately, worrying about it happening again can worsen the problem. For most people the dysfunction is only temporary and will go away naturally if one does not put too much pressure on oneself. If the dysfunction continues there are good treatments for most sexual dysfunction. **A return to illicit drug use is only going to make sexual problem worse in the long run, even if it seems to help in the short run.”**

Session 3

Flip charts & Session Materials/Handouts

Ways Drugs Makes it Easier to Obtain a Sexual Partner

- Relaxes/disinhibits me so I can talk to potential partners (opiates, sedatives, alcohol)
- Disinhibits my partner to be more open to sexual advances (all)
- Increases sexual desire of my partners (stimulants – women primarily with amphetamine)
- Partners are willing to have sex if I get them drugs (all, opiates and stimulants especially)

Ways Drugs Improve the Sexual Experience

- Delays orgasm, increases staying power (opiates, sedatives, alcohol, stimulants)
- Increases sexual desire (stimulants, alcohol in low doses, cannabis)
- Increases sexual sensation, intensifies the orgasm (stimulants, cannabis)
- Disinhibition in self and partner, increased willingness to be sexually adventurous (all)
- Firmer erections (stimulants, especially amphetamines)

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Ways Drugs Make It Harder to Obtain a Sexual Partner

- Non-drug users are less interested in users, limits the field (all)
- Say stupid things to potential sex partners (all, especially sedatives and alcohol)
- Speak too slow, too fast, (stimulants and alcohol initially) or slur words (alcohol, sedatives, opiates)
- Don't have any money left for dating (all)
- Become self conscious about potential sexual dysfunction so do not even start (all)

Ways Drugs Impair the Sexual Experience

- Delays orgasm, makes it very difficult to ejaculate (opiates, sedatives, alcohol, stimulants)
- Decreases sexual desire (opiates, sedatives)
- Erectile dysfunction. Difficulty obtaining or maintaining erections (all)
- You or your partner, passes out or falls asleep before you get to the sex (opiates, alcohol, sedatives)
- You or your partner tweaks before you get to sex (cocaine, amphetamines)

23

Ways to Obtain a Sexual Partner without Drugs

- Attend clean & sober social functions such as dances & picnics.
- Go to non-alcohol club.
- Take a class (local college, community center).
- Identify current or past activities that you have enjoyed and then join clubs or groups in order to do these things with other people (hiking, card playing, bicycling, book reading, volunteer activities).
- Attend church social activities

Ways to Improve the Sexual Experience without Drugs

- Engage in pre-sex relaxing/stress reducing activities (relaxing mood music, breathing exercises, watch a movie video together, go for a walk, provide each other body rubs).
- Use body oils to heighten sensation.
- Ask your partner to touch/kiss/lick you in ways you find pleasing.
- Allow yourself to be directed by her as she tells you where and how she likes to be touched.
- Heighten sexual tension by stopping & starting sexual activity. Allow your self to get close to orgasm and then stop/slow down, and then start up again.
- Shower/bathe together.
- Try different types of condoms, be a manikin for your partner as she puts on the condom.
- Experiment with the female condom.
- Experiment with various positions.
- Strip for each other.
- Undress each other.
- Vary the place or time of day that sex occurs.

25

Sexual Dysfunctions

- **Erectile Dysfunction**

Definition: “Inability of a man to achieve or maintain an erection sufficient for penetration”

Causes: Medical conditions, medications, drug use

Frequency: 7-15% in general population (men), 3-4 times more common in drug users

- **Difficulty Achieving Orgasm**

Causes: Medications, drug use

Frequency: 7-9% in general pop. (men), 3-5 times more common in drug users

- **Decreased Sexual Desire**

Causes: Low testosterone, medical conditions, medications

Frequency: 13-17% in general pop. (men), 3-5 times more common in drug users

- **Premature Ejaculation**

Definition: “Achieving ejaculation sooner than desired”

Causes: Poor voluntary control, stopping certain drugs

Frequency: 28-31% in general pop. (men)

SEXUAL RISK HIERARCHY SHEET

<p><u>Sexual Partner Providing Sex in Exchange for Drugs</u></p> <p>Abstinence Romantic non-orgasmic activities Massage, bathing, dancing, stripping "Outercourse" (grinding, masturbation) Oral sex with protection Oral sex without protection Vaginal intercourse with a condom Anal intercourse with a condom Vaginal intercourse without a condom Anal intercourse without a condom</p>	<p><u>Prostitute</u></p> <p>Abstinence Romantic non-orgasmic activities Massage, bathing, dancing, stripping "Outercourse" (grinding, masturbation) Oral sex with protection Oral sex without protection Vaginal intercourse with a condom Anal intercourse with a condom Vaginal intercourse without a condom Anal intercourse without a condom</p>
<p><u>New Sexual Partner</u></p> <p>Abstinence Romantic non-orgasmic activities Massage, bathing, dancing, stripping "Outercourse" (grinding, masturbation) Oral sex with protection Oral sex without protection Vaginal intercourse with a condom Anal intercourse with a condom Vaginal intercourse without a condom Anal intercourse without a condom</p>	<p><u>Casual Sex Partner – Drug User</u></p> <p>Abstinence Romantic non-orgasmic activities Massage, bathing, dancing, stripping "Outercourse" (grinding, masturbation) Oral sex with protection Oral sex without protection Vaginal intercourse with a condom Anal intercourse with a condom Vaginal intercourse without a condom Anal intercourse without a condom</p>
<p><u>Casual Sex Partner – Non Drug User</u></p> <p>Abstinence Romantic non-orgasmic activities Massage, bathing, dancing, stripping "Outercourse" (grinding, masturbation) Oral sex with protection Oral sex without protection Vaginal intercourse with a condom Anal intercourse with a condom Vaginal intercourse without a condom Anal intercourse without a condom</p>	<p><u>Steady/Main Sexual Partner</u></p> <p>Abstinence Romantic non-orgasmic activities Massage, bathing, dancing, stripping "Outercourse" (grinding, masturbation) Oral sex with protection Oral sex without protection Vaginal intercourse with a condom Anal intercourse with a condom Vaginal intercourse without a condom Anal intercourse without a condom</p>

Session 4:

Beyond the Pick Up Line: Communicating About Sex

Session 4

Beyond the Pick Up Line; Communicating About Sex

Session Length: 90 minutes

Objectives

Participants will explore gender role stereotypes and discuss the role these stereotypes play in intimate relationships. The importance of accepting responsibility in sexual relationships will be stressed. Participants will be introduced to an assertive communication strategy.

Rationale

Men have few opportunities to seriously explore and discuss their sexuality and how it affects their intimate relationships. This lack of opportunity is perpetuated by social and cultural beliefs that often go unchallenged. This session seeks to increase participant's willingness to explore new ways of thinking about gender roles and sexuality. In addition participants will explore the role of sexuality in the drug abuse culture. Finally in the last part of the session there is a beginning focus on communication skills.

Session Outline	Procedure	Time
	I. Welcome, Redo Introductions	5 minutes
	II. Challenging Stereotypes	20 minutes
	III. Unwritten Rules	10 minutes
	IV. Responsibility in Sexual Relationships	20 minutes
	V. Communication about Safe Sex I	35 minutes
	Total Time for Session 4	90 minutes

Materials

- Flip charts:
 - 27. What Women Say
 - 28. Communication Styles
 - 29. TALK Tools
 - 30. I Steps
 - 31. A Steps
 - 32. L Steps
 - 33. K Steps
- Newsprint or chalk/dry erase board and markers
- 2 copies of the "Jessica and Paul" role play to hand out to participants

I. Welcome

Length: 5 minutes



A. Review of last session's group

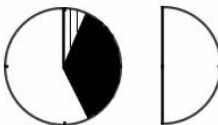
1. "Last week we discussed ways in which drugs improved and impaired sexual functioning. Since the last session did people find themselves thinking more about how drugs enhance sex or more about how drugs impaired sex?"
2. "Did anyone discuss these issues with current sexual partners or potential sexual partners or friends?"
3. "Has anyone changed their sexual risk comfort level?"

B. Overview today's topics:

"We will take the first half of the group today to explore some beliefs we have about relationships between men and women. We will first share our thoughts about what makes up the ideal woman and ideal man. Next we will explore some of the unwritten rules between men and women. Finally we will discuss taking responsibility in sexual relationships. In the second half of the group we will introduce a method for communicating effectively with sex partners or potential sex partners."

II. Challenging Stereotypes

Length: 20 minutes



For the next 20-25 minutes, help participants explore the impact of sexual and gender stereotypes on relationships.

A. Ideal Man / Ideal Woman Brainstorming

1. "Let's start by generating a couple of lists of characteristics of society's 'ideal' man and 'ideal' woman."

At the top of blank newsprint or on a board in the room write, The Ideal Man and The Ideal Woman.

2. "Let's start with the 'Ideal Man.' What does society tell us about the characteristics of the 'Ideal Man'?"

Lead the brainstorming activity by encouraging participants to call out the physical and personality characteristics of the "ideal" man. Write the responses on the blank newsprint paper or board. Then do the same for "ideal" woman.

Encourage participants to think about what they learned or observed as they grew up. Ask them to reflect on what they see and hear on TV, in movies, on MTV, and in music.

B. Ideal Man / Ideal Woman, Process Brainstorming

1. *Process brainstorming and the material on the flip charts by asking the following questions:*

- a. "Where do these ideals come from?"
- b. How real are they in everyday life?
- c. Was it easier to come up with physical or personality characteristics?
- d. What does that tell us?
- e. What's different between the male and female lists?
- f. What are some of the harmful effects of these "ideals"?"

C. Personalizing the stereotypes

1. *Ask the participants to discuss the impact of these stereotypes in their own lives by asking the following questions:*

- a. "Have you ever compared your partner to these so-called ideals?"
- b. How do you think this comparison might make your partner feel?
- c. Take a minute to honestly compare yourself against the so-called male ideals.
- d. How does this kind of comparison make you feel about yourself?
- e. How can these comparisons cause problems in our relationships?"

Now you will lead a brainstorming session on what can be done about these stereotypes

"What can be done to combat these stereotypes?"

"What's one thing you could do over the next week to combat the negative effect of sexual stereotypes in your own lives?"

2. Take home message:

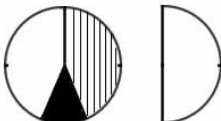
"Our expectations of the ideal partner can set us up for disappointment and can also interfere with communicating clearly with potential partners. If we are constantly comparing our partners to an ideal, we are not accepting them for who they are."

3. Transition to next topic:

"Another set of expectations we have of potential partners that may cause disappointment or interfere with communicating clearly with potential partners are what we call 'unwritten rules'."

III. Unwritten Rules

Length: 10 minutes



A. Introduction

"Unwritten rules are the expectations that we and other people have for the way people behave in different situations. For example, what is the unwritten rule about where to stand in an elevator when there is more than one person?"

"Can you think of other unwritten rules in our society?"

If the group is unable to generate one, provide the following example:

"If you enter a restroom with 5 urinals and a man is using urinal #2,

which urinal would you use? Why not #1 or #3?" (*Assuming most say #4 or #5.*)

"We all have unwritten rules about sex and intimate relationships, and our rules can affect the way we behave. **Knowing our unwritten rules will help us understand why we do what we do.**"

"For example, it used to be that men were responsible for making the first move. Women almost never asked men for dates. Men paid the expenses of a date. Women were responsible for contraception. These were unwritten rules. These rules have changed over the years. It is important to have a sense of your own and potential partners current unwritten rules. **Being aware of unwritten rules helps you communicate better.**"

B. WARM-UP EXERCISE:

"What are the **rules of condom use in relationships** - both regular and casual, such as who brings up condoms, who carries condoms, who puts on the condoms, etc.? *Write responses on flip chart or board.*

Some take-home points:

1. "It's clear that we all have unwritten rules about condoms. I notice a few things about the rules we've listed: first -different people have different rules. This is important because it tells us that **our partners may have unwritten rules for us that we don't want to live by.**"

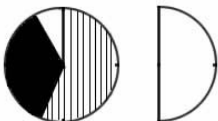
2. "**Acting against these unwritten rules may not always be bad.** An example of this may be when you want to protect yourself and your partner doesn't."

"But **going against unwritten rules is not always easy.** There is a lot of pressure out there to follow the rules. It takes practice.

Finally, **rules can change, and you can change them by being assertive.** This is a skill which we can all learn."

IV. Responsibility In Sexual Relationships

Length: 20 minutes



A. Introduction:

Use the next 15–20 minutes to discuss responsibility issues in sexual relationships. Here are some ideas for starting the discussion:

"So far today we can see that we all have expectations of potential sex partners and some expectations of ourselves in sexual relationships. Most men like to think of themselves as a 'good lover.' So, what makes a man a good lover?"

List characteristics on flip chart paper or erasable board and discuss them. Use some of the following questions:

1. How do we learn what a “good lover” is?
2. What images do we get in the media, movies, TV?
3. Are these images helpful or realistic?
4. How can we learn to be better lovers?
5. In this group we are focused on the power of clear communication to get what you want, to stay safe, and to be a better lover.

B. Wrap up:

“To summarize this discussion, I think what we’re hinting at here is that being a ‘good lover’ is more about who a man is and how he treats his partner than it is about what he does or how he “performs” in bed.”

“Once again, a lot of it comes back to that idea of having an open attitude - an attitude of mutual respect, honesty, listening, and compromise. I can guarantee that 97% of women would choose a man who respects her and listens to her over a man with a large penis, any day.”

“In fact, we have the results of an informal survey in which women list what’s important for men to remember if they want to be good lovers, husbands, and partners. As in the earlier exercises today, we’re trying to point out that our ideas and expectations are one thing, and the reality may be something else. Let’s see what we can learn from the ladies, and whether our ideas match up with reality. Here’s what women say:



C. Flip chart #27 “What Women Say”

Before showing the flip chart, encourage participants to guess at what they think were the results of the survey. Then you can compare their responses to what is written on the flip chart.

1. Never Use Force.

“It is never alright to use force or violence with a sexual partner. The media and other fantasy sources of information about relationships have presented a lot of unhealthy myths. The unhealthiest myth is that good sex is violent, rough, and aggressive and that all women have a ‘secret desire’ to be taken by force, overwhelmed, or swept away. Another unhealthy myth is that men have a ‘right’ to sex whenever they want it and that they can take it from a partner if it’s not given freely. ‘No’ means ‘no’ - any person, man or woman, has the right to refuse sex and not have to argue about it. **Force, violence, and aggression work against healthy, intimate relationships.”**

2. Share Responsibility In A Sexual Relationship.

“Both partners are responsible for contraception and STD

prevention. For some reason many men believe that 'protection' is the woman's responsibility only. We sometimes hear guys say 'She got pregnant' or even 'She got herself pregnant.' Well, she didn't do it by herself! When two people have sex, both people are responsible for the consequences. A man who's a good lover does what he needs to do to share the responsibility."

3. Communicate Openly.

"It's important to share feelings, thoughts, and needs with a partner. In the media, we see the strong, silent type a lot. Have you ever wondered why these characters are usually loners? The importance of communication in a close, intimate relationship cannot be overstressed. The biggest sex organ you have is your brain. Next is your heart. A good lover is willing to open up and share who he is with his partner. **It's also very important to communicate with your partner about your sexual relationship - what you like, what you don't like, what feels good.** Using I-Statements can help you communicate your needs and your preferences without sounding demanding. For example, 'I really like it when you massage my shoulders.'"

4. Be Considerate.

"Just as it's important to communicate openly with your partner, **it's also important to be concerned about your partner's feelings, thoughts, and needs.** Patience and willingness to compromise can go a long way in showing your partner you care about her. Many people are socialized to be shy or unassertive about their bodies and their sexuality. A good lover can show consideration for his partner by being willing to ask about their partner's needs and what their partner likes or doesn't like. As we've discussed before, listening is another way to show love and consideration for a partner."

5. Respect Sexual Privacy.

"It's not okay to brag or tell stories about you and your partner's sex life, past or present. Such talk is disrespectful of yourself and your partner, and it's also immature and childish. A close, intimate relationship is built on trust and respect. Telling stories 'out of school' can shatter that trust and hurt the relationship."

D. Conclusion:

"Given what we've talked about today,

- 1.** What would you tell your son is the most valuable characteristic he can develop as a husband or partner? Why?

2. What would you tell a daughter is the most valuable characteristic to look for in a husband or partner? Why?"

V. Communicating About Safe Sex I

Length: 35 minutes



A. Introduction

"Today's discussion lead us to the importance of focusing on good communication to improve relationships and combat faulty expectations that may be generated from stereotypes we have of men and women, from unwritten rules about relationships, or from misperceptions about what sex partners really want. The last portion of today's group, and the entire next group, will focus on developing effective communication tools."

GENERAL NOTE TO FACILITATORS: *Assertive TALK will be most effectively learned by participants if the information is presented in as personally relevant a form as possible. Any information you have about your participants (e.g. risky behaviors, past difficult safe sex situations, favorite bars, etc.) should be incorporated into the session. Use what you know about your participants to make the scenarios and role-plays meaningful to them.*

B. Communication styles

"People have different ways of talking to people. You talk to your close friends differently than you might talk to someone you've just met. When we talk with partners about safe sex, how we talk can affect whether we are successful. We are going to focus on three communication styles frequently used by people (present **flip chart #28**), Assertive, Aggressive, and Passive. By the end of the session you should be able to distinguish the different styles. We feel one of these three ways is a very effective way to talk; the other two are not.

"Has anyone heard of these three styles? Describe them"

Answers generated are written on the board or newsprint.

Using flip chart describe the three styles:

1. Assertive talk –

a. **"Assertive talk means saying what you want, in a way that's respectful of the other person's feelings."**

b. "It can be the most effective way to talk, because it allows you to state what you want and still have the person you are talking to feel good also."

c. What are the different ways in which assertiveness is expressed? **Assertiveness is expressed through a combination of (1) eye contact, (2) body language, (3) verbal content of the message, and (4) tone of voice.**

d. Examples:

- i. "I know getting high would allow me to forget my problems for awhile, but using will just make them worse later. I'm committed to keeping my recovery going."
- ii. "I know you think it feels better without a condom, but I made a promise to myself before I met you only to have sex with a condom."

2. Aggressive talk

a. "Aggressive talk means saying what you want, in a way that's may be hurtful or ignores the other person's feelings or ideas."

b. "You may get your way when you use aggressive talk, but you may have damaged the relationship with the other person once you're through."

c. Examples:

- i. "Getting high won't help me with my problems. You are just too afraid to deal with your problems without drugs."
- ii. "I don't care what you think. We're going to do it with a condom or not at all."

3. Passive TALK

a. With Passive talk you fail to state your goal, need, or view, ignoring your own needs and wishes.

b. Passive talk doesn't respect your own feelings and ideas. When you use passive talk, you simply aren't going to get your way.

c. Examples

- i. "We can get high if that will help you deal with legal problems."
- ii. "OK, if that's what you want, we don't have to use a condom."

C. Practice Assertive Talk

"To make sure we are all clear on assertive, aggressive, and passive talk styles, let's practice picking out these different types of talk.

Facilitators should enact the following role plays without telling participants which one they are modeling.

1. Assertive:

FEMALE: Honey, look what I have for us. It's a lubricated, latex condom and I can't wait for you to put it on.

MALE: C'mon, baby, I can't feel with that thing on. Let's just do it natural.

FEMALE: I know you don't like the idea, but I think that it's really important for us to use condoms.

MALE: But sweetie, I like just feeling you.

FEMALE: You know that the condom will make you last longer, so our lovemaking will be even better than it already is.

MALE: All right, give me the condom. I'll give it a try.

Questions: Which talk style was being demonstrated?
How could you tell?

2. Aggressive:

MALE: Let's get out of here and go back to my place.

FEMALE: We can go, but you've got to put a condom on. I don't know where you've been.

MALE: Don't you want me, baby?

FEMALE: I don't want any of your diseases.

Questions: Which talk style was being demonstrated?
How could you tell?

3. Passive:

MALE: You are a special lady.

FEMALE: You ain't so bad yourself.

MALE: Do you have a latex condom?

FEMALE: I don't need one baby. I'm healthy.

MALE: Are you sure?

FEMALE: Look at me. Of course I'm sure.

MALE: Yeah, you do look great.

FEMALE: So then, let's go.

MALE: Sure, OK, let's go.

Questions: Which talk style was being demonstrated?
How could you tell?

4. Discussion.

"Which of these types of talk do you think is best for making sure you stay safe? Why?"

Allow a few moments of discussion. Try to get consensus that assertive is the most effective talk style. Some people may be more comfortable talking aggressively or passively, but we can all learn to talk assertively in ways that fit who we are now.

"We think assertive talk is the best way too, and we've come up with a way to remember what we can do to talk assertively. We call them TALK tools."

D. DEFINE: TALK Tools

"TALK is a set of tools you can use to be assertive and persuasive. You can use TALK tools in all aspects of your life. For example: when you are telling a partner you want to have safe sex, when you are telling a partner you won't have unsafe sex, or in any situation where you want to be assertive."



*Facilitator shows **flip chart #29** with TALK written as shown below.*

TALK Tools

T = Tell my partner "I hear you" "

A = Assert what I want in a positive way

L = List my reasons for wanting to be safe

K = Know our alternatives and my bottom line

"These TALK tools can help us tell our partners assertively that we want to have safe sex. TALK tools can be used to refuse drugs, refuse sex without a condom, negotiate outercourse or ask a partner to use a condom. TALK tools can work with new partners, off and on partners, and partners you may have been with for a long time. And in general, **TALK tools are useful whenever you want to assert what you want in a positive way.**"

E. Role Play

1. "Let's run through a role play to see how talk might work."

Have copies of the role-play available. Ask two group members to volunteer reading through the following scenario. One member will need to play the female role. If no one volunteers one of the facilitators can read the role of Jessica. Tell the person playing Paul to substitute the drug he most associates with sexual behavior the first time a drug is mentioned and the person playing Jessica should use that drug in her lines. Sometimes it is difficult to get men to be willing to role play women, especially in conversations around sex. One way to ask for a volunteer is, "who here is 'man enough' to play a woman?"

Running into a friend of friend still using

JESSICA: Paul, do you remember me? We met at your friend Dave's place a few months ago. We had a wild time. Dave had gotten some great stuff. What you been doing?

PAUL: I'm in treatment now. I haven't done any [crack/coke/crystal] for over a month now. I am just starting to feel normal again.

JESSICA: I was in treatment once. I missed the excitement though. I try not to do so much anymore, but I still like to get high. I am on my way over to Dave's right now to party. Dave called and said he has some killer stuff. Want to join me?

PAUL: No thanks. I'm sticking to my program. I can get way out of control on that stuff.

JESSICA: I remember the last time I saw you at Dave's. It looked like you and that woman you were with were having a great time. I could show you an even better time. I know I'll get all sexed up once I get high.

PAUL: I'm sure you could show me a good time, and I get very horny when I do [crack/coke/crystal] also. The sex use to be good, but after awhile, I had trouble getting off. Then I got paranoid. I'm committed to staying straight. I need to get going.

JESSICA: Paul when was the last time you got laid? You don't need to do any [crack/coke/crystal]. Just come for the sex. I'm getting all turned on just thinking about it. Come join me.

PAUL: There is no way I can be around other people getting high and not use myself. It has been awhile since I have had sex, but that's OK. I like being straight and am not willing to start using again just to have sex.

JESSICA: Good for you. I'm not ready to stop using now. I'm off to get high. See you later.



PAUL: I'm sure that down the road some sexual opportunities will come my way that do not include getting high. Who knows, maybe even we could get together if you decide to do recovery again.

Go to Flip chart #30 "I"

a. Tell them "I hear you."

"How should you do this? The two things you should do are: 1)-acknowledge what your partner is saying, 2)-use an "I" statement and 3) Show understanding of your partner's thoughts and feelings."

"Let's think back to our assertive talk example. Jessica said "

It looked like you and that woman you were with were having a great time. I could show you an even better time." Anyone remember Paul's response?

If no one can remember provide it: "I'm sure you could show me a good time, and I get very horny when I do crystal also. The sex use to be good, but after awhile I had trouble getting off".

"Paul told Jessica he heard her by stating he was sure she could show him a good time and he also gets horny."



Go to flip chart #31 "A"

b. Assert what I want in a positive way.

"There are just three things to do: 1) state what you want, 2) be positive, 3) use an 'I' statement."

"How did Paul do this?"

If no one can remember provide it: "I'm committed to staying straight. I need to get going."

"He stated clearly what he wanted and used 'I' statements to communicate and assert his desire."



Go to flip chart #32 "L"

c. List my reasons for staying straight and being sexually safe.

"This tool can be a little tricky because some reasons work better to persuade partners than other reasons. When you give your reasons, try these three things: 1)-be brief, 2) -use a reason that's about you, 3) -don't mention disease."

"How did Paul do this?"

If no one can remember provide it. "The sex use to be good, but after awhile I had trouble getting off. Then I got paranoid. I'm committed to staying straight."

"Paul gave some consequences of his use, including a sexual one. Remember, TALK is about you and the choices you make in your life. It's not about blaming the other person."

NOTE: *If participants want to know why it's better not to mention disease, say the following:* "If you mention disease, your partner might think you have a disease or that you're accusing them of having a disease. Neither of these is positive."



Go to flip chart #33 "K"

d. Know our alternatives and my bottom line.

"When it comes to safer sex, alternatives include: 1) condoms, 2) outercourse and 3) no sex."

"How did Paul do this?"

If no one can remember provide it. "I like being straight and am not willing to start using again just to have sex" and "I'm sure that down the road some sexual opportunities will come my way that do not include getting high. Who knows maybe even we could get together if you decide to do recovery again."

"Paul is clear in his bottom line, stated with 'I statements' and even provides the alternative of possibly getting together with Jessica in the future if she gets into recovery."

F. Summary

"Using TALK is a great way to tell people what we want. This doesn't mean we will always get exactly what we want. But it helps us stay true to what we believe and respect our partners. Knowing our bottom line before we get in a tough situation with a partner lets us stop before using or engaging in unsafe sex."

Session 4

Flip charts & Session
Materials/Handouts

What Women Say . . .

- **Never Use Force**
It is never alright to use force or violence.
- **Share Responsibility in a Sexual Relationship**
Both partners are responsible for birth control and safer sex.
- **Communicate Openly**
Share feelings, thoughts, and needs.
- **Be Considerate**
Care about your partner's feelings.
- **Respect Sexual Privacy**
Don't brag or tell stories.

Communication Styles

- **Assertive**
 - State what you want/need
 - In a way respectful of others
- **Aggressive**
 - State what you want/need
 - In a way that ignores the desires of others. Often can be hurtful
- **Passive**
 - Own wants/needs not clearly stated, defended
 - Don't respect your own feelings, needs, desires

Assertive TALK Tools

- T Tell my partner “I hear you”.
- A Assert what I want in a positive way.
- L List my reasons for wanting to be safe.
- K Know our alternatives and my bottom line.

I Steps:

Tell my partner “I hear you”

- Acknowledge what your partner is saying.
- Use an “I” statement.
- Show understanding of your partner’s thoughts or feelings.

A Steps:

Assert what I want in a
positive way

- State what you want.
- Be positive.
- Use an “I” statement.

L Steps:

List my reasons for being
safe

- Be brief.
- Use a reason that is about you.
- Do not mention disease.

K Steps:

Know alternatives and bottom line

- Condoms
- Outercourse
- No sex

Session 5:

Communicating About Sex II

Session 5

Communicating About Sex II

Session Length: 90 minutes

Objectives

Participants will become more experienced with assertive communication using TALK tools. Skills will be enhanced through the use of role-plays. In addition participants will learn an advanced communication skill, "Turning Around What They Say."

Rationale

Increasing communication skills is one method to empower men to keep themselves safe from risky sexual behavior and prevent relapse to drug associated with sexual behavior.

Session Outline	Procedure	Time
	I. Welcome, Redo Introductions	5 minutes
	II. Practice with Coaching and Feedback	25 minutes
	III. Turning Around What They Say	25 minutes
	IV. Workshop Summary	25 minutes
	V. Workshop Closure	10 minutes
	Total Time for Session 5	90 minutes

Materials

- Flip charts:
 - 29. TALK Tools
 - 30. I Steps
 - 31. A Steps
 - 32. L Steps
 - 33. K Steps
 - 34. Turning Around What they Say
- Newsprint or chalk/dry erase board and markers
- Copies of the role plays to hand out to participants: Copy from the manual and cut out as necessary prior to the session.

I. Welcome

Length: 5 minutes



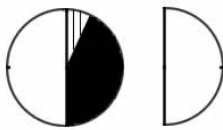
A. Review of last session's group

"Last session we discussed gender roles and stereotypes, taking responsibility in sexual relationships and communicating with partners.

1. Did anyone find himself challenging a sexual stereotype?
2. Can anyone name the three communication styles we discussed last session?"

II. Practice with Coaching and Feedback

Length: 25 minutes



B. Overview

"In today's final session we are going to discuss in more depth communicating about safe sex and the relationship between sex and drugs."

A. Review the Talk tools

Go to flip chart #29 "TALK Tools." Briefly summarize what each letter in TALK stands for.

"Does anyone have any questions about using the TALK tools before we do some more practicing?"

B. Role Play

"Last session we walked through one role play to see how TALK tools might work. Jessica attempted to get Paul to join her in a sex and drugs adventure. Paul's bottom line was to not use drugs and avoided any sexual risk by not using drugs in that example."

"It is now a month later and Paul is again going to be challenged by Jessica. When Jessica went to Dave's a month ago the crack/speed was very potent. After using for 24 hours she became very paranoid, was having hallucinations, and started acting in a bizarre way. Eventually she was hospitalized on a psychiatric ward for three days. The hospitalization scared her to the point of swearing off drugs. She now has three weeks clean. She and Paul have gone out a few times for coffee. Tonight they have rented a movie both wanted to see and have finished viewing it at Jessica's place.

Ask two group members to volunteer reading through the following scenario. Tell the rest of the group to focus on when Paul is using one or more of the TALK tools.

Dating a person with whom you used to use

JESSICA: Paul, it's been a long time since I watched a movie without being high. Thanks for renting it and bringing it over.

PAUL: Like you, I hadn't watched movies in a long time, let alone watching them straight. Since I got into treatment renting movies has been one of my favorite things to do. My VCR has gotten a real workout in the past few months. However, usually I watch them alone. Sharing the movie with you has been a real treat.

JESSICA: When we talked the day I went to Dave's and got messed up, I was coming on to you pretty strong. I suppose some of that come on was the drugs talking, but some was I am attracted to you. I was a little hurt that you rejected me. I thought you found me attractive.

PAUL: The rejection was nothing personal. I find you hot. You were a lot closer to getting me to go with you on that day than you realize. Now that you're straight I find you even sexier.

JESSICA: I promised you a good time that day. I'd like to show you a good time now, but I haven't done it straight for a long time.

PAUL: It's been over two months since I have had sex and I can't remember the last time I had sex when I wasn't high. I am very turned on and ready to go right now.

JESSICA: Paul why are you getting out that rubber. I hate those things. I want to feel **you** inside me. I am on the pill, you don't have to worry about getting me pregnant.

PAUL: In treatment I promised myself I would not have sex without a condom. It is my way of saying I care about myself and I care about you. I have several kinds here. I have fantasized all day about you putting one of these on me. Which one would you like?

JESSICA: I don't know about this. Last time a guy used a condom I had trouble coming, it just didn't feel natural.

PAUL: Let's use this brand it a bit thinner than the rest. I bet you didn't come, because the guy didn't take his time or you were both high. We'll go slow, and I'll do my best to make sure you get lots of stimulation.

JESSICA: OK, let's try this black condom, it looks interesting. I'm going to need you to direct me in putting this on you.



1. "How did Paul use the TALK tools?"

Go to Flip chart #30 "T"

a. Tell them "I hear you."

"How should you do this? The three things you should do are: 1) acknowledge what your partner is saying, 2) use an 'I' statement and 3) Show understanding of your partner's thoughts and feelings."

"Let's think back to our assertive talk example. Jessica said 'Last time a guy used a condom I had trouble coming, it just didn't feel natural.' Anyone remember Paul's response?"

If no one can remember provide it: "Let's use this brand; it's a bit thinner than the rest. I bet you didn't come because the guy didn't take his time or you were both high. We'll go slow, and I'll do my best to make sure you get lots of stimulation."

Paul told Jessica he heard her by stating he understood that she had trouble coming and offered an alternate explanation to condoms being the problem.



Go to flip chart #31 "A"

b. Assert what I want in a positive way.

"There are just three things to do: 1) state what you want, 2) be positive, 3) use an 'I' statement."

"How did Paul do this?"

If no one can remember provide it: "In treatment I promised myself I would not have sex without a condom."

"He stated clearly what he wanted and used 'I' statements to communicate and assert his desire."



Go to flip chart #32 "L"

c. List my reasons for staying straight and being sexually safe.

"This tool can be a little tricky because some reasons work better to persuade partners than other reasons. When you give your reasons, try these three things: 1)-be brief, 2) -use a reason that's about you, 3) -don't mention disease."

"How did Paul do this?"

If no one can remember provide it. "It is my way of saying I care about myself and I care about you." "I have fantasized all day about you putting one of these on me. Which one would you like?"

"Paul stated he cared about himself and Jessica by being safe, and stated he's been fantasizing about her applying the condom. Remember, TALK is about you and the choices you make in your life. It's not about blaming the other person."

NOTE: *If participants want to know why it's better not to mention disease, say the following:* "If you mention disease, your partner might think you have a disease or that you're accusing them of having a disease. Neither of these is positive."



Go to flip chart #33 "K"

d. Know our alternatives and my bottom line.

"When it comes to safer sex, alternatives include: 1) condoms, 2) intercourse and 3) no sex."

"How did Paul do this?"

If no one can remember provide it. "In treatment I promised myself I would not have sex without a condom. It is my way of saying I care about myself and I care about you. I have several kinds here. I have fantasized all day about you putting one of these on me. Which one would you like?"

"Paul is clear in his bottom line, stated with 'I statements' and did not give much opportunity for protest by having various types ready. He also provided the alternative of using a thinner condom and taking more time to make sure she came. If she continued to insist on no condoms he could have suggested outercourse."

Ask group members to come up with scenarios where they might be tempted to practice unsafe sex. Ask them to generate a corresponding role play. If none are forthcoming, you can use the following roleplay:

Regular partner asking to get drugs to make sex better.

FELICIA: Malcolm, I really like you and I like having sex with you.

MALCOLM: I like you too, and I enjoy having sex with you very much.

FELICIA: I think the sex we had together when we were smoking crack (may substitute primary drug of abuse) was better though.

MALCOLM: The sex was very good sometimes, but our lives were pretty crazy then. I would not want to go back to that lifestyle

FELICIA: I know you like to do it doggy style sometimes or have me suck you off. If you got me a small rock I know I could show you a better time in bed.

MALCOLM: I must admit I would like a little variety in our sex life, but I can't do just one rock and stop. Let's think of other ways to get variety in our sex life without going back to crack.

FELICIA: Honey you do not need to smoke any crack. Just get me some. We can then do it any way you want. Remember how good I can be?

MALCOLM: Although your offer is tempting and I am getting awfully horny, I know I cannot be around crack, or other people smoking crack and not eventually use. I would be willing to consider exploring other ways to improve our sex life. Don't ask me anymore to get crack just to improve our sex lives.

FELICIA: I'm shocked. I didn't believe I'd ever see you turn down hot sex.

MALCOLM: I am committed to not using, even if it means missing out on great sex. You once told me you did not like yourself after some of the things you did sexually while chasing crack. I don't want you to feel bad later about something we do sexually. Let's go to the library or bookstore and look for a book on how to spice up our sex life. We don't need no stupid drugs.

FELICIA: Getting some crack would be a lot easier, but I willing to try things your way.

2. "How did Malcolm use the TALK tools?"

Start with "T" and work down to "K" using flip charts #30, 31, 32, and 33



Go to flip chart #30 "T"

a. Tell them "I hear you."

How did Malcolm do this? *Solicit responses from the group.*

FELICIA: I think the sex we had together when we were smoking crack (may substitute primary drug of abuse) was better though.

MALCOLM: The sex was very good sometimes, but our lives were pretty crazy then. I would not want to go back to that lifestyle



Go to flip chart #31 "A"

b. Assert what I want in a positive way.

How did Malcolm do this?

MALCOLM. "I would not want to go back to that lifestyle."



Go to flip chart #32 "L"

c. List my reasons for staying straight and being sexually safe.

How did Malcolm do this?

MALCOLM. "but I can't do just one rock and stop."



Go to flip chart #33 "K"

d. Know our alternatives and my bottom line.

How did Malcolm do this?

MALCOLM: "I know I cannot be around crack, or other people smoking crack and not eventually use. I would be willing to consider exploring other ways to improve our sex life. Don't ask me anymore to get crack just to improve our sex lives."

C. Come Backs

"Now that you've seen TALK works in the role plays, let's all practice making assertive statements with the TALK tools. I am going to ask each of you to use drugs or have unsafe sex. Your job is to use assertive talk to stay sober and safe. Staying safe doesn't necessarily mean using condoms. You can suggest any of the safe alternatives we've discussed in groups: mutual masturbation, no sex, whatever. But whatever you suggest, do so assertively. Look at the TALK tools on the chart to help you talk assertively."



*Have **flip chart #29 "TALK tools"** showing during this section*

Procedure: Take turns feeding the following lines to each participant. The interaction with each participant should go back and forth a few times in order to give them an opportunity to gain confidence in making assertive statements. For participants who are having difficulty making assertive statements, ask other participants, or the other facilitator to help them out.

Again, when appropriate, point out the use of TALK tools and the elements of TALK.

"COME-ON" statements to be used with each participant: Examples of responses that use TALK tools are provided in [] for the first few "come-ons", but the goal of the exercise is to get the participants to generate responses. There are many "right" answers that use TALK tools besides the ones in []. Encourage group members to help participants that are struggling. Provide examples as a last resort or to help get them back on track. Verbally reinforce responses that use TALK tools.

- 1. COME-ON:** Honey, I love you, and I want to feel all of you. A rubber between us won't let that happen.

[I love you too. You will feel all of me deep inside you. I'll use this thinner condom and this sexy lube. I'll make sure you feel so good that a condom will be the furthest thing from your mind.]

- 2. COME-ON:** Hey baby let's get some coke, and then I'll let you take me anyway you want.

[I know you want to do some coke baby, but if I do any I won't be able to stop. Last time I went on a run I blew our rent money and ended up in jail. How about you show me a good time in bed without coke?]

3. COME-ON: You want to use condoms? You're telling me you don't trust me!

[Wanting to use condoms doesn't mean I don't trust you. I do trust you, but when I got straight I promised myself I'd take better care of myself and you. When I was using I did some pretty crazy things. For now I think condoms are best.]

4. COME-ON: I didn't come the last time we had sex. I think I was too uptight having sex straight. Let's smoke some pot so I can relax.

[I hate it when I can't come. It happened to me when I used to use drugs. Let's come up with some other ways to relax besides smoking pot. How about we take a bath together and then I'll give you a back rub. Anything else I can do to help you relax?]

5. COME-ON: Why use a condom? I'm on the pill.

6. COME-ON: You want a blow job? I'm going to need some rock if you want that.

7. COME-ON: We don't have any condoms. I know we agreed to no unsafe sex, but I'm horny and want you inside me now.

8. COME-ON: You won't have to give another UA for a week. Let's get high, I always get very horny when I get high...

9. COME-ON: You want to use a condom! Are you cheating on me?

10. COME-ON: Fucking straight last time was a drag. Let's get high so I can enjoy sex.

D. Discussion

- 1.** "Were some come-ons easier or harder to manage?"
- 2.** "Did people find it difficult to be assertive?"
- 3.** "Anyone find themselves slipping into aggressive or passive styles?"
- 4.** "Do you feel you could realistically use these tools in risky sex situations?"

III.

Turning Around What They Say

Length: 25 minutes



A. DEFINE SKILL: "Turning around what they say"

"Now we are going to focus an additional way to use TALK for getting your partner to cooperate with not using drugs and being sexually safe without getting into blaming, fighting, or escalating patterns that could lead to a fight. 'Turning around what they say' is one specific use of the TALK skills. It is a way to ask for what you want by turning a negative into a positive. It involves letting your partner know that you hear them, but you change a partner objection to not using or safer sex to something positive. Then you can assert what you want positively with a greater chance of success."

"The key skill in turning around what they say is to identify the other person's objection, communicate that you hear it, and then to turn it around into a positive. A good way to do this is to respond to their objection with a compliment, or an expression of love or trust, as this will soften their resistance and increase the chances that they will hear what you are trying to say. If you do this without blaming or being argumentative, you will increase the chances that your message will be accepted."

B. MODELING: "Turning around what they say"



*Go to the "Turning around what they say" prepared **flip chart (#34)**, and read off the steps involved in the skill.*

"Let's see how this might work in an example. I'd like a volunteer to read these statements with me. After we read each statement, we will try to figure out the female's negative objection, and how the male turned it around into a positive."

A counselor always reads the first statement, and a participant always reads the second statement. After each scenario ask, "What was the person's negative objection?" and "How did he turn the negative into a positive?" Possible answers to these questions are provided on the following page.

SCENARIO 1

FEMALE: If you loved me you'd get me some coke so we could enjoy sex again.

MALE: It's because I love you I want us to learn to have good sex without drugs. It is like learning how to have sex all over again. It takes time, but there's no one I'd rather learn how to do it with than you.

SCENARIO 2

FEMALE: If you want to use condoms, you do not trust me.

MALE: I trust you more than anyone I've ever been with. You're a beautiful, sexy woman. It's because I care so much about our relationship that I want us both to feel safe when we're together.

SCENARIO 3

FEMALE: I'm a lousy lover straight. Let's get some crank and I'll show you how hot I can be.

MALE: I hear that you think you are a lousy lover straight, but I find you much more attractive straight. I think we can spice up our sex life in other ways without going back to drugs. Let's get a book on ways couples improve their sex lives.

SCENARIO 4

FEMALE: Condoms will ruin sex! I hate them!

MALE: Honey, we are so hot there's no way anything will come between us. And I can hardly wait, and I'll last longer with a condom.

SCENARIO 1

What is the female's negative objection? That she wants to use drugs to enjoy sex.

How did he turn the negative into a positive? He explained that it is BECAUSE he loves her that he wants to have sex without drugs. He expressed his interest in her by saying there's no one else he'd rather learn it from than her.

SCENARIO 2

What is the female's negative objection? She doesn't want him to use condoms because condom use means he doesn't trust her.

How did he turn a negative into a positive? He reassured his trust in her and complimented her attractiveness. He explained that it is BECAUSE he cares that he wants to use condoms.

SCENARIO 3

What is the female's negative objection? She thinks that they need drugs during their sex in order for it to be "hot."

How did he turn a negative into a positive? He explained that he finds her MORE attractive straight, rather than less attractive. He generates some ideas, which communicates his interest in pleasing her.

SCENARIO 4

What is the female's negative objection? She believes that using condoms will ruin their sex

How did he turn a negative into a positive? He complimented her by telling her that she was hot so nothing could ruin their sex. He also showed her that he was interested in her satisfaction by saying that he'd last longer.

C. REVIEW SKILL COMPONENTS



Go to **flip chart #34** to review the skill components again.

1. Find something positive in what your partner is saying, and turn their negative objection into a positive thing. If you cannot think of a way to turn around your partner's specific statement, at the very least say something complimentary. Providing compliments helps make the listener more receptive to what you are trying to say.
2. Never blame the other person. Try to blame the environment or someone else, but not your partner.
3. Once things are more positive, continue the conversation using the other TALK tools. Continue to use assertive communication.

D. PRACTICE WITH COACHING AND FEEDBACK

Facilitator asks participants to form two small groups. Each facilitator takes one of the groups. Participants are given the six scenarios below. Two volunteers should participate to come up with an objection and a response in each scenario. The listening group members can then help generate other possible responses. Switch volunteers for each scenario. The goal is to use TALK skills and Turning Around What They Say to negotiate safer sex, clean sex, abstinence, or whatever the scenario calls for. As the facilitator, reinforce group participation and help them generate responses if they are stuck.

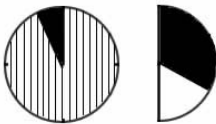
"Now we're going to break up into two groups (*or stay in one group depending on the size of the group*) and practice using TALK skills and Turning Around What They Say. I'll give you a scenario. I'd like two volunteers to role play the conversation that might occur in this scenario. Use the skills you've learned."

1. Someone who you have sex with every now and then but who you haven't seen in a while comes back into your life. You started using condoms after the last time you had sex with them. You have to bring up the subject of using condoms.

2. You've been clean for a few months and you run into a woman you used to have sex with when you were using. She says she wants to have sex with you now, and you're interested, but you know that they'll be drugs involved. You need to decide what you're willing to do and assert it without offending her.
3. You're out with your friends at your favorite club. A person you have sex with off and on wants to have sex right away. You sometimes use condoms with them (when one of you has them) but neither of you has one. She/he wants to have sex immediately.
4. You and your partner get ready to have sex, you're feeling really close and you both realize you don't have any condoms at home. Your partner says, "Oh just this once, let's not use a condom."
5. You've been dating this person for 6 months. You always use condoms. But now your partner brings up the idea of not using them. You want to continue using condoms. You have to refuse unsafe sex.

IV. Workshop Summary

Length: 25 minutes



Close the workshop with a summary of the key topics learned. Do this in a question and answer format to get them to say what they've learned. Make sure to provide reinforcement for their participation, even if their answer is incorrect. If time is running short, do not show all the flip charts as listed below – simply keep it in a discussion format.

"During the past 2 ½ weeks we have covered a lot of material during these groups. We want to take the next few minutes reviewing the most important take home messages"

A. Transmission of HIV and STDs

"In which Body fluids is HIV present?"

Provide any answers not given (blood, semen, vaginal fluids, breast milk).



"What behaviors are associated with transmission by blood?"

*Review **flip chart 8** for any answers not given.*



"What behaviors are associated with transmission by semen or vaginal fluids?"

*Review **flip chart 9** for any answers not given.*



*Review **flip chart 14** to remind them of the safe sex hierarchy.*



B. Condom Use

Take out penis model and one condom.

"Walk me through how to correctly put this condom on, step by step."

*Review **flip chart 11**; remind them of any steps left out.*

Take out vaginal model and one female condom

"Walk me through how to correctly insert this condom, step by step."

*Review **flip chart 12**; remind them of any steps left out.*

"Many men have objections to using condoms. What do you remember about what people can do to overcome these objections?"

*Review **flip chart 17**. Ask if any one has done any of these things listed on flip chart 17.*

C. Identifying Triggers

"We identified triggers for engaging in unsafe sex. What were some of the triggers that came up?"

"Has anyone been faced with one of these triggers in the past 3 weeks?" If so how did you handle it? If not what do you plan to do if faced with the trigger?

D. Enhancing Sex without Drugs

"We talked about how drugs can make it easier to obtain a sexual partner and how drugs can make the sexual experience better."



"What are some things you can do to obtain a sexual partner without using drugs or visiting prostitutes?"

*Review **flip chart 25** for ideas not given.*



"What are some things you can do to improve your sexual experience without using drugs?"

*Review **flip chart 26** for ideas not given.*

E. Communicating about being sexually safe



"TALK Tools are a way to communicate assertively about being sexually safe. What does TALK stand for?"

*Review **flip chart 29** to confirm or correct responses.*

F. Self Assessment

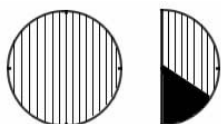
"What did people learn in this group that was new?"

"Has anyone changed their own sense of their risk as a result of being in the group?" If so, how?

"What changes do people see themselves making in the future with regard to their sexual behavior?"

V. Workshop Closure

Length: 10 minutes



A. Wrap up

Here are some ideas for closing comments:

"Learning to make our relationships healthier and safer is important for our well-being and for our recovery. We've spent the last few weeks talking about ideas and skills that we can use to make our wishes of happiness a reality."

"It is important to be able to make a realistic evaluation of our personal risk of contracting AIDS or other STDs. This evaluation includes both past and future behaviors."

"Even when a person is committed to a healthy sexual lifestyle it can be difficult to convince potential partner to be sexually safe. Hopefully some of the skills taught in this workshop will assist you in efforts to be sexually safe."

"Sometimes it seems safer, easier, and more comfortable to just continue with old attitudes and ways of doing things. Change is always a little bit scary and difficult. Change requires courage. And you guys are some of the most courageous I've met. The fact that you're here today, and that you've been coming to this workshop tells me you're all going to make it happen, and make it work - not just in your relationships, but in your recoveries as well."

"Remember that practice is the key. It's very easy to drift back into old patterns and habits. One way to overcome this is to review the materials from this class from time to time, and to encourage your partner to be open to reviewing materials and making changes when needed. As with all things related to living a good life - strive for progress, not perfection."

B. Thank participants for their involvement

C. Graduation

Distribute graduation certificates or some other form of recognition.

Session 5

Flip charts & Session Materials/Handouts

Assertive TALK Tools

- T Tell my partner “I hear you”.
- A Assert what I want in a positive way.
- L List my reasons for wanting to be safe.
- K Know our alternatives and my bottom line.

I Steps:

Tell my partner “I hear you”

- Acknowledge what your partner is saying.
- Use an “I” statement.
- Show understanding of your partner’s thoughts or feelings.

A Steps:

Assert what I want in a
positive way

- State what you want.
- Be positive.
- Use an “I” statement.

L Steps:

List my reasons for being
safe

- Be brief.
- Use a reason that is about you.
- Do not mention disease.

K Steps:

Know alternatives and
bottom line

- Condoms
- Outercourse
- No sex

Turning Around What They Say

- Identify the negative objection and tell them you “hear it.”
- Identify a positive aspect to the objection, or say something complementary.
- “Turn” the negative into a positive.
- Never blame the other person.
- Proceed with assertive communication

Sample Certificate of Completion
See accompanying Word file for editable version

Certificate of Completion

Name

has successfully completed sessions of the

REAL MEN ARE SAFE GROUP

Date

Name of the Treatment Program

Counselor Name
Group Facilitator



Counselor Name
Group Facilitator

References & Appendix

References

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Appendix

Creating Flip Charts

For the REMAS clinical trial the flip charts were created by enlarging the flip chart images found at the end of each session section in this manual to 2' by 3' so as to fit on a standard newsprint easel. This was done by having a copy center (FedEx/Kinko's in this case) enlarge PowerPoint images from a file provided to them. In the REMAS trial the flip charts were held together with three metal rings at the top of the charts and final chart was attached to a stiff backing to stabilize the flip charts on the easel.

Slideshow Alternative to Flip Charts

Some providers may prefer to show the flip chart material as an ongoing slideshow running during the REMAS workshop. To do this one needs to have the appropriate computer and projector equipment available. This strategy has several advantages: 1) the flip chart materials do not wear out and need to be replaced, 2) for sessions where there is a going back and forth between flip charts the slideshow can do this more easily by the use of duplicate slides placed in the proper sequence, 3) for exercises in which you want the participants to fill in boxes on the flip chart this can be done easily by having information of interest inserted with an additional click rather than being presented all at once. On the CTN Dissemination Library website are two sets of PowerPoint slideshows: <http://ctndisseminationlibrary.org/display/397.htm>. The "print" set has one copy of each chart in numerical order, suitable for printing. The "session" version features the flip charts in the order they are referred to in the manual themselves, suitable for use in actual sessions.

Handouts

Handouts were prepared by simply copying those materials as they appear at the end of each section, except for the risk behavior cards from Session 1. For these cards the images were copied onto 8 1/2 x11 paper that was the weight and thickness of index cards. Cards were then cut so as to have two sets for each group participant. Each set of cards was copied onto a different color of paper so that after the group completed card sets could be easily reassembled.

Materials

Condoms, lubricants, penile models and female pelvic models used in the condom demonstration and practice sessions were purchased from the Total Access Group (<http://totalaccessgroup.com>). Total Access Group provides low cost safe sex supplies and educational materials to public and non-profit agencies.